Trait Emotional Intelligence: A Strategy for Managing Nurses' Affective Wellbeing at Work

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DECLARATION

I, Chrysi Leliopoulou, declare that this research contained in this thesis is entirely my own work.

Signed: 

The views expressed in this Thesis are those of the author and not of the University.

ABSTRACT

Background: Contemporary nursing is ambitious but also challenging. The nursing profession has been changing faster than ever before and nurses are faced with new challenges they need to handle carefully if nursing as a profession is to be reformed. Nurses are called up to undertake complex and challenging roles in health care which they found significantly demanding and demoralising in the current shortage of nursing staff across the NHS. Nurses increasingly report leaving the profession because of ill health, anxiety and stress at work. **Aims:** To explore nurses' perceptions of their wellbeing and discuss related issues such as their work environment, their jobs and their roles in the team, and to inform and shape the development of an intervention to help nurses develop further their trait emotional intelligence. This thesis argues that trait emotional intelligence is sensitive to training and can be developed in short 'bite size' chunks to allow nurses to benefit from the training and grow their trait emotional intelligence attitudes and behaviours to protect nurses' affective wellbeing at work and home, but also keep stress at bay. **Design:** This is a mixed sequential exploratory research study and consisted of phase 1 (exploratory study) and Phase II (quasi-experimental study). **Findings:** This thesis found that trait emotional intelligence is connected to positive perceived affective wellbeing and other health outcomes. A transitional model for nurses' affective wellbeing was supported in phase II of this thesis. Nurses reported experiencing emotional and role dissonance in their job which were reflected in their negative self-talk reported in the discussion groups analysed in phase I of this thesis. Nurses identified several negative emotions and feelings associated with their current work environment, as they described their jobs and roles as heavy emotional work. Interestingly, nurses reported struggling to navigate relationships and feeling isolated and disillusioned in their jobs. This thesis incorporated phase I, an exploratory study (the qualitative component), and Phase II, a quasi-experimental study (the quantitative component).

In total, 84 nurses participated in Phase II of this research. They were allocated into an intervention (n=35) and a control group (n=48). There were two data collection points at T_1 (baseline measures) and at T_2 (six to eight weeks after the intervention) and the interpersonal awareness training included an action plan

with clear, self-identified goals based on coaching conversations. Neuroticism was found to be moderated significantly post training which in effect mediated feelings of anxiety and depression and self-perceived affective wellbeing at work were reduced significantly in the intervention group. **Discussion:** This interpersonal awareness training was designed as a short developmental strategy for improving nurses' perceived affective wellbeing. The mode of delivery of this training aimed at strengthening nurses' emotional agility in a pace that was also acceptable to the needs of the nurse at any time in their career. This training may also benefit student nurses and other healthcare professionals, such as midwives and midwifery students, who share similar job characteristics and are under similar demands and pressures to those of nurses.

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Chapter 1. Background to the research

Over the past decades, many workforce changes took place in the NHS and the wider society, but in particular there were many significant organisational restructures of services and reforms that changed the way nurses work. The role of the nurses was redesigned to support the new provision of services and meet the needs and demands of today's society. Hence, nurses were bound to develop and extend on certain skills and responsibilities and expanded their scope of practice. Historically, the nursing profession drew on a tradition of caring and human values. In recent times however, nurses' roles also consist of a number of higher level technical skills and specialist competencies, which nurses need to take up in order to undertake their extended roles, such as clinical nurse specialists, nurse practitioners and advanced nurse practitioners (NHS Employers, 2014; BBC, 2012). The graduate nurse training initiative and the "Agenda for Change and Knowledge and Skills Framework" paper aimed to enable nurses have a better career structure and a pathway to modernise the profession (NHS 2005), which also hoped to help recruit and retain more nurses to the job. Although, nurses leave their jobs for different reasons, mainly personal, this issue remains high on the agenda for NHS managers, nurse tutors and the government, as shortage of nurses can threaten public health initiatives, and health and social care outcomes (NHS Digital, 2018; Hayward et al. 2016).

An increase in the use of technology in healthcare meant that nurses, as frontline staff, needed to update quickly to meet the continuous demands of society and to modernise healthcare delivery (such as online appointment booking system and online consultation). These changes also meant that changes in the role of the nurse were inevitable and the old training wasn't matching up to the needs of the new nursing roles. The new NMC (2018b) standards for pre-registration nurse education indicate that higher education institutes (universities) need to educate nurses to a more advanced level, with a wider range of clinical and technical skills.

The introduction of these new standards for education and training for student nurses (NMC, 2018a) coincided with changes in the NHS bursary system for nurses and midwives, who were no longer entitled to it, but instead student nurses were required to pay tuition fees of £9,250 per year, same as other university students. However, the nursing associates were funded by the NHS, as long as the student nurse associates committed to take a job with the trust funding their course. The King's Fund (2018) highlighted the possible impact of these arrangements in the breakdown of students across the different age bands, in particular in the 35 and above age range. Later on, the NMC register report (2019) confirmed this earlier prediction by the King's Fund, as the NMC reported that forty-nine percent (49%) of the register currently were between 31-50 years old, while nurses over 51 years old were on the rise and 35 percent of nurses registered with the NMC over the last five years were over the age of 51. Interestingly, nurses under the age of 30 who joined the register, fell to 67 percent for the first time in recent records (NMC 2019).

1.1 The extent of the problem

Historically, the nursing profession has attracted young females, but today many individuals join the nursing profession in their late 30s and even later in life (NMC, 2019). As a result newly registered nurses come in with a wealth of life and work experience, which may have an impact on their expectations and perceived ideas of what nursing work is or should be about. Newly registered nurses understand that the nursing job is stressful and demanding, but they only relate to the job when they are in training or in the job. Nurses are expected to work shifts and deal with difficult and at times, challenging situations. Nurses working in hospitals and in the community are increasingly caring for patients with more complex physical and emotional needs, while staffing levels remain low and resources are stretched to breaking point. Recruitment and retention of nurses has been a long standing issue for the profession, however, retention of nurses has become more challenging and complex in recent times, because of workforce needs (NMC, 2019). In a recent report from the NMC, twenty percent of nurses who had already left their jobs, reported to be dissatisfied with their job and disillusioned while one third of those nurses who quitted nursing, also reported

work pressures, stress and poor mental health as the main reasons for leaving the job. Other evidence also supports this view that nurses suffer from mental health illnesses more than ever before ((Tajvar et al. 2015).

This report by the NMC might have been prompted by an increase in the suicide rate among nurses, reported by the office for national statistics (2017). It appears that nurses' wellbeing may be a key factor in their decision to quit nursing, which in turn may contribute to increased and unmanageable workloads, but also feeds into the vicious circle of low staffing levels and permanent shortage of staff. In this climate, nurses are bound to feel stressed and anxious about their work lives and their workload, but also the standard of care delivered to their patients. The overall aim of this research is to find a way to enable nurses to maintain their wellbeing at work before they become too overwhelmed and stressed. As nurses are reported to be reluctant to accept that they are stressed and anxious at work, possibly because they may feel as health professionals they ought to cope with their stresses and anxieties, they may not seek help early (Van den Berg et al. 2010) because they may feel ashamed to accept that they experience feelings of hopelessness and depression (Pompili et al. 2006).

Furthermore, restructures in the NHS in 2007 to 2009 due to the economic recession, have meant that many nurses were made redundant, as services were reconfigured and restructured. Some nurses had to train up to cover different roles in their jobs, which in years to come created a vacuum for new roles and tiers within the profession, such as the nursing associate, the nurse practitioner and advanced nurse practitioner (NMC 2019). Currently, there are many higher education institutions which provide programmes and training for these roles (Health Education England 2017) with the intention to support the role of the nurse and create ways to reconcile potentially conflicting aspects of the nursing job, as well as to enable the nursing workforce to progress and modernise in order to meet the service demands. Therefore, there is an urgent need for nurse educators and clinical leaders to support staff in order to avoid further shortages and also improve nurses' wellbeing and work experiences, in order to avoid anxiety and depression, which may lead to ill health.

In recent years, nurses complained of heavy workloads, unsafe practices due to low staff levels and skill mix, but also lack of support from other nurses and nurse managers. Registered nurses today are required to delegate and supervise

a larger number of junior staff, such as health care workers, nursing associates and nursing practitioners, as well as lead and manage complex health care needs for their patients. These new responsibilities may put extra demands on nurses, causing further physical and mental strain (Robson 2002). There is evidence that when nurses are exposed to those chronic demands for longer, they are found to report mental health problems earlier than the general population (Demerouti et al. 2001).

Statistically, the average nurse is exposed to negative experiences more than the average employee, therefore nurses may experience mental health problems more often than expected, because they are exposed to these experiences more often and for longer periods (Lambrou et al. 2015). In addition, Arora et al. (2013) and Jeurissen and Nyklíček, (2001) argued that nurses who scored high on neuroticism reported to experience lower wellbeing than nurses who scored low on neuroticism. They also argued that nurses who continuously experience difficult and stressful situations at work, may develop higher levels of anxiety and stress, than those nurses who are not exposed to such events. For example, if a nurse works in an area with permanent staff shortage, this work environment may lead the nurse to think that this is “normal work conditions” and feel expected to cope and deliver high standard care. This may lead the nurse to feel confused and overwhelmed.

The staffing levels in the NHS are currently at their lowest ever (Buchan and Seccombe, 2013), as there is currently a huge number of vacancies across the UK, which doubled in the last three years in England (RCN, 2020). Wider economic and political issues may have contributed to these figures, such as the UK decision to leave the European Union (Brexit), lack of interest from young people in nursing (RCN 2019) and the pay cap and higher cost of living in the capital and other major cities in the UK (RCN 2017). These factors may have also contributed to further loss of staff. Furthermore, nurses have also found themselves working in ambiguous and conflicting roles, which are poorly paid, having to work long hours and unpaid overtime, with an increasingly large workload (RCN 2020). These work environment factors can fracture a nurse’s sense of their work value and their work life, as they may feel undervalued and demoralised. These feelings may reduce significantly nurses’ job and life satisfaction, but also impact on their mental health and wellbeing.

1.2 Overview of the Rationale for the Research

Arguably, a staff-friendly work environment and supportive colleagues can be critical to a nurse's mental health (Nuikka et al. 2000), as nurses find themselves working in teams, having to manage a large workload and being dependent on other professionals' decisions, to enable them to proceed with their work. Nurses in their new roles hope to have more control over their workload, but this also means that they will have to assume bigger responsibilities without necessarily being rewarded for this extra work in pay. Nurses are also leading on government initiatives and manage a large portion of the healthcare delivery to patients, but with the current levels of staffing this won't be sustainable for the longer future. There is a large body of existing literature that examines burnout among the nursing workforce. By contrast, the focus in this thesis is on wellbeing and how this can be maintained and improved. Nurses are already reported in the nursing literature to be emotionally exhausted and burnt out, but this research aims to find out nurses' perceptions of their work environment, discover the most influential factors on nurses' affective wellbeing and also to identify nurses' support systems at work.

Predominately, nurses' work environment is a stressful one for the reasons discussed in this chapter and research has indicated that there are certain work characteristics in nurses' work environment that nurses cannot control or have little influence over, such as staffing levels, bed management, sudden death, physical or verbal assault and so on. These work environment characteristics are often interwoven with the job characteristics of a nurse, therefore this thesis argues that there is a need to find a way to raise a nurse's self-awareness and awareness of those work environment characteristics that interfere with the job, with the hope that this awareness may enable nurses to understand better their work experiences and help them cope better, but also protect their mental health and wellbeing. Nurses are exposed to traumatic events and experiences from early on in their careers, and even as student nurses would have dealt with some distressing and very unpleasant situations at work and they may felt at times particularly vulnerable both physically and emotionally (Leineweber et al. 2014; Laposa and Alden 2003). Research has found that nurses often suffer from

feelings of irritability and fruitlessness during their careers and many experience difficulties with sleeping and a sense of detachment from others (Pompili et al. 2006). Nurses' continuous efforts to achieve and perform in a demanding work environment, with little support or control, can be physically and emotionally draining. These experiences may get worse for nurses when their work is not appreciated or valued as much as other health care professionals' contribution in delivering high standard nursing care (SCIE Social Care Online 2017; Good Government Institute 2015). The nurses' contribution is overlooked or worse criticised, both by their managers and the public or the Government, leaving them feeling unworthy and invisible to the public (Nursing Times, 2019). Nurses, unlike other professionals, are far more severely criticised when things don't work as expected or in high incident reports, where they are exposed to the media criticism far more that other health care professionals, which in turn may push nurses to become disillusioned with care (The King's Fund, 2013; Podaskoff et al. 2007).

Phase one of this research is a qualitative interpretative phenomenological study which asks the question: what is it like to be working as a nurse in the NHS? The work environment has previously been discussed in many stress theories and models, hence in Chapter two there is a discussion on such stress theories and models, which may explain certain environmental contributions towards nurses' affective wellbeing at work. The nursing workforce has its own characteristics and professional culture, which adds perhaps a different dynamic to the concept of work environment and what that entails for a nurse. Chapter two critically analyses and discusses theories and models of occupational stress and affective wellbeing at work, with the aim of enabling the reader to understand the argument behind the role of occupational stressors and work characteristics, how these may be translated into nursing related stressors and nurses' work related characteristics and how these may interplay in nurses' affective wellbeing at work, which is currently at risk. This research is looking at preventing stress and promoting wellbeing at work, hence it is important that we understand the various models and theories explaining stress in order to argue how stress in nurses can be prevented. There is further analysis on the pros and cons of each theory and model and an argument for proposing a model for nurses' affective wellbeing at work.

The next chapter focuses on the theories and models of stress and wellbeing to help understand this phenomenon, how these two concepts are interconnected

with each other and why this connection is important to be understood, in order to enable nurses becoming stress resistant and enjoy affective wellbeing at work. Nursing is about a positive relationship with a fellow human being and this relationship begins from one's inner calmness and happiness, hence it is an important step in any relationship.

PHASE I – LITERATURE REVIEW

Phase one involves the qualitative component of this explorative sequential mixed method study. This study is an interpretative phenomenological study that aims to explore nurses' perceptions of their wellbeing and discuss related issues, such as their work environment, their jobs and their roles in the team. The results from this study aim to help design phase two of this research, which involves the quantitative component of the research, as well as enable the conceptualisation and development of the intervention offered to a group of nurses in the quasi-experimental study. The results from phase one are also pivotal in deciding on the measures used in the quantitative component of this research.

Chapter 2. Theoretical underpinnings to this research

This chapter discusses the theories and models of occupational stress and work-related wellbeing, to enable the operationalisation of the concept of nurses' affective wellbeing at work. It discusses critically the role of occupational stressors, environmental characteristics, individual differences and personal resources in relation to nurses' affective wellbeing at work. This chapter aims to expand our current knowledge of nurses' affective wellbeing at work. In order to assume such a discussion, there is a need to examine the models and theories of occupational stress in general and how the concept of stress relates to wellbeing and vice versa.

The general literature on stress and wellbeing found that there are three distinct, yet overlapping, approaches to the definition and study of stress (Dewe et al. 2012; Cox and Ferguson, 1991). These are the stimulus-based (engineering), the response-based (physiological) and the transactional (psychological) approach. The three sub-sections below in this chapter discuss these three dominant approaches to stress and wellbeing.

2.1 Stimulus-based and response-based models of stress

Selye's relatively simple stimulus-response (S-R) physiological approach to stress and the General Adaptation Syndrome model (GAS) aim to maintain physiological homeostasis through adaptation to adverse (stressful) environmental stimuli (Selye 1956). Nonetheless, both tend to ignore individual differences and assume that sources of stress have the same effect upon different individuals (Cox and Ferguson 1991; Brough 1997). The S-R concepts of stress and the GAS model do not explain the important differences in patterns of interactions between persons and their various environments.

Response-based definitions of stress focus on the physiological outcomes of the stressful situation and there is a focus only on the physiological responses to stress, for example anxiety, high blood pressure or headaches, without consideration of the psychological effects of the stress process on the person, such as levels of anxiety among different people as they may appraise stressors differently from each other.

The stimulus-based approach views stress as a stimulus or a characteristic of the environment in the form of a demand (for example, high workload), which may

exert pressure (strain) on an individual (Cox et al. 2000). This approach suggests that adverse stimuli produce symptoms of stress within the otherwise passive individual and exert pressure on an individual, thus producing strain in the way that an amount of external force can cause an iron bar to bend (Wilson 2000). Thus the stress experienced by an individual is measured via external environmental stimuli. The result of such symptoms can have an adverse effect upon an individual's wellbeing (Cox et al. 2000; Cox 1993). In this approach to stress, the individual is viewed as a passive recipient of stress (Cox et al. 2000; Cox and McKay 1981), while stress is the stimulus in the person's environment and the response to the stimuli is the stress experience, for example fatigue (Selye 1976).

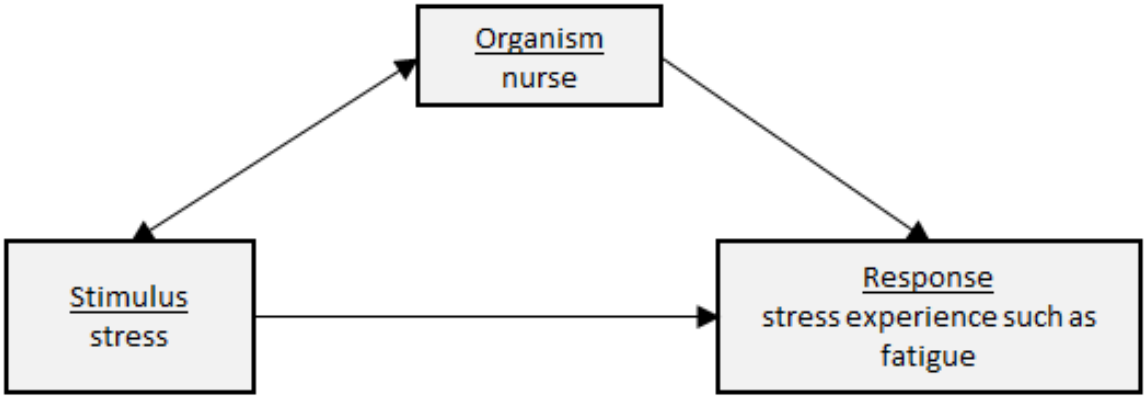


Figure 1 Stimulus-based approach to stress (Cox and McKay, 1981)

According to this approach, when a person encounters a "stressor" or "environmental demand", the person's physiological response goes through three phases: the alarm stage, the resistance stage and finally the stage of exhaustion. In this last stage, some irreversible damage may occur to the person if the stimulation (stress) does not cease, which may eventually lead to death. This is known as the response-based or physiological approach.

The main criticism for both the stimulus-based and the response-based approaches, is that they cannot explain fully the stress process and the stress experience. The main argument for this is that both approaches ignore individual differences that may act as moderators or mediators in the stress process (Lazarus and Folkman 1984a). The stress process may be understood better with models that account for the role of mediating or moderating variables, such as individual differences, as they may explain individual response to stress more adequately.

Both the stimulus and response-based models reside within a basic stimulus-response paradigm and they treat the individual as a passive vehicle in the stress process as shown in Figure 2.

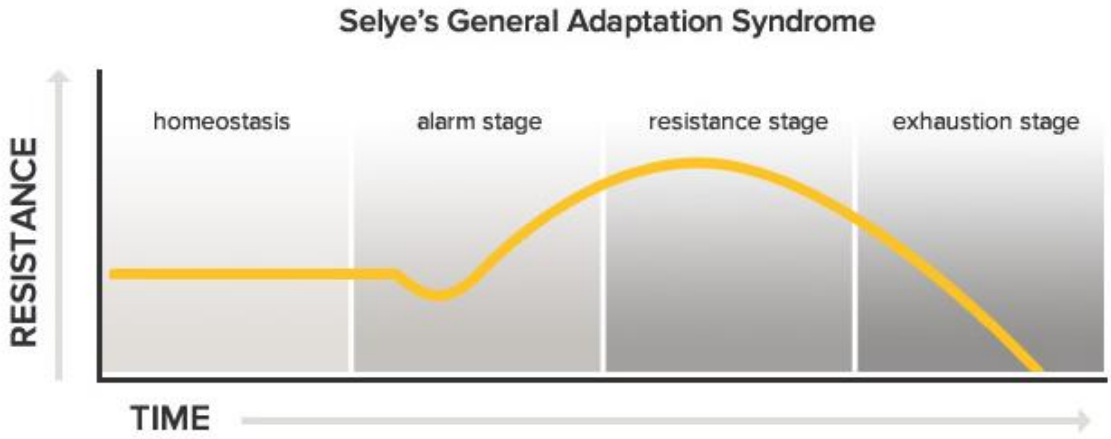


Figure 2 General Adaptation Syndrome (Selye, 1976)

2.2 Transactional models of stress

The transactional approach focuses on the employee's perceptions and cognitive processes involved in the stress experience. The transactional models incorporate both interactional and transactional models. The interactional models focus on an individual's interaction with their environment (Person-Environment Fit or P-E Fit) and they argue that this interaction may determine the behaviour and health of the individual (Lewin 1938, 1951). In this paradigm it is argued that the more a person matches their environment, the better is their overall wellbeing (Karasek 1979; McGrath, 1976; French, Rogers and Cobb 1974; French, 973). This theory links stress and wellbeing in one continuum and argues about their interdependency. There are two distinct versions of the person-environment (P-E) fit model. One concentrates on the importance of the match between the person's needs, motives, goals and values and the resources available to them such as skills and abilities, and this P-E fit model is known as the "needs-supplies fit model". The transactional models focus on the degree of match between the demands placed on people and their abilities to meet those demands. This version

of the P-E fit model is known as the “demands-ability fit model”, which may cause moderate to severe psychological strain affecting a person’s overall wellbeing.

French et al. (1982) argued that the P-E fit approach can be described both objectively and subjectively, and that a subjective P-E misfit can cause negative psychological, physiological and behavioural strains on the employee. This research by French et al. (1982) pinpointed the possible link between subjectivity and job-related affective wellbeing, and also how emotionality and misfit, whether subjective or objective, between the person and the environment can cause problems for the individual (Sonnentag and Frese, 2003). Increasing demands and pressures may translate into strains such as low levels of satisfaction, resulting in high levels of anxiety and depression (Sonnentag and Frese, 2003; French et al. 1982). For example, denial, reappraisal of needs and coping are behaviours that individuals may adopt in their effort to reduce subjective misfit (Buunk and Hoorens, 1992) because any mismatch can create a strain and therefore, reduce the person’s sense of wellbeing as shown in Figure 3 below.

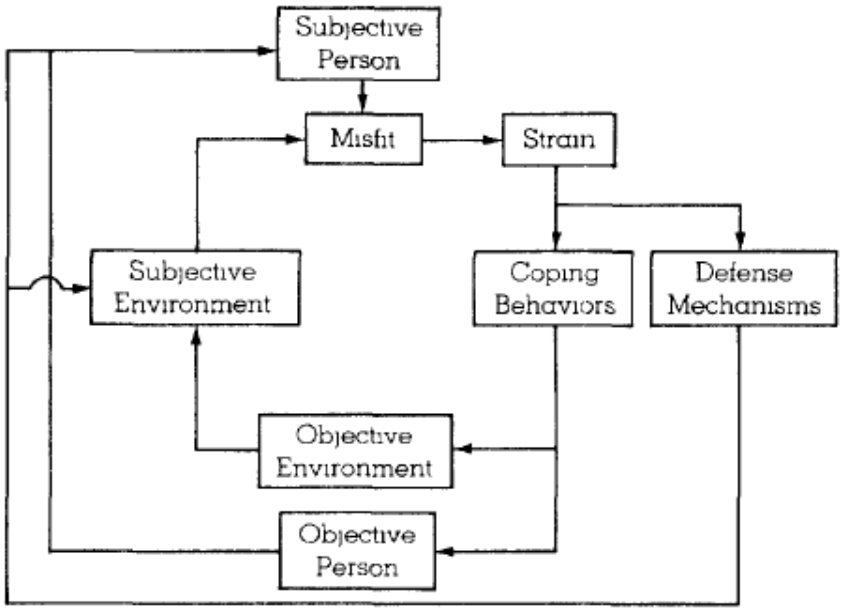


Figure 3 Schematic representation of the ‘demands-ability fit model’ from French, Caplan and Harrison (1982) adapted from Edwards (1992)

This is an interesting perspective on the role of subjectivity and perception in the stress experience that explains why the subjective misfit is an important

dimension to stress and wellbeing. It argues that the more important the stimuli to the person, the more the person takes notice of any mismatch between the demands-ability and needs-supply aspect of their environment (Wallace et al. 2009; Edwards 1998).This principle of the transactional models which claim that individual appraisal and perception of their job demands and stressors can be either a positive or a negative experience, is pivotal in the idea that reactions to stressors depend on the individual's personality, characteristics and traits, for example, extraversion and agreeableness found to relate to the nature of the stressor and eustress (Saksvik and Gustafsson, 2004; Penley and Tomaka, 2002), but also to the frequency with which the individual is exposed to it.

Another transactional model is the Cybernetic Theory of Stress, Coping and Wellbeing by Edwards (1992), which states that stress is the discrepancy between the individual's perceptions and desires. This theory also argues that stress occurs when this discrepancy is considered important by the individual. Thus, this discrepancy between individual desires and perceived state, appears to trigger coping, which then determines the level of stress experienced by the individual (Edwards, 1992). In this context, coping behaviours are described as "efforts to prevent or reduce the negative effects of stress on wellbeing", such as hobbies. For example, the use of exercise may help the individual cope with a stressful job. These efforts are also known as predictors of coping efficacy.

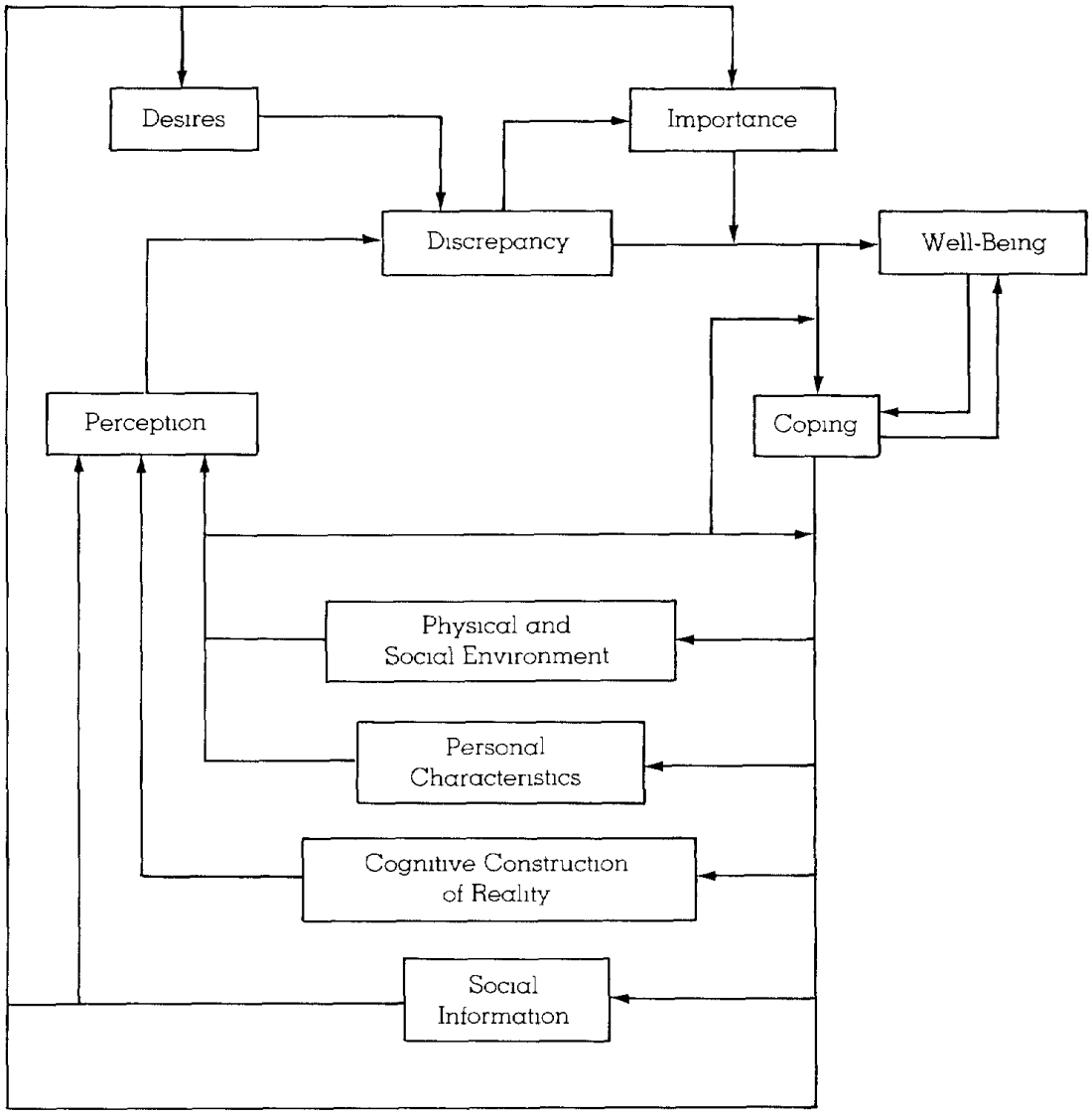


Figure 4 Schematic representation of the 'Cybernetic theory of stress, coping and wellbeing' from Edwards (1992)

Interestingly, perceptions in this theory are defined as the "non-evaluative subjective representation of any situation, condition or event", and the appraisal processes are considered to activate coping which may influence the determinants of stress (Edwards, 1988) and the negative feedback loop at its core. This is thought to act in a way to minimise discrepancies. However, it is not realistic to assume that individuals engage in non-evaluative perceptions of their environment, as these may be influenced by various individual factors.

To sum it all up Lazarus (1966) described the transactional model of stress and coping as a four-fold model that is consisted of four key components which interact with each other in this process: the stressor or stressful event; the

environment; the person; and the outcome, which can be either psychological or physiological stress, or both. Conversely, this model recognises the adaptive processes (personal resources, support, cognitions, values and external stimuli) involved in the process of stress and coping and how the individual interacts with the stressor in order to mediate the stress process.

Lazarus (1990, 1999) also explains in his model how stress is experienced as a “discrete emotion” in the person that resides in the environment, and analyses the stress process as a transactional process between the individual’s cognitive processes and the environment (Dewe et al. 2010). Lazarus and Folkman (1984b) focused on the “perceived” stressors that arise from the individual’s interpretation of stressors which on the first encounter the person quickly appraises the situation as threatening or not to their wellbeing (known as primary appraisal) and then the person moves into the second stage of this evaluative process (Lazarus, 2001) known as secondary appraisal. These appraisal processes bridge what a person experiences and how this person feels in a particular encounter with the stressor, therefore each encounter should be treated as a single emotional experience. The primal appraisal indicates the first stage of an individual’s interpretation of a situation as a threat, harm or challenge. If the threat is perceived as real, then the person moves on to a “second appraisal” of the situation and weighs up his ability and resources to manage the threat, harm or challenge from the stressor. These appraisal processes initiate coping and of course they always involve evaluation of the coping resources and options available to the person to deal with the stressor, as described in Figure 5.

Lazarus (2001) and Lazarus and Lazarus (1996) discuss coping as problem-focused when the individual employs a flexible and adaptable approach and works towards resolving the problem or situation that is causing upset and distress to the individual. But they also describe coping as emotion-focused, which refers to ways of avoiding the emotional distress caused by stressors, either objective or perceived. Individuals who adopt the emotion-focused coping behaviour tend to distract themselves from the negative feelings associated with the stressor by employing maladaptive behaviours such as aggression, alcohol abuse and absenteeism. Therefore, the success of each coping approach is determined by the level of stress experienced by the person.

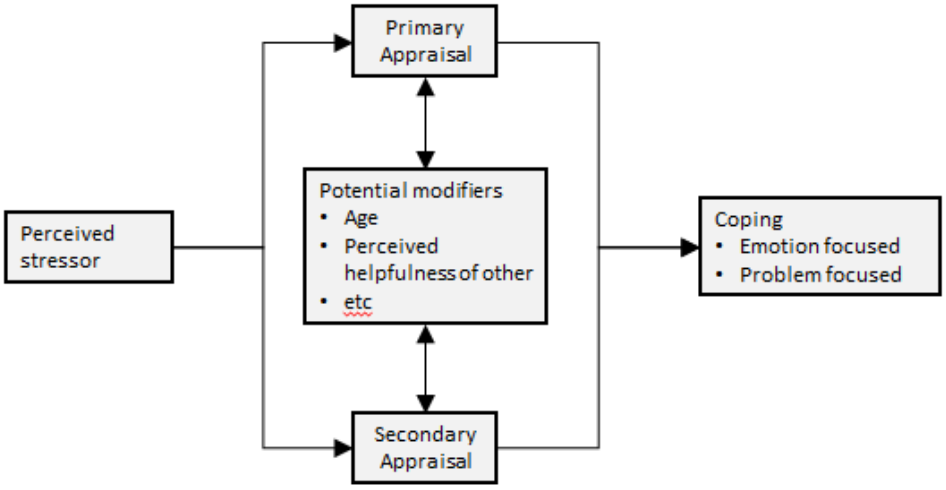


Figure 5 Transactional Model of Stress and Coping from Lazarus and Folkman (1984a)

This process may involve an evaluation of the personal resources and options available to the person to deal with the stressful event. The more the person is likely to engage in coping responses, the more resources this person is likely to have at his disposal. The transactional models of stress and coping recognise the pivotal role of individual characteristics in the interaction of the individual with their environment and the psychological effects of stress. However, transactional models of stress do not fully appreciate the physiological effects of stress on the person (McKay et al. 1978).

Lazarus's cognitive-motivational-relational theory of coping (1966) is an extension of his previous model but this theory regards coping as a process and what the person actually "thinks and does in a stressful encounter". It argues that coping is also "context dependent" and influenced by the particular encounter or appraisal that initiates it and by the resources available to the person to manage the encounter, as shown in Figure 6. More often, an individual employs both problem-focused and emotion-focused coping strategies to inform the appraisal process but also feedback into this process, so they are not non-evaluative perceptions.

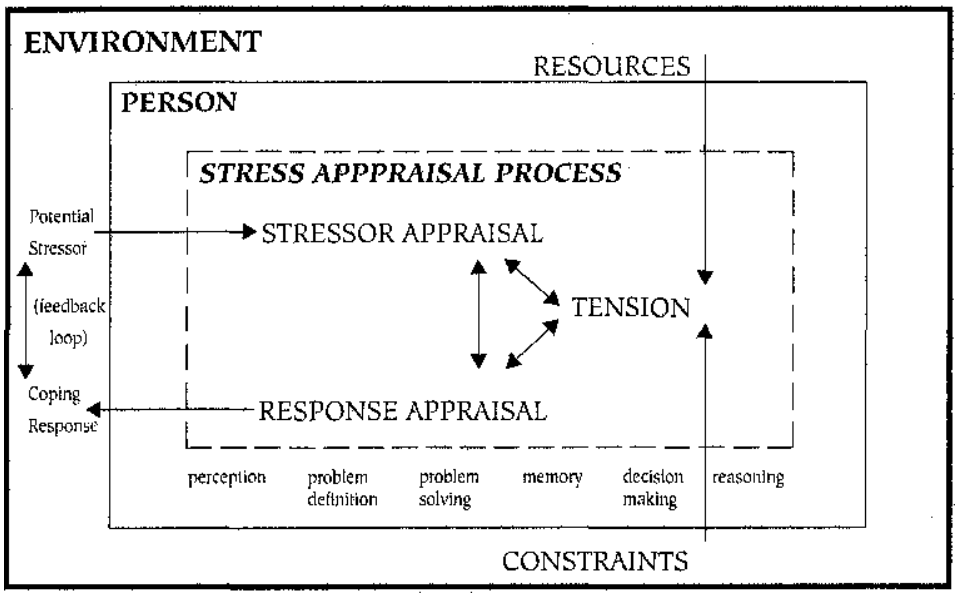


Figure 6 Lazarus's cognitive-motivational-relational theory of coping (1966)

On this note, it is important to argue that individual appraisals can be influenced by a number of factors such as, beliefs about control, goal commitment and the novelty of the stressor. Arguably, coping may involve both the cognitive and behavioural efforts employed by an individual to deal with the demands created by the stressful person-environment transaction (Folkman, 1984). And of course, different individuals can be expected to use different coping strategies at different stages of the same stressful event, or from one stressful encounter to the next. Also, some coping strategies used more often than others (Endler and Parker, 1990; Krohne, 1996) and this is dependent on some emotions which can be both antecedents and outcomes of coping efforts (Krohne, 1996).

Another prominent transactional model is Cox's model of occupational stress (McKay et al. 1978) which expands on Lazarus and Folkman's (1984a) transactional model because this model also includes job characteristics, subjective perceptions of stressors and individual differences. This model also argues that the situation starts with a demand for an action of some kind and with the person perceiving, either accurately or not, this demand and their ability to cope with it. The individual cognitively appraises the match between perceived demand and perceived capability, and if the individual perceives that they cannot adequately cope with the demands, the person experiences stress. This can be either an emotional (psychological) response or a physiological or behavioural

response, which then also feeds back into the original demand and cognitive appraisal (Cox and Ferguson 1991; McKay et al. 1978).

Later on, Cox, Griffiths and Rial-González (2010) re-evaluated their model and questioned the level of awareness that exists during the appraisal process (Cox and McKay 1981). They argued that the first stage of this cognitive appraisal includes the sources of demand placed upon the individual in their environment followed by the second stage that is when the individual becomes aware of the demands and starts recognising the "problem". This stage almost leads the person to the third stage of this process, when the person starts thinking "what am I going to do about this?", and the fourth stage of the model incorporates the psychological and physiological changes that the individual may experience when they become more consciously aware of the problem and threats to their wellbeing. These changes are mostly emotional changes that usually define the experience of stress for the individual (Cox, Griffiths and Rial-González 2010; Cox and McKay 1985).

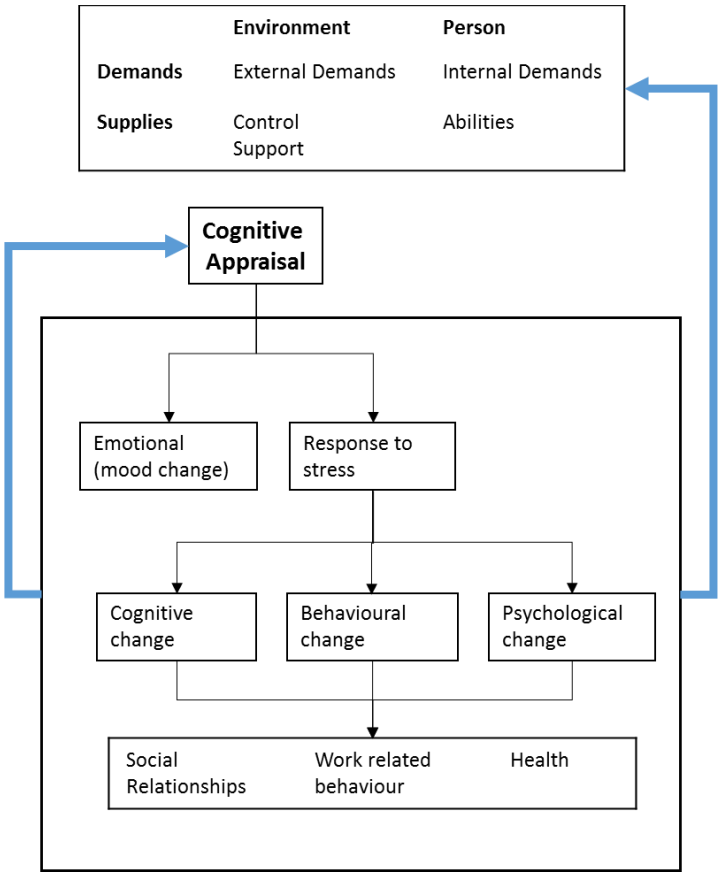


Figure 7 Transactional model of occupational stress (adapted from Cox and McKay 1981, 1978)

The final stage of this model involves more secondary appraisal and feedback in relation to all other stages of the model, and involves perceptions of control and social support. The main criticism of this model is that it is hard to develop a subjective measure of experiential stress (mood) that can correlate to the stress state as defined in this approach (Cox, Griffiths and Rial-González 2010; Cox and McKay 1985). This model argues that perceived environmental demands seem to be more important than the actual demands, which suggests that subjectivity may play a bigger role in the stress and wellbeing process. This proposition is also supported by some other research (Chirico 2016).

In principle, transactional models focus on the influence of individual differences and cognition in the stress process. Another popular transactional model is Cooper's model of occupational stress (Cooper and Baglioni, 1988) and this was designed to explain stress at the workplace. This model consists of several levels of stress and it subsumes aspects of the "Person-Environment Fit" model by French et al. (1982), the "Demands-Control model" by Karasek (1979) and the "Transactional stress theory" by Lazarus and Folkman (1984a). This model recognises that the stress process is complex, but there are distinct levels of stress. It appears that these levels of stress in this model relate to Maslow's hierarchy of needs model almost linearly because some stressors may be viewed as more important than others, hence they may be more closely related to survival needs.

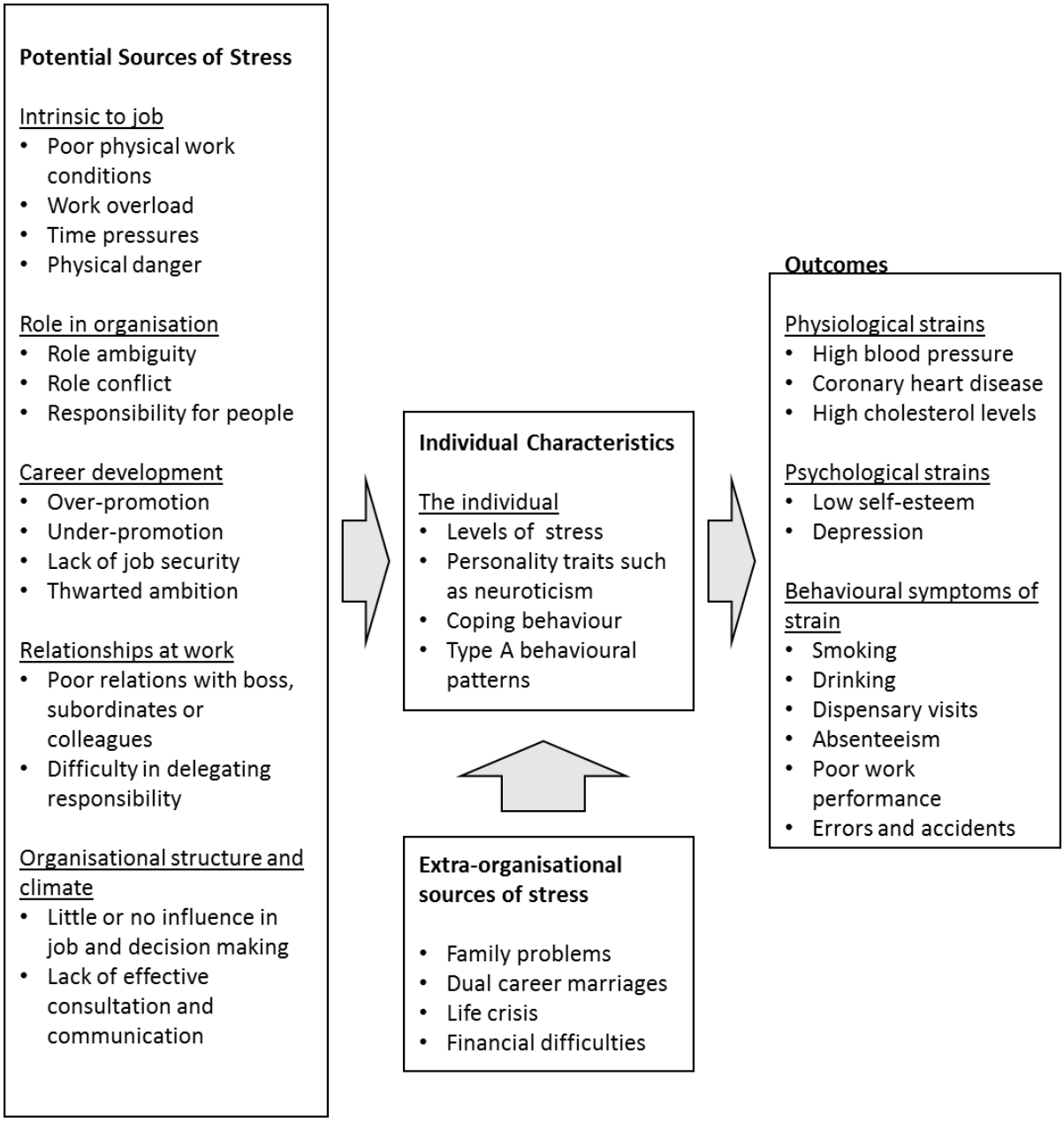


Figure 8. Cooper's model of stress at work (Cooper and Baglioni 1988)

The first level of stress in this model is *"sources of pressure"* at work, as shown in Figure 8, which also contains five sub-levels: (a) the *"intrinsic job factors"* such as poor physical conditions, shift work, work overload or underload, time pressures, job satisfaction and responsibility for lives; (b) the "*individual's role"* in the organisation and that includes role ambiguity and/or role conflict, the perceived image of the occupational role and boundary conflicts; (c) the "*individual's career development"* which involves over-promotion, under-promotion, job insecurity and thwarted ambitions; (d) the "*relationships at work",* such as the nature of

relationships and social support from one's colleagues, boss and subordinates; and finally (e) the "*organisational structure and climate",* such as office politics, lack of effective consultation, lack of participation in the decision-making process and restrictions on behaviour.

The second level in this model of stress at work by Cooper and Baglioni (1988) is *"individual characteristics"* contributing to the degree of the stress experience. These characteristics are divided into two factors: (a) the "*individual factors"* and (b) the *"home-work interface factors".* In the individual factors are included levels of anxiety and neuroticism but also role ambiguity and personality such as type A personality characteristics. The home-work interface factors are dual-career marriages, family and life problems and financial problems.

The third level of stress of the model is the *"symptoms of occupational ill health"* and these are in two sub-levels: (a) the "individual" and (b) the "organisational symptoms". The individual symptoms that relate to occupational ill health are changes in the individual's blood pressure, heart rate and cholesterol level but also the individual's health behaviour such as smoking, drinking and eating patterns. Psychological changes such as, job dissatisfaction, depression and reduced aspiration, are also included in the individual symptoms in this model. The organisational symptoms of occupational ill health are characterised by high absenteeism, high labour turnover and problems with industrial relations.

The fourth level of the model is the "outcomes or diseases" produced by the sources of stress. This level is again divided into the individual and the organisation sub-level. At this fourth level, the individual may suffer from diseases such as, coronary heart disease, mental ill health and other health disorders. At an organisational level the outcomes may be displayed as drug error incidents, accidents at work and poor performance.

This model of occupational stress provides researchers with a comprehensive repertoire of sources of stressors at work to consider in the development of interventions for stress and wellbeing. It also offers the option to focus either on the individual or on the organisation, or the interface between the two. Most importantly, this transactional model offers potential outcomes related to specific levels of stress at work that can be used to direct efforts and goals to either the individual or the organisation, or both.

However, this is a complex model to use in planning an intervention because of its all-inclusive approach to understanding work-related stress, which may make this model unworkable in practical terms. This may have been the reason for simplifying this model by using only three of its core elements in the occupational stress process: *stressors* (sources of pressure); *moderator variables* (individual differences); and *outcome variables* (effects). Williams and Cooper (1998) simplified the model and argued that sources of pressure coupled with individual differences may produce the effects on the individual and the organisation. In this simplified model, the home-work interface is included as one of the sources of pressure and coping strategies, while social support is included in the individual differences as part of the model, as shown below in Figure 9.

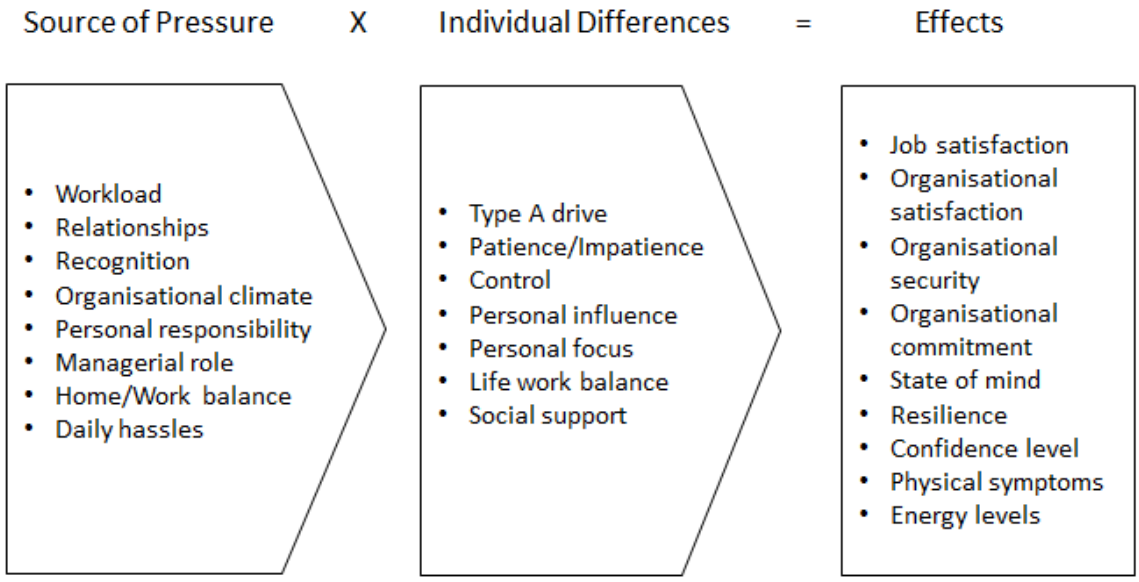


Figure 9. Revised Williams and Cooper's model of work (Williams and Cooper 1998)

Williams and Cooper (1998) understood that stress is a complex, multivariate process, therefore they devised a simpler version of the model but they also accepted that diverse measures of occupational stress such as psychological health, anxiety and job satisfaction should be combined and used in measuring the stress process. Hart et al. (1995) also agreed that stress cannot be expressed as a single variable because there are many contributing factors to the stress and wellbeing process, such as personality characteristics, coping processes and

positive and negative work experiences which must all be considered when studying occupational stress.

Cooper's occupational model of stress was tested on several occupational groups and found to focus more on the organisational levels of stress, hence overlooking individual differences and their possible impact at the various stages of the stress process. Therefore in 1998, Williams and Cooper also developed the Pressure Management Indicator (PMI) questionnaire to measure occupational stress. The PMI comprises: (a) stressors (sources of pressure); (b) moderator variables (individual differences); and (c) outcome variables (effects). It aimed at measuring organisational health in order to provide continuous feedback on employees' health and wellbeing. Prior to PMI, Cooper and Marshall (1978) developed the Occupational Stress Indicator (OSI), which included six scales that measure core elements of the stress process. However, internal reliabilities reported for the OSI were low, ranging from 0.03 to 0.92 (Steiler and Paty 2009; Lyne et al. 2000; Williams and Cooper 1998), which led to the development of the PMI (Lyne et al. 2000; Kirkcaldy, Cooper and Brown 1994, Ingledew et al. 1992). Hence, the PMI replaced OSI because of it was found to be a more valid and reliable measure. But also OSI was found to assess perception of a job environment at organisational level rather than at individual level (Steiler and Paty 2009; Davis 1996; Rees and Cooper 1992).

The PMI aimed to measure the relationship between job pressures and stress-related outcomes, such as mental health and job satisfaction, but also measure the moderating effect of individual characteristics, such as type A behaviour, locus of control and job satisfaction (Kompier and Cooper, 1999; Biggam et al. 1997; Baglioni et al. 1990) which made it the preferred measure of Copper's model of stress.

At this point in the discussion, we need to be reminded that both transactional and interaction models of stress and wellbeing strongly argue that the perception of stressor by the individual is the most single important factor in the process of stress and wellbeing. This universal view of the transactional theories and models is pivotal to this research. Another significant contribution to this research is the work of Warr who introduced the Vitamin Model in 1994. This model argues that environmental features or job characteristics may also act as potential determinants of a person's job-related mental health. Therefore, Warr claimed that

there are nine environmental factors or job characteristics which are significant in the work place of an employee. These are as discussed below: (1) opportunity for control (autonomy, decision latitude and participation in decision-making); (2) opportunity for skill use (skill utilisation); (3) externally generated goals (demands, workload and role conflict); (4) variety (varied roles and skill variety); (5) environmental clarity (task feedback, future ambiguity and role ambiguity); (6) availability of money (income level, absence of poverty and material resources); (7) physical security (absence of danger, adequate health and safety conditions and low physical risk); (8) opportunity for interpersonal contact (contact with others, social and emotional support and good communication); and (9) valued social position (social rank, job importance and personal evaluation of task significance).

Warr also argued that job characteristics work in a similar way to vitamins in that an intake is usually considered beneficial to the physical health of the individual up to a certain point, beyond which any further increase generally makes little or no difference to the body. However, certain vitamins in larger doses can be harmful to the body ("hypervitaminosis"). In a similar vein, the absence of certain job characteristics, such as autonomy and social support, can damage mental health, but their presence beyond a certain point, can also be detrimental and harmful to the mental health of the individual (Van Veldhoven et al. 2005). Furthermore, Warr (1987) argued that the association between job characteristics and mental health is non-linear. For example, very low levels of job autonomy are reported to be harmful to employees' mental health, but very high levels of job autonomy can also harm the person's mental health because too much autonomy may lead to uncertainty, difficulty in decision-making and high responsibility on the job (Warr 1987). These job characteristics are also incorporated in work-related and context-free domains, but focus mainly on the individual level.

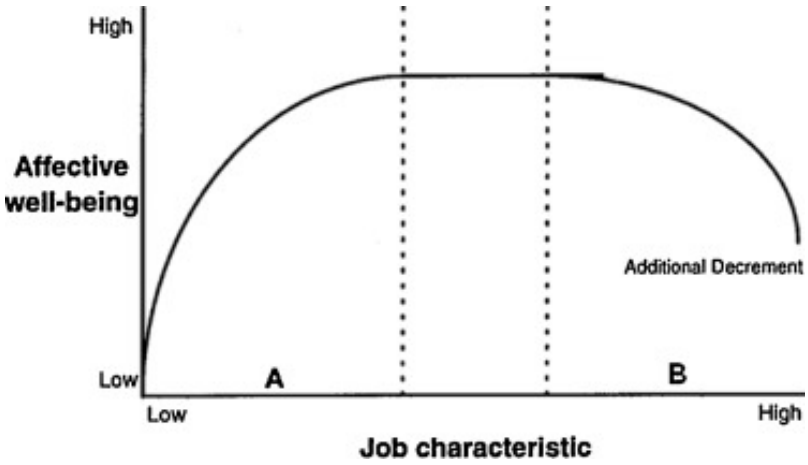


Figure 10. Vitamin Model (Warr 1987)

The above figure argues that a certain job characteristic (Warr 2007, 2011) has a beneficial effect on an employee's affective wellbeing (segment A) before a plateau is reached, after which it remains constant (segment B). Further increases of the job characteristic (segment C) may either produce a constant effect (analogous to Vitamins C and E) or may be harmful and impair affective wellbeing (analogous to Vitamins A and D, and hypervitaminosis). Furthermore, Warr (1987) argues that a particular characteristic can both enhance and impair wellbeing depending on its level and duration.

Furthermore, Warr argued that there is a curvilinear association between mental health and some of the features within the environment, yet he did not specify which of them have more of a linear or curvilinear association. Instead, Warr used the label "additional decrement" to denote the inverted U-shaped curvilinear relationship of these job characteristics to wellbeing (Warr 1990). However, Makikangas et al. (2007) found that job control and support at work were almost always linearly associated with job-related affective wellbeing, while De Jonge and Schaufeli (1998) found that job demands and job autonomy were curvilineal and related to some aspects of employees' mental health as predicted by the model. However, salary, safety and task significance were found to follow a linear pattern and mirror the ways in which vitamins act on the body (Diener and Seligman, 2004; Buunk and Hoorens, 1992).

This model was chosen for this research because it suggests a different view on occupational stress and recognises the importance of "work context" and "work stress" which are different from "non-work context" and "non-work stress" (Warr

1987, 1990). Copper's model makes a similar distinction but it does not extend on this idea further while Warr's model focuses particularly well on an individual's mental health in the workplace and outside the workplace. Another interesting principle of this model is that it considers *wellbeing* as central to mental health and *affective wellbeing* is the component studied most in occupational stress research (Warr 1994, 1987) and therefore, it is important for this research. Warr's model of wellbeing extends into affective-behavioural themes such as affective wellbeing, competence, aspiration, autonomy and integrated functioning (Warr 2007) and examines them in the domains of context-specific wellbeing (job-related) and context-free wellbeing (non-job-related) which makes this model even more relevant to this research.

"Job-specific wellbeing" refers to people's feelings about themselves in relation to their job, whereas "context-free" wellbeing has a broader focus, covering feelings in any setting (Warr 1990). It is interesting to note here that "job-specific" and "context-free" stressors epitomise a full range of characteristics both at individual and organisational level, which are considered crucial to workplace behaviour such as employee retention (D'ambra and Andrews, 2014; Twigg and McCullough, 2013).

The other three affective-behavioural aspects of mental health exhibited by behaviour in transactions with the environment are competence, aspiration and negative carry-over, which are intrinsically related to affective wellbeing, yet they are distinct (Hosie and Sevastos, 2010; Sevastos et al. 1992). Warr argues that the cognitive components of wellbeing refer to aspects of mental health as they are non-hedonic in sensation (for example, competence and aspiration) and defines competence as a person's ability to handle life's problems and act on the environment with at least a moderate amount of success. He goes on to explain that competence has an intrinsic association with affective wellbeing which may moderate environmental factors that, in turn, may impact on mental health (Warr and Inceoglu, 2012). In stress literature, competence has been linked to environmental mastery (Jahoda 1958), ability to cope (Bradburn 1969) and beliefs about self-efficacy and expectations of personal mastery (Warr and Inceoglu 2012; Bandura 1977). These are some interesting ideas that relate to the aims and objectives of this research.

Aspiration, on the other hand, is when an individual is interested in and wants to achieve goals in life (Warr 1990). Thus, a mentally healthy person sets out realistic goals within the environment, makes efforts to achieve them and is motivated to do so. Therefore, high levels of aspiration within an individual are always associated with high levels of motivation, alertness to opportunities and efforts to meet challenges, whereas apathy and acceptance of the present state reflect low levels of aspiration (Warr 1987). On this note, Warr (1987) explains that a person with high levels of aspiration is not necessarily free from anxiety from a mental health perspective. This is because this person who aspires to achieve personal goals, may also create stressful encounters through such pursuits adversely impacting on their mental health.

Unlike cognitive wellbeing, which is far more stable over time (Eid and Diener, 2004, 1999), affective wellbeing tends to be stable over shorter periods of time (Chamberlain and Zika, 1990). Therefore, cognitive wellbeing may be more influenced by dispositional characteristics, whereas affective wellbeing may be more influenced by life events. This research aims at exploring this relationship in phase one and possible measure it in phase two.

Furthermore, the negative carry-over or “spill-over” component of mental health is considered as a possible link between work carry-over and non-work carry-over (Warr 1996, 1987). The extent to which work experiences, either positive or negative, carry over into non-work life for example family life and vice versa is interesting in occupational stress research and Warr’s stress model recognises the role of individual differences such as neuroticism, on mental health outcomes. Furthermore, Warr et al. (2012) explained that such traits or individual characteristics may reflect an individual’s feelings and perceptions about themselves and explain further the individual’s response to their work environment but also the individual’s level of affective wellbeing either high or low (Warr and Inceoglu, 2012).

Context-specific mental health needs to be assessed within a single setting, for example nurses’ workplace is usually a hospital or out in the community. Non-work affective wellbeing usually refers to all other settings, such as family life and/or student life, but not work life. Context-free wellbeing relates to an individual’s state of wellbeing in life in general. Warr (1987) argues that carry-over effects are found between work and context-free wellbeing and job factors, which

are shown in Figure 11 as the larger circle, indicating the importance of carry-over effect on job-related mental health.

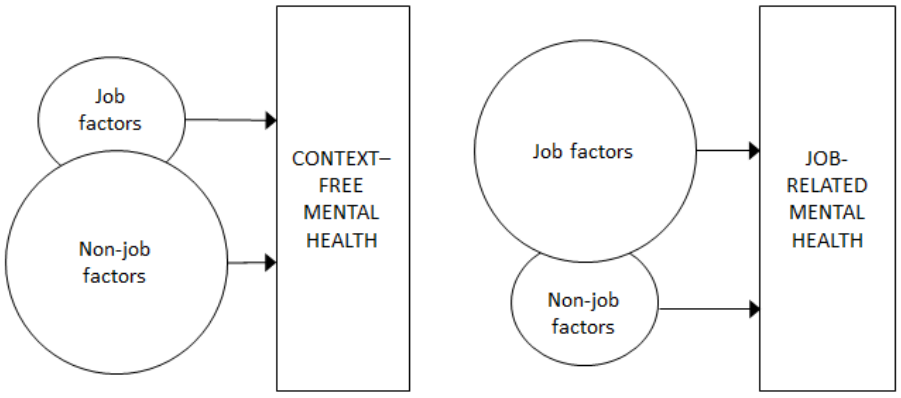


Figure 11. Schematic representation of the importance of job and non-job factors influencing context-free and job-related mental health from Edwards (2004)

Interestingly, Warr (2007, 1990, 1987) also argues that non-job factors are more strongly associated than job factors with a state of wellbeing in life in general, but job factors are of greater significance to job-related affective wellbeing than non-job factors. The overlap between circles indicates mutual associations between job and non-job factors. Furthermore, Warr's (1990, 1987) model of wellbeing and mental health can explain how different personality characteristics may vary the experience of the nurses' work environment and, in turn, vary the impact of these experiences on aspects of nurses' mental health in a work-related context.

Therefore, this thesis argues that these specific aspects of the Warr model combined with aspects of the Cooper's model of occupational stress model can serve as a wider theoretical framework for understanding how nurses' job characteristics and work environment may interact with nurses' perceived job-related affective wellbeing (SCIE 2017; GGI 2015; D'ambra and Andrews, 2014).

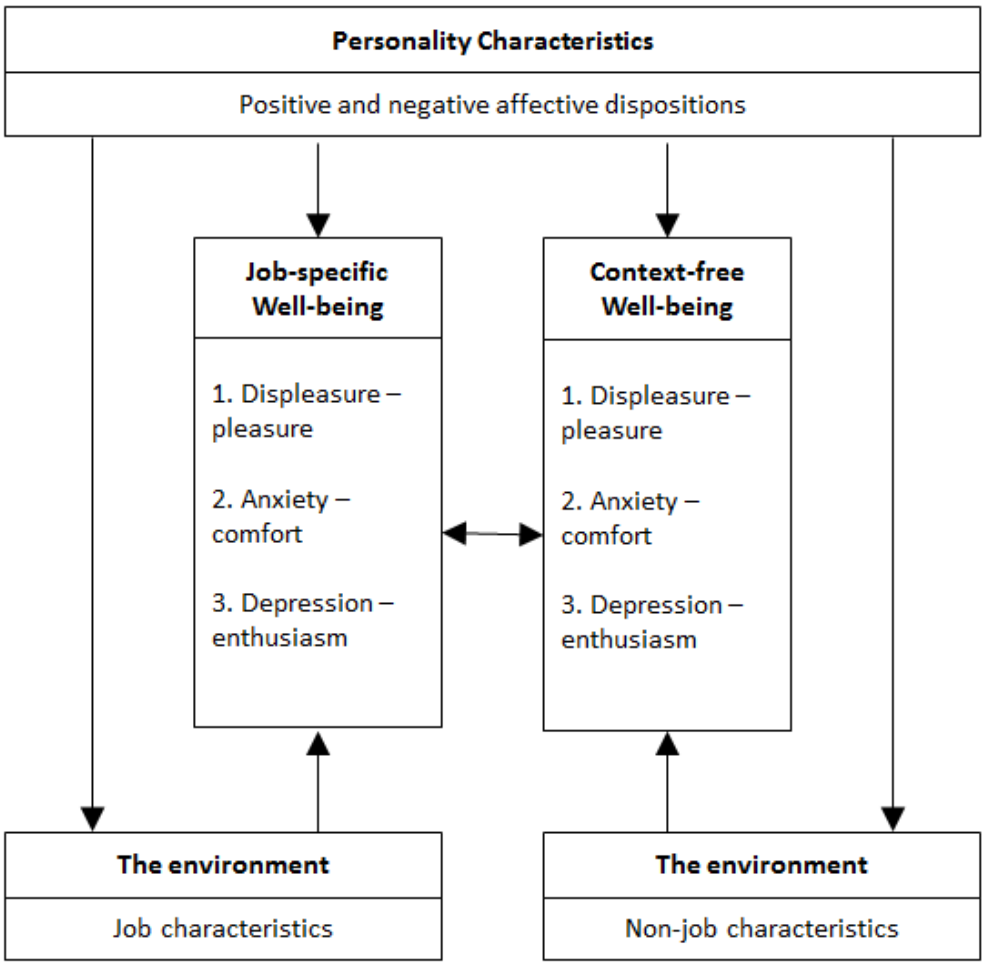


Figure 12. Schematic representation of Warr's Model of Wellbeing from Edwards (2004)

The assumption here is that by creating a synergism between Warr's model of affective wellbeing and Cooper's occupational stress model a new, flexible transactional model of wellbeing can be proposed to be used to explain and interpret nurses' behaviours and attitudes towards their job related affective wellbeing. The current literature explains nurses' current stress levels but it does not offer an alternative model to contextualise nurses' experience of job related wellbeing or offer ways to prevent stress and promote perceived wellbeing at work (Edwards and Shipp, 2007; Katwyk et al. 2000; Daniels, 2000). To add to this syllogism, Warr's (1987) vitamin model has suggested a non-linear relationship between components of the environment and mental health (Hosie and Sevastos, 2010; De Jonge and Schaufeli, 1998; Edwards and Cooper, 1990).

Warr's model suggests that there are causal pathways between job characteristics and job-related mental health, but there is also reverse or reciprocal linkage between environmental features and job-related affective wellbeing (Makikangas et al. 2007; De Jonge et al. 2001). In the research carried out by Makikangas et al. (2007) found that the model was highly stable across the three years the study run and that there was a non-linear relationship between job characteristics and job-related affective wellbeing. However, Warr (2011) argues that work-related affective wellbeing may mediate the relationship between environmental factors or job characteristics and non-work affective wellbeing, which is an interesting proposition. Warr (1987) also developed a job-related affective wellbeing measure to capture specific types of work-related wellbeing as a subtype of general types of wellbeing (Taris and Schaufeli 2015).

Warr (2011) and Wright et al. (2007) found that employees who scored high on positive emotions were less prone to stress and that these positive emotions were found to moderate their job satisfaction (a measure of affective wellbeing) and work performance. This is an interesting finding that is inconsistent with this model that argues that work experiences may contribute far more to an employee's context-free and work-related affective wellbeing than currently believed.

2.3 The development of the research question for the interpretative phenomenological study (IPA)

Following a critical analysis of the literature on the theories and models of stress and wellbeing, one can argue that the work environment is a major contributing factor in the health and wellbeing of an employee. Nurses are faced with a number of stressors which are specific to their work and type of work they carry out, hence they are exposed to different challenges and problems in the context of their work. These stressors have been well documented in the general nursing literature for many decades but there is still a need to evaluate the work context of contemporary nurses in order to understand and appreciate barriers and efforts nurses may put forward to overcome daily occupational hassles and difficulties. In the first part of the thesis, the current situation and work context for nurses was discussed and it has come to our attention that there are models and

theories of stress and wellbeing which can explain the levels of stress experienced by nurses.

However, there is still a need to establish nurses' lived experience of being a nurse working in the NHS. There is also a need to establish whether years of work is a critical factor in shaping nurses' views and perceptions of their wellbeing at work. There is a need to establish what the current views of working nurses are, regarding their work related wellbeing and how they feel about their work. So the research question for this phase was "what is it like to be working as a nurse today?". The first aim of phase I is to explore nurses' perceptions of their wellbeing and discuss related issues such as work environment, the job itself and nurses' roles and responsibilities within the team. The second aim of this phase of the research is to enable the development of an intervention for phase II to help nurses' ability to appraise emotions and feelings both in self and others and therefore, become more emotionally agile and stable.

2.4 The development of the proposed IPA groups

After reviewing the literature on nurses' work related stressors and work environment it became apparent that work experience may contribute to nurses' behaviour and attitudes towards problems and stress, experienced nurses may be able to adjust differently to less experienced nurses. It is interesting to note that in general, experience enables individuals to form opinions and views on matters of importance to them and they may learn ways of managing over time. Furthermore, nurses' work environment is fully interactive and nurses are subject to emotional work from early on in their careers.

Work and life experience may contribute to stress and anxiety when it comes to deal with emotions and positive or negative interactions with others. Experienced nurses may have learnt to choose to enhance positive emotions and selectively dampen negative experience and emotions (Marino and White 1985).
The reason for this is that their interpersonal skills may have also improved over years of work experience because they were exposed to these situations over time and learnt to reappraise situations as more emotionally satisfying and reduce their subjective experience of negative emotions and situations (Marino and White 1985). This research also found that nurses with many years of work coped better

with high workloads and felt satisfied with their jobs and age was not found to be associated with coping and job satisfaction (Marino and White 1985).

Current statistics on younger nurses also reconfirmed that younger nurses experience higher levels of stress and that they want to leave their jobs and quit the profession much sooner than previous generations of nurses (NHS Digitals 2018). These nurses are reported to have not got enough work experience to draw upon and enjoy some job satisfaction. This would have allowed them to develop confidence and self-efficacy to carry out and progress in their career and eventually commit to the job (Capital Nurses of the NHS 2017). Therefore, NHS London currently offers training opportunities and incentives to younger nurses to stay in nursing by focusing them on gaining work experience. For example, newly registered nurses are offered rotational posts and a year-long preceptorship to enable them develop a sense of belonging and satisfaction from their work.

The primary aim of this exploratory study was to find out how nurses of today felt about their affective wellbeing at work, whether they were happy with their work and how well they think they manage their stresses at work. This exploratory study aimed to produce some data to enlighten current staffing trends in nursing.

PHASE II - METHODOLOGY OF THE EXPLORATORY STUDY

This part of the thesis aimed at explaining the rationale for choice of methodology for the exploratory research and justify the methods used to collect the data in this phase of the research. Chapter Three explains how these took place and includes a detailed analysis that led to the emergent themes. The results from phase I were used to design and develop the intervention in the quasi-experimental study in phase II. Chapter Four enables this discussion by explaining in detail how the results from this research (the emergent themes) may have informed and shaped the development of the intervention in phase II and chapter Five describes how this intervention was fine-tuned and designed. This chapter also discussed the rationale for choice for the measures used to collect data in the quasi-experimental study to test the proposed model for nurses' wellbeing.

Chapter 3. Methods of the exploratory study

This chapter aimed at explaining the rationale for choice of methodology and methods and the process involved in the development of the intervention within the context of a proposed model for nurses' wellbeing at work that derived from the literature and the results from the qualitative study in this phase of the research. This chapter also aimed at laying down the principle idea behind the proposed intervention and wellbeing model for nurses and enabled this research to move forward with the second component of this research, the quasi-experimental study discussed in Chapter Six.

3.1 Rationale of the choice of the interpretative phenomenological analysis in the exploratory study

The overall aim of the exploratory study (which is the qualitative component of this mixed sequential exploratory research) was to explore nurses' perceptions of their emotions and wellbeing. This research aimed at exploring the phenomenon "what is it like to be working as a nurse today?" There is a plethora of research

examining nurses' stress at work and the possible factors contributing towards this problem are well researched but there is little on nurses' perceived levels of wellbeing at work. This research aimed at filling this gap in the literature and allow nurses to tell their own story in their own words.

This exploratory study enabled nurses to evaluate their own wellbeing and explain why they may feel the way they do. The aim of this phase is to utilise the results from this study to understand in depth the nursing work and psyche, and possibly elaborate on what it means to the nurses themselves, to be a nurse in the current environment and interpret for themselves what they have said in order to explain why they may have said it (Willig 2013). This intimate notion of self-interpretation and self-evaluation is the reason why interpretative phenomenological analysis was chosen as the methodological approach to this research.

The principal aim of the exploratory study was to capture nurses' subjective "feel" of what is like to be working as a nurse and understand nurses' perceived stress and wellbeing at work, their general satisfaction with their work and how they may perceive their work life impacts and impinges on other aspects of their lives. Furthermore, another objective of this study was to identify "unique" and "nursing specific" stressors associated with nurses' work environment that may inform and possibly direct the focus and content for the development of the intervention in Phase II.

The literature review highlighted the complexity of issues affecting nurses' attitudes and behaviours, but also pinpointed nurses' low expectation and low confidence (Cowin and Hengstberger-Sims 2006), which have been found to contribute towards nurses' general feeling that they do not fit with the expectations of their roles and the organisational demands. However, nurses were reported particularly satisfied with their nurse-patient relationships despite adversities and struggles at work. Nurses reported repeatedly that patient care and interaction are giving them the most satisfaction from work, but there were other parts of the job they didn't particularly enjoy or felt interfered too much with the caring aspect of the job they most enjoyed.

The use of interpretative phenomenological analysis (IPA) is considered appropriate to the aims of this phase of the research as it enables the exploring of nurses' wellbeing at work as a phenomenon from nurses' perspective. That way

nurses were given the task to rethink and articulate the complexities of this problem but also contextualise the issue within their current situation at work and relate with the issue as an individual nurse and as a group of nurses facing this problem. What did that mean for the participant nurse as a person and as part of a group?

The IPA has its origins in phenomenology and of course, symbolic interactionism, and argues that human beings are not passive perceivers of an objective reality but come to interpret and understand their experiences, situations and events (phenomena) by taking their own biographical stories into account to make sense of them (interpretative). Therefore, reflecting on the processes through which individuals make sense of their own experience is both acceptable and desirable in this approach (Reid et al. 2005; Chapman and Smith 2002), and the researcher focuses on these "processes" of self-reflection, and the ways that participant nurses seek to interpret their experiences to make sense of them and put them in a form understandable to them. The researcher also focused on the participants' subjective reports and endeavours to "access the participants" personal world through a process of interpretative activity (Smith et al.1999). Hence, interpretations were bounded by participants' abilities to express and articulate thoughts, emotions and experiences adequately, and also by the researcher's ability to reflect and analyse them (Baillie et al. 2000).

The IPA methodology is inductive in its approach, hence open-ended questions were included to interview three discussion groups (sample groups) while the researcher monitored her own interpretation of the data and kept a trail to trace steps back if there was a need during analysis. A further objective was to identify gaps in nurses' support system at work and explore what other means of support nurses may have to draw upon in order to cope with daily hassles at work, for example low staffing levels. The results from this study were key to the development of phase II of this research because data from phase I needed to be mixed and connected with data collection in phase II (Creswell, 2009). This can be argued to be the primary focus of this mixed method research that aimed to explore a phenomenon. IPA recognises that experiences are contextual (Smith et al. 2009) and it is considered a powerful methodology because it assumes that subjective data can inform us about people's understandings of their experiences. This principle is at the heart of this research because it explores a phenomenon

(Snelgrove 2014) and it recognises that the central role of interpretation is negotiating meaning (Smith et al. 2009). Hence, its idiographic paradigm where focus is on the “particular” rather than the “universal” thought to enable detailed in-depth analysis of the experiences of particular people in particular settings which this research emphases and focuses on temporality by revealing “what is at a particular time”.

There are several research studies (Akhtar et al. 2015, Noorbakhsh et al. 2010, Karimi et al. 2014 and Nelis et al. 2009) which highlighted the significance of emotions in nurses’ health and wellbeing but their research designs were weak and their findings were inconclusive. Hence, the aim behind this thesis is to address those design weaknesses and unpick issues around nurses’ wellbeing at work by employing a mixed method research design in order to explore nurses’ perceptions and conscious awareness of themselves and their working environment in phase I, but also develop an intervention in phase II. Phase I aims to focus on how participant nurses perceive they feel at work, their behaviours and attitudes towards their work life and overall satisfaction at work and life in general.

The exploratory design aimed at discussing current affairs in nursing work and nurses’ understanding of how these may affect their work satisfaction and their wellbeing. Nurses are working in stressful and demanding environments therefore, they may well experience a wide range of feelings and emotions at work leading to certain attitudes about themselves, the profession and others so it is important to note that feelings can be either positive or negative and they can impact on attitudes and perceptions. Individual perceptions can interfere with the kind of attitudes and beliefs we may adopt in life and these are usually aligned with each other and galvanise our actions.

In the current literature, nurses’ perceived affective wellbeing has not been investigated and most research focused on nurses’ stress management, job satisfaction and sickness and absence. There is currently a gap in the literature about nurses’ perceptions of their wellbeing at work as a way to prevent stress, improve wellbeing and retain nurses at work. This research aimed at exploring the importance of self-perceptions and self-perceived emotional abilities. It is understood from the literature survey that life events or the perception of those life events can impact on affective wellbeing.

3.2 Rationale for using a Mixed Methods Design

Research carried out on individual characteristics (Cooper and Cartwright 1994; Cooper and Payne, 1991; Cooper and Baglioni, 1988; Warr, 1990) found that there is a place and a role for these individual characteristics in this process. In particular, the Cooper and Baglioni's occupational stress model highlighted the different levels of sources of stress and the various levels of outcomes one may expect which begs the question of what different levels of nurses may think about their work and own wellbeing at work? In high emotional labour jobs such as nursing individuals are required to demonstrate caring and compassion feelings but they may not always feel confident to do so as they may suffer from low levels of self-efficacy. Furthermore, environmental and individual characteristics such as neuroticism and sense of mastery are considered important factors in nurses' self-perceived emotional abilities, self-esteem and self-confidence which may be responsible for nurses' perceived affect, general health and wellbeing. Hence, this research was designed as a sequential exploratory design of mixed-method that involves an exploratory study.

The mixed methods research design was adopted because it allows triangulation of the data collected in the two studies and although this design may appear easy to employ, there is a need for additional time to analyse and expand on the qualitative data as careful selection and consideration of significant findings was needed in order for these findings to be used towards the development of an intervention. The disadvantage of this design is that it is time consuming to collect the data required and of course, the other consideration is to carefully deciding which findings from the qualitative phase can be used in the next phase of the research.

On this note, one may also argue that the research methodology is usually prescribed by the researcher's epistemological position because it refers to a general approach to studying a research problem. This epistemological position of the researcher involves her view of what can be known and how empirical evidence can be collected, and it usually influences the kind of knowledge that a methodology aims to produce. On the other hand, method is about a specific research technique of data collection and analysis (Silverman, 2015). This phase of the study aimed at improving understanding of nurses' own perceptions of wellbeing and interactions at work, and this approach was chosen because of its

idiographic focus and reliance on offering an insight into how a given person or group with similar backgrounds in a given context makes sense of their experience. It is this characteristic of IPA which attracted the researcher to decide that this is the better method and methodology for this research. This exploratory study aimed to focus on the subjectivity, texture and quality of nurses' experiences, and the meaning that individual nurses or group of nurses may attribute to their experiences of wellbeing at work. The researcher's own epistemological position is that of pragmatism which argues that a shared understanding from different perspectives may enable the researcher to understand and research a problem far better by combining concepts and accepting shared meanings of those concepts (Morgan, 2014) and therefore can answer the research question more completely.

3.3 The research question and ethical considerations for the exploratory study

The research question in this phase of the study hence, was "what is it like to be working as a nurse today?" The common method to collect data using IPA is to undertake individual interviews but when a circumscribed and homogenous population is considered to be faced with similar issues, then discussion groups can be used (Dunne and Quayle, 2001). Therefore, in this study discussion groups were used because each group of nurses was homogenous as it consisted of nurses with similar working experience and settings. For example, nurses working on accident and emergency departments and medical admission units were put together because these nurses would have dealt with similar groups of patients and faced with similar problems and issues. These nurses were also studying together for the same course, for example, the minor illness module. With this in mind, nurses were allocated to three different groups and formed three discussion groups. Nurses' work experience and banding were taken into consideration when planning these groups (Smith, 2004).

IPA studies usually employ purposive and broadly homogenous samples but there is a preference for smaller sample sizes (Smith and Osborn, 2007), however there is no right sample size (Smith and Osbourn, 2007). Sample sizes in IPA studies can vary from one person sample (Robson 2002) to forty-eight participants in a sample (Clare, 2003). The important thing in this approach is to select

participants who can provide rich data and therefore, enable the development of a full and interesting interpretation of the data (Smith and Osborn, 2007).

3.4 Sampling and ethical considerations

In this phase of the research, nurses volunteered to take part in this research and were allocated to the three aforementioned groups. They all worked in the regional hospitals in the area around the University and thirty-three (n=33) were women and five were men, with an average age of 37 years old (mean=37, SD=9) with an average work experience of 13 years (mean=13, median= 10, SD=10). These three groups were made of nurses of similar work experience and age but they differed between groups in terms of work experience. Phase II focuses on developing an intervention to facilitate participant nurses reflect on some of their beliefs and perceptions about work and own wellbeing to allow them to develop consciously self-awareness. Therefore, this study employed a purposive sample of thirty-eight (n=38) nurses who volunteered to participate in this study. Nurses were allocated to three groups according to the amount and type of their work experience. These nurses were either attending continuous professional development courses at the University such as the minor illness module, the physical assessment module or the mentorship module and they were invited to participate in the study voluntarily and anonymously. They were all given an information sheet and a consent form (see appendices 1 and 2) prior to them being allocated to their group. These nurses were allocated to three discussion groups on the basis of their work experience so group A was consisted of relatively inexperienced nurses (n=14) who had worked from two to six years. Group B were the experienced nurses (n=14) who had worked between seven and twenty years of experience. These nurses were expected to respond differently to work pressures and demands from their less experienced colleagues. Group C were highly experienced nurses (n=9) who had worked from twenty-one to thirty-five years of work in the NHS. This group was consisted of nurses in senior positions or managerial roles. Hence, these nurses were also expected to report different views to those in the other groups of nurses. These nurses may experience different challenges in their individual roles which may be significant to their role and responsibilities.

As discussed earlier in this chapter, IPA researchers aim to understand what the world is like from a participant's point of view and there is an acknowledgement that this understanding is always mediated by the context of cultural and socio-historical meanings participants share in that context (Shinebourne, 2011). Thus, nurses were allocated to their respective groups so they can experience collegial support and trust, and therefore they were enabled to explore their fears and worries with other nurses, who may felt they were in a similar position to them. This in itself may have created some problems for the researcher as the discussion group may well turned out to be a forum where nurses lay bare their anxieties and inhibitions and divert the focus of the discussion onto irrelevant discussions, therefore, the researcher had to monitor the group dynamics and steer them promptly to the discussions they needed to focus on. While this approach may allow nurses to freely express their view, fears and opinions about work life and being a nurse, the researcher has a duty to gently manage nurses' expectations and shift their focus on the importance of discussing the particular and significant events and issues related to their wellbeing at work. This required skilful negotiation skills and mindful interactions with the group to enable them make sense of these experiences in order to become aware of their own understandings and impressions.

Apart from the information sheet and the consent form nurses were also briefed about the aims of the study and the overall purpose of the research in a written letter and verbally to ensure that nurses were clear about the groups and why they were put in their relevant group. Nurses were also reassured about confidentiality and anonymity and were asked to sign and return the form before the discussion. Nurses were reminded that their participation was on a voluntary basis and that they could decide to leave the study at any point without giving an explanation. Participating nurses were also informed that their discussions would be recorded, transcribed and analysed and that this research was approved by the University's ethical approval committee.

3.5 The interview questions and the interpretative phenomenological data analysis process

As explained earlier the IPA is concerned with a detailed examination of particular instances either in a single case study or in studies of a small group of

cases and the researcher begins the analytic process by carefully analysing and examining each case for similarities and differences across cases to identify patterns of meaning and produce some reflections on the shared experience amongst cases (Shinebourne, 2011). The researcher aims to draw together some ideas and views from the participants and then move forward towards more general claims and themes. In this research each nursing group was asked the questions: (a) “What is it like to be working as a nurse today?” (b) “Which aspect of your job you consider demanding or stressful?”, (c) “Can you give me an example of a stressful or demanding situation you have been in?” and finally (d) “Do you feel you receive adequate support from work?”. Please also refer to appendix 4 for details on the interview protocol.

Questions such as (a) and (b) enabled nurses to tell in their own words their story which is in line with a phenomenological approach, whereas question (c) is more interpretive because invites participant nurses to reflect and evaluate their experience and their perceptions of it. Therefore, questions (a), (b) and (c) were used to help nurses make sense of their experiences while question (d) aimed at steering them on the particularity of the lived experience and what made it so special to them (Shinebourne, 2011). These conversations were to elicit some rich and personal accounts of experiences, but also allow the researcher to navigate these personal experiences and help the individual sharing these experience to understand the unexpected turns in the experience which were also important to them in this experience (Smith et al. 2009) as this is a flexible framework to work with as a participant and as a researcher.

This exploratory study aimed at producing data (transcripts) which were transcribed verbatim and analysed using the IPA method which is idiographic in nature. This approach aimed at critically analysing and arguing on nurses’ responses to the research question of this research. This analysis was based on an interview schedule used during the data collection process. The interview schedule was based on the work carried out by Shinebourne (2011), as discussed earlier in the chapter, but can also be found in Appendix 4. The researcher used this interview schedule to explore the lived experience of nurses working in a restricted environment while the researcher was continuously reflecting on the data while interpreting the data simultaneously. IPA data analysis offered a great opportunity to learn a great deal about nurses’ struggles and pitfalls in their

continuous battle to continue carrying for patients (Shinebourne, 2011). IPA analysis usually aims at finding some connection between nurses' narrative and meanings to existing psychological concepts. Hence, each transcript was typed out in verbatim, double spaced and each line was assigned a number at the side for easy identification of relevant extracts and for making notes and reflections on the side. This is a laborious process because each transcript was read several times and examined independently and in relation to other transcripts while attributes such as the content, the use of language and own comments (interpretations) were noted. The researcher had to return to the transcripts on several occasions and amend initial notes and comments before they were written into emerging themes. In IPA analysis, the researcher keeps comments and notes on the side of the transcripts next to the line numbers in order to make further sense of the comments and the words and eventually connect emerging ideas, patterns and concepts into themes.

At the end of this process, emergent themes were given a descriptive label before finalising the name of the cluster theme (initial clustering of themes) and short notes on each transcript were made with reflections noted in a dairy. This technique helped compare and contrast each theme from one group to another and gain an insider's perspective of the problem (Smith, Flowers and Larkin 2009). Initially, the cluster themes were arranged as tables of superordinate themes alongside extracts from the transcript that contained enough particularity to remain grounded in the text but also looked out for patterns to produce a wider conceptual understanding of ideas. Eatough and Smith (2006) argued that superordinate themes are the outcome of an iterative process, so the researcher makes sure that the integrity of what the participant said is preserved and reflected in the table and then in the narrative. Therefore, should another researcher wanted to track the analytic journey from raw data to the superordinate themes table, this can be done. In this analysis, a second experienced IPA researcher also read the transcripts and read through the analysis on the transcripts to ensure credibility and transferability across the different transcripts. One should not forget that in this approach there is an assumption that people are self-interpreting beings therefore the researcher is asked to go in without prior thoughts and ideas and listen to what participants are saying and how they interpret and perceive their world or problem without the researcher interfering by putting their own interpretation of participants perceptions

of the world or the problem. This is particularly challenging as the researcher may have to move between their own thought processes, known as “emic” and the participants’ thought processes, known as “etic” perspective, as the researcher is looking through the data from her perspective and positions but also from that of the participant and attempting to interpret data without putting their own interpretation or position on the matter. The IPA researcher is required to be flexible while she continuously looking to connect the participants’ interpretations to psychological concepts (Pietkiewicz and Smith, 2014), so keeping notes in a diary or on the side of the transcript helped clarify some ideas and thoughts, but also feelings during the analysis of the data.

3.6 Reflection and reflexivity on the process and procedures

The bracketing method used in phenomenology is a way for the researcher to manage research biases during data analysis because bracketing allows the researcher to reflect and think about own perceptions, ideas and experiences which may contaminate the data (Heidegger, 1962). By reflecting on the assumptions researchers may make when listening to participants’ stories (reflexivity), and by recording their reflections during the analytic process (bracketing), it is often that researchers find that their own ideas or perceptions may interfere with what participants may be saying. Therefore, bracketing enables the researchers to control these interferences by recording those ideas, thoughts and feelings while reflecting on them simultaneously and thus, enabling the researcher to understand their own interpretations of participants’ stories in a more meaningful way (Giorgi, 2011). But, this also allows the researcher interpret and understand participants’ stories (the data) as a whole experience (Kay and Kingston, 2002). This way the researcher shows that they are aware of how previous knowledge and personal experiences may influence their understanding of the phenomenon as described through participants’ stories and why they may interpreted participants’ stories the way they did to reflect how the participants may experience their world (Flowers et al. 1998). The researcher makes a conscious effort to reflect on personal thoughts and values while listening to participants’ stories, understand their interpretation of events and feelings, but also be fully aware of her own interaction with the data (participants’ stories). This awareness from the perspective of the researcher is what gives data analysis credibility and

reliability as the use of reflexivity and reflection ensures that instant ideas and views on the data are noted and the researcher becomes instantly aware of any frictions or clashes of ideas experiencing by the researcher during the analysis. Reflective diary notes are often compared with the notes on the transcripts before participants' stories are transformed into themes to ensure transparency across the findings but also show that themes are grounded on the data and not on personal views. This way the researcher can maintain the voice of the participants but also maintain the credibility and reliability of the data. Once the participants' stories are formed into clear themes in terms of relevance and fitness to the data, the researcher then may undertake a literature review to ensure these are meaningful findings (Kay and Kingston, 2002).

3.7 The process of extracting cluster and master themes

The analytical process aimed at producing narrative accounts that capture participant nurses' experiences, but also unravelled the meaning of these experiences to the participants. The results from this exploratory research study were to provide the empirical evidence to support an intervention (training) to help nurses protect their wellbeing at work and contribute towards a model for managing nurses' wellbeing at work. The IPA method aimed at enabling the identification of cluster themes which progressively were integrated into master themes. The aim here was to capture the essence of the phenomenon.

Each transcript was read and re-read several times in order to identify distinct patterns which were then highlighted across the three discussion groups in order to connect these to themes and concepts. This part of the data analysis was a laborious process and required attention to the thought patterns revealed by the participant nurses. These were then devised and later on merged into more general patterns and specific ideas and themes. In this process several ideas and patterns were either collapsed or branched out to higher-order cluster themes. This was an intense, but also creative part of the analysis, as it meant that themes needed to be identified by a name or label that summarised well the issue and represented its essence accurately in a word or a phrase.

As in most qualitative methods including IPA, there is a reliance on language as it is the vehicle participants use to communicate their experiences and

emotions. Therefore, the role of language is vital in capturing the meaning of the experience and not just simply describe it. Hence, the words nurses chose to describe their experience needed to be looked at as meaningful blocks of a particular version of that experience. Participant nurses described their experiences within a particular context and used different words and ways to describe them which also highlights the issue of the role of the language used by the participants' in shaping their experiences. This may be looked at as a shortcoming of IPA that needs to be noted when analysing transcripts using IPA (Willig, 2001).

3.8 The narrative accounts from the analytic process

Narrative accounts usually mix extracts in participants' own words (extracts) with interpretative comments to ensure that the "voice" of the participants is retained so the researcher can evaluate the appropriateness of the interpretation offered each time. The cluster themes were arranged in order to support the emergent master themes. Interestingly, there is a notion of emotional agitation across the thematic analysis which represents the texture of the experience and this can be identified across the transcripts. The use of IPA was considered as best suited for these participants because it allowed participant nurses to explain and describe their inner thoughts, feelings and behaviours and reflect on these but also connect their descriptions of situations, events, places and people with their experience. The IPA enabled the researcher to focus on participant nurses' perceptions and understandings of their wellbeing at work, but also their perceived work experience as a registered nurse working for the NHS, that is, their reality, in real life as nurse participants perceived it to be at the time of the discussions (O'Connor and Hallam, 2000; Kvale, 1996). IPA appeared to fit well with the overall aim of this phase of the research.

3.9 The process of building on the cluster themes to develop master themes

This process involved several steps in order to identify the different types of themes emerging from the analysis and then integrate them into meaningful cluster

themes within groups and then across groups. As discussed in section 3.2, the research question which guided the interview schedule consisted of open-ended and non-directive questions to enable nurses transcend feelings, moods and behaviours into the group discussion. This research aimed at enabling participant nurses' to pinpoint specific and "unique" conditions, events or factors they perceived as contributing towards their experiences. The process of building and developing cluster and master themes was laborious and slow at times because participants' stories were not always articulated clearly and some participants' ideas and thoughts were not clearly volunteered in the discussion groups which created difficulties in transcending these into patterns and connecting them to concepts.

3.10 Negative feelings about self

The narrative accounts were extracted from the transcripts (please refer to appendices 6 and 7) and discussed in depth to explain why they were interpreted the way they were and further explanations were included alongside the extracts to help connect the data with the comments and interpretations of the data. "Negative feelings about self" constitutes one of the first themes drawn out of the data reflecting the nature of their experience but also the mood of the participant nurses. Nurses appeared agitated, angry and negative towards their work experience but also towards themselves as professionals. Interestingly, this theme encompasses their negative experiences at work and their perceived emotional inability to cope with work-related issues and demands. Several smaller themes can be found within this theme such as overworked and stressed, emotionally exhausted, angry and frustrated and undervalued. In group A, there were nurses who had worked in the NHS from two to six years, in group B were nurses who had worked from seven to twenty years and group C were nurses who had worked from more than twenty years.

3.10.1 Overworked and stressed

This theme is about nurses' perceived workload at work and how they think they manage with their increasing heavy workloads. Nurses talked about paperwork and other aspects of their workloads as relentless:

> There is more paperwork. The risk of legislation is always there now. Documentation, documentation, documentation and that's on top of the physical care, the more senior staff get roped into paperwork instead of providing physical care which is what we want to instead of filling bits of paper. [lines 20-25] Group C

> If you have a conversation if you don't record it doesn't count or you are open to complain or disciplinary if there is a problem in the future. [lines 259-260] you get some nurses who are far better at doing the paperwork than actually looking after the patients [line271-2] Group C

Nurses argued that they were expected to manage these heavy workloads regardless and in their minds they were questioning the effectiveness of their role by stating that "they were doing a junior doctor's role". So it becomes clearer in this sentence that nurses felt confused about their role and nervous about what was expected of them.

> Too much work is put upon them (nurses) because we have so many tasks on board like cannulation and all these extra tasks and you have your paperwork. To do all the proper things you need to for a discharge to work takes a lot of time. It's a system's failure really. You are putting more and more jobs and more and more tasks on the nurses and less people (to do the job) with no extra resources you know. You are doing a junior doctor's role. [lines 616-636] Group B.

Nurses also appeared to think that they were made to fail in their jobs as they were given more and more extra work without the time and the resources to complete the work. They saw themselves as part of the "system's failure" to deliver safe care and felt nervous about management's condescending behaviour towards nurses.

> Working as a nurse it can be quite stressful and it's frustrating because there is a lot of dependence on computers and if they go down then all your work is backlogged up! [lines 18-20] Group A

Nurses were concerned about the tension that exists between the perceived "nursing work" and the perceived "non-nursing work" aspects of their work. Also, they were worried about the amount of effort and time nurses put in the job on a regular basis to cover the extra tasks given to them. Nurses reported here that they were expected to cover the extra workloads and meet expectations and priorities set for nurses on a regular basis by the organisation. Nurses felt being pulled in different directions and felt frustrated and stressed with the "non-nursing work" aspects of the job as they reported working harder and managing wider-ranging responsibilities. Nurses were angry with this invisible extra workload onto top of their daily workload which is not adequately captured in the nursing role and pay.

3.10.2 Emotionally exhausted

Nurses reported here that nursing work is far too stressful to carry on doing it as a lifelong career as pressures and demands on nurses are getting increasingly unmanageable. Nurses reported to be physically and emotionally exhausted from being a nurse:

> When I wake up the following day I feel so exhausted and you know I feel all tight before I start the following day. I don't really have a way to solve the stress situation personally I lay down there in no lights. I use this one to solve my stress situation definitely [lines 886-889] Group A

> When I have a bad day, I carry that bad mood from the workplace to my house and then I'll have a sleepless night [Lines 880-882] Group B

> You can't keep carrying being a nurse with that day job when you are 50 or whatever. [Lines 1036-1037] It's so physical and emotional [Lines 1041] Group C

Nurses reported feeling emotionally overwhelmed and exhausted and if given the option they would have opted out of nursing. Some of these nurses had already thought at some point in their career to quit nursing but this didn't happen to them either because they were too scared that they couldn't find another career or that they needed to support their families so they had to accept that they had no choice.

> There was a time I thought about opting out from nursing and doing another thing but on a second thought I said I have been in this (nursing) all the time all that I know is nursing you know? So, I can't opt out and start all over again if only I knew I would have started before going into nursing [Lines 1045-1050] Group B

I was thinking about changing my career but it never came. It was just a dream really I don't know, just needed a change maybe [1063-1068] Group C

It was interesting to note how palpable nurses' suffering was in these transcripts. Initially, nurses were determined to defend their choices and "solve the stress situation" they found themselves in. Then, they thought to act on it by leaving nursing altogether, only then to accept that "all that they know is nursing". There was a sadness and loss of sentiment. Nurses were found to be demotivated and low in morale which begs the question how can we support and re-energise nurses in the job? How can we boost nurses' confidence and morale? There is an urgent need for educators and managers to understand that nurses may often reach a point that they are too emotionally and physically exhausted to carry on doing the job and they need to be offered the choice to even have a break from the job with a clear return plan to work. It may be that current support systems at work are not enough to reach out to nurses in that way. It is also imperative that the role is reconfigured and work patterns revisited in order to enable surviving nurses to thrive in their jobs.

3.10.3 Angry and frustrated

Nurses reported "feeling frustrated" and worried to voice an opinion, particularly when their opinion differs from that of the management. Nurses argued that they were expected to "understand" and "not speaking out against it" (the system) as otherwise perceived as being "old fashioned". "Toeing the line" in their own words was what expected of a nurse who "understands". Nurse participants' mood changed from being negative to feeling vulnerable, but also profoundly disappointed and angry.

You can't say anything because then they say you have been unreasonable so you don't say anything so you feel frustrated because things are happening and you don't say much because you never know when the cards are going to turn on you and the issue is not going to be about what they are doing but about you are saying something [lines 87-98]. Group A

I think if you go against the system if you start speaking out against it. (You are told by your manager) you don't understand, you are old fashioned.

So, you have to toe the line. If you don't toe the line you do not understand you are old fashioned [lines 785-796]; Group B

Nurses also talked about "being pushed away" and feeling "embarrassed" to ask for help and support from their own (other nurses). They felt "isolated", "ignored" and "low" but mostly "disappointed". Nurses were reported to struggle to navigate professional relationships at work with other nurses.

She (another nurse) keeps pushing me away and while three, four times I asked and feel somehow embarrassed to keep asking about something which is not your personal issue, it's something to do with the job, and it's a professional matter! Then you give up and you take a step back and feel isolated, you feel ignored and then you lose your confidence, you lose the wish to do something and you feel low. And sometimes I feel disappointed that I have ever started this I shouldn't. [Lines 627-633] Group B

Nurses described other nurses as "not happy to return the help back" but they didn't seek out help from management as they didn't think management would "help" them with their situation. Interestingly, nurses felt they needed to take it upon them and resolve the issue rather than going to management for help and support. This may suggest that nurses viewed management as weak and possibly dismissive so they felt resentful towards management.

They (other nurses) would ask for the help but they are not happy to return the help back [lines 457-8]; they may say to a colleague, Well, they can't do it (help) and you will be stuck going solo with your patients. Many, many times I have experienced that [lines 460-462] Group C

It is also interesting to note that nurses were reluctant to complain about other nurses' unprofessional behaviour because of fear of retaliation from the other nurses, so this added to their frustration and anger. They also talked about their added frustration and anger with the doctors who were also "just dismissive" towards the nurses as others (other nurses and nurse management).

They (medical teams) don't treat you with respect and not realising that you've got some expertise and they are just dismissive… this team had a patient admitted with fluid in his lung and they said he is going to go down for a scan because they are going to do a pleural tap on him. And I took one look and I thought 'my god if they take him off the ward he is going to

arrest' and I said 'he is not safe to go downstairs' but they insisted on taking him down there without the crash trolley…[lines 908-914] Group C

However, senior nurses were far more confident to challenge a doctor, but they didn't necessarily do the same with another nurse.

… And I was so cross and I said to the doctor 'I think you should go and have a look at this patient instead of sitting here' and she looked at me and she was so dismissive. I went back there and I said 'Well, I am going to go and get the relatives now to come and sit with him while he dies because he is dying now, not tomorrow, next week or next month when it suits you, now!', so I went and got the relatives out and he died five minutes later [lines 914-920] Group C.

Nurses also expressed negative emotions and frustration over the issue of "truly autonomous practice" and complained again for "doing a junior doctor's job" but without the rewards and recognition. They felt dissatisfied and resentful of doctors' autonomous practice which didn't match their own "autonomous practice".

I don't think that nurses are ever truly autonomous because they always looking at the guidelines they always regard the job autonomous to a degree, but not truly in the full sense of the word in that we can work totally independent of anyone. Doctors are truly autonomous but I don't think nurses are [lines 662-670] Group A

Nurses were also frustrated and angry because the senior nursing leadership appeared to be weak and unsupportive towards nurses when it came to disputes and rewards. Nurse leaders are depicted as weak and unethical who don't recognise and reward nurses' contribution, hence younger nurses don't aspire to become nurse leaders and move onto managerial roles and jobs.

3.10.4 Undervalued

Many experienced nurses reported here that nursing is changing rapidly as a profession, but it is also significantly expanding its scope of practice which to some extent explains nurses' heavy workloads. However, these changes in the profession are not matched up with the rewards or salaries given to nurses. Senior nurses, in particular, admitted to be "doing in fact three-quarters of a doctor's job" but they "don't get the status that goes with it". Interestingly, senior nurses admitted

that they may “think in that way they might have a bit of a powering thing to the job” but this is an illusion because although nurses are willing to undertake the extra work because they deeply desire to be recognised for their hard work and contribution to care instead they get more disillusioned with the job.

The biggest change is probably professionally in that we are taking on a lot of doctor’s roles but not being recognised for it. You are doing in fact three-quarters of a doctor’s job and we are all on this course trying to be mini doctors but we don’t get the status that goes with it but professionally it has changed (the job) a lot, nurses are willing to do all the doctors’ jobs because we think in that way we might have a bit of a powering thing to the job [lines1136-1159] Group C

Nurses here also commented on the shortage of staff which cripples nursing care at many different levels and interferes heavily with the role and the job of the nurse manager.

There is lack of staff for a start so it’s very difficult for all these multi-agencies to supply to your demand or to meet your demand because they are also constricted and restricted by changes in government policy which has cut out the budges so every single area under that umbrella has been suffering and I think as a result every single one of them is frustrated not just the nurses [lines 320-325] Group C

I am 14 Band sixes and 4 Band fives for an intensive care unit. Trying to fill them! Be in my shoes and try to be 14 Band sixes… it’s hard work. [lines 214-229] Group C

Hospital nurses can say their beds are full. District nurses have to admit and admit and admit ad infinitum with insufficient staff, which makes it very dangerous… it’s paying Peter robbing Peter to pay Paul [lines 165-177] Group C

This issue impacts on all levels of nurses, but it is reported to be more of an urgent issue to manage for the senior nurses rather than the junior nurses. Although, junior nurses also reported to be affected by heavy workloads due to shortage of nurses on the wards.

The workload on the ward is so much for instance if a nurse is allocated as your mentor she has to always strike a delicate balance between patient care, managerial duties and other things and her own personal things to do [Lines 593-599] Group A

There is a lot of pressure from above (management) to get people out of the hospitals, we also have to look at the fact that so many hospital beds have been decreased there is a big push in the past ten years and hospital beds have been halved to what they were ten years ago [lines 103-113] Group B

Nursing shortage was also blamed here for inadequate support nurses give to each other and for creating a condescending atmosphere on the ward. Nurses here suffered from low morale because nurses were often criticised or even blamed openly for the care they provided. Nurses both senior and junior reported feeling exhausted and undervalued as others “seem to think they know best” and they felt dishearten by them dismissing nurses’ experience and continuous efforts to help the patient. In this part of the extract, nurses’ mood changed from sadness to agitation and despair.

There is a lot more pressure on recording data and writing because your job is at risk if your data are not good enough they can cut members of your staff and that you have insufficient staff to do what is the proper standard. You are also expected to take on increasing amounts of GP’s work but at the same time it can be very, very satisfying [lines 24-30] Group B

They (doctors) seem to think they know best. I mean how long have you been qualified? What’s that five minutes? Maybe a nurse with twenty years’ experience might actually have something useful to say. [lines 952-54] Group C

We had a patient who came in with a sore hip and then all of a sudden she had a spinal cord compression but they didn’t know that at the time they said we (nurses) had paralysed her…. The worst thing was that straight away all the fingers went out and we all of us nurses had to write statements and we want to know what was going on here. [1006-1018 &1028-29] Group B

Nurses understood the wider issues relevant to their profession, but they were also adamant that nursing leadership ought to defend nurses’ strong emotions particularly, in times of uncertainty and difficulty. An ethical nursing leadership should be guided by the voices of the nurses and put them on the

political agenda. By promoting the nursing values, the nursing profession can aspire younger nurses to stay in the job.

3.11 Negative feelings about others

The narrative accounts were examined both separate on their own but also together in relation to each other in order to enable the researcher recognise patterns and themes which were similar but also different from each other during the analytical process. Interestingly, the experiences described by the nurses in the three discussion groups, shared a common negativity and low mood across the narratives. In all discussion groups, nurses reported feeling lost and troubled, feeling disillusioned with the job and isolated from others.

3.11.1 Disillusioned

Nurses reported “feeling inadequate” as the demands on services were continuously growing and in their own words were “unrealistic portrayal” of what was available to the patients. This “unrealistic portrayal” was believed to create unrealistic expectations from patients about their care that nurses recognised they were not in a position to deliver. Nurses were troubled and concerned with the amount of high demand and high expectation put on services and nurses.

> The continuing care is now so difficult to get, it makes you feel inadequate in a lot of ways, but it’s not your fault because the services and the way they are organised it’s not fair anymore. I think there is an unrealistic portrayal of what care is available. Like all the advertising about people being able to die at home and you will be able to see a nurse every day. All those things when in reality it doesn’t happen. There isn’t the funding really for it [lines 135-159]. Group A.

> You know that the patient’s best interest might not be what the best interest of your role is. It’s like the four hourly wait it might be better for the patient to stay and be observed and it doesn’t fit I just think that the aim of the business is different to the aim of the professionals there is a lot more targets now there is always targets and for our managers all they are interested in is the number of face to face contact we have and patients they are not interested in anything else [lines 1203-1226] Group C

Nurses also talked about the impact of these “unrealistic portrayals of what care is available” had on nurses’ targets, but also on the targets set for their managers’ and the disillusion created over these “targets”.

We have got targets. The government has set the targets for our matrons or whatever. The only thing is they forget that what these targets are about is not machines these are people. [lines 602-4] Group B

What different today to what was before is that the patient was paramount we are now getting this sort of business concept and sort of saying to reduce admissions and you have got a dichotomy [lines 1194-1199] Group C

Nurses appeared disillusioned with the idea that care should be offered as a readymade pack to the patients and they "suffer with this idea that the patient comes first". Nurses appeared to feel that their situation was unresolvable.

I think most of us suffer with this idea that the patient comes first. How would you defend that in a court? If this is your sort of rule stick if you are standing in a court you want to have a damn good argument and at the end of the day is your licence [line 643-651] Group C

You can't say I can't assess a patient in twenty minutes it might be that patient is upset and uncooperative. Some patients come in particularly unwell they can't help it if the patient needs to be calmed down. That will take an extra ten or twenty minutes. [lines 608-611] Group B

Reasons for being disillusioned reported by the nurses were nurses' inability to act autonomously, but also lack of support from management and chronic shortage of staff made nurses to be "kind of depending one everyone else" and "working in isolation because of shortage of staff".

Because they are (nurses) so short staffed everyone is kind of depending on everyone else at ward level but also out in the community… people doing the nursing care and the acute care are run off their feet and there are always risks for mistakes or drug errors or whatever. A lot of nurses (in the community) work in isolation because of shortage of staff [lines 382-388].They (community nurses) have got the doctor [line 394] but you (the nurse) have to make decisions [line 402]. You can have some good GPs who are very responsive… there are other doctors that you can't get hold of, they are like mercury [lines 416-420] Group C

Hence, nurses were "run off their feet" and "there were always risks for mistakes or drug errors or whatever" which transcends clearly nurses disillusion with the job. Nurses talked about "not doing it on their own back" and "risking so much litigation" because they knew that "nurses stab each other in the back". This

last quote was a powerful way to describe nurses own behaviour towards each other in times of uncertainty and conflict, in times of stress and difficulty.

> If I want to override the guideline I would seek a second opinion I would not do it on my own back. You need to get the other opinion as well to cover myself because we are risking so much litigation. The medical profession has already been very powerful, how many mistakes do doctors do make and they never get any sanction? Nurses don't have that at all. Nurses stab each other in the back [lines 678- 712] Group C

Nurses' hostile behaviour was particularly concerning to these nurses and they were clearly upset with how nurses treated each other in difficult and challenging situations.

> You can make your own decisions, but if your manager is pressurised by this business idea of how to run the hospital you end up arguing [lines 566-569]. Group C

> Our union does not match our autonomy whereas with the doctors if something was to go wrong they have the representative on the day itself with the management whereas if something goes wrong it's you and the management having a discussion about it, and you will want your union and (you) try to get an appointment takes ages. Your main insurance is very, very limited and that makes us (nurses) more cautious, warier [lines 747-758] Group B

> I am with the RCN and I don't think they are powerful enough for autonomous practitioners. There are episodes where you have gone to the union and the union hasn't backed you up but if you were a doctor there are there with you they stand in the dock. They will pay the lawyers they will be in discussions with your manager; I have seen that a lot with the nursing unions. They are not there [lines 729-745] Group C

Nurses reported that their professional values were constantly dwindled to fit the needs and demands of their organisations while nurse managers and nurse leaders failed to provide reassurances and support to nurses when needed. Nurses were reported to feel vulnerable, isolated and utterly disillusioned with the job and the expectations and demands placed upon them. Nurse leaders ought to support and advocate nurses to find their place in the current political, economic

and societal landscape, but also they needed to resolve the retention and recruitment crisis in the nursing profession.

3.11.2 Isolated

Nurses here reported some strong negative emotions related to their work and work environments. Nurses also reported that “most nurses are selfish” and they don’t help each other, but they also talked about feeling upset, emotionally exposed and isolated.

> Most of them (nurses) are selfish. They probably hear the same level… the same as we do [lines 433,445] Group A

> I got an allocated mentor who’s always away from me and if I approach somebody and ask about something they say ‘oh didn’t she tell you this? Ask her, stop asking me!’ [lines 555-558] Group A

They also talked about feeling isolated from each other as “the hardest thing” a nurse can do is to “sit and watch another nurse get crucified”. Such experiences may make a nurse to isolate and distance herself from the situation.

> it was the hardest thing in the world for me not to burst into tears and am not exactly a teary person. I am not exactly a shrinking violet but the hardest thing I had to do was to sit there for that afternoon (for the team building day) and watch crucify my manager at the time who’s now retired, that was it for her. But it was so upset at how vicious and bloody minded and ignorant these people were. And I went to the pub and got absolutely pissed… [lines 373-378] Group B

Nurses may isolate themselves because they fear they will “get the stigma” because “women are very unkind to women” as they “haven’t learned what a supporting team work is all about” and “this culture continues” and “nurses become danger to themselves”. This again was a powerful statement which pinpoints the issue of female gender of the profession and its barriers to the profession.

> If you are a bit more vocal or want to take it to the public arena, you are trouble maker, militant trouble maker. You get the stigma. Women are very unkind to women [lines 1013-20] if you work in an environment that you feel unsupported then you don’t want to support because you haven’t learned what a supporting team work is all about so of course this culture

continues [lines 1082-90] somehow it is linked to status and local power and make us nurses to become danger to ourselves [lines 1020-22] Group B

Furthermore, nurses also pinpointed that “women like to talk about it” but “they don’t like to get involved actively or politically”. Nurses tend to “talk about these things in small groups” because we “don’t feel powerful in the job”. These words summarise the nursing culture and psych.

I was just going to say that as nurses we are lacking involvement in the political side of the NHS. Nurses who are mainly women like to talk about it but we don’t like to get involved actively or politically and being vocal about our rights we tend to talk about these things in small groups and we don’t take it up in the public arena and this is because we don’t feel powerful in the job [lines 953-967] Group B

Breaking through barriers requires strong and ethical leadership, but also the nurse educators’ role is vital in nurturing professional autonomy and professional values. Nurses are the backbone of the NHS and are invaluable in the delivery and organisation of health and social care. Health care Innovation and technology may be able to level nurses with other health care professional’s autonomy should the right level of support and training is available to nurses.

Chapter 4. Discussion of Results

This chapter aimed at discussing the emergent themes from the analytic process of the data collected in the exploratory study, in phase I. As mentioned before in section 3.1.the overall aim of phase I was to elucidate a possible way to preserve nurses' wellbeing. In Chapter 2, it is argued that nurses' emotional response to pressures at work may be dependent on the individual's ability to appraise own and others' feelings and emotions, but also depends on other factors related to the work environment. Interestingly, results from this research support similar findings in the general nursing literature.

4.1. Emotional dissonance

One can argue that nurses may have lost the sense of their work importance and significance which may have led them to feeling negative about themselves and others and of course, their work. Nurses like most employees need to believe that their work is meaningful and they are useful and important, not "inadequate" to quote from the data. Nurses expressed many negative feelings amongst them emotionally exhausted, frustrated, disillusioned and undervalued which signifies the need to empower nurses and increase nurses' control over work. This emotional response to stress was identified in the general nursing literature reviewed as emotional exhaustion (Maslach, 1982), anxiety and irritation (Begley 1998).

Nurses understood that they needed to be seen to behave in a certain way and to fit in with the needs and values of their organisation despite that they may not necessarily accepted or understood why they were expected to behave that way. Nurses may felt frustrated and under much pressure which may have caused all these negative emotions. Nurses questioned their professional and personal values and obligations and they found these incompatible, hence emotional dissonance may be the reason why nurses reacted to work pressures the way they reported to be feeling about things at work.

Employees are expected to be usually able to adjust to the organisational values and goals, but nurses here reported to "suffer" from this "idea that the patient is important" and they struggled to readjust causing them internal conflict and unexpected changes in behaviour, such as feelings of isolation and frustration.

Furthermore, nurses reported that their heavy and taxing workloads are getting unmanageable and they are concerned over the effectiveness of their role. Nurses reported managing an overinflated workload almost invisible to others but mandatory for the nurse to complete as many nursing roles over the years expanded significantly and crossed-over other roles within the team.

Nursing leaders and managers may need to reconfigure the role and capture several aspects of the job which are currently not been recognised or rewarded in pay. Awarding nurses for their work can add value to the work nurses do and may reduce stress. Nurses need to feel appreciated and valued, particularly the younger nurses so they are encouraged and motivated to pursue a future career in nursing. These can be invaluable structures within the profession to progress younger nurses on to the next step in their careers and keep them in the profession for longer.

Work conditions are also important for experienced nurses as they also need to be supported to achieve their ambitions and progress in their jobs. They are also in need to get directed and guided because they are the back bone of the profession. Unmanageable work pressures can be demoralising for all levels of nurses and it is important that nurses perceive themselves as able to manage their workload and that they are in control of their work. Individual nurses may perceive their emotional abilities differently because individual characteristics may encourage positive and discourage negative emotional experiences by averting negative feelings and attitudes about self and others (Mikolajczak et al. 2007b). Therefore, empowering the individual may be key to this process.

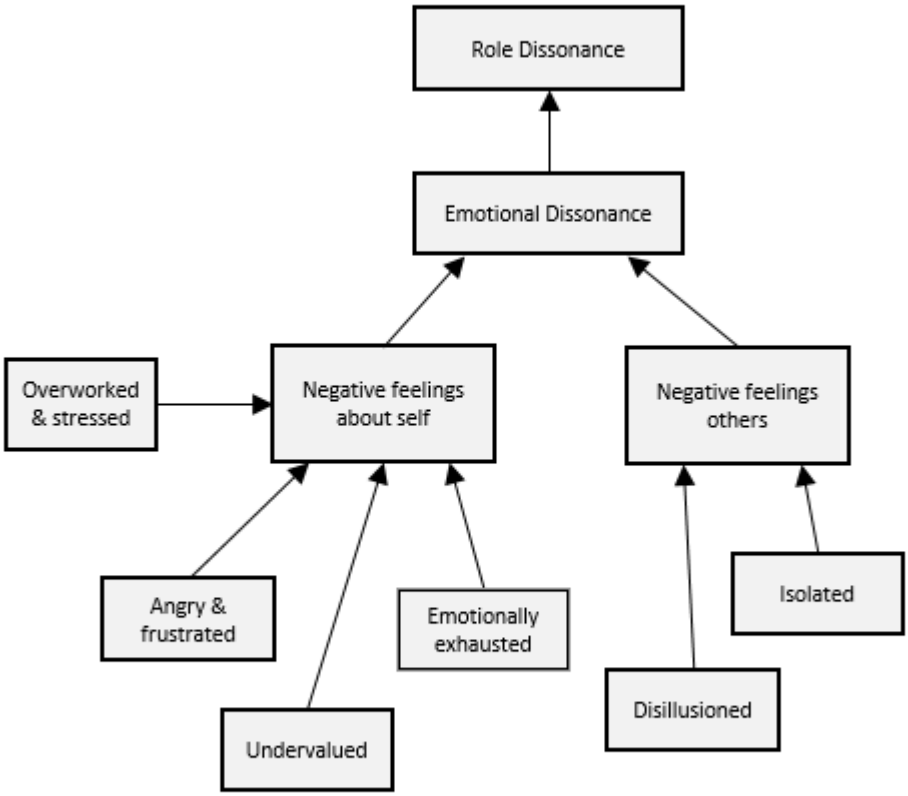


Figure 13. The emergence of role dissonance and emotional dissonance from the interpretative phenomenological analysis of the data from the exploratory study

4.2. Role dissonance

Strong and negative emotions experienced by nurses in this exploratory study may explain the low retention rate noted in recent statistics (NHS digital 2019) but such strong negative emotions may also be an underlying factor they lead nurses to negatively perceive their affective wellbeing at work and quit from nursing earlier than expected in their nursing careers. Nurses expressed some strong negative emotions which are found to be associated with role dissonance such as feeling being undervalued, frustrated and disillusioned with work, but also feeling disengaged and perceiving to have little or no authority in their jobs. This is evidenced in nurses' narratives, where nurses talked about their workload and how it affected them and their work but they also explained how lack of peer support

and management support contribute to them feeling isolated and disillusioned with the job. Interestingly, nurses in this study explained in their own words how important the nursing culture is to them and its significance to them feeling detached from their work environment. Nurses expressed their frustration with what is expected of them and to “tow the line” and to “understand” so they behave as expected. Nurses clearly argued that these expectations and demands on them were incongruent with their professional and personal beliefs of what is right and safe practice for the patient (Gevers et al. 2010; Van Der Tooren and De Jonge 2008; Finlayson et al. 2002; Laschinger et al. 2000).

They also talked openly about the little support nurses received horizontally (peers and colleagues) and vertically (management and senior management) in their workplace and they expressed feelings of frustration and anger and nurses reported to be drained and exhausted from the daily grind of working as a nurse. In this explorative study, nurses expressed feeling uncomfortable about certain aspects of their work, feeling isolated and overworked but also indecisive about their future in nursing. Nurses’ narratives in some cases, raise the issue of emotional dissonance (Mann 2005; Morris and Feldman 1997; Kahn et al. 1964), but fundamentally many expressed experiencing role dissonance in their job which may be the step before exiting nursing.

There is an increasing number of nurses, particularly younger nurses, who leave the profession early in their career because of mental health illnesses such as anxiety and depression. About 33,000 nurses leave the NHS each year reported by the NMC in 2017 and movements such as the Capital Nurse Movement (2017) were put in place to stop the haemorrhaging of nurses from the service, however this phenomenon continues to be a significant problem for the profession (RCN, 2020; NMC, 2019; The Guardian, 2019) despite significant efforts to support nurses early on in their careers, such as the NHS one year long preceptorship scheme which aims to enable newly registered nurses develop the skills and competencies to take up their new roles. Role dissonance can also be described as lacking in capacity for one person to care for self and own wellbeing (Couser, 2008) and the significance of this finding of this research is critical in understanding nurses’ experience of their work-related wellbeing. Role dissonance may explain why nurses may become less aware of the importance to care for themselves and lose perspective. Nurses may also become even more

disillusioned with the job as they become increasingly more aware that their expectations do not match the expectations of others putting them at risk of experiencing more negative emotions and feelings such as anxiety and distress (Lombardo and Eyre, 2011).

4.3. The role of self-awareness in emotional and role dissonance

Nursing work is about caring and helping others therefore, nurses are expected to understand another person's perspective and maintain a strong sense of direction in order to be able to steer the patient without forcing him. Therefore the nurse needs to pay attention to what's happening around her and be aware of her environment, so that the nurse is able to provide appropriate and safe care (Pieterse et al 2013). Reflection may help the nurse develop such awareness and enable the nurse to interact with the environment appropriately.

The fact that nurses reported in this phase of the research feeling devalued, stressed and demoralised, is indicative of nurses being aware of work environment factors that contribute towards feelings of emotional and role dissonance but they are not aware how they can reverse these negative feelings and experiences into positive feelings and learning opportunities. Student nurses and registered nurses may experience some particular distressing events or experience trauma therefore, they need more than self-reflection on the negative experiences and negative feelings, they may need to reposition themselves and they may need to be steered carefully and guided through those traumatic experience and negative feelings before they can re-contextualise their experiences. This is of particular importance to those nurses who are sitting on the fence and they may not experience vivid signs of distress yet. This group of nurses may benefit from being coached carefully and from being engaged in some self-analysis and self-awareness, which may enable them to understand why they may feel the way they do, how they may need to re-appraise these events in order to change their mood, attitudes and behaviours towards work life and therefore, understand how these may affect their perceptions of their wellbeing at work. Therefore, it is argued here, that a training intervention built on the principles of trait emotional intelligence may enable the trainee to reflect under careful supervision and re-evaluate difficult or challenging experiences and finally re-contextualise this experience and develop.

This way by improving trait emotional intelligence one can address emotional dissonance as this will allow the trainee to appraise one's work needs and work life may generate positive feelings such as work and life satisfaction but also offer nurses a way to control their experiences and use it as a preventative measure to help nurses understand their feelings and emotions about work and in particular, affective wellbeing at work. Festinger (1957) and later on Scher and Copper (1989) linked emotional dissonance with motivation and they explained how dissonance can affect an individual's wellbeing as it is considered to be a discrepancy between what a person believes should happen and what actually they think is happening.

This discrepancy may explain why nurses end up feeling negative emotions about themselves and others. Nurses in this study expressed some strong emotional dissonance in their narratives but the original finding is role dissonance, which is linked to nurses' negative experiences and emotions, related to nurses' agony over their roles and the feelings of being inadequate for the role, as they appear to believe they are not achieving in their current jobs and roles. By addressing emotional dissonance that way role dissonance should also improve. Nurses reported feeling inadequate for the care done or undone for patients, they were angry and frustrated and felt disappointed and distant from their roles and jobs. Many of them thought about quitting the job in order to relieve themselves from the negative feelings and emotions they experience in the job and felt responsible about. This may explain to some degree the role dissonance these nurses experienced which is also reported to be explained by the nurses as personal responsibility for the standard of care provided. Personal responsibility is directly associated with the dissonance experience which is the feeling that one feels deeply personally responsible for what happens around them and may explain some of the national statistics on nurses in the literature.

These nurses may, therefore, benefit from some coaching focused on reflection and re-examination of what they think or perceive they need or can do to keep them motivated, afloat and engaged within the current context of nursing. Nurses may need to be coached carefully on their perceived personal responsibility and negative feelings about work and focus them more on self- awareness and self-care abilities which may impact on their perceived affective wellbeing. This work is pivotal for the future of the profession because there is data from this study

that signals high levels of negativity in mood, attitudes and behaviour in nurses which need to be addressed.

4.4. Self-awareness and emotionality

Self-awareness is central to understanding one's self, but also in the development and growth of a person, it is also the building block of a person's emotionality and the cornerstone of trait-emotional intelligence. Self-awareness is an integral part of a person's self-esteem and self-concept and it is based on the person's subjective experiences, which is their perceptions of their experiences. With younger nurses leaving their jobs because of anxiety and depression and other mental health illnesses (NHS Digital 2018), it's imperative that the role of self-awareness in nurses' emotionality is re-examined and re-evaluated (Hoeve et al. 2017; BBC 2017; Aiken et al. 2013; Black 2008) and developed using trait-emotional intelligence activities and methods to develop nurses' self-awareness and emotionality. Furthermore, the literature review also suggested that individuals with high emotional intelligence may respond to emotion-laden experiences and encounters far more competently and may be able to maintain positive mental states for longer (Zeidner and Shani-Zinovich, 2011) which is suggestive of emotional intelligence's moderating and salient role for high emotional labour professions such as nursing.

Emotionality is also one of the four factors of trait emotional intelligence as explained in the research led by Petrides (2001). According to his definition trait emotional intelligence integrates the affective aspects of personality, suggesting that emotionality may significantly impact on one's self-esteem and affective wellbeing. Therefore, emotionality is about feelings, emotions but also the bodily sensations associated with these feelings and emotions and it is also defined as the emotional response to a stimulus but it is also a transactional process similar to the stress process with observable behavioural as it is a physiological component of emotion. Therefore, developing self-awareness it is possible that positive emotionality is also developed and higher levels of trait emotional intelligence scores recorded which may translate in healthier choices and behaviours.

In the past two decades, there was a substantial decrease in government funding towards nursing education and training, but also towards nursing workforce development. The NHS funding was reduced significantly which was translated into

wider restructuring of the NHS and services. These changes implicated further the organisation of services within the NHS and more demands were put on nurses to deliver high standards of care with less staff (Bégat et al. 2005; Grandey et al. 2005; Grandey, 2003). The new NMC education standards for nurses (NMC, 2019) were put in place to address the issue of skill mix in the nursing workforce, which deteriorated in the past decade due to chronic shortage of staff but also due to large numbers of senior nurses retiring from their jobs. The recruitment targets set by the government for universities for student nurses were up by twenty five percent for 2019 and fifty percent by 2020 (Buchan, 2019). Therefore, it is argued that retention more than recruitment of nurses, either registered nurses or student nurses, appear to be the way forward in addressing the problem of permanent shortage of nurses in the NHS and a better approach to workforce planning.

4.5. The development of a transactional model for nurses' affective wellbeing

In the nursing literature, emotional labour is considered to be a significant occupational stressor for nurses (Hochschild, 1983) because nurses are expected to actively manage their feelings and display positive emotions as part of their caring role. This, in turn, may explain the results of the exploratory study in phase I which highlighted nurses' feelings of emotional dissonance but also role dissonance (inauthenticity of the nursing role). The protective role of trait emotional intelligence may be of particular benefit to the nursing profession in the long future in terms of recruitment and retention in the profession. Interestingly, some research found that emotional intelligence can be developed over time. It is argued that when individuals use their emotions more flexibly in the workplace, they may exercise better self-control and deal with their work environment more efficiently (Petrides et al. 2004). Therefore, it is argued here that if emotional support given to nurses by developing their level of emotional intelligence needed in nurses' work this improvement in nurses' emotional intelligence may improve also nurses' perceived health and affective wellbeing at work. Karimi et al. (2014) undertook a cross-sectional survey on 312 community nurses and asked them to complete measures on emotional intelligence, emotional labour, job-related stress and

general wellbeing. They hypothesised that a higher level of emotional intelligence is associated with a lower level of job-related stress and possibly higher level of general wellbeing. They used the SREIT by Schutte et al. (1998), the General Wellbeing Questionnaire by Cox (1985) and the Emotional Dissonance Scale by Zapf et al. (2001) to collect data from the nurses. Higher levels of SREI were reported to be associated with higher levels of wellbeing ($b=0.29$, $p<0.01$) and less experience of job-related stress ($b= -0.12$, $p<0.05$). In addition, community nurses were found to score lower levels of wellbeing ($b=-0.18$, $p<0.01$) and higher levels of job stress ($b=0.35$ $p<0.01$) if they had scored higher on emotional labour ($b=-0.12$, $p<0.05$). This study may suggest the possibility of a link between emotional intelligence, emotional labour and wellbeing, but further research is needed to confirm these findings further. They also found that nurses experiencing more emotional labour in the job, they also experienced lower level of wellbeing ($b=-0.18$ $p<0.01$) and higher levels of job related stress ($b=0.35$ $p<0.01$) reported. This study may suggest that trait EI plays a salient role for high-level emotional labour professionals such as nurses.

Sailaxmi and Lalitha (2013) also run an intervention study on 53 nurses working in an intensive care unit in a hospital in India. Nurses were offered 10 taught sessions on stress management and participant nurses were found to report reduced stress ($M=57.45$ pre-intervention and $M=41.06$, post-intervention), but there was no control group in this study therefore, these findings need to be treated tentatively too. In a similar study to the above, Light and Bincy (2012) offered a mixture of training such as time management, assertiveness, muscle relaxation and stress awareness to 30 nurses, who reported better wellbeing post-training, but there is confusion over the design of the research study as well as the measures used to collect the data. A repeat study may shed light into these findings.

A longitudinal study carried out by Cheng et al. (2012) on 157 Chinese nurses found that nurses with higher levels of emotional intelligence reported fewer somatic complaints such as increased heart rate, dizzy spells and trouble sleeping ($b=-.21$, $p<.01$), and they argued that emotional intelligence appears to moderate somatic complaints when job security is at risk. This study aimed to assess impact of emotional intelligence on the physical (somatic) health and wellbeing rather than

emotional wellbeing, they are encouraging findings, although this study's focus was on organisational commitment and emotional intelligence.

A study carried out by Por et al. (2011) found a negative correlation between emotional intelligence and perceived stress (r_s=-0.40, p<0.01) in a small sample of student nurses, and they also found that students with the highest educational background had the strongest correlation with emotional intelligence (r_s=0.23, p<0.01), followed by age (rs=0.18, p<0.05), which may suggest that education and age are important contributing factors towards the development of emotional intelligence. However, this is a small scale study so findings should be treated with caution.

Benson et al. (2010) conducted a cross-sectional longitudinal study on emotional intelligence on 100 baccalaureate nursing students. They measured the emotional intelligence level of student nurses over a four-year training programme and compared stress levels among students at different years of study. They used the short version of the Bar-On EQi measure on 25 students from each year. They argued that there was a statistically significant positive linear association (p<0.05) between year of study and emotional intelligence skills and reported that there was a significant increase in scores from Year 1 to Year 4 on the interpersonal and stress management scale, but correlations were reported low.

In another study led by Noorbakhsh et al. (2010) on a large survey on undergraduate students, found that problem-focused coping styles accounted for 28 per cent of the variance and these styles were positively correlated to emotional intelligence (R=0.532, F=53.88, p<.001). Furthermore, in a study by Petrides et al. (2007), young adolescents who scored high on trait EI were also found to cope better with everyday life than those who scored low on emotional intelligence. This research also suggests that trait EI may reduce somatisation of depression in young adolescents by improving their coping styles and general health.

Beauvais et al. (2011) also conducted a descriptive correlational study of 138 students to determine the relationship between emotional intelligence and nursing performance among nursing students, but most findings were inconclusive due to a very low response rate. In a similar vein, Fletcher et al. (2009) conducted a pilot study on third year medical students, assessing emotional intelligence training and communication skills. Unfortunately, they did not describe their intervention but described how they proceeded with the intervention only. There were no significant

results to report from this study due to a high drop-out rate and a very low response rate.

Nelis et al. (2009) also conducted a study looking at whether emotional intelligence can be developed with training. Nineteen psychology students were assigned to a training group and 18 students were allocated to a control group. Students in the training group were given four sessions of two and half hours teaching for four weeks. The training included teaching on: (a) Mayer and Salovey's ability emotional intelligence theory and model; (b) multiple components of emotion and emotional perception and (c) Ekman, Friesen and Tomkins (1971) and Gross's work (1998) on facial expressions. Researchers used several detailed measures to collect data on these students, such as (a) the TEIQue measure by Petrides and Furnham (2001); (b) the Emotion Regulation Profile Questionnaire (ERP-Q) by Mikolajczak and Luminet (2008); (c) a vignette based measure; (d) the Emotion Management Ability Test by Freudenthaler and Neubauer (2005); (e) the Dimensions of Openness to Emotional Experiences (DOE) by Reicherts (1999a); (f) the Toronto Alexithymia scale (TAS-20) by Bagby et al. (1994); and (g) the Situational Test of Emotional Understanding by MacCann and Roberts (2008). However, they found that the measures scored low on internal consistency in this study (they ranged from 0.33-0.66 except for TAS-20), probably because of the very small samples. However, they did find that the training group scored significantly higher on TEIQue after training at T_2 ($M=673.78$, $t(18)=-1.05$, $p=0.308$) and at T_3 ($M=685.36$, $t(18)=-2.25$ $p=0.036$) in comparison to the control group at T2 ($M=661.78.$, $t(17)=0.01$, $p=0.998$) and at T_3 ($M=661.59.$, $t(17)=-0.02$, $p=0.981$). This research may suggest that traits that are considered relatively stable over time can be modified by intensive training, which in itself is an encouraging finding. However, this training was not linked to an outcome, therefore, their claim that emotional intelligence can be developed is treated with caution.

A large study across a sample from the general population by Gallagher and Vella-Brodrick (2008) reported a positive interaction among emotional intelligence, social support and subjective wellbeing at low and high levels of emotional intelligence (Low: $b=0.4217$, $t=4.7152$ $p<0.0001$; high: $b=-0.0617$, $t=-0.6903$ $p=0.2454$) and positive affect. This suggests that social support may not always be necessary for subjective wellbeing while emotional intelligence may be. This study used self-reported measures on a large general sample, therefore these findings

cannot be directly transferred across to a nursing sample, yet it offers some insight into the role of emotional intelligence as an individual characteristic in the stress and wellbeing process. Notably, in most nursing studies emotional intelligence was measured either by the TMMS by Salovey et al. (1995) or the SREIT by Schutte et al. 1998). Both scales view emotional intelligence as a three-intrapersonal dimension concept that consists of: (a) attention to feelings; (b) emotional clarity and (c) own emotion repair. Further research is needed using a variety of emotional intelligence measures in order to establish further the validity and reliability of the emotional intelligence measures but also approaches to develop emotional intelligence.

Landa et al. (2008) measured the emotional clarity, emotional repair and emotional attention of 197 nurses. They measured occupational stress using the Short Form Health Survey (SF-36) by Ware et al. (1996) and reported that nurses who scored below 33 in emotional clarity, emotional repair and emotional attention were low on emotional intelligence, while those who scored above 67 were high on emotional intelligence. They reported a low significant difference in health outcome between those low and high on emotional regulation. Interestingly, they found that younger nurses reported being more motivated and satisfied with work than older nurses. Married nurses reported overall better health than single nurses. Finally, this research found that some particular aspects of emotional intelligence, as opposed to overall emotional intelligence, correlate to some health outcomes, but the correlations were low, therefore these findings should also be treated tentatively.

Morrison (2008) conducted a small survey of 94 nurses to find out how the conflict-handling styles of registered nurses are related to stress. The Emotional Competence Inventory by Goleman (1998) and Thomas-Kilmann Management of Differences Exercise Instrument (1974) were used to collect data. The findings were also inconclusive because of low correlations. Mikolajczak et al. (2007a) carried out an experimental study on 56 students in order to first examine the extent to which trait EI buffers the relationship between a laboratory stressor and subjective (mood) and objective (salivary cortisol) responses of the participants to that stressor, but also examine the added value of trait EI to predict cortisol secretion and mood change vis-à-vis concurrent predictors. They found that high

and low emotional intelligence people differ in their overall responses to potentially stressful situations, yet they found no significant results in their study.

In another cross-sectional study, by Austin et al. (2008) on a large sample of university students, emotional intelligence was found to be negatively associated with emotional labour. This study argues that emotional intelligence may moderate the emotional labour process. It would also appear that individual characteristics, such as extraversion and neuroticism, may influence emotional labour behaviour, but the findings were inconclusive.

Mikolajczak et al. (2007b) carried out a longitudinal study to explain the protective role of trait EI on emotional labour and stress. The study run over several months and 124 nurses completed the questionnaire at T_1. Only 49 nurses followed it up by completing the second questionnaire at T_2. This study found that trait EI related negatively to burnout ($r=-0.58$, $p<0.001$) and somatic complaints ($r=-0.27$, $p< 0.1$). Therefore, these results are promising and repeat studies are needed to further confirm these findings.

Montes-Berges and Augusto (2007) explored the relationship between perceived emotional intelligence, coping, social support and mental health in nursing students. The hypothesis for this study was that emotional clarity and repair would be positively related to adaptive coping strategies. The measures were (a) the TMMS by Salovey and Mayer (1995), (b) the Coping Scale by Basabe et al. (1993), (c) the Vaux's Subjective Social Support and Objective Social Support scale by Conde and Franch (1986) and (d) the Mental Health 5 scale by Ware, Sherbourne and Davies (1992). This study found some relationship between these factors but the directions of these relationships were not consistent and may be indicative of complex interactions. Student nurses who were better supported socially may experience a greater feeling of emotional clarity and subsequently, they may experience personal emotional repair more often that those with less social support. Emotional clarity was negatively associated with behavioural and cognitive coping and repair was positively associated with objective social support and mental health. Correlations were very low, so findings from this study should also be treated tentatively.

Oginska-Bulik (2005) surveyed a large mixed sample group of 330 participants including nurses, teachers, physicians, managers and probation officers. They completed a revised version of the SREIT by Schutte et al. (1998), in

Polish, and the subjective work evaluation questionnaire by Dudek et al. (1999). The internal reliabilities for these measures were reported to be 0.84, and participants also completed the Polish version of GHQ-28 by Makoeska and Merecz (2001) to measure their general health. However, the findings from this large survey were conflicting. For example, probation officers were reported to score the highest on emotional intelligence (M=127.72 SD=16.36) and teachers were reported to score the lowest emotional intelligence (M=117.42, SD=12.80, $p<0.01$), yet when these findings were correlated with health, probation officers scored the worst for health (M=25.52 SD=12.94) while teachers scored the best for health (M=17.18 SD=9.93).These findings are confusing and they should also be treated with caution.

Humpel and Caputi (2001) conducted a small study with 43 mental health nurses to determine the relationship between emotional competence and work stress. They used a number of measures, such as the symptoms of depression as a measure of stress by Lazarus and Folkman (1984a and 1984b) and the MEIS by Salovey and Mayer 1990), but the findings were inconclusive because of low correlations due to the small sample employed. Interestingly, nurses who had worked for more than six years in their jobs were found to score higher on emotional competency r=0.36, while nurses who had worked less than five years scored less on emotional competency r= 0.32. Length of time in the job was positively associated with emotional competency (r=0.35, p=0.027), but emotional competency was not found significant in relation to stress.

Ciarrochi et al. (2002) conducted a large cross-sectional survey on 302 students, including student nurses, psychology students and art and sciences students. Most findings were inconclusive, apart from that emotionally perceptive people reported higher levels of depression, hopelessness and suicidal ideation (M=0.65, M=0.43 and M=0.54 respectively).

This literature review highlighted the need for further research studies, in particular longitudinal and experimental research studies as these research designs can allow more sophisticated statistical tests to be employed. Also, larger and more homogenous samples might produce more consistent findings and therefore, increase the generalisability of results across populations. Follow-up measurements should also be built into the research design of future studies to enable evaluation of the long-term efficacy of research outcomes. However, there

was some evidence that emotional intelligence may moderate wellbeing, but there is currently little scientific evidence to support this assertion.

Figure 14 below is a visual representation of the results from this exploratory study which are interpreted within the current evidence from the literature in order to understand and contextualise the meaning of emotions and emotionality in the nursing work. This figure starts with nurses' negative emotions and feelings to explain emotional dissonance in nurses and the original finding from this research of role dissonance which may explain nurses' self-care inability which may lead to further anxiety and distress, but also depression in terms of affective wellbeing. Nurses may also suffer from dissatisfaction due to role dissonance and low motivation which may lead nurses to decide to quit their jobs and in effect lead to further shortages of nurses. It appears that these problematic areas recycle themselves to lead to more emotional dissonance, role dissonance and negative emotionality which deepens nurses perceived low affective wellbeing.

Figure 14. Role of feelings and emotions in nursing work and its effect on nurses' perceived affective wellbeing and nursing shortage

The results from this exploratory study highlighted the need to understand nurses' emotionality within the framework of emotional intelligence. It is also critical to evaluate this transactional process of affective wellbeing but within the work environment where nursing culture is an important characteristic of their work environment. A different approach to address nurses' affective wellbeing at work is needed to address the person-work interface and contextualise the problem of nurses' low self-esteem and negative emotionality. Existing conceptual frameworks can be used to contextualise nurses' reality and evaluate significant factors, which the literature and the results from this work may suggest to moderate or mediate the affective wellbeing. The process of developing a transactional model to explain nurses' affective wellbeing is considered necessary in order to evaluate the impact of an intervention to reduce role dissonance for nurses.

The occupational stress model by Cooper and Payne (1991) and Warr's (1990) affective wellbeing model were chosen to be used in the design and development of this transactional model for nurses' wellbeing and trait emotional intelligence was chosen as the way to evaluate whether neuroticism (negative emotionality and a stable trait) and sense of mastery (self-control) can moderate affective wellbeing and other work related outcomes reflecting the structure of Cooper and Payne's model.

This transactional model focused on individual characteristics which may be affected by nurses' work environment such as neuroticism (negative emotionality) and sense of mastery (self-control). These individual characteristics were chosen to be the mediators in this model. A mediator is a variable that is responsible for the transmission of an effect, but cannot alter the nature of that effect (BarOn and Kenny 1986). Trait emotional intelligence was chosen to be the moderator which is a variable that can alter the direction or strength of the relationship between two other variables. Neuroticism and sense of mastery may either intensify or abate the effect of environmental characteristics on affective wellbeing and health. Therefore, trait emotional intelligence was chosen to be the moderator for neuroticism and sense of mastery but also for coping, affective wellbeing, anxiety and depression and control at work. It is highlighted here that mediators refer to a variable that is involved in a causal relationship between a predictor and an outcome and they can either increase or reduce the impact of a particular characteristic (BarOn and Kenny 1986). The moderator, on the other hand, is the effect that usually refers to

an interactive effect that changes the magnitude and/or direction of the effect of A on C, which depends on the level of B (Arnold 1982).

It is apparent that emotions play a salient role in nursing work and trait emotional intelligence can be developed (Petrides and Farmham 2001) but there is a need to evaluate the effectiveness of a tool or method. This has to focus on the individual's emotional intelligence and increase the four factors found in trait emotional intelligence. The aim of the method or tool (intervention) was to unlock nurses' self-awareness.

The literature review so far found that emotional intelligence may link to health outcomes for nurses but low correlations or inconclusive findings needed to be addressed by studies more robust in design and use of more powerful statistics to address the problem. Interestingly, some of the studies reviewed pinpointed that emotional intelligence can be developed and nurses may benefit from it by enabling nurses to become more aware of their emotions and behaviours at work but also their perceived wellbeing at work. The suggested transactional model for nurses' affective wellbeing at work, shown in Figure 15, suggests that an intervention (tool or method) is to be used to develop and improve awareness in nurses. This intervention suggested in the model may develop and increase emotional intelligence, which has been linked with health outcomes in the literature reviewed but low internal reliabilities demand repeat studies to provide stronger evidence on this. This model also suggests that neuroticism can be reduced if trait emotional intelligence is developed high and sense of mastery may increase if high trait emotional intelligence is developed too. Individual characteristics are found to either moderate or mediate the stress and coping processes, because they distinguish individuals from each other in the way they react to stress and cope with stress. Individuals tend to react and behave in a certain way because they draw upon these characteristics which may move them towards or away from a certain reaction or behaviour (Pearlin and Schooler 1978). Dispositions such as neuroticism may affect how an individual or a nurse perceives stress and wellbeing, high neurotic individuals tend to perceive stress sources far more threatening than they may be, therefore their experience and behaviour may be different from others with lower neuroticism. Therefore, individual characteristics may contribute to higher or lesser degree in one's perceptions and behaviour. Individual characteristics were included in Cooper and Payne's model of

occupational stress such as coping behaviour and neuroticism and they were used to explain variance in health outcomes. The proposed transactional model for nurses' affective wellbeing puts neuroticism and sense of mastery central to this model's structures because these were found to be related to nurses' work and therefore they were considered to be principle meditators between trait emotional intelligence and affective wellbeing and other health outcomes for nurses. Trait emotional intelligence was chosen to be a strong individual characteristic and moderator which is suggested that it may affect neuroticism and sense of mastery both directly and non-directly. The role of trait emotional intelligence is viewed in this research as significant in the relationship between neuroticism, sense of mastery and affective wellbeing.

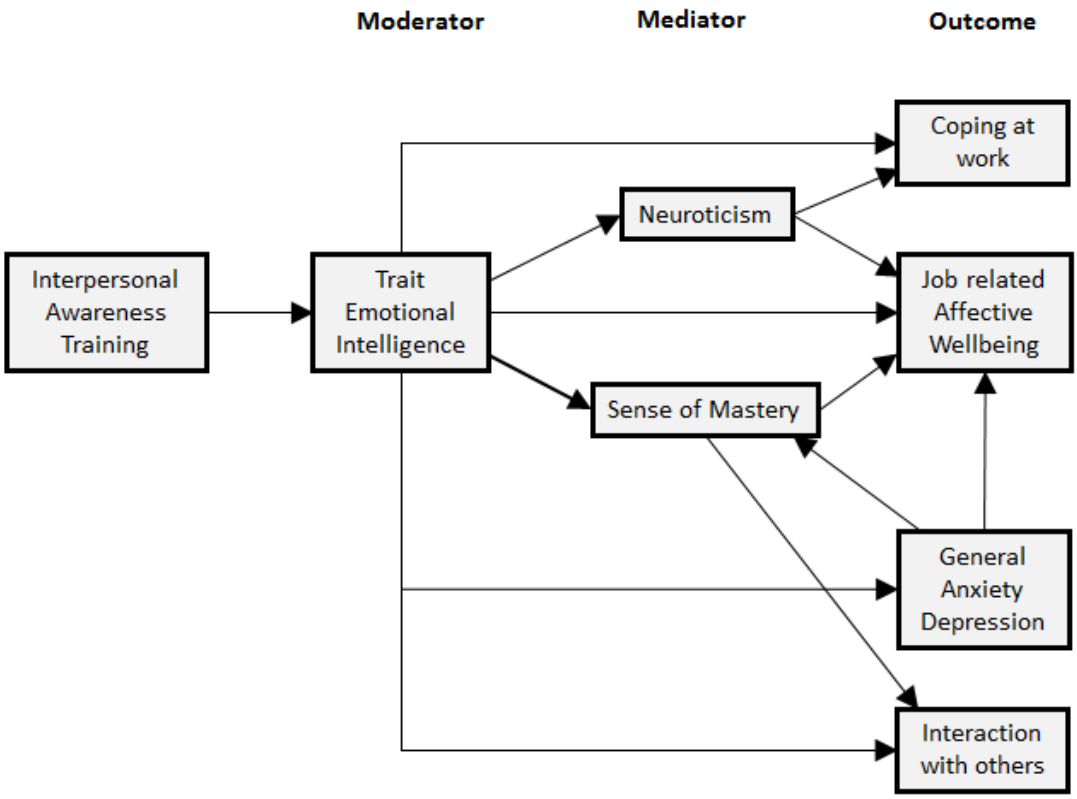


Figure 15. The transitional model for nurses' perceived job related wellbeing suggested in this research built on the IPA data from the exploratory study and the literature review on nurses' wellbeing at work

These characteristics can then be found to either moderate or mediate perceptions of experiences, hence setting up goals may be confusing for the

individual. Therefore, developing self-awareness is pivotal for the individual in order to check up on their goals. Personality traits have been found to be strong predictors of affective wellbeing (Costa and McCrae 1980) and they have some degree of stability and consistency, but importantly they can be developed. This is key to the rationale for the intervention in this thesis

Historically, personality was viewed as an assortment of different traits grouped into domains and types, but in 1923, Jung (1953) argued that there were two main domains or types of personality – introverts and extroverts (Jung 1953) and that there is a continuum of individual differences rather than discrete types of personality. Cattell (1946) found that personality is made of a structure of traits rather than types and he argued for the trait theory which recognises that there were sixteen primary factors and eight second-order factors that can describe a personality (Cattell's 1948). However, Fiske (1949), who conducted a repeat study using 21 of Cattell's bipolar scales and found that there were only five factors. Similarly, Tupes and Christal (1961) found a five-factor solution in their research, supporting Fiske's results. Later on Eysenck and Eysenck (1969) found an even smaller number of traits following factor analysis of Cattell's 16 personality factors (16PF).

Goldberg (1981) also analysed a large number of adjectives used to describe traits and he also found that the McCrae and Costa "Big Five" model can explain personality and further work undertaken by Costa and McCrae (1985) helped produced the "Neuroticism Extraversion and Openness Personality Inventory" (known as NEO-PI). McCrae and Costa (1985) tailored their inventory around the five-factor model and added 40 scales to the set of 40 developed by Goldberg (1981), who found that the five trait scores of NEO-PI from Costa and McCrae (1985) correlated highly with the Big Five solution that he had found, hence established convergent validity of the NEO personality inventory (NEO-PI).

Personality may influence individual behaviour, choices and general health (Cohen and Edwards, 1989) because personality traits are fairly stable over long periods of time and they can interact with environmental characteristics and vice versa hence, they were found to be critical in predicting a person's behaviour. Cooper's occupational stress model and Warr's Vitamin Model for example, explain to some extent the interrelationship of these characteristics but they don't necessarily explain how these characteristics or which of them can be developed

to enable the individual perceive higher affective wellbeing. However, these models recognise the role of individual characteristics and environmental characteristics within the work, non-work and context-free domains and they offer a more comprehensive explanation of the outcome variables. The current model built on these models aims at showing that if neuroticism can be reduced and sense of mastery increased, by increasing trait emotional intelligence, then nurses' perceived affective wellbeing may also increase. The building blocks of this model are trait emotional intelligence, neuroticism and sense of mastery and there is a suggestion in the literature that such a hypothesis may be supported, as there are several processes found to mediate associations between individual characteristics and affect (Matthews et al. 2003). This model was designed to focus on the individual characteristics, as they can be more easily manipulated in a research context than environmental characteristics, such as the workplace factors. Furthermore, the results from the exploratory study helped pinpoint the transferability of emotions in nurses' work, perceptions of their experience and perceptions of their affective wellbeing.

The literature review also highlighted that certain characteristics to be more prevalent in negative individual behaviour for example, individuals high on neuroticism were found to be more susceptible to higher levels of perceived anxiety, anger and feelings of isolation but also interpersonal sensitivity. These individuals are described in the general literature as experiencing a greater number of the negative feelings and emotions and low moods. These transactions may be mediated by cognitive drivers of affect such as coping (Costa and Paul 1996), but individual characteristics are the main drivers of individual patterns of thought, emotions and behaviours (Funder 1997).

This model also builds on the role of awareness in relation to trait emotional intelligence and in relation to perceived affective wellbeing and behaviour (Petrides and Furnham 2000a and 2000b; Costa and McCrae 1992). The role of neuroticism cannot be undermined as it is found to relate to distress, worry and anxiety which also leads to emotion-focused coping (Matthews et al. 2006). Neurotic individuals tend to amplify and sustain negative mood responses (reactivity), whereas an individual low in neuroticism tends to tone down such responses (Mroczek and Almeida 2004). Therefore, a person high in neuroticism may experience more negative affect and they may need to be helped by offering more clear guidance

and direction because they have difficulty in coping with exposure to stress and life's demands affecting dramatically their perceived life and work experiences and their mood.

Emotional intelligence may therefore influence coping behaviour and a person's coping efficacy positively, because it may moderate neuroticism positively and mediate perceived affective wellbeing (Zhang and Tsingan 2014), however, there are no concrete findings to support such association. Emotionality is linked to neuroticism because emotionality describes observable behaviour and is the sensational component of emotion (physiological or bodily component), hence it may affect health. In a large-scale cross-sectional study on high school students carried out by Sutton et al. (2011), high levels of neuroticism were found to be associated with self-reported anxiety and depression and high neuroticism appeared to be the most dominant trait in explaining variance in affective wellbeing in school children. This may be because individuals high on neuroticism may have a tendency to respond negatively or to a disproportionate degree to difficulties and challenges and be exceedingly self-critical (McCrae and Costa 2003).Therefore, individual with high neuroticism experience distress, negative feelings and their mental health suffers (Sutton et al. 2011). Interestingly, Matthews et al. (2006) found emotional intelligence to contribute significantly to the prediction of worry ($r=-0.407$, $p<0.01$), distress ($r=-0.315$, $p<0.01$) and emotional focus ($r=-0.373$, $p<0.01$) which may suggest that emotional intelligence may moderate the effect of neuroticism on coping. This research was valuable to the development of the model. Neuroticism refers to individual differences in negative emotional response to threat, frustration or loss (Goldberg 1993; Costa and McCrae 1992) but it also refers to irritability, anger, sadness, anxiety, worry, hostility, self-consciousness and vulnerability. Those individuals high on neuroticism are usually self-critical, sensitive to the criticism of others and feel personally inadequate (McCrae and Costa 2003) and is a major individual characteristic (Matthews, Deary and Whiteman 2003; Costa and McCrae 1992; Eysenck 1947).The proposed model aimed at addressing the gaps identified in the literature reviewed and enabling the development of a tool or method to develop trait emotional intelligence.

Chapter 5. Intervention

5.1 Literature review on emotional intelligence

The building block of this intervention is self-awareness, which is central to emotional intelligence as a concept and a construct. Emotional intelligence was considered a newly developed construct in the 1990s but appeared in the early work of Thorndike in the 1920s, who talked about “social intelligence” and “understanding of people”. Similarly Gardner discussed an “interpersonal intelligence” in his theory of multiple intelligences and these two theorists identify a form of social intelligence as the ability to identify, assess and control emotions of oneself, of others and of groups. In reviewing the current scientific literature, emotional intelligence theories and models are found to fall into three main categories: (a) the ability emotional intelligence models (Salovey and Mayer 1990), (b) the mixed emotional intelligence models (Goleman 1998 and Bar-On 1987) and (c) the trait emotional intelligence models (Petrides and Furnham 2001, Dulewicz and Higgs 2004). The ability models of emotional intelligence refer to the capacity to think about feelings and the ability to perceive emotion, integrate emotion to facilitate thought, understand emotion and regulate emotion to promote personal growth (Mayer and Salovey 1997). Ability-based models regard emotions as useful sources of information that help a person to make sense of and navigate the social environment (Salovey and Grewal 2005). They proposed that the brain has a separate processing system for dealing with emotional information which detects, considers, processes and regulates emotions within the overall thinking process. They asserted that having emotional intelligence depends on the ability to process emotional information and to use core abilities related to emotions.

Mayer et al. (1992) found that individuals were repeatedly reflecting on their feelings, evaluating and regulating them and adapting their behaviour and they named this process as the “meta-mood experience”. They also developed the Trait Meta-Mood Scale (TMMS) which is a 48-item self-report measure that includes three sub-scales: (a) attention (perceived ability to attend to moods and emotions), (b) clarity (perceived ability to discriminate clearly among feelings) and (c) repair (perceived ability to regulate moods) (Salovey et al. 1995). Cronbach’s alphas for this measure were reported to range from 0.82 to 0.88, with clarity found to be

associated with greater skill at mood repair (r(104)=0.52 p<0.001) and repair associated with greater levels of satisfaction with interpersonal relationships (r(93)=0.39 for clarity (r(94)=0.31 for repair p<0.01). Salovey and Mayer (1990) suggested that emotional intelligence involves verbal and nonverbal assessment and expression of emotions, control of emotions and the use of emotion in solving problems as they argued that this ability model of emotional intelligence focuses exclusively on the interplay between emotion and intelligence. They also proposed that the individuals vary in their ability to process information of an emotional nature and in their ability to relate emotional processing to a wider cognition.

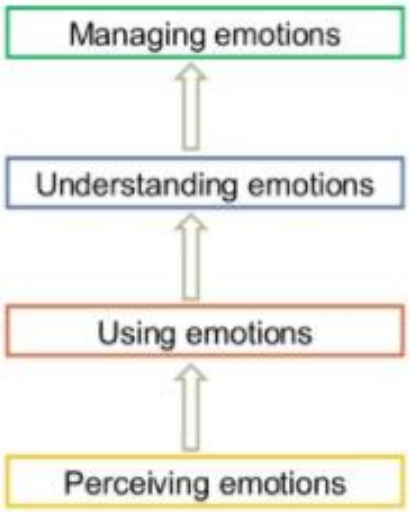


Figure 16.Mayer and Salovey's Ability Emotional Intelligence Model (1987)

Also, Salovey and Mayer (1990) regarded intelligence as the aggregated or global capacity of the individual to act purposefully, to think rationally and to deal effectively with his environment, but they differentiated emotional intelligence from other types of "intelligence" such as cognitive intelligence. They also argued that emotional intelligence is not genetically fixed, therefore, emotional intelligence can be learned and developed through training (Higgs and Dulewicz, 2014; Fletcher et al. 2009; Nelis et al. 2009). Their argument energised research in the past decade and focused research on how emotional intelligence can be developed and measured. Following this argument, ability emotional intelligence measures were developed as maximum performance tests while trait emotional intelligence measures were designed as self-reported personality questionnaires (Austin et al.

2005; Petrides and Furnham 2003).These conceptual differences between them were verified by either very low correlations between the measures between ability and trait emotional intelligence or they were found to be independent of each other (Smith et al. 2009) which split the scientific community on what these measures were actually measuring.

Mayer et al. (1999) also developed the Multifactorial Emotional Intelligence Scale (known as MEIS) which then was revised to model an ability-based IQ test (Mayer, Salovey and Caruso 2004) and it was renamed as the MSCEIT (which stands for Mayer-Caruso-Salovey Emotional Intelligence Test), an ability-based measure which uses maximum performance scoring procedures for a series of emotion-based problem-solving items similar to an IQ test. However, the measure was strongly criticised on the grounds that it cannot objectively measure an emotional experience as there is no right or wrong answer because it is only available to the person who experienced it (Føllesdal and Hagtvet 2009; Føllesdal 2008; O'Sullivan 2005; Petrides and Furnham 2001; Ekman and Friesen 1974).The MSCEIT scale was found to lack incremental validity and was criticised to be tapping into constructs such as personality factors, knowledge and conformity rather than ability (Petrides and Furnham 2003, 2001; Roberts et al. 2001). Landy (2005) and Lewis et al. (2005) also argued that the MSCEIT and MEIS produced contradictory and inconclusive findings and that ability-based emotional intelligence measures were found to yield low reliability.

Mixed models viewed emotional intelligence as an ability to be self-aware and self-managed and to be aware of others' emotions and able to manage relationships with others (Goleman 1998). Bradberry and Greaves (2009) divide emotional intelligence competencies and skills into personal competence (or self-awareness and self-management) and social competence (or social awareness and relationship management). In a similar vein, Goleman also argued that emotional intelligence competencies are (a) self-awareness; (b) self-regulation; (c) motivation; (d) empathy and (e) social skills. Goleman's model of emotional intelligence (1996) was initially presented as a general cognitive ability model of emotional intelligence, distinct from personality.

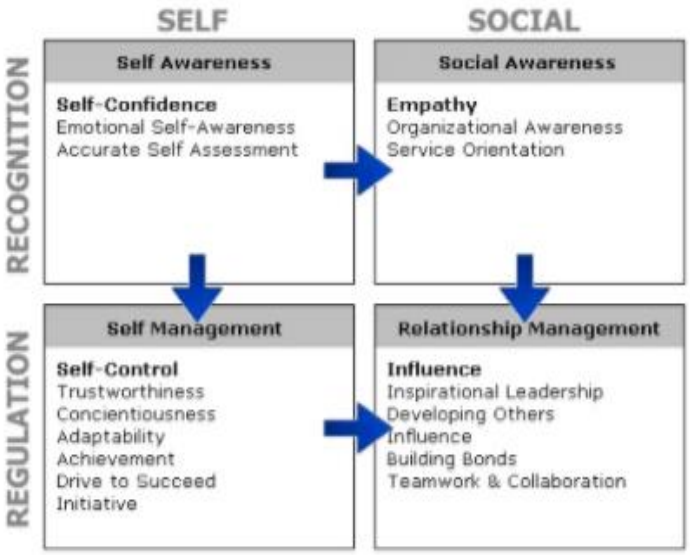


Figure 17.Goleman's Emotional Intelligence Model (1998)

He developed the emotional competence Inventory (ECI) to measure intelligence competencies and positive social behaviours (Boyatzis et al. 2000). The ECI consisted of 110 items, but later was reduced to 73 items. They are 20 competencies in the inventory, which are organised into four groups: (a) self-awareness; (b) social awareness; (c) self- management and (d) social skills. Again, several studies found the inventory to yield low discriminant and convergent validity (ranging from 0.11-0.29) and its criterion-related outcomes and internal reliabilities were reported to be from 0.61-0.85 which are adequate but not satisfactory (Byrne et al. 2007). Murensky (2000) found that ECI correlated with the Big Five personality factors such as extraversion (r ranged from 0.24 to 0.49), agreeableness (r from 0.20 to 0.28) and conscientiousness (r from 0.21to 0.39), suggesting some overlap between ECI and personality measures. These findings questioned ECI's discriminant validity further (Landy 2005; Conte 2005) and criticised the model's reliance on imprecise terminology that makes it harder to evaluate and measure (Petrides 2010).

Another popular mixed model is Bar-On's Emotional Social Intelligence (ESI) model whose principle concept relies on the theories on environmental adaptation and this incorporates mental abilities, traits and dispositions because it was designed to explain the determinants of positive psychological wellbeing (Bar-On 1988). Bar-On (2005, 2006) defined emotional intelligence as the array of non-cognitive capabilities, competencies and skills that influence an individual's ability

to succeed in coping with environmental demands and pressures. Bar-On included in his model five key competencies: (a) interpersonal skills; (b) intrapersonal skills; (c) adaptability; (d) stress management and (e) general mood. Bar-On (2006) argued that emotional social competence may be a predictor of performance and he agreed with Mayer, Salovey and Caruso (2004) and other researchers (Petrides et al. 2016; Sjölund and Gustafsson 2001) that emotional intelligence can be teachable and learnable, therefore it can be developed. This characteristic of emotional intelligence found to be common feature across the different models of emotional intelligence which is encouraging for this study.

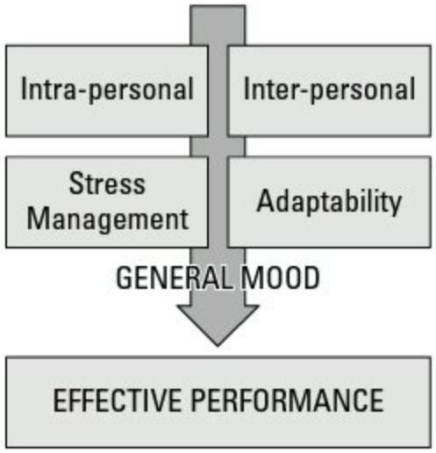


Figure 18. Bar-On's Emotional and Social Intelligence Model (1987)

Both ECI and EQ-i are predicated on the assumption that emotional intelligence is either an ability or a skill and therefore, can be assessed through self-report questions. However, self-report measures can only tap into self-perceptions, not abilities or competencies. Therefore, psychometrically this was not a viable position. Bar-On also developed the Emotional Quotient Inventory (EQ-i) to measure emotionally and socially competent behaviour and this inventory consists of five composite scales (a) self-perception; (b) interpersonal; (c) decision-making; (d) self-expression; (e) and stress management. Within these five scales there are 15 sub-scales and 133 items and they measure the mental ability to navigate environmental demands and pressures, yet some criticism of this model stems from Bar-On's position that the EQ-i measures an ability through self-report items which psychometrically is an invalid position. Some researchers also found

the EQ-i is highly susceptible to faking (Day and Carroll 2008; Grubb and McDaniel 2007), while others voiced their distrust to its construct and discriminant validity because they found to score low for these two types of validity when tested on large and diverse samples (Brackett and Mayer 2003; Brackett, Mayer and Warner 2004; Matthews et al. 2004a; Newsome et al. 2000). Another criticism of the measure was that it takes too long to complete and it is difficult to use in the workplace as well as expensive. Petrides and Furnham (2001) argued that the EQ-i ignores important parts of the emotional intelligence domain, such as emotion expression, emotional regulation and self-motivation. But, Kun et al. (2012) conducted a factor analysis on the youth version of EQ-i YV (30 items) on a large-scale sample of adolescents and found construct validity and reliability to fit their data inadequately. But by reducing the scale's items from 30 to 24 items, they also found that the degree of fit improved for their data and this shorter EQ-I YV was found to produce a more coherent factorial structure of the measure for adolescent and young adults.

Another performance-based measure of emotional intelligence is the Emotional Intelligence Questionnaire (EIQ) from Dulewicz and Higgs (1999, 2000). These researchers developed EIQ from a literature review on emotional intelligence and relevant personal competencies were included in the following scales: (a) self-awareness; (b) emotional resilience (c) motivation; (d) interpersonal sensitivity; (e) influence; (f) decisiveness; (g) conscientiousness; and (h) integrity. This scale was piloted mostly on senior managers, CEOs and team leaders and was found to be a competency-based model that measures emotional, intellectual and managerial competencies because it describes personal factors associated with competency (Dulewicz, Higgs and Slaski 2003). Dulewicz and Higgs (2004) found that Cronbach's alpha reliability coefficients for each of the elements were above 0.50, and the alpha for the overall EIQ score obtained from the seven elements was 0.77, which is fairly satisfactory. However, this measure does not fit adequately into any of the emotional intelligence models and theories because it regards emotional intelligence as a competency rather than an ability or trait. In general, competencies are behaviourally anchored but emotional intelligence is concerned with internal states and self-awareness.

Mixed-based measures such as the EQ-I were found to be unclear on the specific traits and skills that they measure but they include more positive abilities

and traits such as self-consciousness, self-esteem and empathy. This literature review showed that the scientific community hold different views on this construct hence, they produced different methods for measuring emotional intelligence which led to disjointed and inconsistent scientific evidence (Byrne 2004).

The most widely acceptable trait model of emotional intelligence was developed by Petrides and Furnham (2001) and they defined trait emotional intelligence or emotional self-efficacy theory as a constellation of emotion-related self-perceptions and dispositions that incorporates affect-related variance forming a distinct construct at the lower levels of the Eysenckian and five-factor personality taxonomies. Petrides and Furnham (2001) argued that trait emotional intelligence integrates the affective components of personality into a single trait. They also argued that although, traits are considered to be the building blocks of personality because of the way they are organised with each other can create the basic structure of a person's personality, some traits may be hidden or even remain unexpressed if the individual has only had a few encounters of a situation in which those traits might be expressed. Therefore, they explained that behaviour occurs in a specific environment and not in isolation. This is in line with Epstein's (1979) argument that the environment in which the behaviour occurs is important in order to explain the behaviour fully which in turn usually reflects personality and environmental influences on the person. Therefore, an assessment of both personal factors and environmental situations is needed in order to understand and possibly predict behaviour (Epstein 1979) as behaviour should be viewed as a joint function of the person and the situation.

Petrides and Furnham (2001) acknowledged this idea as a valid concept in the appraisal process and they argued that our own appraisal of our experiences and our reactions and behaviours to life events may be partly filtered through our perceptions of our emotional abilities. In addition, Petrides et al. (2007) argued that these self-perceptions can be developed and nurtured so that individuals understand how emotions may affect their own behaviour and that of others. Petrides et al. (2007) further argued that trait emotional intelligence captures unique personality variance. Trait emotional intelligence can be considered as a distinct intelligence because it can be isolated in personality space and is a distinct compound of intelligence. It is also correlated with several higher-order personality dimensions constructs lying at the lower levels of personality hierarchies.

In addition to the affective disposition of emotional intelligence, Petrides et al. (2016) argued that trait emotional intelligence connects to the literature of differential psychology that integrates the construct further into established personality models. The trait emotional intelligence factor is oblique rather than orthogonal to the Giant Three and the Big Five which on the one hand, distinguishes trait emotional intelligence from other types of personality traits, but on the other, connects trait emotional intelligence with mainstream personality theories because of where it can be found on the personality hierarchy. Petrides and Furnham (2001) hypothesised trait emotional intelligence as a personality trait. Later on, Petrides, Furnham and Mavroveli (2007) developed the trait emotional intelligence 133-item questionnaire, organised under four factors: (a) wellbeing; (b) self-control; (c) emotionality and (d) sociability. Because of its length TEIQue-Full Form was difficult to use in the workplace hence, a shorter version was devised. This consists of 30 items known as the TEIQue-Short Form, which was tested and found as strong as the full version, with high internal reliabilities and scores normally distributed across the sample (Mikolajczak et al. 2007a).

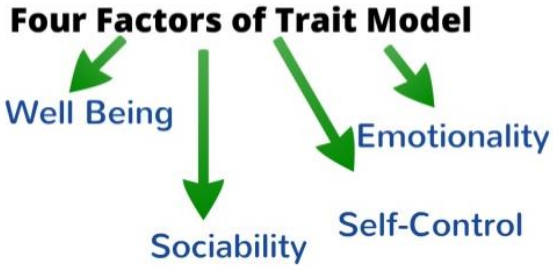


Figure 19. Petrides and Furnham Trait Emotional Intelligence Model (2001)

This measure offers total scores for each factor (wellbeing, self-control, sociability and emotionality) and a global trait EI score can also be obtained to make this measure easier to use and understand because it relates to the structure of IQ tests but it is much more user friendly (Petrides et al. 2016). Higher scores in global trait EI are associated with greater life satisfaction, less rumination over negative events and less use of maladaptive coping strategies (Mikolajczak et al. 2007a). In addition, all three types of the TEQue forms, for example the short form, the child and 360 degree TEIQue form, were found psychometrically sound and were also tested out in many different languages, which adds to the construct and

discriminant validity of the measure. Further evidence supports this measure's strong discriminant and incremental validity for all three different versions of TEIQue (Andrei et al. 2016, 2014; Cooper and Petrides 2010; Petrides et al. 2010).

Another trait emotional intelligence measure was developed by Shutte et al. (1998) who developed the Emotional Intelligence Scale (or EIS), also known as Self-Report Emotional Intelligence Test (SREIT) and Self-Report Emotional Intelligence Scale. This incorporates 33 items within three sub-scales: (a) regulation of emotion; (b) utilisation of emotion and (c) appraisal of emotion. These items load on factors that represent the conceptual model of Salovey and Mayer's model of ability emotional intelligence and it also assesses self-perceptions of emotional intelligence. The Cronbach alphas for this scale range from 0.84 to 0.88 (Noorbakhsh et al. 2010). Interestingly, Shutte et al (2002) found that higher emotional intelligence is significantly correlated with higher self-esteem ($r(49)= 0.59$ $p<.0001$) and this finding is consistent with research carried out by Ciarrochi et al. (2000, 2002), who found that emotional intelligence may be linked to emotional wellbeing.

Also, Palmer et al. (2003, 2009) developed another trait emotional intelligence measure, a 70-item multiple-rater assessment of trait emotional intelligence initially known as the Swinburne University Emotional Intelligence Test (SUEIT), and later on as Genos Emotional Intelligence Inventory. The Genos EII measure is a taxonomic model for emotional intelligence that assesses how often people demonstrate 70 emotionally intelligent workplace behaviours. Therefore, this inventory does not measure emotional intelligence as such, but instead how often people think they typically demonstrate emotional intelligence behaviour in the workplace. It is a self-rated measure, but it can also be used by others to assess a person's emotional intelligent behaviours at work (Palmer et al. 2003, 2009). Palmer et al. (2009) asked a sample of human resource professionals and business leaders to determine the purpose of employee development and define the "ideal" emotional intelligence inventory by completing SUEIT (Palmer and Stough 2001). Then, Palmer and colleagues used factor analysis to develop the Genos inventory, which includes seven oblique factors: (a) emotional awareness; (b) emotional expression; (c) emotional awareness of others; (d) emotional reasoning; (e) emotional self-management; (f) emotional management of others and (g) emotional self-control (Palmer et al. 2009). The Cronbach's alphas for this

measure range from 0.71-0.85 and test-retest correlations are of 0.83 and 0.72, based on two-month and six-month intervals for total scores respectively. The inventory was criticised for lacking in construct validity and conceptual clarity in relation to the TEIQue (Gignac 2008). However, the Genos inventory is far more straightforward than the Bar-On EQ-i and Goleman and Boyatzis's ECI measures, which are both complex and involve large numbers of variables (Sala 2002).

Furthermore, Petrides et al. (2016) argued that measurement of trait EI is far more straightforward than ability EI measures such as ECI and MSCEIT, and there is strong evidence that the incremental validity of trait EI measures can be assured more easily (Martins et al. 2010; Gardner and Qualter 2010), whereas ability EI measures were reported to be more challenging and controversial. In addition, TEIQue was developed on a clear and replicable factor structure, but also within a conceptual content to interpret variance (Freudenthaler et al. 2008).

In short, this review found that the TEIQue is psychometrically stronger and easier to administer and analyse than other measures. It consists of self-perceptions and behavioural dispositions, which are compatible with the subjective nature of emotions. It is acknowledged that the trait emotional intelligence questionnaire was criticised for measuring a meta-experience instead of actual emotions (Barchard 2003), but this is a shortcoming of self-reported measures. However, this model argues that self-perceptions can be developed (Petrides 2007) and that emotional intelligence is significantly correlated with higher scores of self-esteem therefore, this intervention was designed on the principles of trait emotional intelligence to address emotional dissonance and role dissonance in nurses found to have reported to be suffering in the exploratory study of this research. This literature review pinpointed critical links between emotional intelligence and self-esteem as well as satisfaction and perceived affective wellbeing. This theory argued that self-perceptions and self-esteem are connected via self-awareness which is the foundation of trait emotional intelligence.

5.2 Protocol

This protocol was designed on the main principles of emotional intelligence theories and models to amalgamate these into one single method to develop individual's level of emotional intelligence. This training intervention was designed

to enable the trainee to reflect under careful supervision and re-evaluate difficult or challenging experiences and finally re-contextualise this experience and develop. This process is broken into the following steps and discussed accordingly.

5.2.1 Step 1: The Interpersonal Awareness Questions

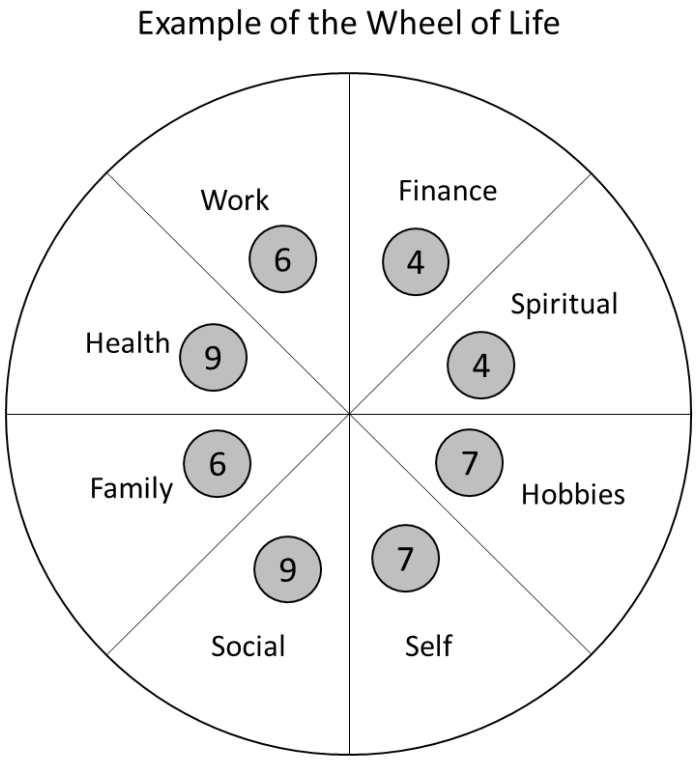
The interview questions used in the training intervention were generated from the work of Shinebourne P. and Smith J.A. (2009) but questions were also informed from the results of the exploratory qualitative study of this research. This same set of questions was also used to conduct the discussion groups for the exploratory study. This means they were piloted and reviewed on the previous study to ensure they were fit for purpose (i.e. part of the process was for the interviewer to address issues with language and clarity, but also focus on self-awareness). These questions were pre-published and standardised, but the researcher also discussed these with her IPA mentor who guided and advised her in this process. The questions were open ended and each trainee was carefully guided and questioned as and when deemed appropriate to the discussion point the trainee and the trainer were at the time. Examples of such questions are as follows and can also be found in appendix 4. Can you give me an example of a recent event that you found particularly difficult or challenging for you? What happened? What did you do? How did you feel at the time? How did you feel afterwards? Did you discuss this with anyone? Can you describe how your role in this has affected your life at present? How do you describe yourself as a person? What do you like about yourself? What do you dislike? What would be for you a positive development? How can your situation improve? More examples of these questions can be found at the back of this thesis in appendix 4. These questions were used in conjunction with the Wheel of Life and the Johari Feedback Window Model discussed below as part of the training.

5.2.2 Step 2: The Wheel of Life

Participants (all nurses) were asked to draw a circle and then put some lines across the circle to create segments (the circle is called the Wheel of Life and each segment represents an aspect of life, for example, work life). Then, each participant was asked to name each segment of the area of life it represents and score it from 1 “being very unhappy with this aspect of my life” to 10 “being very

happy with this aspect of my life" (Mahar et al. 2012; Whitworth et al. 2007). This visual tool provides a helicopter view of one's life and offers a quick overview of one's situation. This activity was included in this intervention to enable the participant to visualise the areas she/he needs to focus on or pay attention to while it also offers the person an opportunity to self-analyse and identify future goals.

The Wheel of Life was used to connect the person to recent and past events and actively reflect on these events, but also reflect on own thinking, perceptions, emotions and feelings. This tool was also used to encourage nurses rethink their coping behaviours and problem-solving skills.



**Note: Each number represents a score for an aspect of life. Score1 is for "very unhappy" with this aspect of one's life, and10 is for "very happy" with this aspect of one's life.*

Figure 20. Example of how a participant can score on the Wheel of Life (Mahar et al. 2012; Whitworth et al. 2007)

The Wheel of Life encourages a person to become more aware of which parts of his/her life they may enjoy most, or least at the time, and what it is that the person

seeks to achieve. The figure above illustrates how this wheel can be scored by the trainee.

5.2.3 Step 3: The Johari Window Feedback Model

The Johari Window Feedback Model for feedback consists of four quadrants. Each can help the person to explore a different side of their individuality (Shinebourne and Smith 2009) and help them to unlock emotions and feelings about various aspects of their life. They may be encouraged to rethink options, choices and decisions they can make for the future. The Johari Window Feedback Model is shown in the figure below.

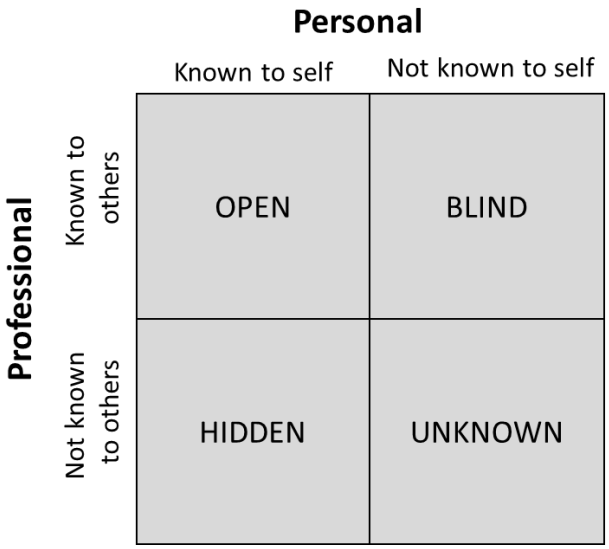


Figure 21. Visual representation of the Johari Window Feedback Model (Luft and Ingham 1955)

A bank of “open”, “blind”, “hidden” and “unknown” questions were used while coaching the person through the quadrants and depending on the quadrant the person wanted to progress with. The role of the trainer was of that of a facilitator and the speed of this stage was dependent on how much or how little the trainee needed or wanted to volunteer and share with the trainer. Participants were reminded of how perhaps themselves or others may distort their perception of events and their appreciation of their experiences, thus the role of the questioning was highlighted at every opportunity. The “exposure” and “feeding” stages are pivotal to making sense of what participants want to achieve in that aspect of life, and to identifying appropriate goals to achieve these. Therefore, the use of open

questions to encourage participants re-evaluate and re-examine their situation (Exposure) was vital to this process as it may increase awareness and understanding of the experience or of their situation (South 2007). Another important stage in this process is “feeding” (South 2007; Luft and Ingham 1955), when the trainee is offered a choice of different options to receive direct feedback.

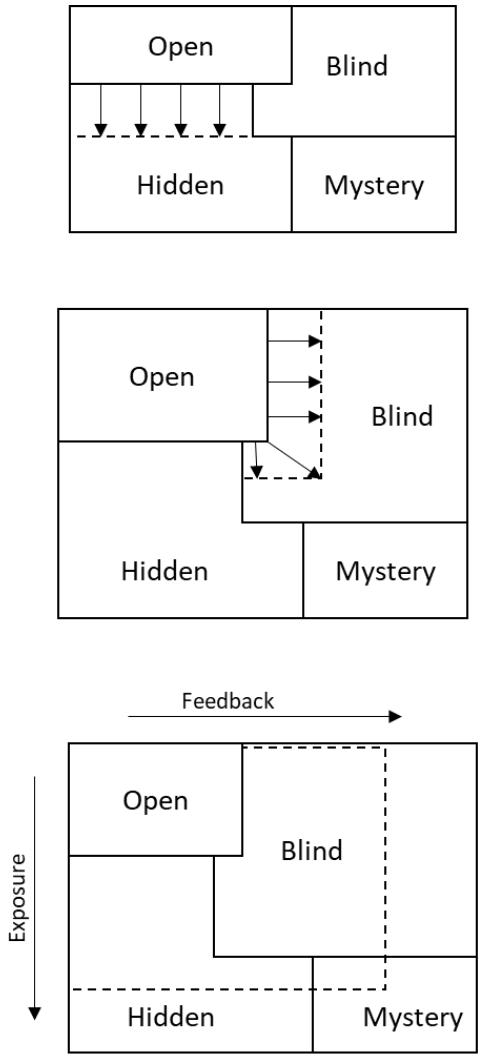
Some examples of “open” questions used are “How do you describe yourself as a nurse?” and “How does your patient describe you as a nurse?”. The “blind” quadrant questions were about things that others may see in the person that they may not necessarily let the person know, or the person may know but may not be fully aware of those things. Such questions are, for example, “How do you think others see you?”, “Can you describe how your role in this situation, did affect your life at present?” and “Were you told recently how good you are in your job by your manager?”. Questions for the “hidden” quadrant were questions about the person’s feelings, fears or anything that the person does not want to make known to others or does not want to share with others. Therefore, some of the “hidden” questions were harder for participants to open up to and answer, because they were not always aware or ready to explore, for example, “What image would you use to describe yourself”?’ or “Can you describe yourself as a person?”. On the other hand, the “unknown or mystery” quadrant questions were about things that neither the person nor others may know about the person, for example “What would it be for you a positive development?” and “How do you see yourself in the future?”. These questions represented opportunities to explore new ideas and set out new goals, but they were harder to explore with the participant as they were things that the participant may not have considered before the interview. Hence, this quadrant of the Johari Window Feedback Model was used to encourage participants to review areas of their lives that they were not particularly happy with or were unsure with. This may have helped the trainee to commit to a change about an aspect of their lives that they were not particularly happy with and were also unsure how to change.

5.2.4 Expected Outcomes and Measures

The aim of this training was to increase participants’ self-awareness, enabling them to become aware of how they may filter situations and events in the work environment and how they make sense of them. Therefore, they were asked to re-

examine their perceptions of things and experiences. Furthermore, this training offered participants the space to form a self-development plan with clear goals, so they could direct their efforts, energy and interest in achieving these goals.

The “exposure” and “feeding” stages shown in the figure below are more about sharing and exchanging information and experiences that may help expand the open and blind areas while reducing the hidden and unknown area.



*Note: “Exposure” and “Feeding” using the Johari Window Model may expand the “Open” and “Blind” areas and reduce the “Hidden” and “Mystery” or “Unknown” areas.

Figure 22. “Exposure” and “Feeding” using the Johari Window Model (Luft and Ingham 1955)

This part of the session was thought to be of interest to the trainees because it was aimed at building on their understanding of themselves and their perceived emotional abilities and perceived satisfaction, coping and affective wellbeing at work. This tool also gave opportunities to explore work and non-work related aspects of their lives, but also context-free situations because trainees were not restricted to choose an experience from the workplace, but they were free to choose any aspect of their life.

The results from the exploratory study pinpointed the need to enable nurses reframe and reconstruct their perceived experiences. This may improve nurses' self-perceived emotional abilities and therefore, improve their perceived affective wellbeing at work. Intervention nursing studies reviewed in this thesis aimed at either to change the work environment of the employee (Chen and Johantgen 2010; Ho et al. 2009; Kramer and Schmalenberg 2008) or to focus on the individual and their interventions were either educational programmes or cognitive-behavioural interventions (Klatt et al. 2015). Most of these studies were criticised for their poor research designs and sampling methods. Most studies aimed at large samples, but they had high attrition rates due to high drop-out rates.

Intervention studies were also criticised to measure interrelated concepts and constructs hence, they produced findings with low internal reliabilities because many studies overlooked the importance of designing their study using an appropriate scientific framework or theory so they struggled to interpret inconsistent findings. This sequential exploratory study aims at addressing these methodological issues and a "bite size" specific to nurses training was developed by utilising the results of a wide literature review and the results of the exploratory study (emotional and role dissonance). This training has three steps and aims to improve trait emotional intelligence (measured with the global trait emotional intelligence scores). The sequential exploratory study was designed to provide data to confirm the validity of the training (intervention) and provide evidence to support the proposed transactional model for nurses' perceived affective wellbeing as shown in the figure below.

Figure 23 shows the interrelationship between interpersonal awareness training and trait emotional intelligence that may moderate neuroticism and sense of mastery (mediators) and possible wellbeing outcomes.

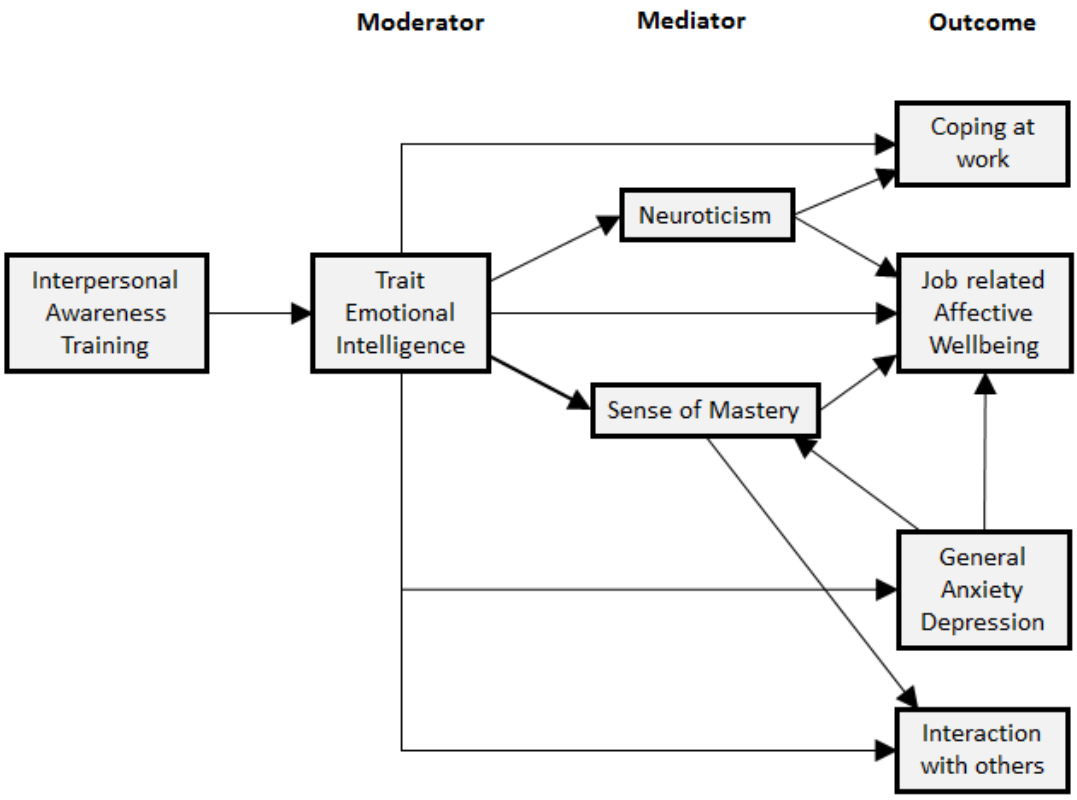


Figure 23. The interrelationship between interpersonal awareness training and trait emotional intelligence that may moderate neuroticism and sense of mastery (mediators) and possible wellbeing outcomes

The model above presents a summary of key variables identified from the literature and the neuroticism and extraversion scale by Eysenck, Eysenck and Barrett (1985) and the sense of mastery scale (SOM) by Pearlin and Schooler (1978) were chosen to measure neuroticism and sense of mastery for nurses respectively and these scales are discussed later in the thesis. The trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) by Petrides and Furnham (2001) was chosen to measure trait EI and to evaluate the effectiveness of the training intervention on the global scores of trait EI and job-related affective wellbeing scores (Warr, 1990), the cybernetic coping scale (CCS) by Edwards 1988 and the job satisfaction scale (JSS) by Warr, Cook and Wall (1979) were also used to measure related outcomes and they are also discussed later in the thesis. The general health questionnaire-12-item (GHQ-12) by Goldberg (1972) and the social support scale (SSS) by Daniels and Guppy (1995) were also included in the battery of measures used in this sequential exploratory study to assess the impact

of the intervention on these variables (measured on a pre-post basis). These measures and the concepts they relate to are discussed in the following sections of this chapter.

5.2.4.1 Measure 1: Trait emotional intelligence questionnaire (TEIQue)

The work by Petrides and Furnham (2001) and later on by Petrides, Furnham and Mavroveli (2007) developed the theory of trait emotional intelligence on the basis of emotional self-efficacy theory that covers emotion-related behavioural dispositions and self-perceived abilities measured via self-report questionnaires. Following that, they also developed the trait EI questionnaire which measures self-perception (Furnham and Petrides, 2003) and its incremental validity was found to extend beyond the Big Five personality dimensions across distinct criteria, such as life satisfaction (Petrides, Pérez-González and Furnham, 2007). This research carried out by Petrides et al (2007) argued that trait emotional intelligence did not correlate strongly with measures of general cognitive ability, whereas ability emotional intelligences measures, such as the MSCEIT, did relate to such measures. Another strong argument was that this questionnaire was embedded in the theory of trait emotional intelligence, which argues that trait emotional intelligence is a personality trait located at the lower levels of personality hierarchies. Therefore, it was argued that trait emotional intelligence encapsulates the affective aspects of personality in the form of self-perceptions (Petrides et al. 2007) and it was found to be significantly related to job satisfaction (Judge et al. 2002) and affective wellbeing (Warr 2011; Warr and Clapperton, 2010). This confirms Judge et al. (2002) and Bandura et al. (2001) arguments that people who believe in their own abilities were found to score high on self-efficacy and trait emotional intelligence, because they believed that their abilities were to be rewarded (they also scored high on internal locus of control) and were more successful than people who did not have those beliefs. However, one may argue that traits such as self-efficacy can describe, but they do not always explain fully, individual differences. Petrides et al. (2007) argued that trait emotional intelligence is an individual difference that can explain well affective wellbeing but this measure was criticised as lacking face validity in the workplace because it did not lend itself to multi-rater assessment (Palmer et al. 2009).

This sequential exploratory research introduced a short “bite size” type of training (intervention) to encourage and focus individuals on: (1) the role of awareness in developing therapeutic relationships with others, (2) the role of self-appraisal and self-perceived emotional abilities, (3) the role of self-perceived wellbeing and (4) the role of developing a strong sense of personal boundaries through clear goals setting. Trait emotional intelligence is about beliefs, values and attitudes, which can be changed if perceptions on which these are built upon can be modified, therefore the aim of the training is to dismantle and promote conscious awareness. This is aimed to empower nurses to examine consciously their own beliefs, values, attitudes and perceptions of their situation. Trait emotional intelligence is argued to provide the scientific framework to forge positive and discourage negative emotional experiences (Mikolajczak et al. 2007b).

The transactional model discussed in section 5.2.4 reflects some of the principles of the model of occupational stress by Cooper and the model of affective wellbeing by Warr and aims to evaluate the effect of an intervention (training) on nurses’ perceptions of their health and affective wellbeing, satisfaction, coping and control. Clearly, the focus of this transactional model of wellbeing is to evaluate the effectiveness of a “person-work interface” intervention on specific outcomes related to nurses’ work life.

Expected outcomes from this sequential exploratory research are anticipated to be an increased sense of self-control (sense of mastery), higher score for trait emotional intelligence post training (intervention) and reduced neuroticism for the intervention group of nurses. The hypothesis for this research is that nurses with high level of trait emotional intelligence may score higher levels of perceived affective wellbeing. The expectation here is that trait emotional intelligence may be linked to problem-solving skills, which may enable the individual nurse to set clear personal and professional goals, through which she/he may seek a positive evaluation of their situation and encourage nurses’ belief in personal power to control life circumstances, create achievable goals and generate a positive mood.

The overall purpose of this intervention (training) was to develop self-awareness in relation to self and others and enable nurses to become aware of how they may be able to mitigate stressful experiences via the re-appraisal process of self and others during the training and set positive personal and professional goals for their future. Although, appraisal is about information

processing, it is also largely evaluative in nature and this intervention aimed at developing a strong sense of awareness, critical thinking and to translate these into achievable goals, which in this research are deemed critical for achieving affective wellbeing (Salovey and Mayer 1990). Nevertheless, appraising a situation that demands mental activity, involves judgment and choice of behaviour that is largely reflective of past experience (Grinker and Spiegel 1945). Perception is the product of these cognitive appraisals that may transform the emotional and behavioural response of the person to situations and events.

This training may enable nurses to dismantle their own beliefs and attitudes, which may have blocked their own awareness, bearing in mind that trait emotional intelligence is largely about attitudes. This training therefore, aims at enabling nurses to address their individual attitudes and this may be achieved during the one-to-one coaching session nurses are offered to develop their conscious awareness. The one-to-one coaching session aligns itself with the transactional approach to wellbeing adopted in this research and fits well with the interpretative phenomenological analysis approach adopted in phase I of this research. The proposed transactional model aims to reflect how beliefs and attitudes towards self and others can mediate the process of perceived affective wellbeing. Therefore, this training was developed to help nurses take a stepped approach to developing a strong sense of awareness of self-perceived emotional abilities and their perceived affective wellbeing at work. Self-appraisal was encouraged in this training so participants learn to review their perceived emotional abilities, their problem-solving skills and understand the role of personal and professional goals in re-evaluating their situation at the workplace.

Nurses in the intervention group needed to notice feelings and make a note of their feeling and score it too. Nurses were also asked to explain their score to ensure that way they pay attention to their feelings, think about them and take them into account when planning their action plans and set out their goals.

5.2.4.2 Measure 2: Sense of mastery

The work of Pearlin and Schooler (1978) defines sense of mastery or perceived sense of personal control as the capacity of an individual to guide thoughts, words and actions in integrity with self. It is considered as an individual characteristic that allows an individual to draw upon and assists in coping with

stressors because it can help create formidable barriers to stress and increase coping. Sense of mastery is associated with feelings of control of emotions over moderate demands at work (Karasek 1979) and an individual's ability to voluntarily sustain focus or shift attention in order to successfully control emotions, and therefore influence positively emotional experiences and improve coping. Pearlin and Schooler (1978) argued that mastery has two opposing qualities: (a) a sense of personal control and (b) a sense of external control. Therefore, sense of mastery or perceived sense of personal control may increase a person's sense that their work is important and that the individual makes a significant contribution to it (Pines and Keinan 2005) which may contribute positively towards the person's coping efficacy because the person strives to change their circumstances rather than accept that they are unable to shift and manipulate the stressor. Pearlin and Schooler also argued in their research that age was found to significantly correlate with sense of mastery which is understood to help with self-determination and self-image. Another explanation was that with age the person may understand better the beliefs and attitudes underlying their impulsive emotions and they may correct any misguided beliefs they may hold and change their attitudes which may help their emotions to settle. Other research also found that feelings of mastery were correlated with age and work experience (Calkins and Fox 2002) and attitudinal outcomes such as job satisfaction and affective wellbeing (Jacobsson et al. 2001). A recent research paper suggested that sense of mastery may help an individual to focus on desired goals (Carver, Scheier and Segerstrom 2010) because the individual may regulate self and emotions better and form more positive interpersonal relationships and better perceived wellbeing (Carver and Scheier 2014). This is an important finding in this literature review for the research discussed in this thesis.

Pearlin and Schooler's sense of mastery scale is a widely used scale with good internal reliabilities. In a large-scale survey, nurses reported experiencing less work-related stress (r_2= -0.35) and burnout (r_2=-0.30) when they perceived having more control at work (Schmitz et al. 2000). Similarly, a large-scale meta-analytic study conducted by Judge and Bono (2001) found that self-esteem (p=0.24 and 0.26), internal locus of control (p=0.32 and 0.22) and generalised self-efficacy (p=0.45 and 0.23) to be positively correlated to job satisfaction and job performance. These findings support Lazarus and Folkman's (1984b) argument

that sense of mastery can influence a person's appraisal and coping and they also argued that sense of mastery found to be positively associated with improved general health.

The sense of mastery scale was also found to have strong structural validity, with Cronbach alpha coefficients of 0.80 (Thoits 1995, 1987). Guppy et al. (2004) found that the seven-item scale can be made work-specific by simply adding the word "work" at the end of each item and found that Cronbach alpha coefficients for three different samples to range from 0.71, 0.86 and 0.75 when used a modified three-item scale. This much shorter version of the scale can be used in the work-specific domain while the seven-item scale can be used to assess the non-work and context-free domains. This scale is also easy to administer and analyse (a low score indicates a high degree of personal mastery).

5.2.4.3 Measure 3: Neuroticism

As discussed before neuroticism refers to emotional instability and negative emotionality and the Eysenck Personality Questionnaire was designed to measure neuroticism and extraversion. This is a widely researched measure that has been used across various occupational sample groups and cultural groups (Barrett et al. 1998; Eysenck, Eysenck and Barrett 1985; Eysenck and Eysenck 1975). In particular, Barrett et al. (1998) used gender-specific data collected from 34 countries and found that Eysenck's factors were strongly replicable across all 34 countries. The original scale was made of 48 items, but over the years was revised and reduced to 23 items and then to a 12-item questionnaire. Cronbach alphas for extraversion and neuroticism were found to be 0.84 to 0.88 (23-item) and 0.80 to 0.84 (12-item) for the respective questionnaire (Eysenck, Eysenck and Barrett 1985) which also confirms that this is a reliable and valid scale.

5.2.4.4 Measure 4: Coping

The Edwards and Baglioni's (1993) cybernetic coping scale is based on Edwards's (1992) theory of stress, coping and wellbeing. They reviewed existing coping measures available and tested items from various coping scales before they developed the cybernetic coping scale which taps on five distinct coping behaviours also described in their cybernetic theory of stress, coping and wellbeing. Coping efficacy is a way of preventing a stressor causing overbearing

emotional stress and it is a process of learned patterns of behaviour (Pearlin and Schooler 1978) and they aim to enable the individual to adapt to stimuli that the individual may appraise as threatening to wellbeing. Coping can act as a moderator in the stress process and individual appraisals may reflect perceptions of situations, conditions and events which may interfere in this process either positively or negatively (Folkman and Greer 2000; Pearlin and Schooler 1975). Coping in the suggested model for this research is an outcome, therefore coping is measured using the cybernetic coping scale. Cox (1987) described coping as the cognitions and behaviours which follow after the individual recognises that a stressful transaction took place and the individual's attempt to deal with that transaction. These cognitions and behaviours are using behaviours related to (a) changing the situation, (b) changing its meaning or (c) efforts to manage their symptoms from stress. There are problem-focused and emotion-focused coping behaviours (Folkman (1984b). The problem-focused coping happens when the individual focuses on solving the problem, reappraises the meaning of the problem or stressful transaction and acts on the problem to relieve stress and protect own wellbeing. The problem-focused coping aims to resolve the problem and preserve sense of control. On the other hand, emotion-focused coping focuses on behaviours to distract the individual from the emotional burden and distress caused by the stressor (problem). Individuals who cope this way choose to avoid experiencing negative emotions and feelings associated with a stressful experience, by engaging in distractive behaviours such as drinking, smoking, drug abuse and overeating. However, there are also other interferences in this process which are significant contributors of coping efficacy. Past experiences of dealing with stressful situations for example, may cloud an individual's appraisal process (Cooper and Payne 1989; Edwards 1992).

Successful coping aims to improve satisfaction by increasing sense of personal control (Cooper and Payne 1989). Most times individuals employ a mixture of problem-solving, reappraisal and avoidance behaviours to succeed as empirical research suggests (Cooper and Payne 1989). The generic research related to the CCS scale, rather than nursing-specific related research, was reviewed and in the interest of brevity, the most recent and relevant studies that compare CCS with other coping scales such as the Ways of Coping Questionnaire (WCQ) and Ways of Coping Checklist (WCCL) by Folkman and Lazarus (1985)

and Folkman, Lazarus et al. (1986) are discussed here such as a large-scale, longitudinal study carried out by Brough et al. (2005) that aimed to compare the CCS to WCQ and found CCS to be statistically identical across two large independent samples with a strong psychometric structure. Similarly, a large-scale study conducted by Guppy et al. (2004) found that the confirmatory factor analysis on the 20-item version of CCS was moderate across four large studies and moderate to strong for the 15-item version.

Factors such as accommodation and devaluation were found to decrease the internal consistency of the scales in the Guppy et al. (2004) study, the Brough et al. (2005) study and the Edwards and Baglioni (1993, 1999).When item 23 and item 31 from the accommodation sub-scale and item 13 from the symptom reduction scale were deleted, the model fit of the scale improved, and the 15-item version of the CCS produced good internal reliability. The overall internal reliabilities for the 20-item version in Guppy et al. (2004) and Edwards and Baglioni's (1993, 1999) studies produced greater Cronbach alpha coefficients than the 15-item scale. The two sub-scales (Accommodation and Devaluation) were found to be problematic in all versions of CCS, which raises some concern over the conceptualisation of this dimension of the CCS rather than the structure of the scale. Nonetheless, the CCS is currently the most valid and reliable coping scale available and is also embedded in the cybernetic theory of stress, coping and wellbeing which helps interpret inconsistent findings. Edwards and Baglioni (1993) developed the CCS to measure four coping behaviours supported by the cybernetic theory of stress, coping and wellbeing: (a) changing the situation (active problem solving), (b) accommodation (adjusting to the situation), (c) devaluation (reduce the importance of perceived discrepancy) and (d) avoidance (directing attention away from the stressor). This is a scale widely used in published research, despite some items being substantially revised and further supplemented in accordance with the five components of the cybernetic theory. Most importantly, the CCS was found to score high on internal reliabilities and it is considered as a stable dispositional coping measure (Brough et al. 2005) that is still used widely in stress research (Guppy et al. 2004).

5.2.4.5 Measure 5: General health

The general health questionnaire-12 or GHQ-12 was used to measure context-free wellbeing and anxiety and depression. The GHQ-12 is a robust measure for the assessment of general mental health (Goldberg, 1972). It is considered an easy to complete measure and it is widely used in medical and psychology research (Abubakar and Fischer 2012; Padron et al. 2012). The GHQ measure was originally developed for the identification of non-psychotic individuals within a clinical setting and since then it has been successfully applied to other occupational samples (Banks et al. 1980).The GHQ-12 possesses a high degree of discriminant validity (Williams and Goldberg 1988) and a good internal consistency across cultural groups with a minimum Cronbach's alpha of 0.84 (Gelaye et al. 2015).

There are several versions of this measure (Goldberg 1972) such as the 60-item, the 30-item, the 28-item, the 20-item and the 12-item version which was used to collect data in the quasi experimental study component of this research. The GHQ-12 is easy to administer (Chin et al. 2015) and there is strong evidence that it is psychometrically robust (Gelaye et al. 2013; Werneke et al. 2000).

5.2.4.6 Measure 6: Affective wellbeing

Affective wellbeing is an individual's perception of how often they experience positive or negative emotions and moods and how strong these emotions and moods are perceived to be experienced by the individual. These perceptions of the frequency and intensity of emotions and moods experienced by the individual is fundamental in the model structure of affective wellbeing by Warr (1990). The model is presented in two separate dimensions: arousal and pleasure and affective wellbeing is central to the construct of mental health. Affective wellbeing is distinguished on three principal axes: (1) discontented-contented (1a-1b), (2) anxious-comfortable (2a-2b) and (3) depressed-actively pleased (3a-3b) as shown in Figure below. Therefore, a person's wellbeing is described in terms of position along the arousal and pleasure dimensions.

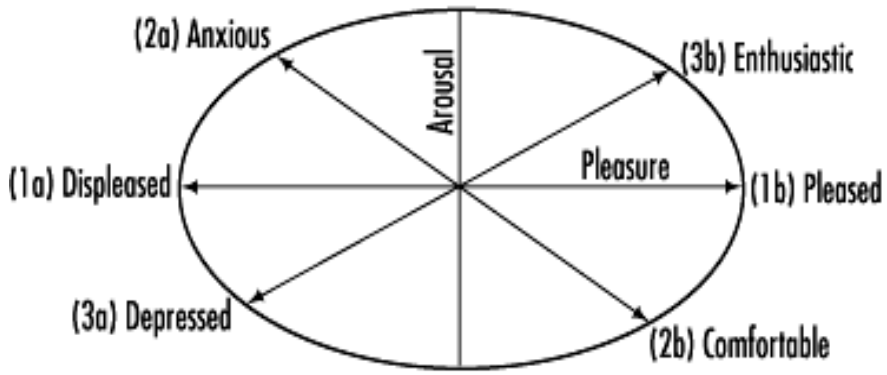


Figure 24. Three principal axes of affective wellbeing (Warr 1987)

Warr's two-dimensional model also argues that high or low mental health can be expressed behaviourally in transactions with the environment. Behaviour is governed by personality characteristics that may influence the interaction between the individual and their environment and high or low levels of arousal may accompany a particular level of pleasure (Warr 1990). Negative aspects of affective wellbeing are shown at the left-hand side of the elongated shape of the schematic representation of the model shown above in the figure whereas positive aspects are depicted at the right-hand side. The elongated shape of the model suggests that the pleasure dimension is more important than the arousal dimension in representing affective wellbeing.

Warr also developed a scale based on diagonal axes 2 (anxious–comfortable, 2a-2b) and 3 (depressed–actively pleased, 3a-3b), both measuring six affective states of wellbeing. Those on axis 2a-2b are tense, uneasy, worried, calm, contented and relaxed and those on the axis 3a-3b are depressed, gloomy, miserable, cheerful, enthusiastic and optimistic.

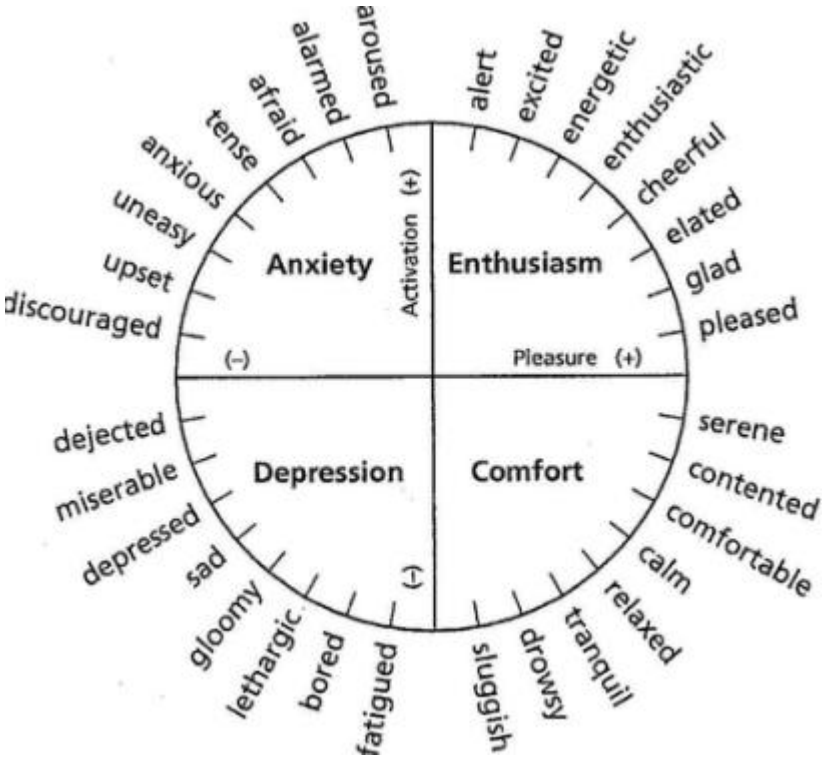


Figure 25. Warr's job-related wellbeing measure (1990)

The horizontal axis is discontented–contented and represents job satisfaction under occupational stress. Gilman et al. (2015) found that the discontented–contented axis to account for most of the covariance between aspects of affective wellbeing and many measures for occupational wellbeing. For example, job satisfaction, organisational commitment, tension and fatigue at work are found to relate to the affective dimension of wellbeing (Gilman et al. 2015). Warr's affective wellbeing measure is asking the individual to indicate for each emotion how much time, their job had made them feel this emotion during the past few weeks. The individual is given a Likert scale from 1 for "never" to 6 for "all the time" to circle their answer.

5.2.5 The development of the research hypothesis

The research hypothesis for this thesis is based on Petrides et al. (2004) assumption that individuals who score high on trait emotional intelligence may be able to exercise mastery (self-control) and deal with their work environment more efficiently. Furthermore, Carver and Scheier (2014) and Carver et al (2010) argued that mastery (self-control) may help an individual to focus on desired goals, so they

are expected to demonstrate better self-regulation and enjoy positive interpersonal relationships. The research hypothesis for this thesis was “nurses who score high on trait EI also score high on job-related wellbeing” and the null hypothesis was H_0: “There is no difference between those nurses who score high or low on trait EI and the job-related affective wellbeing”. Arguably, sense of master or self-control may increase self-awareness, the building block of emotional intelligence, because it is concerned with internal states and self-awareness. The intervention proposed in section 5.2. is an interpersonal awareness training that aimed at encouraging nurses to review their problem-solving skills and the role of personal and professional goals and urge nurses to re-evaluate their situation. This training (intervention) aimed at focusing on perceptions of wellbeing which contribute towards or mitigate perceived stress therefore, may enable nurses to develop a flexible approach to adaptive coping behaviours. This is based on Warr’s assumption that job-related affective wellbeing is situation specific and unstable whereas non-work affective wellbeing and context-free wellbeing are considered more stable (Warr 1994) and changes to these areas of affective wellbeing are noted only under prolonged distress.

The qualitative component of this exploratory sequential, mixed methods research study employed a purposive sample and nurses with different work experience were placed in relevant groups. Nurses were interviewed on various aspects of their jobs and their impact on their affective wellbeing. The IPA methodology considered appropriate to the aims of this research study because it aimed to explore, understand and gain a deeper insight into the work life of those nurses. The idiographic and inductive approach to interviewing of this methodology required the researcher to step into the conversation with the participants without prior ideas and views about the participants. Thus, the decision was to collect basic demographic data from these nurses and the soundness of the results of this exploratory study was confirmed by another IPA researcher who confirmed the trustworthiness and inter-rater reliability for the data collected. This IPA researcher was part of the supervisory team and provided direction and guidance with the interpretation of the results. The researcher was a prominent member of the London IPA group and offered online support once every eight weeks. The researcher also kept a diary to reflect on the data analysis process and noted on the steps of this process.

The discussion group interviews were audio recorded and were transcribed verbatim to enable easier analysis and direct annotation on the transcript. The transcripts were read and analysed by two IPA researchers who discussed the responses of each group and shared iterative feedback with each other. Each group was relatively homogenous because nurses were placed in these groups in accordance to their years of work experience. The groups were designed that way so they were consistent with the idiographic nature of the IPA methodology. The results from this IPA exploratory study pinpointed nurses' emotional needs and wants, but also revealed some important aspects of nurses' strong work ethos and commitment to patient care and welfare. Nevertheless, nurses also reported that their mental wellbeing was under threat and reported feeling overwhelmed, anxious and disillusioned. The quantitative component of this exploratory sequential mixed method study, is a quasi-experimental research study with repeated measures longitudinal research that aimed to evaluate the relationship between trait emotional intelligence and affective wellbeing at work. This research was designed on the argument put forward by Petrides, Pita and Kokkinaki (2007) that self-perceptions can be developed and nurtured so individuals understand how emotions may affect their own behaviour and others' which is also suggesting that trait emotional intelligence can be taught, learned and therefore, developed.

PHASE III – METHODS OF THE QUASI-EXPERIMETAL STUDY

Chapter 6. Quasi-experimental study

6.1 Design of the study

This is a mixed between-within subjects research study aimed at evaluating the effectiveness of an interpersonal awareness training (intervention) on nurses' perceived job related affective wellbeing over a specified time period using pre-post measurements. In this phase of the thesis, the proposed transitional model for nurses' wellbeing was also evaluated and tested for correlations between the independent variable, trait emotional intelligence and the dependent variables such as anxiety and depression, job satisfaction, coping and affective job related wellbeing. Another aim was to examine whether trait emotional intelligence can be developed through training and also whether trait emotional intelligence can be connected to positive self-perceived affective wellbeing for nurses at work. In the proposed transitional model for nurses' wellbeing, trait emotional intelligence was hypothesised to moderate the effect of neuroticism and mastery on nurses' self-perceived affective wellbeing at work and other health outcomes such as job satisfaction and coping.

The proposed interpersonal awareness training (intervention) aimed at nurturing self-awareness and a positive attitude towards problem-solving based skills. The development of those were assumed to increase nurses' scores on trait emotional intelligence and impact on perceived job related affective wellbeing and connected to other health outcomes. The intervention (training) was a short one-to-one session designed to develop nurses' self-perceived emotional abilities or self-efficacy to increase self-awareness. Another aim of the training was to enable nurses to rethink and possibly reconstruct their coping behaviour, perceived job and life satisfaction and perceived affective wellbeing at work. Furthermore, the hypothesis for this study was that "$H_{1:}$ Nurses who score high on trait EI also score high on job-related wellbeing" and the null hypothesis was "$H_{0:}$ There is no difference between those nurses who score high or low on trait EI and the job-related affective wellbeing".

6.2 Participants

The participants were all post-graduate student nurses recruited from level 7 modules at a large north London university and they were a self-selecting sample. The modules were either continuous professional development (CPD) modules, the mentorship course or the MSc course. Nurses were asked to volunteer to take part in the study and an information letter and consent form (Appendices 1 & 2) were given to the nurses in class to complete, which also informed participants that they had the right to refuse to participate and withdraw at any time as ethically appropriate. A total of 232 nurses were initially invited to take part to the study via their tutors, but only 118 participants were eventually met in person in their classes and were given information about the research study, but 34 participants withdrew. Finally, 84 participants accepted and completed both questionnaires at T_1 and T_2.

Participant nurses were approached in their respective classes and were given verbal and written information about the research, including the right to withdraw. A consent form was attached to the questionnaire and they were asked to complete and return their questionnaire before the end of their session. Their right to withdraw without any consequences at any time during their participation in the study was emphasised. Participants were randomised and allocated to the intervention or control group. Participant nurses were also encouraged to ask questions about the study and were offered the opportunity to find out more about the research at the time they were placed in a group. Participants were put into groups (strata) by age and assigned to individual groups according to an algorithm (please refer to the table below). There were three strata: stratum 1 consisted of nurses who were studying on continuous professional development courses (CPD group). Stratum 2 consisted of MSc nursing students (MSc group) and stratum 3 consisted of registered nurses on the mentorship courses (Mentorship group). The percentage from each group was calculated to be proportionate to the size of each stratum inclusively to ensure homogeneity with respect to participants' age and student course in both the intervention (training) and control group.

The proportion taken from each stratum was calculated as the number of nurses in each stratum for specific age subgroup divided by the total number of nurses in that stratum. This gave the percentage required to sample from each age-specific stratum. Nurses were matched by age in their randomised blocks and by student course and this process is known as randomisation block sampling

(Efird ,2010). Randomisation block sampling method is a stratified method of randomisation and it is the preferred method for smaller-sample size research studies. This is because this sampling method can avert severe imbalances in the baseline characteristics of treatment groups, for example intervention (training) and control group (Schulz and Grimes 2002). This sampling method was chosen because it may produce a more balanced comparison and may reduce biases in the findings.

Nurses who consented to the study were assigned to groups (strata) by age and randomly allocated to the either intervention (training) group or control group. Individuals from the same stratum were matched by age where possible. The age strata were under 30 years old and 40 years old and above and nurses were allocated by their day of birth, with those born on odd days of the month assigned to training, even days of the month to control, to ensure an unbiased allocation into the intervention and control group. The participants were briefed in their respected groups about the study, anonymity and confidentiality and their right to withdraw at any time without penalty. This method ensures that the intervention and the control group are composed of individuals with similar characteristics to reduce the impact of confounding factors and interference in the findings.

Table 1: Randomised block sampling method from each stratum and age sub-groups

Block	**Block size**	**Age groups**	**No. of nurses by age**	**Sample size per sub-group**	**Intervention group No. of subjects**	**Control group No. of subjects**
	A		B	(B/A)*B		
CPD	77	Under 30 years	35	16	8	8
		40+ years	42	23	12	12
MSC Nursing	67	Under 30 years	42	26	13	13
		40+ years	25	9	4	5
Mentorship	88	Under 30 years	42	20	10	10
		40+ years	46	24	12	12
Total	**232**		**232**	**118**	**59**	**59**

The intervention group consisted of 35 nurses who were randomly allocated into the intervention group and the control group involved 48 nurses. Their scores were compared with the scores from the intervention group. Nurses in the control group were offered a general conversation on wellbeing instead of the interpersonal awareness training which focused on problem solving and goals setting. Two-thirds of the nurses from the control group did not participate in the debriefing session offered to them post intervention and one third did take the offer.

6.3 Measures

The questionnaire consisted of several measures and scales as discussed in chapter 5. Data from participant nurses were collected at T_1 (baseline) and at T_2 (six to eight weeks after the intervention was given). The questionnaire was made of measures and scales which were previously used in research or pre-published and known to be standardised measures which yield high Cronbach alphas for their factor items. These measures were either used as a complete measure as originally designed by researchers or as a slightly modified version of them to ensure that the questionnaire was easy to administer and avoid repetition yet assessed to be equally valid and reliable as the original measure. Eight scales were incorporated into this questionnaire and formed four parts as follows: “Section A: All about you”, “Section B: Work experience and education”, “Section C: About your health” and “Section D: Nursing practice”. A sample of the questionnaire used for this research is available to review in Appendix 3. The questionnaire also asked participants to volunteer information about their gender, age, ethnicity, marital status, number of children they have, religion, job title, working status, numbers of years of work and educational background. The questionnaire took 30 to 45 minutes to complete and included:

- General Health Questionnaire-12-item (GHQ-12) by Goldberg (1972),
- Neuroticism and Extraversion Scale by Eysenck, Eysenck and Barrett (1985),
- Job-related Affective Wellbeing by Warr (1990),
- Cybernetic Coping Scale (CCS) by Edwards 1988,
- Job Satisfaction Scale (JSS) by Warr, Cook and Wall (1979),

- Social Support Scale (SSS) by Daniels and Guppy (1995),
- Sense of Mastery Scale (SOM) by Pearlin and Schooler (1978),
- Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF) by Petrides and Furnham (2001).

Twenty-four participants (24 out of 59 from the intervention group and 10 out of the 59 from the control group) left some sections incomplete, despite that it was stressed to them the importance of making sure that both sets of questionnaires were fully completed. If there was more than 40% of the questionnaire items missing, the questionnaire was not included in the analysis, therefore the data from 34 participants were not included. Nurses were also provided with a stamped envelope with a postal address on it to put in the post to the researcher after six to eight weeks post-training.

6.3.1 Principal component analysis (PCA)

All data entered into SPSS v21 for data analysis and PCA was employed to evaluate every measure in the questionnaire to ensure that those slightly adapted items were valid and content validity, construct validity and criterion-related validity (concurrent validity and predictive validity) were maintained throughout the measure. Cronbach's alpha reliability coefficients were calculated for each measure and each dimension of the measure to see how reliable the measures were for this sample of data collected in this research. It is important to note that Cronbach alpha coefficients were found to be above 0.80 for most of the measures and scales used in this research. Therefore, it is argued here that this questionnaire found to be a valid and reliable questionnaire. This was of vital importance to this research because some data were incomplete and therefore the remaining data needed to be screened in order to ensure that any incomplete or missing data or entry errors were identified and rectified prior to statistical analysis. If the missing data identified were less than 40% of the questionnaire then data were included in the final analysis but if there were more blanks then the figure seven was entered in the database. Any errors found in this process were located and corrected. For example, if an entry of 55 was found on a Likert scale, it was amended to 5. Furthermore, data were plotted on histograms to ensure that data

were normally distributed and any outliers were spotted. Also, frequencies were performed to assess for normality, linearity and homoscedasticity (homogeneity of variance) and none of them found to be of concern.

6.3.2 General Health Questionnaire-12 (GHQ-12)

The General Health Questionnaire-12 or GHQ-12 was used to measure context-free wellbeing, anxiety and depression. The GHQ-12 is a robust measure for the assessment of general mental health (Goldberg, 1972). It is considered an easy to complete measure and it is widely used in research (Abubakar and Fischer 2012; Padron et al. 2012). The GHQ measure was originally developed for the identification of non-psychotic individuals within a clinical setting but since then it has been successfully applied to other occupational samples (Banks et al. 1980).The GHQ-12 possesses a high degree of discriminant validity (Williams and Goldberg 1988) and a good internal consistency across different cultural groups with a minimum Cronbach's alpha of 0.84 (Gelaye et al. 2015).

There are several versions of this measure (Goldberg 1972), such as the 60-item and the 30-item version, the 28-item, the 20-item and the 12-item version. The 12-item version was chosen in this research because it can be easily administered to the participants as it is a short questionnaire and it only takes few minutes to complete (Chin et al. 2015). The 12-item version was also found to be psychometrically strong (Gelaye et al. 2013; Werneke et al. 2000).

In this thesis, the participant nurses were invited to consider their general health behaviours over the past few weeks and indicate on the answer scale one of four answer alternatives: "Better than usual", "Same as usual"; "Less than usual" and "Much less than usual". The first two choices scored 0 and the next two choices scored 1. The maximum possible score for this measure is 12, with higher scores suggesting higher mental distress (Gelaye et al. 2013; Fernandes and Vasconcelos-Raposo 2013). Using PCA for this measure, two factors accounted for 61 per cent of variance for T_1 and Cronbach's alpha was found to be 0.82 and 0.85 for factor 1 and factor 2 respectively, as expected. For T_2, the two factors accounted for 65 per cent of variance and Cronbach's alpha were 0.85 and 0.88 for factor 1 and 2 respectively. These findings confirm that GHQ-12 is a consistent and reliable measure of mental health. These findings were consistent with findings

from previous research studies that reported Cronbach's alpha between 0.80 and 0.90 across various occupational and diverse demographic groups (Gelaye et al. 2013; Werneke et al. 2000). The GHQ-12 factors and items are presented in the table below for easy reference and they were all included in the questionnaire used to collect the data.

Table 2. GHQ-12 Factors and Item presentation

PCA for GHQ-12		**Item**
Factor 1	Anxiety & Depression	1. (able to concentrate) 2. (lost much sleep) 3. (playing useful part) 4. (capable of making decisions) 5. (under stress) 6. (could not overcome difficulties)
Factor 2	Social Dysfunction	7. (enjoy day-to-day activities) 8. (face up to problems) 9. (feeling unhappy and distressed) 10. (losing confidence) 11. (thinking of self as worthless) 12. (feeling reasonably happy).

6.3.3 Neuroticism and extraversion scale

A slightly modified and revised 12-item scale based on the 48-item Eysenck Personality Questionnaire Revised-Short form (EPQR-S) by Eysenck, Eysenck and Barrett (1985) was chosen to be used to assess neuroticism and extraversion in this research. This modified version of the EPQR-S produced Cronbach alpha coefficients ranging from 0.80 to 0.84 for neuroticism and 0.84 to 0.88 for extraversion respectively. Therefore, it was found that the alpha coefficients for the 12-item scale were similar to the 48-item EPQR version (Eysenck, Eysenck and Barrett 1985). Both neuroticism (factor 1) and extraversion (factor 2) accounted for 46 per cent of variance and Cronbach's alpha for neuroticism were 0.67 and 0.71 for T_1 and T_2 respectively. The Cronbach's alpha for extraversion were 0.78 and 0.36 for T_1 and T_2 respectively. These findings compare less well with published norms for this scale. The extraversion factor at T_2 yielded a lower Cronbach alpha

than generally reported in the literature. This may be particular to this set of data collected as it was found that when item 11 (practical jokes) from factor 2 was removed from the analysis, the internal reliability for neuroticism improved from 0.67 to 0.73 for T_1. One may also argue that these low scores may be indicative of this particular occupational group with a strong female representation (Forrest et al 2000) or they misunderstood some of the items on this scale.

Table 3. Neuroticism and extraversion scale factors and item presentation

PCA for Neuroticism and Extraversion scale		**Item**
Factor 1	Neuroticism	2. (mood up and down) 4. (just miserable) 6. (annoyed) 8. (guilt) 10. (strung) 12. (sleeplessness)
Factor 2	Extraversion	1. (excitement) 3. (lively) 5. (mixing) 7. (happy-go-lucky) 9. (lively) 11. (practical jokes).

6.3.4 Job-related affective wellbeing

Warr and Clapperton (2010) and Diener and Larsen (1993) argue that affective wellbeing is the cumulative experience of affects (Diener and Larsen 1993) and these assessments of experiences should cover periods of one or two weeks (Warr, 1990a). In this research, participants were asked to answer the following question: “Thinking of the past week, how much of the time has your job made you feel each of the following?” Participants were then asked to indicate which adjective represents the feeling or emotion that they associated with their experience in the past week. The scale is used to assess job-related wellbeing by choosing a specific adjective that reflects a specific emotion. This is a 15-item scale (Warr, 1990), but Items 13 (anxious), 14 (comfortable) and 15 (motivated) were excluded because Warr’s job related affective wellbeing 12-item scale is

found to produce higher internal reliabilities ranging from 88-91 when items 13, 14 and 15 were removed (Brough, 2005).

This is a self-reported measure that asks participants to rate each item on a six-point Likert scale ranging from 1 to 6 in order of “never”, “occasionally”, “some of the time”, “much of the time”, “most of the time” and “all of the time”. The overall score for each item can be found by summing the responses and dividing them by the number of items (Warr, 1990a). A high score indicates good affective wellbeing, hence a good sense of job-related affective wellbeing.

This measure was found to have two factors, “a job-related anxiety-contentment dimension” factor and “a job-related depression-enthusiasm dimension” factor which were hypothesised to represent the four aspects of the affect circumflex in Warr’s job related affective wellbeing model (Daniels 2000, Warr 1990). These two factors accounted for 58 per cent of variance for T_1 and 69% for T_2. Cronbach’s alpha for factor 1 (anxiety-contentment) was 0.86 and 0.73 for T_1 and T_2 respectively and for factor 2 (depression-enthusiasm) was 0.71 and 0.71 for T_1 and T_2. These findings were found consistent with those in the wider literature.

Table 4. Modified job-related affective wellbeing factors and item presentation

PCA for modified Job-related Affective Wellbeing		**Item**
Factor 1	Anxiety-contentment	1. (tense) 2. (uneasy) 3. (worried) 4. (calm) 5. (contented) 6. (relaxed)
Factor 2	Depression-enthusiasm	7. (depressed) 8. (gloomy) 9. (miserable), 10. (cheerful) 11. (enthusiastic) 12. (optimistic).

6.3.5 Cybernetic Coping Scale (CCS)

Coping behaviours of nurses were assessed by using the short version of Edwards' (1988) CCS. This scale was revised by Edwards and Baglioni in 1993 and Guppy et al. in 2004. The participant nurses were asked to answer how they generally handle situations at work and how they generally cope with problems at work. The respondents indicated the extent to which they used each coping item on a five-point Likert-type scale, where 1 is "never" through to 5 "always". The factors and items in each factor can be found in the table below. This scale consisted of 18 items and it was devised from the original 20-item scale by Guppy et al. (2004). Interestingly, this shorter version of the scale found quite early on that it produced better internal reliabilities (Edwards and Baglioni 1993, 1999) and it was found to be more user friendly. In addition, Edwards and Baglioni (1999) found that Cronbach's alpha for factor 1 was 0.77, for factor 2 was 0.69, for factor 3 was 0.81, for factor 4 was 0.74 and for factor 5 was 0.69.

Table 5. Cybernetic Coping Scale factors and item presentation

PCA for CCS		**Item**
Factor 1	Changing situation	1. (situation) 4. (efforts) 8. (work on)
Factor 2	Accommodation	2. (expectations) 9. (adjust) 12. (standards)
Factor 3	Devaluation	5. (unimportant) 10. (serious) 13. (big deal)
Factor 4	Avoidance	6. (attention) 14. (thinking) 15. (mind off)
Factor 5	Symptom reduction	7. (tension) 11. (off chest) 16. (eat more) 17. (drink) 18. (smoke)

The PCA for this data found that there were five factors that accounted for 65 per cent of variance for T_1 and 71% for T_2. Cronbach's alphas were reported at T_1 to be for factor 1 (change situation) 0.81; for factor 2 (accommodation) the internal validity was 0.35 and for factor 3 (devaluation) it was 0.68. For factor 4 (avoidance) it was 0.77 and for factor 5 (symptom reduction) was 0.60. Cronbach's alpha for T_2 for factor 1 and 2, were 0.67 and 0.58 respectively and for factor 3 and 4 were 0.85 and 0.82 respectively, while for factor 5 was 0.64. The internal reliabilities for T_2 were slightly improved and within the acceptable range of internal reliabilities for this scale of 88-91 (Brough et al. 2005; Edwards and Baglioni, 1993).

6.3.6 Job Satisfaction Scale (JSS)

The JSS is a 15-item scale devised by Warr, Cook and Wall (1979) to measure work attitudes and the degree of satisfaction with various components of the job. It is important to note that overall job satisfaction is directly connected to life satisfaction, affective wellbeing and mental health (Warr, Daniels and Guppy 1995; Warr et al. 1979; Warr 1978) hence, it was used in this research. The measure consists of two scales: the extrinsic and the intrinsic scale. It reported internal reliabilities for the extrinsic scale range between 0.74 and 0.85 and for the intrinsic satisfaction scale between 0.78 and 0.79 (Warr et al. 1979).

For this measure, nurses answered on a seven-point Likert scale to score from 1 for extremely dissatisfied through to 7 for extremely satisfied, relating to various aspects of their jobs. The higher the score, the higher the level of job satisfaction reported. The PCA extracted two factors for T_1 that accounted for 56 per cent of variance and Cronbach's alpha were 0.82 and 0.86 for factor 1 (intrinsic satisfaction/working conditions) and factor 2 (extrinsic satisfaction/employee relations) respectively. For T_2, two factors accounted for 55 per cent and Cronbach's alphas were 0.84 and 0.85 for factor 1 and 2 respectively. These internal reliabilities are consistent with those reported from other research (Heritage et al.2015; Hills et al. 2012).

Table 6. Job Satisfaction Scale factors and item presentation

PCA for JSS		Item
Factor 1	Intrinsic Job Satisfaction/Working conditions	2. (method) 4. (recognition) 6. (responsibility) 8. (abilities) 10. (promotion) 12. (attention) 14. (variety)
Factor 2	Extrinsic Job Satisfaction/Employee Relations	1. (physical work) 3. (fellow workers) 5. (boss) 7. (pay) 9. (relations) 11. (managed) 13. (hours of work) 15. (security)

6.3.7 Social Support Scale (SSS)

The Social Support Scale (SSS) from Daniels and Guppy (1995) is a 15-item self-report scale and it is a three-factor solution: factor 1 (help and support), factor 2 (social dependability) and factor 3 (esteem support). Research from Daniels and Guppy (1995) found that these three aspects of social support improve an individual's coping and increase a person's affective wellbeing. This scale is a self-reported measure assessing perceived social support at work. Internal reliabilities for factors 1, 2 and 3 were 0.78, 0.83 and 0.89 respectively in the research carried out by Daniels and Guppy (1995). Participants responded on a six-point scale by circling their response on how often they found themselves interacting with peers and colleagues in the ways that the statements suggest or seeking help from their managers in the way suggested in the scale. Their responses can range from 0=not at all, 1=once or twice, 2=three or four times, 3=several times, 4=most of the time to 5=all of the time.

Table 7. Social support scale factors and item presentation

PCA for SSS		**Item**
Factor 1	Help/support	1. (to talk) 5. (let off steam) 9. (careless) 11. (let down)
Factor 2	Social dependability	2. (workload) 4. (area of expertise) 6. (own ambitions) 7. (mistake) 8. (information) 10. (confide)
Factor 3	Esteem support	3. (emotional) 12. (confidence) 13. (value ideas)

The PCA found three factors that accounted for 51 per cent of variance both at T_1 and T_2. Cronbach's alphas for factors 1, 2 and 3 were 0.32, 0.51 and 0.54 respectively for T_1 and 0.51, 0.58 and 0.56 respectively for T_2. These internal reliabilities were obtained after removing item 14 "have you been able to talk to someone about how you are feeling?" and item 15 "how often do you get into an argument at work?". These internal reliabilities are lower than those reported by Daniels and Guppy (1995) who used the scale on non-nursing sample groups. Nurses may perceive social support at work differently to other professional groups because nursing is highly hierarchical and structured work. Therefore, the system of support in the nursing ranks may be perceived differently to professional groups with different management structures than the nursing profession.

6.3.8 The Sense of Mastery Scale (SOM)

Pearlin and Schooler (1978) developed a seven-item sense of mastery scale (SOM-7) to assess nurses' self-belief in controlling the important circumstances in their lives. The measure of mastery is found to buffer the stress process and mediate the impact of stress on the individual's mental and physical health and wellbeing (Turner 2010). According to research, this scale's Cronbach's alphas are around 0.70 which makes it a reasonably stable scale (Deeg and Huisman 2010; Togari and Yonekura 2015; Pearlin and Bierman 2013). Nurses were asked to

respond to a statement and indicate the extent to which they agreed with each item on a four-point Likert-type scale where 1=strongly agree through to 4=strongly disagree. The negatively worded items were reverse coded prior to scoring and the higher the score, the greater level of mastery found.

Table 8. SOM factors and item presentation

PCA for SOM		**Item**
Factor 1	Under control	6. (future) 7. (mind)
Factor 2	Fatalistically ruled	1. (little control) 2. (no way) 3. (important things) 4. (helpless) 5. (pushed around)

PCA found two factors that accounted for 58 per cent of variance for T_1 and Cronbach's alphas were 0.58 and 0.65 for factors 1 and 2 respectively. These factors accounted for 55 per cent at T_2 and Cronbach's alphas were 0.71 and 0.52 respectively for T_2. These internal reliabilities found to be consistent with those reported by Pearlin and Bierman (2013).

6.3.9 Trait emotional Intelligence Questionnaire Short Form (TEIQue-SF)

The trait EI questionnaire short form or TEIQue by Petrides and Furnham (2001) assesses self-perceived emotional abilities for self and others. This short version of TEIQue is high on internal consistency for its global score (Cooper and Petrides 2010) but it is also a much shorter measure than the 153-item original trait Emotional Intelligence Scale (Petrides and Furnham (2001) which makes it easier to administer and score. Both the long and short form of trait EI questionnaire involves 15 facets but the short form of TEIQue (TEIQue-v. 1.50) according to Swami et al. (2010) and Petrides (2009) was developed using two items from each one of the 15 facets creating a 30-item TEIQue-SF. This short form also uses a seven-point Likert scale ranging from 1 (completely disagree) to 7 (completely agree) on statements concerning five factors: (a) wellbeing (b) self-control (c) emotionality (d) sociability and (e) motivation. The internal consistency for long trait EI scale was reported to be 0.95 and 0.89 for the short form (Siegling et al. 2014;

Cooper and Petrides 2010). The short form was chosen for this research for the above stated reasons.

The global trait EI score can be calculated by adding the item scores and then dividing them by the total number of items and the total trait EI score can be calculated by adding the factor scores of wellbeing, self-control, emotionality, sociability and motivation. These calculations were performed after the scores were reversed for items 16, 2, 18, 4, 5, 7, 22, 8, 10, 25, 26, 12, 13, 28 and 14. The higher scores on the TEIQue-SF indicate higher trait EI global or total scores. The analysis from this sample found that the five factors account for 53 per cent of variance for T_1 and Cronbach's alphas were found to be 0.66 for factor 1 (Wellbeing), 0.65 for factor 2 (Self-control); 0.66 for factor 3 (Emotionality), 0.38 for factor 4 (Sociability) and 0.59 for factor 5 (Motivation). At T_2 the five factors accounted for 57 per cent of variance and Cronbach's alphas were 0.61 for factor 1 (Wellbeing), 0.56 for factor 2 (Self-control), 0.73 for factor 3 (Emotionality), 0.24 for factors 4 (Sociability), and 0.57 for factor 5 (Motivation). Interestingly, sociability scores were found to be low both at T_1 and at T_2 which may indicate that items on these factors may be either confusing or misunderstood from nurses. This finding fits well with the role dissonance result found in phase I of this research. Nurses reported that they struggled to navigate relationships in the workplace and this is evident in the emergent themes in the analysis of the results for phase I.

Table 9. TEIQue-SF factors and item presentation

PCA for TEI-SF		**Item**
Factor 1	Wellbeing	5. (enjoyable) 9. (qualities) 12. (gloomy) 20. (pleased) 24. (strength) 27.(work out)
Factor 2	Self-Control	4. (regulate) 7. (mind) 15. (stress) 19. (control) 22. (involved) 30.(relaxed)

Factor 3	Emotionality	1. (words) 2. (viewpoint) 8. (figure) 13. (complain) 16. (affection) 17. (get into) 23. (pause and think) 28. (bond)
Factor 4	Sociability	6. (effectively) 10. (stand up) 11. (influence) 21. (negotiator) 25. (back down) 26. (power)
Factor 5	Motivation	3. (motivated) 14. (adjust) 18. (keep) 29. (new environment)

6.4 Procedure

This part of the thesis describes the procedure followed in delivering the interpersonal awareness training for the intervention group. The aim was to offer a clear replicable procedure of how the intervention was delivered. The participants completed a set of measures as explained in section 6.3 at baseline and again followed up with the same measures at post intervention. The procedure includes three steps and each step involved a number of tasks to be completed by the participant nurses in the intervention group. While the control group were offered some general discussion about wellbeing and work.

6.4.1 Step 1: The IPA interview

Activity 1: Using IPA questions to eliminate negative self-talk and increase positive self-talk (30 minutes).The aim of the activity was to increase self-confidence and help nurses cope with stress by identifying negative and positive things in the workplace which they can help nurses change their attitude.

Task 1: To consider and discuss the following: How might what we think about ourselves affect how we feel about ourselves? How might positive self-talk generate positive feelings about self? Can we change the way we feel about ourselves? Can we control our thoughts and feelings? The discussion aimed at focusing the participant on positive thinking followed by positive feelings about self.

6.4.2 Step 2: The Wheel of life

Activity 2: Using the Wheel of Life to identify negative and positive things in life. The aim was if the participant was focusing more on negative things (this would also show on the low scores on the wheel of life) then ask the participant to rephrase the negative talk to reflect what they can do and focus on what they can do instead of what they can't do (approximately 30 mins).

Task 1: To identify and label areas of life important to the individual participant and score each area from 1-10. Score 1 indicates least happy and 10 indicates most happy with this aspect of life.

Task 2: To identify feelings and emotions related to wellbeing such as: What am I feeling? Is it worry, fear? What is the evidence that I should feel this way? What is the worse that could happen? What is the best that could happen? What if everything goes well? What am I going to feel then? And focus on this feeling.

6.4.3 Step 3: The Johari Window Feedback Model

Activity 3: Using the Johari window aimed to improve nurses' emotional intelligence by providing them with a new way to cope with stress and worry (approximately 30 minutes).

Task 1: To identify a negative experience and then rationalise the negative thoughts and feelings surrounding this stressful event and putting it into perspective. The aim was to show the participant that each problem has a solution and by adopting such an attitude, an event becomes easier to cope with. Using the Johari model nurses were provided with a powerful tool to help them rationalise these stressful events and experiences and that way calm their stress and anxiety.

Task 2: To identify a really positive experience when the participant felt good (this can be at work, with family or friends) and describe the experience in detail

and not only in terms of what and where, but also how they felt (a rushed heart beat) and describe what they could see, hear, smell when they were transported into that time and place and revisit this positive feeling or experience.

Task 3: To become aware of own values and clarify individual goals and intentions. To increase awareness of own goals. Feelings are not always obvious to people without some thought and analysis, similarly goals are not always clear and evident to us either. Using key questions to prompt the individual participant to start thinking of goals setting such as, what is important to you? What do you care about? What excites you and challenges you? This can be any aspect of life. What do you admire most in others? Now think about your goals, what are they? Are there any barriers to achieve this goal? Are there any ways you can help achieve this goal? Can you see the link between your values and your goals?

Chapter 7. Statistical analysis in phase II

7.1 Rationale for using mixed analysis of variance (ANOVA) and partial correlation

The statistical analysis used to analyse the data collected in this phase was a mixed analysis of variance (ANOVA). The quantitative component of this research aimed to find out whether nurses who scored high on trait EI also scored high on job-related affective wellbeing. The null hypothesis of this study was that there was no difference between those who score high or low for trait EI and their job-related affective wellbeing. The repeated measures design chosen for its statistical power because it controls for factors that cause variability between subjects. This component of the research used randomisation block sampling as discussed in section 6.2. and there were two data collection points (T_1 and T_2). The use of analysis of variance for repeated measures (ANOVA) that is the equivalent of the one-way ANOVA for related, not independent, groups is also referred to as “within subjects” ANOVA or ANOVA for correlated samples.

The analysis of variance (ANOVA) is a statistical method used to test differences between two or more means, whereas mixed analysis of variance

(split-plot ANOVA) is used to test for differences between two or more independent groups. Therefore, this mixed-design ANOVA was within (Time: T1, T2) and between subjects design (Group: Training, Control) to test for differences between the intervention (training) and control group and over time using repeated measures. The two groups of nurses were given a questionnaire to complete at baseline (T_1) and six to eight weeks post intervention (T_2). The same applied for the control group.

There are four assumptions underlying each parametric test such as mixed-design ANOVA. These are: (a) the level of measurement should be either ordinal or interval; (b) the sample size should be of minimum of 25 to 30 participants; (c) sphericity or homogeneity of variance that refers to the assumption that the variance of one variable is relatively similar or otherwise stable at all levels of another variable and (d) that the participants "line up" in scores the same for all pairs of levels of the independent variable, hence they produce a normal distribution. Therefore, samples are expected to have comparable variances (namely, the squares of SD). Therefore, the largest variance should not be more than four times larger than the smallest variable to be normally distributed.

Levene's test and Mauchly's sphericity test were employed to assess homogeneity of variance for this data. Levene's test is an inferential statistic used to assess the equality of variance for a variable calculated for two or more groups. Mauchly's sphericity test is an important assumption of a repeated measures in ANOVA that refers to the condition where the variances of the differences between all possible pairs of within-subject conditions are equal. Both were found to be non-significant for this dataset. Skewness and kurtosis for each variable tested were found to be less than 0.40. This is an acceptable finding for further parametric statistical analysis (Tabachnick and Flidell, 2007).

7.2 Participant characteristics and response rate

Some 232 nurses were identified on courses such as CPD modules, MSc modules and the mentorship module, but only 118 postgraduate student nurses completed and returned the questionnaire at T_1, and only 84 nurses completed and returned the questionnaire at T_2. Hence, the intervention group consisted of 35 participants and the control group involved 49 participants who completed the

questionnaire at T_2. In total, 168 questionnaires were collected at T_1 and T_2 and analysed on SPSS version 21.

The various scales and measures used to compile the questionnaire that was administered at T_1 and T_2 were discussed in section 6.3. and the rationale for using these scales and measures was that the construct validity of these measures (the degree to which a test measures what it claims or purports to be measuring) and the internal reliabilities yielded in the PCA undertaken in this research were high. These findings confirmed findings reported by other research studies in other disciplines with larger samples.

Table 10. Comparison of training and control group characteristics of study groups at baseline

	Intervention (n=35)	**Control (n=49)**	**Difference (p-value)**
Gender (no. of female %)	30 (86%)	41 (84%)	Ns
Gender (no. of males %)	5 (14.30%)	8 (16%)	Ns
Age (years) Mean (SD)	Mean=39.77 years (SD=7years)	Mean=38.9 years (SD=9.37 years)	Ns
Status (single)	18 (51%)	29 (59%)	Ns
Ethnicity (white)	17 (49%)	22 (45%)	Ns
No. of children	20 (57%)	21 (43%)	Ns
Religion (Christian)	27 (77%)	34 (69%)	Ns
Years of work	M=12.51 SD=7.73	M=10.22 SD=6.17	Ns
Speciality	16 (46%)	22 (45%)	Ns
Grade (Band 5)	6 (17%)	20 (41%)	*p*<.046
Education (Degree)	15 (43%)	21 (43%)	Ns

Data from both the training and the control group were analysed using chi-square analysis and groups were found to be similar in terms of demographics because there were no baseline differences between the training (n=35) and the control (n=49) groups on key demographic and employment-related characteristics with the exception of the number of Band 5 nurses in the control group (X^2=11.28, df=5, p<0.046). Therefore, both the intervention and the control group were found to be not-significantly different from each other with respect to the demographic characteristics as shown in the table below. The cut-off for significance was 0.05 hence “Ns” that indicates a non-significant p-value, when p<0.05. Because if p

value is less than 0.05 the null hypothesis is rejected and we can conclude that significant difference exists between groups.

Table 10 presents individual characteristics such as gender, age and years of work which are considered important in the development of trait emotional intelligence. The overall sample was made up of 71 (84.5%) females and 13 (15%) males. Thirty (n=30, 86%) and 41 (84%) were female for training and control groups respectively. Fifty-one per cent (51%) were below 40 years old and 37 per cent (37%) were above the age of 41 years old, whereas only twelve per cent (12%) of the sample were under 30 years old. The mean age of the sample was 39 years old and the SD was 8.4 years, whereas the average age for the training group was 40 years (SD=7years) and 39 years (SD=9 years) for control group. Therefore, groups were similar in age and homogeneity across samples was maintained.

Table 11. Numbers of different nursing grades in case and control groups

Number of participants	**Intervention Group**	**Control Group**
Male	5	8
Female	30	41
Grade 5	10	16
Grade 6	10	16
Grade 7	13	8
Grade 8	2	2
No grade reported	0	4
White	18	21
Black	3	10
Other	7	5

Considering the ethnic background of the sample, 44 per cent (44%) reported to be white, 19 per cent (19%) black, 15 per cent (15%) Asian, 8 per cent (8%) other and 6 per cent (6%) Irish, and 3 per cent (3%) said that they were mixed and 5% didn’t state their ethnicity. The training and control groups were made of 49 per cent (49%) and 45 per cent (45%) of white ethnic background respectively, while 77 and 69 per cent (69%) reported as Christians respectively.

With regards to personal status, 53 per cent (53%) of the sample were single and 40 per cent (40%) were married; only 1 per cent (1%) was cohabiting and 1 per cent was divorced, while 5 per cent (5%) did not state their status; 47 per cent (47%) reported having no children and 10 per cent (10%) reported having one child, 26 per cent (26%) and 7 per cent (7%) reported having more than one child respectively.

Twenty-five per cent (25%) of nurses reported to have worked more than 16 years as a nurse and 5 per cent (5%) reported having worked as a nurse from six to 15 years while 25 per cent (25%) of nurses said they have worked for five years or less. Overall, mean number of years of work for the sample was 11 years with a standard deviation (SD) of seven years. However, the average years of work for nurses in the training group was 13 years (SD=8 years) and for control 10 years (SD=6 years). Forty-three per cent (43%) of the whole sample population did not report having a speciality, but 27 per cent (27%) recorded themselves as community nurses, 22 per cent (22%) as hospital nurses and less than four per cent (3.4%) as practice nurses. The majority of nurses were diploma and degree educated (30% and 41% respectively) and 14 per cent (14%) had a Masters in nursing or other discipline and 15 per cent did not say, while 30 per cent (30%) of nurses were Band 5 and 30% were Band 6 and 9 per cent (9%) were Band 7. Only 4.5 per cent (4.5%) were Band 8.

7.3 Partial correlation inferential statistics

In section 4.5, the development of a transactional model for nurses' wellbeing discussed and argued that trait emotional intelligence may relate to positive wellbeing outcomes such as increased coping at work, increased job-related affective wellbeing, reduced general anxiety and depression, but also increased perceived support from others. This model also argued that neuroticism and mastery may mediate the wellbeing process. Partial correlation was used to find out whether there is a relationship between these variables as shown in the figure below.

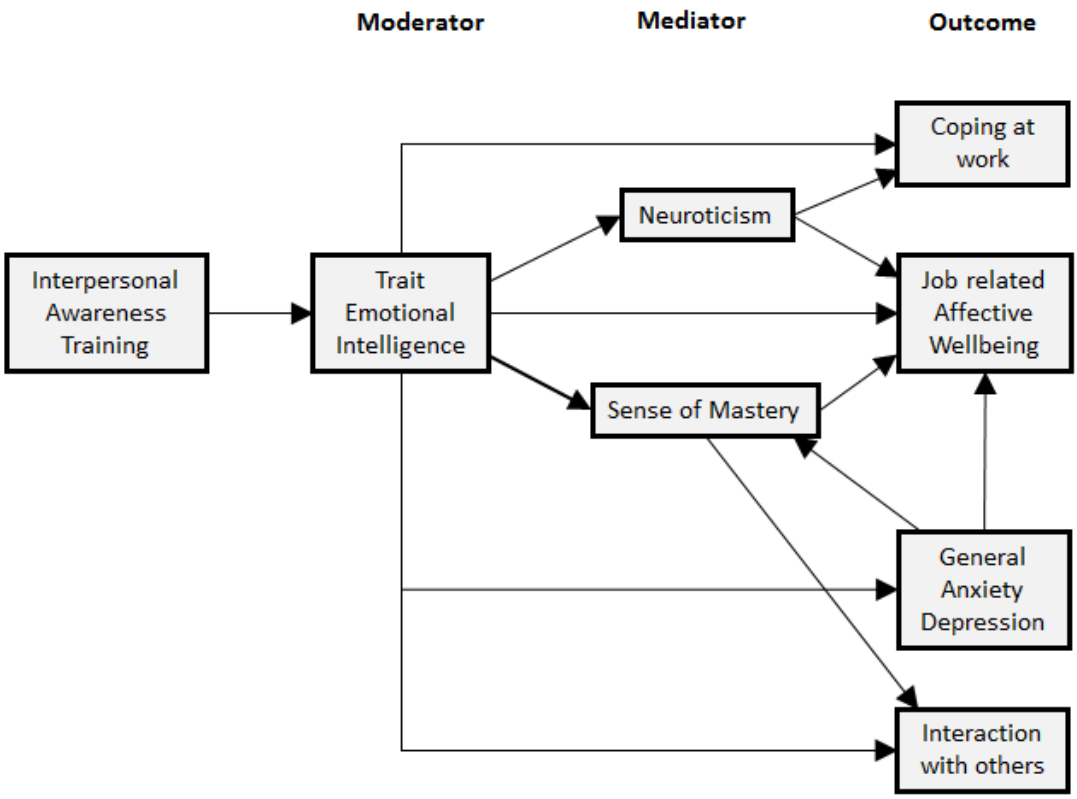


Figure 26. Proposed model for stress and wellbeing at work for nurses

Further statistics were employed to reject the null hypothesis for this phase of the research and this section presents the means and SD for the intervention and control group at T_1 (baseline) and at T_2 (post intervention). It is interesting to pinpoint that the control group scored on global trait EI, general health, neuroticism and job-related affective wellbeing higher at T_1, whereas the intervention group scored on these variables higher at T_2.

Table 12. Mean and standard deviations (SD) for Time 1 (pre-intervention) and Time 2 (post-intervention) are showing for intervention and control group

Variable	Training (n=35)				Control (n=49)			
	Time 1		Time 2		Time 1		Time 2	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Global TEI	4.39	0 .71	4.78*	0.74	4.97	0.77	4.41	1.3
Wellness	28.12	5.88	31.06	5.97	32.21	5.7	30.62	5.9
Sociability	4.43	0.75	4.41	0.77	4.52	0.72	4.26	1.55
Self-control	4.08	0.94	4.46*	0.8	4.77	0.92	4.07	1.4

Emotionality	4.17	0.95	4.71*	1.12	5.01	0.93	4.41	1.4
GHQ	15.17	7.42	14.51	8.1	18.78	6.78	17.57	7.73
Job satisfaction	55.17	12.82	58.03*	13.25	53.37	13.88	54.13	13.31
Coping	44.82	5.99	46.62*	6.79	44.96	6.07	45.85	6.31
Support	30.66	8.00	30.38	6.8	30.85	9.09	30.75	11.21
Mastery	20.23	3.77	19.5	3.99	21.08	3.6	20.52	3.37
Job-related wellbeing	46.66	11.19	40.7	10.25	48.98	8.92	43.96	10.21
Extraversion	17.16	3.60	17.31	4.62	17.16	3.5	16.77	3.0
Neuroticism	16.43	3.40	13.86*	4.58	17.67	3.0	15.51	3.7

*The cut-off for significance was 0.05 that indicates a non-significant p-value, when $p<0.05$. Because if p value is less than 0.05 the null hypothesis is rejected and we can conclude that significant difference exists between groups.

The transactional model for nurses' wellbeing argued that there is a link between the work, non-work aspects and context free aspects of wellbeing and that trait EI may reduce general anxiety and depression (non-work aspect of wellbeing). There was also an assumption that trait EI may also increase sense of mastery and subsequently, job related affective wellbeing.

This research chose to employ both Pearson's correlation coefficient (for measuring the strength of the association between variables) and partial correlation coefficients to reject the null hypothesis for this phase of the research. The proposed model for stress and wellbeing found to be partially supported and supported the argument that trait EI is sensitive to training (interpersonal awareness training) and higher scores in trait EI were associated with lower scores in neuroticism. Therefore, one can argue that the relationship between trait EI and general health and job-related affective wellbeing may be mediate by neuroticism. A partial correlation was used to evaluate the null hypothesis that stated there is no difference between those who score higher or lower on trait EI and their job-related affective wellbeing after controlling for general health and neuroticism (N=84). There was strong positive partial correlation between global trait EI (M=18, SD=4.4) and job-related affective wellbeing (M=43, SD=10), controlling for general health and neuroticism, $r=0.294$, $p=0.008$. Results for the Pearson's correlation also yielded that there was a positive correlation between global trait EI and job-related affective wellbeing, $r=0.337$, $p=0.002$. Therefore, controlling for general

health and neuroticism had an effect on the strength of the relationship between the two variables, hence there is evidence to reject the partial correlation null hypothesis.

Stronger correlations were found between neuroticism and general health and job-related wellbeing than those found between trait EI and general health and job-related affective wellbeing as shown in the figure below.

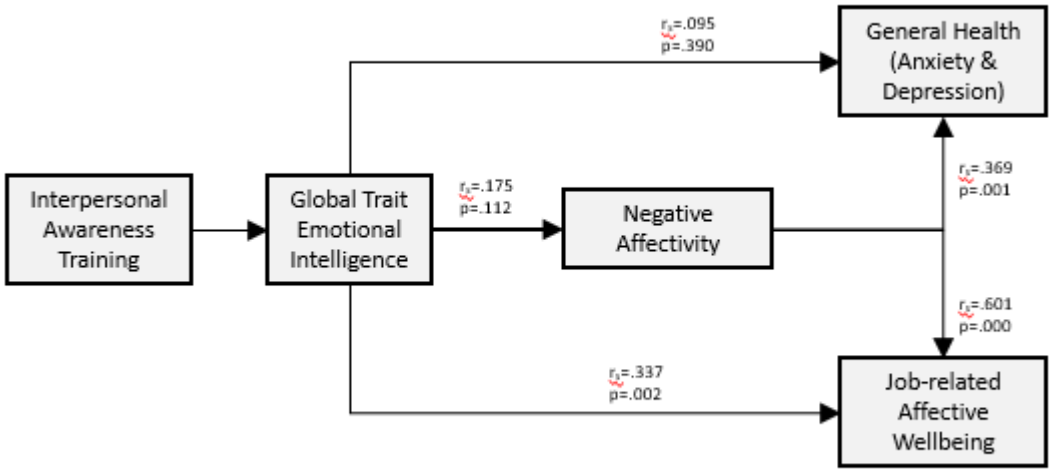


Figure 27. Role of neuroticism in mediating the relationship between trait emotional intelligence and self-perceived general health and job-related affective wellbeing

These findings may suggest that trait EI can be developed and have an impact on nurses' self-perceived affective wellbeing at work. Therefore, these findings from the partial correlation rejected the null hypothesis and accepted the hypothesis that nurses who score high on trait- EI will score high on job-related affective wellbeing. The proposed transactional model for nurses' wellbeing that links trait EI to improve self-perceived affective wellbeing at work, has been partially supported here.

7.3.1 Mixed ANOVA within and between subjects inferential statistics

This section presents the findings from the mixed-design ANOVA within (Time: T_1, T_2) and between subjects inferential statistics (Group: Training, Control) in order to test for differences between the intervention (training) and control group

and over time at T_1 and T_2. The terms main effect, between and within groups, within subjects and interaction were used to report findings from the mixed-design ANOVA for this thesis. The “main effect” is that of one of the independent variables on the dependent variable which ignores the effects of all other variables. “Main effect” is reported in the table by listing the degrees of freedom for the main effect (that is the number of values used in the final calculation and that they are free to vary without violating any constraints imposed by the statistic used) together with the mean sums of squares that determines the dispersion of data points. Therefore, the mean sums of squares reported on variation of data points. Furthermore, the F-value is reported that determines whether the means between the intervention (training) and control group are significantly different from each other, whereas p-value is the probability of finding the observed results when the null hypothesis H_0 is true. If there is an interaction that means that the impact of one factor depends on the level of the other factor and when interaction effects are present, it may also mean that interpretation of the main effects is incomplete. Therefore, if a main effect between groups was significant, this suggests that the means between the intervention and control group were significantly different from each other.

7.3.2 Global trait emotional intelligence

There was no significant main effect for within subjects for T_1-T_2 , $F(1,82)=0.284$, MSE = 2.943, $p=0.596$ or between groups $F(1,82)=0.290$, MSE =5.156, $p=0.591$ for global trait EI, but there is a significant main effect within groups $F(1,82)= 14.632$, MSE=151.781, $p=<0.001$ that suggests that scores within the intervention (training) group improved at T_2 whereas scores within the control group decreased at T_2. Furthermore, the lines intersect, as shown in Figure 28, and there is significant interaction $F(1,82)= 3112.982$, MSE=55278.457, $p=<0.001$. The cross-over interaction in global trait EI may suggest to that it is sensitive to training, but this should be treated tentatively because of the small sample groups.

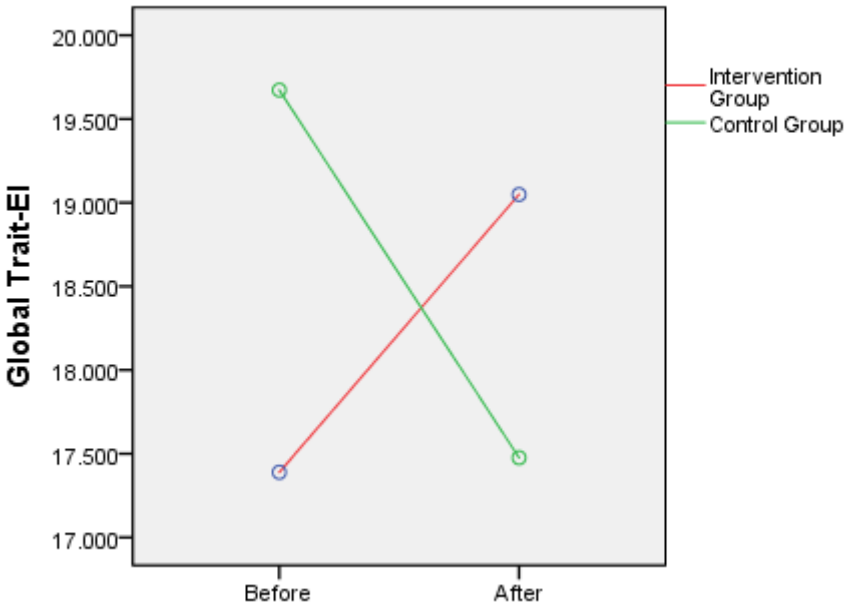


Figure 28. Cross-over interaction between intervention and control group for global trait emotional intelligence

7.3.2.1 Wellness (factor 1)

There were no significant main effects within subjects for T_1-T_2, F(1,82)=0.116, MSE = 0.171, p=0.735 or between groups F(1,82)=0.021, MSE =0.045, p= 0.884 but there was significant main effects within groups F(1,82)=13.478, MSE =19.853, p=.000 and a significant interaction between groups, F (1,82)= 1977.133, MSE=4189.008, p=.000. Please refer to Figure 29 for further details on this factor.

7.3.2.2 Self-control (factor 2)

There were no significant main effects within subjects for T_1-T_2, F(1,82)=1.633, MSE =1 .044, p=0.205 or between groups F(1,82)=0.577, MSE =0.923, p=0.450. But, there was a significant main effect for within groups F(1,82)= 18.688, MSE=11.943, p=0.000 and a significant interaction found F(1,82)=1928.427, MSE = 3085.844 p=0.000. Please refer to Figure 30 for more details on this factor.

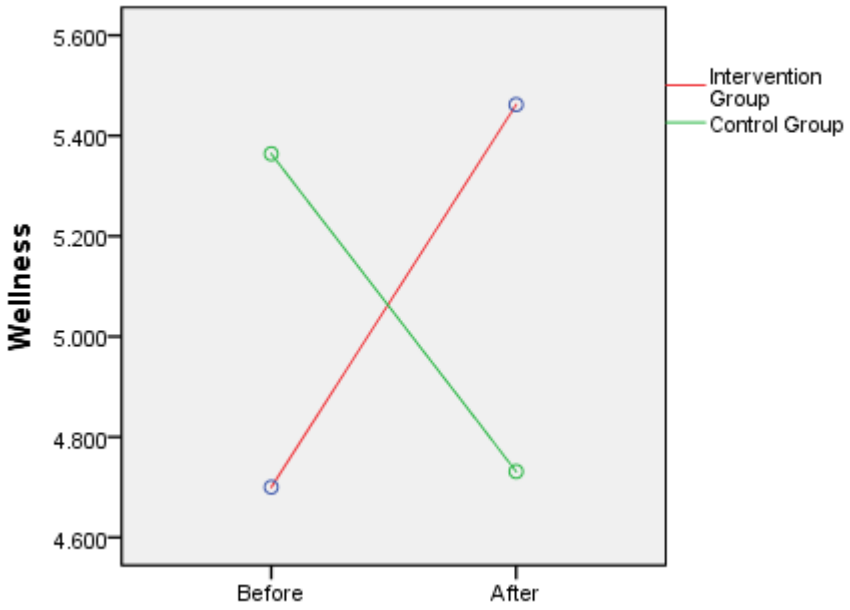


Figure 29. Cross-over interaction between intervention and control group for wellness

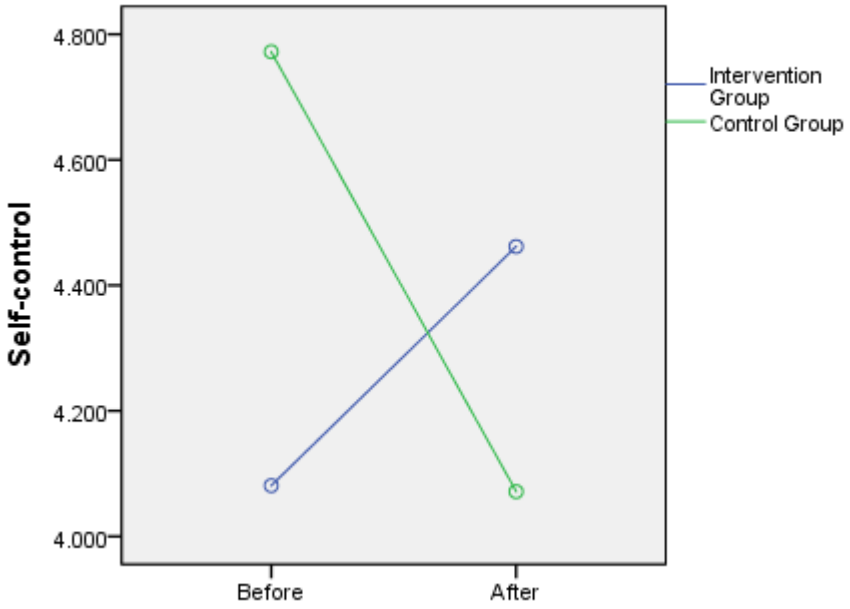


Figure 30. Cross-over interaction between intervention and control group for self-control

7.3.2.3 Emotionality (factor 3)

There were no significant main effects for within subjects for T_1-T_2 F (1, 82)= 0.052,MSE =0.480, p=0.820) or between groups F(1,82)=1.805, MSE =2.924, p=0.183, but there was a significant main effects for within groups F(1,82)= 14.217, MSE=13.274, p=0.000 and significant interaction F(1,82)= 2112.240, MSE=3421.147, p=0.000. Please refer to Figure 31 for further details on this factor.

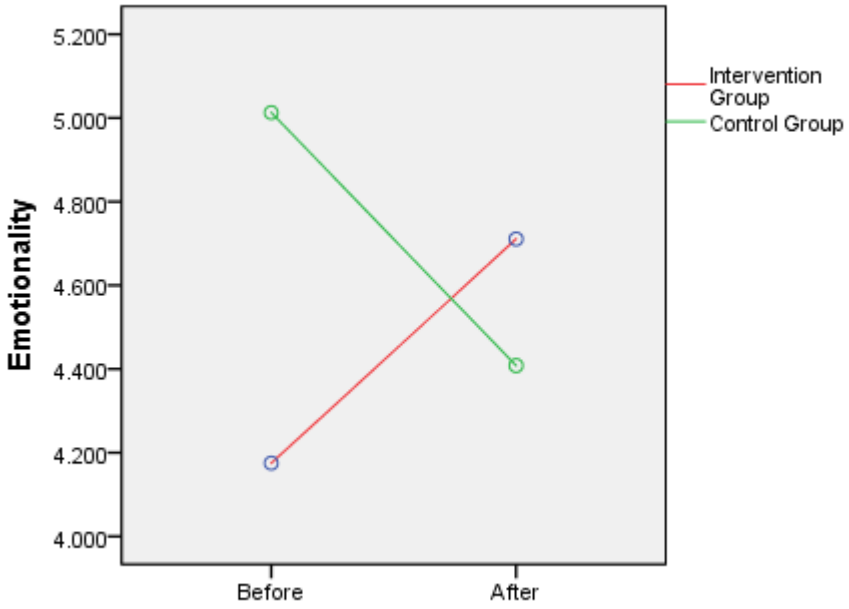


Figure 31. Cross-over interaction between intervention and control group for emotionality

7.3.2.4 Sociability (Factor 4)

There were neither significant main effects for within subjects for T_1-T_2 F (1,82)=0.807,MSE =0.786, p=0.372 nor between groups F(1,82)=0.029, MSE =0.035, p=0.866 or main effect for within groups F(1,82)=0.600, MSE=0.585, p=0.441 but there was a significant interaction F(1,82)= 2607.299, MSE=3175.347, p=0.000. Please refer to Figure 32 for details.

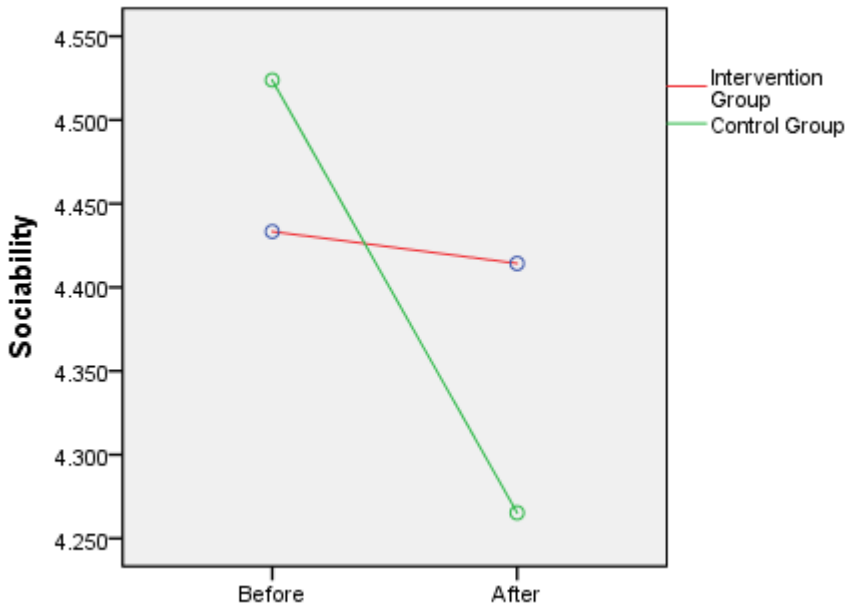


Figure 32.Cross-over interaction between intervention and control group for sociability

7.3.3 General health

There was no significant main effect within subjects for T_1-T_2 F (1,82)=2.259, MSE = 35.363, p=0.137 but found a marginally significant main effect between groups F(1,82)=4.706, MSE =452.963, p=0.330, but no significant main effect for within groups F (1,82)=0.195, MSE = 3.054, p=0.660. However, a significant interaction effect F (1,82)= 462.468, MSE=44511.511, p=.000 was also found. This may suggest that the intervention group scored higher on general health at T_2, as shown in Figure 33.

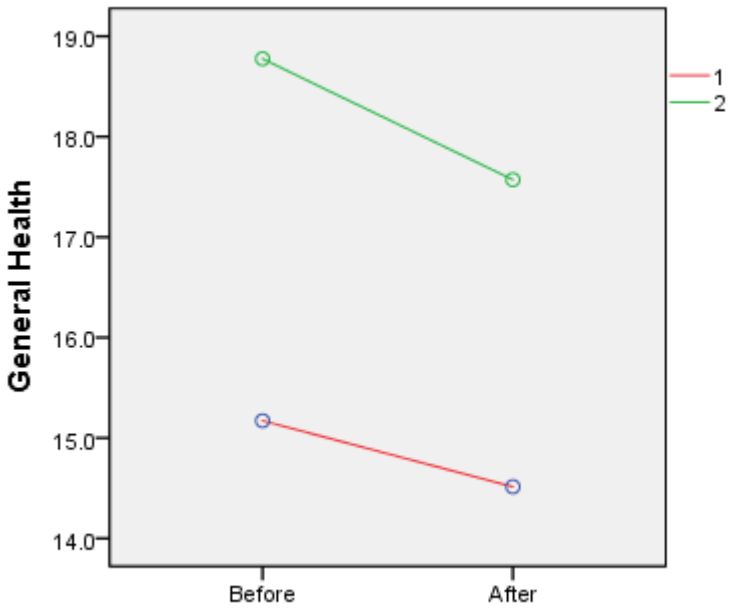


Figure 33. Parallel lines between intervention and control group for general health

Furthermore, Figure 33 shows that the lines are parallel to each other, which suggests that changes at one independent variable are changing systematically at the level of the other variable. Hence, the scores at T_1 for intervention and control group respectively were higher than those at T_2 whereas scores for both intervention (training) and control dropped slightly at T_2. It may be worth noting that this is the biggest drop found with the control group, hence there is some significance which explains the finding of significant main effect between groups.

7.3.4 Job-related affective wellbeing

There was no significant main effect for within subjects for time (T_1- T_2), F(1,77)=252.950, MSE= 1.797, p=0.184, and there was a significant main effect within groups F(1,77)=15.553, MSE = 1000.997, p=0.000, but no significant main effect between groups F(1,77)=0.097, MSE =6.212, p=0.757. However, there was a significant interaction between groups F(1,77)=15.553, MSE = 1000.997, p=0.000.

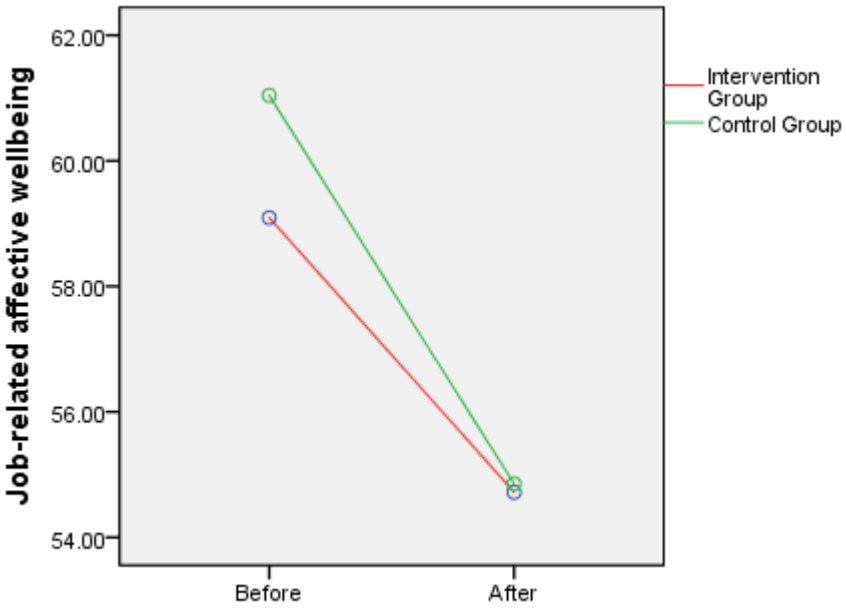


Figure 34. Effect of intervention (training) on job-related affective wellbeing for intervention and control group

In Figure 34 the two lines meet, indicating a significant main effect between groups but scores dropped for both groups at T_2.

7.3.5 Job satisfaction

There were no significant main effects within subjects for T_1-T_2, $F(1,76)=3.571$, MSE = 229.783, $p=0.063$ and between groups $F(1,76)=0.662$, MSE =227.898, $p=0.418$ and within groups $F(1,76)=0.054$, MSE =3.450, $p=0.818$, but there is significant interaction effect $F(1,76)= 1356.881$, MSE=466911.359, $p=0.000$. Please refer to Figure 35 for further details on this variable.

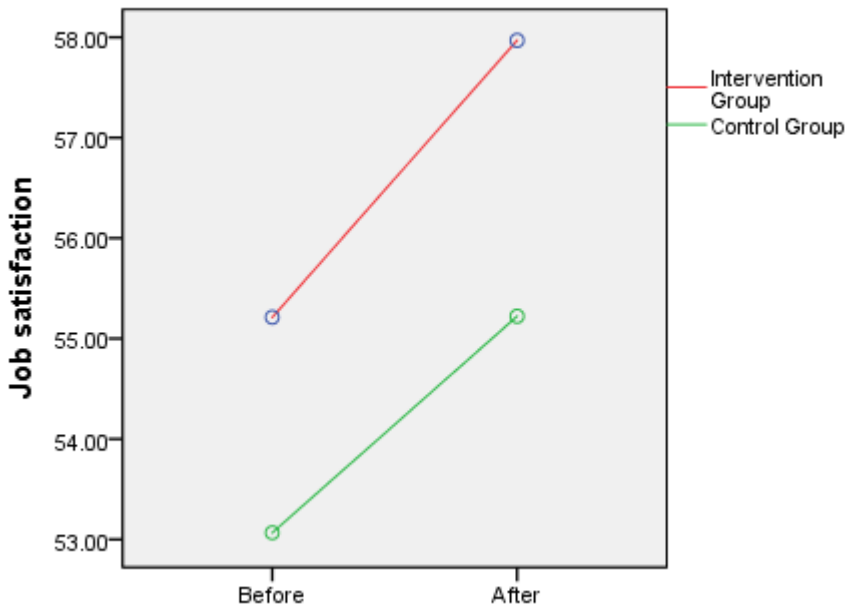


Figure 35. Parallel lines between intervention and control group for job satisfaction

7.3.6 Coping at work

There was a marginal significant main effect for within subjects for T_1-T_2, F(1,77)=3.593, MSE = 73.035, p=0.062 but no significant main effect for between groups F(1,77)=0.146, MSE =8.557, p=0.703 and no significant main effect for within groups over time F (1,77)= 0.342, MSE=6.959, p=0.560. There was, however, significant interaction effect F (1,77)= 5375.614, MSE=315053.570, p=0.000). The intervention group appears, as shown in Figure 36, to score a bit higher than the control group at T_2 which also suggests that these convergent lines support this significant interaction.

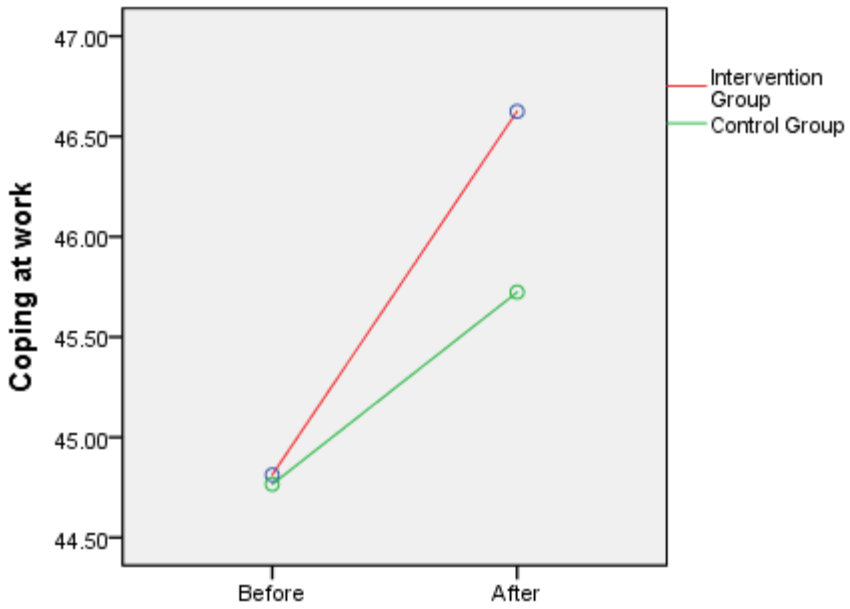


Figure 36. Effect of training on coping at work for intervention and control group for general health

7.3.7 Neuroticism

There was significant main effects within subjects for T_1-T_2 F (1,77)=21.455, MSE =228.844, p=.000, no significance within groups F(1,77)=0.159, MSE =1.701, p=0.691, but there is a significant main effects between groups F (1,77)=5.313, MSE =85.731, p=0.024 and significant interaction effect F (1,77)= 2548.338, MSE=41122.874, p=0.000. As shown in Figure 37 there is a significant drop in scores from the control group at T2.

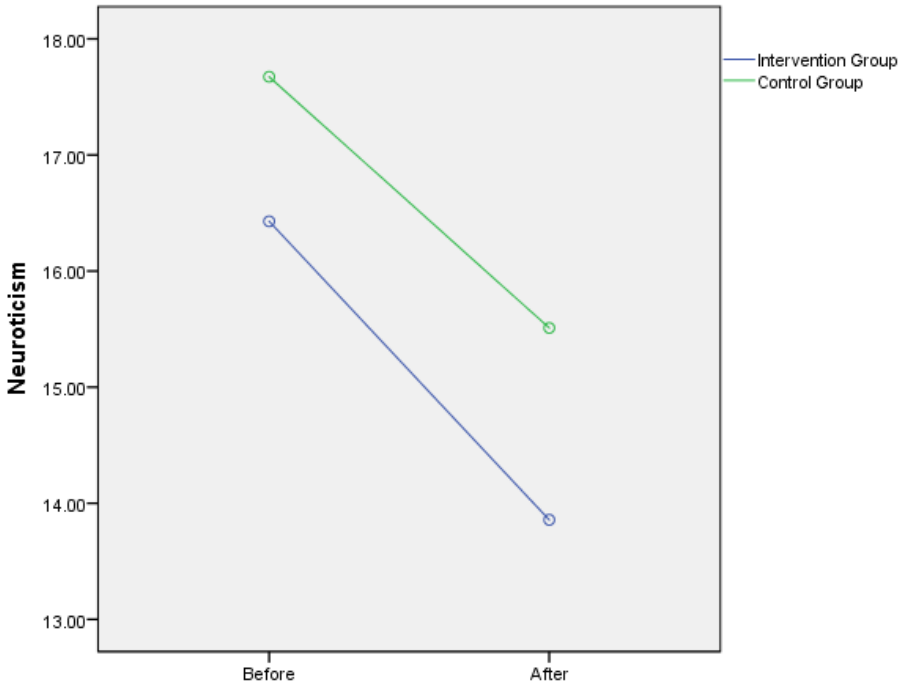


Figure 37. Effect of training on neuroticism for intervention and control group

7.3.8 Significant findings

There are several significant findings from this analysis firstly, there is a significant relationship between intervention and control for global trait-EI, neuroticism, anxiety and depression as well as affective wellbeing. There is also some significance for coping and job satisfaction. The findings on extraversion, support and control were found to be inconclusive. This statistical analysis found that the intervention group scored lower on anxiety and depression and neuroticism and higher on coping than the control group. However, both groups scored lower on self-perceived job-related affective wellbeing. Furthermore, global trait EI scores for the intervention group increased at T_2 in relation to the control group, but there is no main effect between the intervention and control group. Hence, global trait EI may be sensitive to training, however this finding should also be treated tentatively.

The PCA found lower internal reliabilities for the extraversion measures, CCS, SSS and Trait-EI. The SSS scored lower on internal reliabilities than expected but also the sociability factor of the TEIQue-SF. For example, Item 21, “I would describe myself as a good negotiator” may have confused participant nurses

because nurses in general believe they are good listeners but they may not believe they are good negotiators. Likewise, Item 25, “I tend to back down even if I know I’m right”, this is of interest to this sample group as historically nurses were seen to take orders from senior members of the team. Finally, this statistical analysis showed that trait EI may be sensitive to training and found to be linked to some positive wellbeing outcomes, such as reduced anxiety and depression and perceived job related affective wellbeing.

Chapter 8. Discussion of Findings

8.1 Original findings from the exploratory research

This research found that nurses suffer from emotional dissonance and role dissonance. There is evidence in the literature about nurses' suffering a great deal of stress but this is the first study to claim that nurses may suffer from emotional dissonance before they suffer from stress and burnout. This thesis also argues that there is a strong link between emotional dissonance and role dissonance. Role dissonance in nursing is an original finding and there is not enough research to argue that this may be happening to nurses before they quit the profession and leave the job. Furthermore, this research argues that the role of awareness and emotionality is overlooked but it may explain nurses' emotional and role dissonance and therefore, nurses' sliding retention and recruitment numbers. There seems to be a strong link between self-awareness and emotionality in high labour jobs such as nursing and this may explain why nurses leave the profession as a way of resolving their anxiety and distress at work.

This research also found that trait emotional intelligence is sensitive to training. A significant relationship between intervention and control for global trait emotional intelligence was found and a similar strong relationship found for neuroticism, anxiety and depression (non-work and context free wellbeing) and affective wellbeing at work. The intervention or training offered to the nurses in the quasi-experimental research aimed to encourage positive and discourage negative emotional experiences (Mikolajczak et al. 2007b). This approach to training was supported by the results of the exploratory research in this thesis that found nurses suffered from negative feelings about themselves and others at work and negative self-talk. Therefore, it seemed appropriate to address this negative self-talk nurses found to be engaging both in the discussion groups in the exploratory study but also in the quasi-experimental study in this research.

Emotional dissonance is linked to high emotional labour jobs, such as nursing and in a study led by Cecil and Glass (2015) emotional dissonance was associated with unresolved emotional issues such as depression. This research found that neuroticism is a strong mediator on how the individual may perceive to experience demands and how they may perceive these demands affecting their wellbeing. Individuals with high level of trait emotional intelligence or self-efficacy were found

to understand and control their neuroticism better. Trait emotional intelligence was found in this thesis to reduce neuroticism better than personal control or sense of mastery. Sense of mastery was considered to be significant for a nurse's work life but findings from this thesis didn't support this relationship. Sense of mastery in general is defined as the latitude to problem solving and it is linked to confidence in resolving life events (Shanahan and Bauer 2004).This research found that nurses' dissonance is not linked to personal control but rather to nurses' feelings of responsibility towards their patients that is directly linked to dissonance (Cooper, Mirabile and Scher 2005). This is evident in the results found in the exploratory study (nurses reported experiencing conflicting emotions at work and feeling responsible for patients' safety). These conflicting emotions also reappeared in the quasi-experimental study where nurses were invited to take part in a short training session.

Trait emotional intelligence contributes to our ability to appraise emotions and feelings both in self and others accurately and it also enables individuals to pick up emotional cues in self and others and use this information to motivate self and others to achieve better at work and life in general. Emotional dissonance, on the other hand, is defined as the conflict between expressed and experienced emotions. This usually happens when experienced emotions are considered inappropriate to display or express at work because they are not always considered appropriate to the organisational ethos and values. Nurses in the discussion groups in the exploratory study reported on these experienced feelings and emotions and they explained clearly why they struggled with their experienced emotions. This thesis pinpointed the importance of understanding nursing work as a dynamic transactional process of emotional work. Nurses are constantly interacting with each other and their patients and they are both recipients of their transactions with others, but they also learn from each other and their experiences. Therefore, this thesis argues that focusing on understanding emotional dissonance should be used as a predictor of nurses' job related affective wellbeing because it may explain variance in perceived job related affective wellbeing in this occupational group.

The results of the exploratory study argued that nurses' work environment needs to allow nurses offload any negative emotions in a safe environment to enable nurses mitigate work-related stressors (Van Den Tooren and De Jonge

2008). Nurses deal with some difficult situations, such as illness, loss, death and trauma and these experiences can trigger distress and anxiety and other negative emotions. Therefore, nurses need to feel empowered and recharge emotionally often in order to continue with their challenging work. This initial work of the thesis formed the basis for developing phase II of this thesis and an intervention (interpersonal awareness training) that involved a goal-based action plan to encourage nurses set personal and professional goals, was developed. The intervention aimed to encourage participant nurses to identify their own interests, core values and hobbies and re-examine their views and perceptions of their experiences at work (Petrides and Furnham 2003; Bar-On 2001).

8.2 Original Findings from the quasi-experimental study

Nurses were invited to focus on the “Wheel of Life” and score different aspects of their lives and think about how this area or aspect of their life can be improved (goal setting and planning for the future). The “Wheel of Life” offers the participant a means to take a helicopter view of their lives, values and ambitions and start thinking about how they can change things for them. Nurses were encouraged to open up and express deep emotions (Austin et al. 2008) and feelings such as anxieties and worries and explore why they felt the way they did and possibly explain or interpret their experiences. Consistent with the trait EI theory, emotional expression is an important axiom of trait EI and is fundamental in adaptive behaviour (Petrides and Furnham, 2003), which can also increase coping aptitude.

This training was designed on the principles of coaching conversations (Grant, 2007) aimed to increase “flexible thinking” and offered nurses a template to put their choices of behaviour, as well as decide on the amount of effort nurses wanted or could afford to put into their plan. There is a suggestion in the literature that emotional intelligence and goals setting may be related processes (Spence, Oades and Caputi, 2003) because there is empirical evidence that an emotionally intelligent individual can be more self-aware of strong and weak aspects of themselves and act accordingly (Petrides and Furnham, 2003; Salovey and Mayer, 1997).

This process was also facilitated using the “Johari Feedback Window” to help unlock nurses’ skills, knowledge, sources of motivation and emotional expression by differentiating between their own feelings and those of other people. The interpersonal awareness training focused on self-identified goals, which were used to energise, motivate and strengthen nurses’ thinking to aid the development of their self-awareness. Therefore, the overall aims of the intervention (training) were to help nurses assess a situation or event by drawing upon the positive and the negative emotions provoked by the incident (please refer to appendix 8 and 9). Also, it encouraged them to think about own perceptions of the situation or event and modify perceptions if it was deemed appropriate at the time, but most importantly to engage with the task of self-analysis and encourage them to choose future goals that they deemed important to them (Grant 2007). In this way, it was assumed that they would have been willing to achieve them (self-identified goals). The “Wheel of Life” and the “Johari Feedback Window” facilitated this process well and made this process easy but most importantly enabled nurses to reappraise and reconsider their resourcefulness, but also rethink their interactions with others and how they can approach a problem differently both at work and at home. This phase of the research found that nurses who scored high on trait emotional intelligence were less anxious and worried and scored higher levels of perceived job related affective wellbeing. This is an original finding of this research.

In high labour jobs, such as nursing, sociability traits are deemed to be core to most individuals’ personalities that had such roles because individuals are expected and required as part of their job to develop effective relationships both with patients, their families and carers, as well as the nursing team and the inter-professional teams and the multi-disciplinary teams. Interestingly, this research found that nurses scored low on sociability when it was expected to be scored high. However, this finding is consistent with the results from the exploratory study and in particular with the themes “feeling isolated” and “disillusioned”. The key message in all the themes found in phase I was that nurses felt they struggled to navigate relationships. In contrast to this, however, nurses in the intervention group scored better on sociability and neuroticism than the control group did which begs the question as to why nurses perceive themselves as limited when it comes to interaction with others and building relationships with others at work. It may be that nurses are anxious and nervous about this aspect of their job and they may

perceive this far more threatening, therefore, they may experience stressful situations more acutely and they may take longer to recover from these situations (Pishghadam and Sahebjam, 2012; Augusto Landa et al. 2010; Buss et al. 1987).This assumption may explain some of the negative self-talk nurses were found to be doing in the exploratory study. It may be that anxious and neurotic individuals may report more interpersonal conflict because they perceive it to be more threatening to them which may lead to distrust of others and further anxiety and distress (Bolger 1990; Eysenck, 1988a; 1988b; Endler and Edwards, 1982). Neuroticism is a personality trait which is linked to negative attitudes and emotions, and the empirical evidence is that low neuroticism may mitigate nurses' emotional wellbeing at work (Lombardo and Eyre 2011). It may be that nurses need to be supported more as individuals and offered a more individually tailored strategy to deal with these negative attitudes and emotions to improve personal control and coping (Nasseh et al. 2011).

Therefore, nurses were invited to use a visual aid (the Wheel of Life) to take a "helicopter view" of their lives, to enable them to understand the valence of their emotional experiences at work. It was thought important that nurses had the space to articulate their feelings and emotions in a safe environment in which they were urged to reconstruct and analyse their experiences, their emotions, thoughts and feelings and to make sense of them. It seems that emotional intelligence is an important life attitude that can help a person to deal with own and others' emotions and feelings because it enables the person to be flexible and open to themselves and others too and release emotional stress. Nurses' work conditions may improve over the next few decades but nurses will always be faced with similar difficulties and challenges because of the nature of the work they do and lack of resources both human and other will never cease in the NHS. So there is an urgent need to address this issue from within the profession and this can start with nursing education.

This short interpersonal awareness training offered to nurses produced some positive outcomes for nurses but there is a need for a repeat study to confirm these findings further and support the generalisability of these findings on larger samples. Trait emotional intelligence was found to be sensitive to training, which provides another original finding and this pushes the idea of bite size training for embedding life-long attitudes in nursing education as a new and innovative approach to

training and education for nurses. It appears that nurses can be developed to become more emotionally agile individuals if the appropriate training is offered. The timing of this training is also vital in order to see a real behavioural change.

Such personal development, however, requires a clear educational plan that includes both “intrinsic” and “identified” goals (Sheldon and Elliot 1998) that can be developed over time in chunks, so nurses are allowed the space and the time to take it in. Goals were an integral part of this training and may need to be factored in to any further developments of this training, so that progress can be tracked and the nurse can feel that she/he grows as a person and can value the time spent on this training (Emmons 1996).

Emotional intelligence is about being adaptable to change and agile towards challenging behaviour and situations with a strong sense of self-awareness and that of others. This thesis argues that trait emotional intelligence can be taught in small chunks and developed throughout a nurse’s career. This method of developing trait emotional awareness is recommended as being incorporated early in undergraduate nursing programmes, so that nurses learn to draw upon this resource and develop their sense of awareness from the early years of their career. Furthermore, student nurses who have learnt how to manage their emotions and how to respond to demands appropriately so they protect their wellbeing (Mavroveli et al. 2007; Mikolajczak et al. 2007b) they will be able to develop ways of coping in later life and careers.

This short developmental training aimed to help nurses rebuild their perceptions of their own aptitudes affecting their behaviour, their motivations, their thought patterns and their emotional reactions to challenging situations. Continuous training on trait EI or self-efficacy may help nurses to develop a deeper understanding of how perceptions and emotions can mould an individual’s perceptions of abilities and behaviour and influence motivation. It should be acknowledged, however, that it is a delicate task to interpret, value and act on our own and others’ perceptions of emotions (Petrides 2001; Bandura 1977, 1982) therefore, time and space should be allowed for these to grow.

8.3 Limitations of the research

This thesis argues that nurses may benefit from short “bite size” training on trait emotional intelligence and they were found to be sensitive to training. This is an original finding and further research is needed to confirm these findings. This research would have benefited from a larger sample and possibly a longitudinal research design to enable follow-up data collection. This research design would allow consolidation of training benefits because research outcomes would be assessed over time. Lack of resources to support this research to overcome practical difficulties, such as fund travelling expenses, may help retain participants. A larger sample size would avoid inconclusive findings and more complex and robust statistical analysis to be carried out. Another ethical consideration but also research limitation was the unequal proportion of female nurses versus male nurses. The research used a sample that probably reflects the gender ratio currently found in NHS workforce. It would benefit the current research to include equal numbers of female and male nurses to identify possible differences in emotional intelligence development.

This thesis argues that trait emotional intelligence is found to link to positive wellbeing and that trait emotional intelligence can be used as a preventative measure against stress in high emotional labour jobs such as nursing, to keep anxiety and distress at bay and most importantly to promote emotional agility and build emotional stability in nurses at times of crisis but as an everyday tool to overcome barriers, challenges and daily hassles.

There was no conflict of interest in this research or any harm, physical or psychological identified with this training, but participants were informed that should they found themselves feeling anxious or distressed they should contact the counselling services available to all students on campus. There was no such incident reported during the research and no unfair burden of participation as participants were offered the opportunity to come back and discuss the findings of the research. The principle of beneficence applied to both groups of participants to ensure that participants benefit sharing and reciprocity by taking part in this research.

8.4 Implications for Education and Practice

This thesis argues that nurses can benefit from targeted and focused interventions which can be afforded to be implemented throughout a nurse's career life span. This thesis also pinpointed the role of self-care in one's affective wellbeing. Nurses may need to recharge at different points in their careers and this may be inevitable due to the nature of emotional work nurses undertake as regular work. Nurses are not always considered in need of help when they help others recover from major traumatic events and experiences, but they do. Therefore, there is a need to have in place a strategy to help nurses regain confidence and rediscover their passion for their jobs. Nurses, like so many other employees, are under continuous organisational changes, demands and pressures and they are expected to be responsive to these external pressures in their work environment, but at the same time they are expected to provide continuously high standard professional care. This can be achieved because nurses work in teams and they work shifts, but it is also important that the emotional needs of the nursing team as a group of individuals are also looked at closely and supported appropriately and in a timely manner so the team can deliver safe care. Nurses over the years complained of little control over skill mix and staffing levels, workload and ill health. Emotional dissonance may not be a new concept in the general literature but it is a new concept in nursing and it may explain current trends in recruitment and retention. It is vital to prevent nurses falling into the vicious circle of illness and mental health and so we should focus more on preventing nurses getting stressed and burnout as they then may need considerable support to withstand the pressure in the workplace and perform. This thesis argues that self-care should be promoted amongst nurses and supported. It is no surprise that nurses may intend to leave the profession early in their careers because they can't cope and it is pivotal to teach nurses early in their careers to develop self-efficacy to safeguard their affective wellbeing. This thesis argues that trait emotional intelligence development in nurses should be met with a set plan of self-identified goals to enhance further nurses' awareness of own situation, needs and changes that need to be embraced. Trait EI coaching may prevent emotional fatigue and dissonance and nurse educators should focus on developing this short strategy to keep them energised and focused on their needs and personal goals.

Nurses in Phase II of this mixed method research were coached to develop a more flexible way of thinking to increase awareness and emotional agility and reduce anxiety, worry and depression about work and life six to eight weeks after the training. At the heart of this strategy sits self-awareness and self-care and it is focused exclusively on the individual. This intervention requires the individual to concentrate on things that they can influence and control and some self-identified goals were agreed towards the end of the session to move the nurse forward in her/his plan towards changing their situation.

This research argues for an innovative way to prevent distress at work and improve wellbeing in the workplace. This training is not resource heavy and easy to train teachers to coach nurses between their busy schedules and limited time available to them. This intervention addressed emotional dissonance which found in this research to lead to role dissonance. Emotional dissonance is known to link to stress and burnout as well as compassion fatigue and other maladaptive coping behaviours including mental health illness (Brotheridge and Lee, 1998). In this thesis nurses were found to be experiencing emotional dissonance that made them feel inadequate in their jobs and in need to create ways to distance themselves from emotional exposure in the job, which in a nutshell defines role dissonance. Current figures show that nurses quit the profession for many reasons but mainly for mental health reasons related to stress and burnout. This thesis may offer a way forward to relieve this issue and offer breathing space for those nurses who are struggling and thinking to quit the profession as a way to protect their health and wellbeing.

REFERENCES

Abubakar, A. and Fischer, R. (2012) The factor structure of the 12-item General Health Questionnaire in a literate Kenyan population, *Stress and Health*, *28*(3), 248-254.

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Sermeus, W. and RN4CAST Consortium (2013) Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe, *International Journal of Nursing Studies,* 50(2), 143-153.

Akhtar, R., Boustani, L., Tsivrikos, D. and Chamorro-Premuzic, T. (2015) The engageable personality: Personality and trait EI as predictors of work 'engagement, *Personality and Individual Differences,* 73, 44-49.

'All new nurses' (2009) All new nurses to have degrees from 2013. *Guardian*, 12 November, retrieved from https://www.theguardian.com/.../2009/.../nurses-nursing-qualifications-degrees-nmc-rc. Accessed 30/4/2018.

Allport, G. W. and Odbert, H. S. (1936) Trait-names: A psycho-lexical study, *Psychological Monographs*, 47(1), i.

Andrei, F., Mancini, G., Trombini, E., Baldaro, B. and Russo, P. M. (2014) Testing the incremental validity of trait emotional intelligence: Evidence from an Italian sample of adolescents, *Personality and Individual Differences*, 64, 24-29.

Andrei, F., Siegling, A. B., Aloe, A. M., Baldaro, B. and Petrides, K. V. (2016) The incremental validity of the Trait Emotional Intelligence Questionnaire (TEIQue): A systematic review and meta-analysis, *Journal of Personality Assessment*, 98(3), 261-276.

Arnold, H. J. (1982) Moderator variables: A clarification of conceptual, analytic, and psychometric issues, *Organizational Behavior and Human Performance*, 29(2), 143-174.

Arora, M., Asha, S., Chinnappa, J. and Diwan, A. D. (2013) Burnout in emergency medicine physicians, *Emergency Medicine Australasia,* 25(6), 491-495.

Augusto Landa, J.M., Martos, M.P. and Lopez-Zafra, E. (2010) Emotional intelligence and personality traits as predictors of psychological well-being in Spanish undergraduates, *Social Behavior and Personality: an international journal, 38(6), pp.783-793*.

Austin, E. J., Dore, T. C. and O'Donovan, K. M. (2008) Associations of personality and emotional intelligence with display rule perceptions and emotional labour, *Personality and Individual Differences*, 44(3), 679-688.

Austin, E. J., Saklofske, D. H. and Egan, V. (2005) Personality, well-being and health correlates of trait emotional intelligence, *Personality and Individual differences,* 38(3), 547-558.

Baillie, C., Smith, J., Hewison, J. and Mason, G. (2000) Ultrasound screening for chromosomal abnormality: Women's reactions to false positive results, *British Journal of Health Psychology,* 5(4), 377-394.

Bandura, A. (1982) Self-efficacy mechanism in human agency. *American Psychologist*, *37*(2), 122.

Bandura, A. (1997) *Self-efficacy: The exercise of control.* New York: Freeman.

Bandura, A., Barbaranelli, C., Caprara, G. V. and Pastorelli, C. (2001) Self-efficacy beliefs as shapers of children's aspirations and career trajectories, *Child Development,* 72(1), 187-206.

Banks, M. H., Clegg, C. W., Jackson, P. R., Kemp, N. J., Stafford, E. M. and Wall, T. D. (1980) The use of the General Health Questionnaire as an indicator *of Psychology,* 53(3), 187-194*.*

Barchard, K. A. (2003) Does emotional intelligence assist in the prediction of academic success?, *Educational and Psychological Measurement*, 63(5), 840-858.

Bar-On, R. and Kenny, D. A. (1986) The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations, *Journal of Personality and Social Psychology,* 51(6), 1173.

Bar-On, R. (1988) The development of a concept of psychological well-being (Doctoral dissertation, Rhodes University).

Bar-On, R. (2001) Emotional intelligence and self-actualization, in J. Ciarrochi, J. P. Forgas and J. D. Mayer (eds), *Emotional Intelligence in Everyday Life: A scientific inquiry,* 82-97. Philadelphia: Psychological Press.

Bar-On, R. (2005) The impact of emotional intelligence on subjective well-being: research article: general, Perspectives in Education, 23(1), 41-62.

Bar-On, R. (2006) The Bar-On model of emotional-social intelligence (ESI), *Psicothema*, 18.

Barrett, P. T., Petrides, K. V., Eysenck, S. B. and Eysenck, H. J. (1998) The Eysenck Personality Questionnaire: An examination of the factorial similarity of P, E, N, and L across 34 countries, *Personality and Individual Differences*, 25(5), 805-819.

Basabe, N. Valdoseda, M. and Paez, D. (1993) Escala de estrategias de afrontamiento, in Salud, expression y repression social de las emociones, pp. 339-377, Valencia, Spain: Promolibro.

BBC (2012) NHS 'haemorrhaging' nurses as 33,000 leave each year, https://www.bbc.co.uk/news/health-42653542, accessed 17/1/18.

BBC (2017) NHS staff shortages: Why so persistent?, https://www.bbc.co.uk/news/health-38640068, accessed 19/1/18.

Beauvais, A. M., Brady, N., O'Shea, E. R. and Griffin, M. T. Q. (2011) Emotional intelligence and nursing performance among nursing students, *Nurse Education Today*, 31(4), 396-401.

Bégat, I., Ellefsen, B. and Severinsson, E. (2005) Nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of wellbeing – A Norwegian study, *Journal of Nursing –management,* 13(3), 221-230.

Black, C.M. (2008) *Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population.* London: Stationery Office.

Benson, G., Ploeg, J. and Brown, B., 2010. A cross-sectional study of emotional intelligence in baccalaureate nursing students, *Nurse Education Today*, 30(1), 49-53.

Biggam, F. H., Power, K. G., Macdonald, R. R., Carcary, W. B. and Moodie, E. (1997) Self-perceived occupational stress and distress in a Scottish police force, *Work & Stress*, 11(2), 118-133.

Brough, P., (2005) A Comparative Investigation of the Predictors of Work-related Psychological Well-being within Police, Fire and Ambulance Workers, *New Zealand Journal of Psychology, 34(2).*

Boey, K. W. (1999) Distressed and stress resistant nurses, *Issues in Mental Health Nursing,* 20(1), 33-54.

Bolger, N., 1990. Coping as a personality process: A prospective study, *Journal of Personality and Social Psychology*, 59(3), 525.

Boyatzis, R. E., Goleman, D. and Rhee, K. (2000) Clustering competence in emotional intelligence: Insights from the Emotional Competence Inventory (ECI) *Handbook of Emotional Intelligence*, 99(6), 343-362.

Brackett, M. A. and Mayer, J. D. (2003) Convergent, discriminant, and incremental validity of competing measures of emotional intelligence, *Personality and Social Psychology Bulletin*, 29(9), 1147-1158.

Brackett, M. A., Mayer, J. D. and Warner, R. M. (2004) Emotional intelligence and its relation to everyday behavior, *Personality and Individual Differences*, 36(6), 1387-1402.

Bradberry, T. and Greaves, J. (2009*) Emotional Intelligence 2.0*. TalentSmart. Available at books.google.co.uk

Bradburn, N. M. (1969) *The Structure of Psychological Well-being*. Chicago: Aldine.

Brotheridge, C. and Lee, R. T. (1998) On the dimensionality of emotional labor: Development of an emotional labour scale, paper presented at 1st Conference on Emotions in Organizational Life, San Diego, CA.

Brough, P., O'Driscoll, M. and Kalliath, T. (2005) Confirmatory factor analysis of the Cybernetic Coping Scale, *Journal of Occupational and Organisational Psychology* 78, 53-61.

Brown, D. E., James, G. D., Nordloh, L. and Jones, A. A. (2003) Job strain and physiological stress responses in nurses and nurse's aides: Predictors of daily blood pressure variability, *Blood Pressure Monitoring,* 8(6), 237-242

Buss, D. M., Gomes, M., Higgins, D. S. and Lauterbach, K. (1987) Tactics of manipulation, *Journal of Personality and Social Psychology*, 52(6), 1219.

Buchan, J., Charlesworth, A., Gershlick, B. and Seccombe, I., (2019) *A critical moment: NHS staffing trends, retention and attrition,* Health Foundation, London.

Buchan, J. and Seccombe, I., (2013) The end of growth? Analysing NHS nurse staffing, *Journal of Advanced Nursing, 69(9), pp.2123-2130*.

Bussing, A. and Glaser, J. (1999) Work stressors in nursing in the course of redesign: Implications for burnout and interactional stress, *European Journal of Work and Organizational Psychology*, 8(3), 401-426.

Buunk, B. P. and Hoorens, V. (1992) Social support and stress: The role of social comparison and social exchange processes, *British Journal of Clinical Psychology*, 31(4), 445-457.

Buss, J. (2012) Associations between obesity and stress and shift work among nurses, *Workplace Health & Safety*, 60(10), 453-458.

Byrne, J. C. (2004) The role of emotional intelligence in predicting leadership and related work behavior. Available at elibrary.ru

Byrne, J. C., Dominick, P. G., Smither, J. W. and Reilly, R. R. (2007) Examination of the discriminant, convergent, and criterion-related validity of self-ratings on the emotional competence inventory, *International Journal of Selection and Assessment,* 15(3), 341-353.

Calkins, S. D. and Fox, N. A. (2002) Self-regulatory processes in early personality development: A multilevel approach to the study of childhood social withdrawal and aggression, *Development and Psychopathology*, 14(3), 477-498.

Cannon, W. B. (1927) The James-Lange theory of emotions: A critical examination and an alternative theory, *American Journal of Psychology* 39(1/4), 106-124.

Carmic P.M., Roberts, R. D., Zeidner, M. and Matthews, G. (2001) Does emotional intelligence meet traditional standards for an intelligence? Some new data and conclusions, *Emotion*, 1(3), 196.

Carver, C. S. and Scheier, M. F. (2014) Dispositional optimism, *Trends in Cognitive Sciences,* 18(6), 293-299.

Carver, C. S., Scheier, M. F. and Segerstrom, S. C. (2010) Optimism, *Clinical Psychology Review,* 30, 879-889.

Cattell, R. B. (1946*) Description and Measurement of Personality*. Oxford: World Books.

Cattell, R. B. (1948) Primary personality factors in the realm of objective tests, *Journal of Personality*, 16(4), 459-486.

Cattell, R. B. (1950) *Personality: A systematic theoretical and factual study.* New York: McGraw-Hill. http://dx.doi.org/10.1037/10773-000

Cecil, P. and Glass, N. (2015) An exploration of emotional protection and regulation in nurse–patient interactions: The role of the professional face and the emotional mirror, *Collegian*, 22(4), 377-385.

Chapman, E. and Smith, J. A. (2002) Interpretative phenomenological analysis and the new genetics, *Journal of Health Psychology*, 7(2), 125-130.

Chamberlain, K. and Zika, S. (1990) The minor events approach to stress: Support for the use of daily hassles, *British Journal of Psychology*, 81(4), 469-481.

Chen, J. and Gardner, H. (2005) Assessment based on multiple-intelligences theory, *Contemporary Intellectual Assessment: Theories, tests, and issues*, 77-102.

Chen, Y. M. and Johantgen, M. E., 2010. Magnet Hospital attributes in European hospitals: A multilevel model of job satisfaction, *International Journal of Nursing Studies*, 47(8), 1001-1012.

Cheng, T., Huang, G. H., Lee, C. and Ren, X. (2012) Longitudinal effects of job insecurity on employee outcomes: The moderating role of emotional intelligence and the leader-member exchange, *Asia Pacific Journal of Management*, 29(3), 709-728.

Chin, E. G., Drescher, C. F., Trent, L. R., Darden, M., Seak, W. C. and Johnson, L. R. (2015) Searching for a screener: Examination of the factor structure of the General Health Questionnaire in Malaysia, *International Perspectives in Psychology: Research, Practice, Consultation,* 4(2), 111.

Chirico, F. (2016) Job stress models for predicting burnout syndrome: A review, *Annali dell'Istituto superiore di sanita*, 52(3), 443-456.

Ciarrochi, J. V., Chan, A. Y. and Caputi, P. (2000) A critical evaluation of the emotional intelligence construct, *Personality and Individual Differences*, 28(3), 539-561.

Ciarrochi, J., Deane, F. P. and Anderson, S. (2002) Emotional intelligence moderates the relationship between stress and mental health, *Personality and Individual Differences*, 32(2), 197-209.

Clare, L. (2003) Managing threats to self: Awareness in early stage Alzheimer's disease, *Social Science & Medicine*, 57(6), 1017-1029.

Cohen, S. and Edwards, J. R. (1989) Personality characteristics as moderators of the relationship between stress and disorder, In R. W. J. Neufeld (ed.), *Advances in the Investigation of Psychological Stres*s, pp. 235-283, New York: Wiley.

Conte, J. M. (2005) A review and critique of emotional intelligence measures, *Journal of Organizational Behavior*, 26(4), 433-440.

Conde, V. and Franch, J. L. (1986) Escala s de evaluacion conductual para la cuantificacion desintomatologia psicopatologia en lostrastornos ansiosos y depresivos. Valladolid, Spain: Department of Physiological Medicine.

Cooper, C. L. and Baglioni, A. J. (1988) A structural model approach toward the development of a theory of the link between stress and mental health. *Psychology and Psychotherapy: Theory, Research and Practice*, 61(1), 87-102.

Cooper, C. L. and Marshall, J. (1978) Sources of managerial and white collar stress, in C. L. Cooper, C. L. and R. Payne, *Stress at Work: Causes, coping and consequences of stress at work*, pp. 81-105. New York: John Wiley & Sons.

Cooper, C. L., and Cartwright, C. (1994). Stress management invention in the work place: Stress counselling and stress audit. *British Journal of Guidance and Counselling*, 22(1), 65-73.

Cooper, C. L., Kirkcaldy, B. D. and Brown, J., (1994) A model of job stress and physical health: The role of individual differences, *Personality and Individual Differences*, 16(4), 653-655.

Cooper, C. L. and Payne, R. (1978) *Stress at Work*. Chichester: John Wiley & Sons.

Cooper, C. L. and Payne, R. (1989) *Causes, coping and consequences of stress at work.* Chichester: John Wiley/AMP.

Cooper, C. L., & Payne, R. (Eds.) (1991) *Personality and stress: Individual differences in the stress process*. Oxford, England: John Wiley & Sons. Wiley series on studies in occupational stress.

Cooper, J., Mirabile, R. and Scher, S.J., 2005 *Actions and Attitudes: The Theory of Cognitive Dissonance.* In T. C. Brock & M. C. Green (Eds.), Persuasion: Psychological insights and perspectives (pp. 63-79). Thousand Oaks, CA, US: Sage Publications.

Cooper, A. and Petrides, K. V. (2010) A psychometric analysis of the Trait Emotional Intelligence Questionnaire–Short Form (TEIQue–SF) using item response theory, *Journal of Personality Assessment,* 92(5), 449-457.

Costa, P. T. and McCrae, R. R. (1985) *The NEO Personality Inventory.* Amsterdam: Elsevier Science.

Costa, J. R. and Paul, T. (1996) Of personality theories: Theoretical contexts for the Five-Factor Model., in J. S. Wiggins (ed.),*The five-factor Model of Personality: Theoretical perspectives*, chap. 3, pp. 51-87. New York: Guilford.

Cowin, L.S. and Hengstberger-Sims, C., (2006) New graduate nurse self-concept and retention: *A longitudinal survey. International journal of nursing studies,* 43(1), pp.59-70.

Cox, T. (1985) The nature and measurement of stress, *Ergonomics*, 28(8), 1155-1163.

Cox, T. (1987) Stress, coping and problem solving, *Work & Stress*, 1(1), 5-14.

Cox, T. (1993) *Stress Research and Stress Management: Putting theory to work* (vol. 61). Sudbury: Hse Books.

Cox, T. and Ferguson, E. (1991) *Individual Differences, Stress and Coping.* Boston: Pitman.

Cox, T., Griffiths, A. and Rial-González, E. (2000) *Research on Work-related Stress*. Luxembourg: European Agency for Safety and Health at Work.

Cox, T., Griffiths, A., Barlowe, C., Randall, R., Thomson, L. and Rial-Gonzalez, E. (2000) *Organisational Interventions for Work Stress: A risk*

management approach. HSE Contract Research Report. Sudbury, UK: HSE.

Cox, T. and McKay, C. J. (1981) A transactional approach to occupational stress, *Stress, Work Design and Productivity*, 10, 34.

Cox, T. and McKay, C. (1985) The measurement of self-reported stress and arousal, *British Journal of Psychology*, 76(2), 183-186.

Creswell, J. W., 2003. *Research Design: Qualitative, quantitative and mixed methods approaches,* 3rd edn. Thousand Oaks, CA: Sage.

Creswell, J. W. (2009) *Mapping the Field of Mixed Methods Research.* Thousand Oaks, CA: Sage.

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L. and Hanson, W. E. (2003) Advanced mixed methods research design, in A. Tashakkori and C. Teddlie (eds), *Handbook of Mixed Methods in Social and Behavioral Research,* pp. 209- 240. Thousand Oaks, CA: Sage.

D'ambra, A. M. and Andrews, D. R. (2014) Incivility, retention and new graduate nurses: An integrated review of the literature, *Journal of Nursing Management*, 22(6), 735-742.

Daniels, K. (2000) Measures of five aspects of affective wellbeing at work, *Human Relations (*53), 275-294

Daniels, K. and Guppy, A. (1995) Stress, social support and psychological well-being in British accountants, *Work & Stress,* 9(4), 432-447.

Davis, A. J. (1996) A re-analysis of the occupational stress indicator, *Work & Stress*, 10(2),174-182.

De Jonge, J., Dormann, C., Janssen, P. P., Dollard, M.F., Landeweerd, J. A. and Nijhuis, F.J. (2001) Testing reciprocal relationships between job characteristics and psychological well-being: A cross-lagged structural equation model, *Journal of Occupational and Organizational Psychology*, 74(1), 29-46.

De Jonge, J. and Schaufeli, W. B. (1998) Job characteristics and employee wellbeing: A test of Warr's Vitamin model in health care workers using structural equation modeling, *Journal of Organizational Behaviour,* 19, 387-407.

Deeg, D. J. H. and Huisman, M. (2010) Cohort differences in 3-year adaptation to health problems among Dutch middle-aged, 1992-1995 and 2002-2005, *Eur J Ageing,* 7:157–165. doi:10.1007/s10433-010-0157-1

Demerouti, E., Bakker, A. B., Nachreiner, F. and Schaufeli, W. B. (2000) A model of burnout and life satisfaction amongst nurses, *Journal of Advanced Nursing,* 32(2), 454-464.

Demerouti, E., Bakker, A. B., Nachreiner, F. and Schaufeli, W. B. (2001) The job demands-resources model of burnout, *Journal of Applied Psychology*, 86(3), 499.

Dewe, P. J., O'Driscoll, M. P. and Cooper, C. L. (2012) Theories of psychological stress at work, in Handbook of Occupational Health and Wellness (pp. 23-38). Boston, MA: Springer.

Diener, E. and Larsen, R. J. (1993) The experience of emotional well-being. In M. Lewis & J. M. Haviland (eds), *Handbook of Emotions* (pp. 405-415). New York: Guilford.

Diener, E. and Seligman, M. E. (2004) Beyond money: Toward an economy of well-being. *Psychological Science in the Public Interest*, 5(1), 1-31.

DiMattio, M. J. K., Roe-Prior, P. and Carpenter, D. R. (2010) Intent to stay: A pilot study of baccalaureate nurses and hospital nursing, *Journal of Professional Nursing,* 26(5), 278-286.

Dudek, B., Waszkowska, M. and Hanke, W. (1999) *Workers' Health Protection Against Occupational Stress Outcomes.* Łódź: Nofer Institute of Occupational Medicine. [in Polish].

Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., and Aisbett, K. (2011) Nursing staffing, nursing workload, the work environment and patient outcomes, *Applied Nursing Research,* 24(4), 244-255

Duffield, C., Roche, M., O'Brien-Pallas, L., Diers, D., Aisbett, C., King, M., and Hall, J. (2007) *Glueing It Together: Nurses, Their Work Environment and Patient Safety: Centre for Health Services Management.* Sydney: University of Technology.

Dulewicz, V. and Higgs, M. (1999) Can emotional intelligence be measured and developed?, *Leadership & Organization Development Journal*, 20(5), 242-253.

Dulewicz, V. and Higgs, M. (2000) Emotional intelligence – A review and evaluation study, *Journal of Managerial Psychology*, 15(4), 341-372. 87, l.

Dulewicz, V. and Higgs, M. (2004) Can emotional intelligence be developed?, *International Journal of Human Resource Management*, 15(1), 95-111.

Dulewicz, V. and Higgs, M. (2004) Can emotional intelligence be developed? *International Journal of Human Resource Management*, 15(1), 95-111.

Dulewicz, V., Higgs, M. and Slaski, M. (2003) Measuring emotional intelligence: Content, construct and criterion-related validity, *Journal of Managerial Psychology,* 18(5), 405-420.

Dunne, E .A. and Quayle, E. (2001) The impact of iatrogenically acquired hepatitis C infection on the well-being and relationships of a group of Irish women, *Journal of Health Psychology*, 6(6), 679-692.

Duvall, J. J, and Andrews, D. R. (2010) Using a structured review of the literature to identify key factors associated with the current nursing shortage, *Journal of Professional Nursing (*26), 309-317

Eatough, V. and Smith, J.A. (2006) I feel like a scrambled egg in my head: An idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 79(1), 115-135.

Eatough, V., Smith, J. A. and Shaw, R. (2008) Women, anger, and aggression: An interpretative phenomenological analysis, *Journal of Interpersonal Violence,* 23(12), 1767-1799.

Edwards, I. R. and Shipp, A. I. (2007) The relationship between person-environment fit and outcomes: An integrative, *Perspectives on Organizational Fit*, 209.

Edwards, J. R. (1992. A cybernetic theory of stress, coping, and well-being in organizations. *Academy of Management Review*, 17(2), 238-274.

Edwards, J. R. (1998) *Cybernetic Theory of Stress, Coping and Well-Being: Review and Extension to Work and Family,* in C. C. Cooper (ed.),

Theories of Organizational Stress, pp. 122-152. Oxford: Oxford University Press.

Edwards, J. R. and Baglioni Jr, A. J. (1993) The measurement of coping with stress: Construct validity of the Ways of Coping Checklist and the Cybernetic Coping Scale, *Work & Stress*, 7(1), 17-31.

Edwards, J. R., and Baglioni Jr, A. J. (1993) The measurement of coping with stress: Construct validity of the Ways of Coping Checklist and the Cybernetic Coping Scale, *Work & Stress,* 7(1), 17-31.

Edwards, J. R., Caplan, R. D. and Van Harrison, R. (1998) Person–environment fit theory, *Theories of Organizational Stress*, *28*, 67.

Edwards, J. R. and Cooper, C. L. (1988) The impacts of positive psychological states on physical health: A review and theoretical framework. *Social Science & Medicine*, 27(12), 1447-1459.

Edwards, J. R. and Cooper, C L. (1990) The person-environment fit approach to stress: Recurring problems and some suggested solutions, *Journal of Organizational Behavior*, 11(4), 293-307.

Efird, J. (2010) Blocked randomization with randomly selected block sizes, *International Journal of Environmental Research and Public Health*, 8(1), 15-20.

Egan, M., Bambra, C., Petticrew, M. and Whitehead, M. (2009) Reviewing evidence on complex social interventions: Development and testing of a new tool for appraising implementation, *Journal Epidemiol. Community Health*, 63, 4-11.

Eid, M. and Diener, E., 1999. Intraindividual variability in affect: Reliability, validity, and personality correlates, *Journal of Personality and Social Psychology*, 76(4), 662.

Eid, M. and Diener, E. (2004) Global judgments of subjective well-being: Situational variability and long-term stability, *Social Indicators Research*, 65(3), 245-277.

Ekman, P. and Friesen, W. V. (1974) Detecting deception from the body or face, *Journal of Personality and Social Psychology*, 29(3), 288.

Ekman, P., Friesen, W. V. and Tomkins, S. S. (1971) Facial affect scoring technique: A first validity study, *Semiotica*, *3*(1), 37-58.

Emmons, R. A. (1996) Striving and feeling: Personal goals and subjective well-being, in P. M. Gollwitzer & J. A. Bargh (eds), *The Psychology of Action: Linking cognition and motivation to behavior* (pp. 313-337). New York: Guilford.

Endler, N. S. and Edwards, J. (1982) Stress and personality, in L. Goldberger and S. Breznitz (eds), *Handbook of Stress: Theoretical and clinical aspects,* pp. 36-48. New York: Free Press.

Endler, N. S. and Parker, J. D. (1990) Multidimensional assessment of coping: A critical evaluation, *Journal of Personality and Social Psychology*, 58(5), 844.

Epstein, S. (1979) The stability of behaviour: On predicting most of the people much of the time, *Journal of Personality and Social Psychology*, 37(7), 1097.

Erikson, E. H., Paul, I. H., Heider, F. and Gardner, R.W. (1959) Identity and the life cycle: Selected papers, *Psychological Issues* (vol. 1). New York: International Universities Press.

Eysenck, H. J. (1947) Screening-out the neurotic, *Lancet*, 249(6451), 530-531.

Eysenck, H. J. (1988a) The concept of 'intelligence': Useful or useless?, *Intelligence*, 12(1), 1-16.

Eysenck, H. J. and Eysenck, S. B. G. (1975) *Manual of the Eysenck Personality Questionnaire (junior and adult)*. London: Hodder and Stoughton.

Eysenck, M. W. (1988b) Anxiety and attention, *Anxiety Research*, 1(1), 9-15.

Eysenck, S. B. G. and Eysenck, H. J. (1969) Scores on three personality variables as a function of age, sex and social class, *British Journal of Clinical Psychology*, 8(1), 69-76.

Eysenck, S. B. G., Eysenck, H. J. and Barrett, P. (1985) A revised version of the psychoticism scale, *Personality and Individual Differences,* 6(1), 21-29.

Fernandes, H. M. and Vasconcelos-Raposo, J. (2013) Factorial validity and invariance of the GHQ-12 among clinical and nonclinical samples, *Assessment*, 20(2), 219-229.

Finlayson, B., Dixon, J., Meadows, S. and Blair, G. (2002) Mind the gap: The extent of the NHS nursing shortage, *British Medical Journal,* 325(7363), 538.

Fiske, D.W. (1949) Consistency of the factorial structures of personality ratings from different sources, *Journal of Abnormal and Social Psychology*, 44(3), p.329.

Fletcher, I., Leadbetter, P., Curran, A. and O'Sullivan, H. (2009) A pilot study assessing emotional intelligence training and communication skills with 3rd year medical students, *Patient Education and Counselling*, 76(3), 376-379.

Flowers, P., Smith, J. A., Sheeran, P. and Beail, N. (1998) 'Coming out' and sexual debut: understanding the social context of HIV risk-related behaviour, *Journal of Community & Applied Social Psychology*, 8(6), 409-421.

Folkman, S. (1984) Personal control and stress and coping processes: A theoretical analysis, *Journal of Personality and Social Psychology*, 46(4), 839.

Folkman, S. and Greer, S. (2000) Promoting psychological wellbeing in the face of serious illness: When theory, research and practice inform each other, *Psych-Oncology* 9, 11-19.

Folkman, S. and Lazarus, R. S. (1985) If it changes it must be a process: Study of emotion and coping during three stages of a college examination, *Journal of Personality and Social Psychology*, 48(1), 150.

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., Delongis, A., and Gruen, R. J. (1986) Dynamics of a stressful encounter: Cognitive appraisal, coping and encounter outcomes, *Journal of Personality and Social Psychology*, 50(5), 992.

Folkman, S., Lazarus, R. S., Gruen, R. J. and DeLongis, A. (1986) Appraisal, coping, health status, and psychological symptoms, *Journal of Personality and Social Psychology,* 50(3), 571.

Folkman, S., Lazarus, R. S., Pimley, S., and Novacek, J. (1987) Age differences in stress and coping processes, *Psychology and aging,* 2(2), 171.

Føllesdal, H. (2008) Emotional intelligence as ability: Assessing the construct validity of scores from the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT). Available at duo.uio.no. (Downloaded 6th February 2108).

Føllesdal, H. and Hagtvet, K.A. (2009) Emotional intelligence: The MSCEIT from the perspective of generalizability theory, *Intelligence*, 37(1), 94-105.

Fontana, D. (2000) *Personality in the Workplace*. London: Palgrave Macmillan.

Fox, N. A. and Calkins, S. D. (2003) The development of self-control of emotion: Intrinsic and extrinsic influences, *Motivation and Emotion,* 27(1), 7-26.

Fox, S., and Spector, P. E. (2002) Emotions in the workplace: The neglected side of organizational life introduction, *Human Resource Management Review,* 12(2), 167-171.

Forrest, S., Lewis, C.A. and Shevlin, M., (2000) Examining the factor structure and differential functioning of the Eysenck Personality Questionnaire Revised-Abbreviated, *Personality and Individual Differences, 29(3), pp.579-588.*

Fredrickson, B. L. (2000) The undoing effect of positive emotions. *Motivation and Emotion*, 24, 237–258.

Fredrickson, B. L. and Branigan, C., 2005. Positive emotions broaden the scope of attention and thought-action repertoires, *Cognition & Emotion*, 19(3), 313-332.

French Jr, J. R. (1973) Person role fit, *Occupational Mental Health,* 3(1), 15-20.

French, J. R., Caplan, R. D. and Van Harrison, R. (1982) *The Mechanisms of Job Stress and Strain* (vol. 7). Chichester: Wiley.

French, J. R., Rogers, W. and Cobb, S. (1974) *Adjustment as a Person–Environment Fit*. New York: Basic Books.

Freshwater, D. and Stickley, T. (2004) The heart of the art: Emotional intelligence in nurse education, *Nursing Inquiry*, 11(2), 91-98.

Freudenthaler, H. H. and Neubauer, A. C. (2005) Emotional intelligence: The convergent and discriminant validities of intra-and interpersonal emotional abilities. *Personality and Individual Differences*, 39(3), 569-579.

Freudenthaler, H. H., Neubauer, A.C., Gabler, P., Scherl, W. G. and Rindermann, H. (2008) Testing and validating the trait emotional intelligence questionnaire (TEIQue) in a German-speaking sample, *Personality and Individual Differences,* 45(7), 673-678.

Funder, D. C. (1997) *The Personality Puzzle*. London: W. W. Norton & Co.

Furnham, A. and Petrides, K. V. (2003) Trait emotional intelligence and happiness, *Social Behavior and Personality,* 31(8), 815-823.

Gaither, C. A. (1998) Career commitment: A mediator of the effects of job stress on pharmacists' work-related attitudes, *Journal of the American Pharmaceutical Association,* 39(3), 353-361.

Galbraith, N. D. and Brown, K. E. (2011) Assessing intervention effectiveness for reducing stress in student nurses: quantitative systematic review, *Journal of Advanced Nursing,* 67(4), 709-721.

Gallagher, E. N. and Vella-Brodrick, D. A. (2008) Social support and emotional intelligence as predictors of subjective well-being, *Personality and Individual Differences*, 44(7),1551-1561.

Grant, A.M., 2007. Enhancing coaching skills and emotional intelligence through training, *Industrial and commercial training, 39(5), pp.257-266*.

Gardner, K.J. and Qualter, P. (2010) Concurrent and incremental validity of three trait emotional intelligence measures, *Australian Journal of Psychology*, 62(1), 5-13.

Gates, D. M. (2001) Stress and Coping, *AAOHN Journal (*49), 390-398.

Gates, D. M., Gillespie, G.L. and Succop, P. (2011) Violence against nurses and its impact on stress and productivity, *Nursing Economics,* 29(2), 59-66.

Gelaye, B., Williams, M.A., Lemma, S., Deyessa, N., Bahretibeb, Y., Shibre, T., Wondimagegn, D., Lemenhe, A., Fann, J.R., Vander Stoep, A. and Zhou, X. H. A. (2013) Validity of the patient health questionnaire-9 for depression screening and diagnosis in East Africa, *Psychiatry Research*, 210(2), 653-661.

Gelaye, B., Tadesse, M.G., Lohsoonthorn, V., Lertmeharit, S., Pensuksan, W. C., Sanchez, S. E., Lemma, S., Berhane, Y., Vélez, J.C., Barbosa, C. and Anderade, A. (2015) Psychometric properties and factor structure of the General Health Questionnaire as a screening tool for anxiety and depressive symptoms in a multi-national study of young adults, *Journal of Affective Disorders*, 187, 197-202.

Gevers, J., Van Erven, P., De Jonge, J., Maas, M. and De Jong, J. (2010) Effect of acute and chronic job demands on effective individual teamwork

behaviour in medical emergencies, *Journal of Advanced Nursing,* 66(7), 1573-1583.

Giardini, A. and Frese, M. (2006) Reducing the negative effects of emotion work in service occupations: emotional competence as a psychological resource, *Journal of Occupational Health Psychology (*11), 63-75.

Gignac, G. E. (2008) Higher-order models versus direct hierarchical models: g as superordinate or breadth factor? *Psychology Science*, 50(1), 21.

Gilboa, S., Shirom, A., Fried, Y., and Cooper, C. (2008) A meta-analysis of work demand stressors and job performance: Examining main and moderating effects, *Personnel Psychology*, 61(2), 227-271.

Gillman, L., Admans, J., Kovac, R., Kilcullen, A., House, A. and Doyle, C. (2015) Strategies to promote coping and resilience in oncology and palliative care nurses caring for adult patients with malignancy: A comprehensive systematic review, *JBI Database of Systematic Reviews and Implementation Reports*, 13(5), 131-204.

Giorgi, A. (2011) IPA and science: A response to Jonathan Smith, *Journal of Phenomenological Psychology*, 42(2), 195-216.

Goldberg, D. (1972) *The Detection of Mental Health Illness by Questionnaire.* London*:* Oxford University Press.

Goldberg, D. P. (1981) *Manual of the General Health Questionnaire (GHQ-28).* Windsor, ON: Nelson.

Goldberg, D. P., Bridges, K., Duncan-Jones, P. and Grayson, D. (1988) Detecting anxiety and depression in general medical settings, *British Medical Journal*, 297(6653), 897-899.

Goldberg, L. R. (1981) Language and individual differences: The search for universals in personality lexicons, *Review of Personality and Social Psychology*, 2(1), 141-165.

Goldberg, R. J. and Posner, D. A., 1993. Anxiety in the medically ill. *Psychiatric care of the medical patient. Oxford University Press, New York*, pp.87-104.

Goleman, D. (1998) *Working with Emotional Intelligence*. New York: Bantam.

Goleman, D., Boyatzis, R.E. and McKee, A. (2002) *The New Leaders: Transforming the art of leadership into the science of results*. London: Little, Brown.

Good Governance Institute (2015) The nursing journey: Recruitment and retention, retrieved from https://www.good-governance.org.uk/.../the-nursing-journey-recruitment-and-retention.... Retrieved from https://www.good-governance.org.uk/.../the-nursing-journey-recruitment-and-retentio...July 2015. Accessed on 20.06.2018.

Grandey, A. A. (2003) When the show must go on: Surface acting and deep acting as determinants of emotional exhaustion and peer-rated service delivery, *Academy of Management Journal*, 46(1), 86-96.

Grandey, A. A., Fisk, G. M., and Steiner, D. D. (2005) Must service with a smile be stressful? The moderating role of personal control for US and French employees, *Journal of Applied Psychology* (90), 893-904.

Grandey, A. A., Fisk, G. M., Mattila, A. S., Jansen, K. J. and Sideman, L. A. (2005) Is 'service with a smile' enough? Authenticity of positive displays during service encounters, *Organizational Behavior and Human Decision Processes*, 96(1), 38-55.

Greenglass, E. R. and Burke, R. J. (2000) The relationship between hospital restructuring, anger, hostility and psychosomatics in nurses, *Journal of Community & Applied Social Psychology*, 10(2), 155-161.

Grewal, D. and Salovey, P. (2005) Feeling Smart: The science of emotional intelligence: A new idea in psychology has matured and shows promise of explaining how attending to emotions can help us in everyday life, *American Scientist,* 93(4), 330-339.

Griffin, M. A., Hart, P. M. and Wilson-Evered, E. (2000) Using employee opinion surveys to improve organizational health, Health and Productive Work, in L. R. Murphy and C. Cooper (eds), *Healthy and Productive Work: An international perspective, pp. 15–36. London: Taylor Francis*.

Grinker, R. R. and Spiegel, J. P. (1945) *Men under Stress.* Philadelphia, PA: Blakiston, http://dx.doi.org/10.1037/10784-000

Gross, J. J., Carstensen, L. L., Pasupathi, M., Tsai, J., Götestam Skorpen, C. and Hsu, A. Y. (1997) Emotion and aging: Experience, expression, and control. *Psychology and Aging*, 12(4), 590.

Grubb III, W. L. and McDaniel, M. A. (2007) The fakability of Bar-On's emotional quotient inventory short form: Catch me if you can, *Human Performance*, 20(1), 43-59.

Guest, G., MacQueen, K. M. and Namey, E. E. (2011) *Applied Thematic Analysis*. Thousand Oaks, CA: Sage. ISBN: 9781412971676

Guppy, A., Edwards, J. A., Brough, P., Peters-Bean, K. M., Sale, C. and Short, E. (2004) The psychometric properties of the short version of the Cybernetic Coping Scale: A multigroup confirmatory factor analysis across four samples, *Journal of Occupational and Organizational Psychology*, 77(1), 39-62.

Hallin, K. and Danielson, E. (2007) Registered nurses' experiences of daily work, a balance between strain and stimulation: A qualitative study, *International Journal of Nursing Studies,* 44(7), 1221-1230.

Han, K., Trinkoff, A. M., Storr, C. L. and Geiger-Brown, J. (2011) Job stress and work schedules in relation to nurse obesity, *Journal of Nursing Administration*, 41(11), 488-495.

Hart, P. M., Wearing, A. J. and Headey, B. (1995) Police stress and well-being: Integrating personality, coping and daily work experiences, *Journal of Occupational and Organizational Psychology,* 68(2), 133-156.

Hayward, D., Bungay, V., Wolff, A. C. and MacDonald, V. (2016) A qualitative study of experienced nurses' voluntary turnover: Learning from their perspectives, *Journal of Clinical Nursing,* 25(9-10), 1336-1345.

Hawton, K. and Vislisel, L. (1999) Suicide in nurses, *Suicide and Life-Threatening Behavior*, 29(1), 86-95.

Healy, C. M. and McKay, M. F. (2000) Nursing stress: The effects of coping strategies and job satisfaction in a sample of Australian nurses, *Journal of Advanced Nursing,* 31(3), 681-688.

Heidegger, M. (1962) *Being and Time* (trans. J. Macquarrie and E. Robinson). New York: Harper and Row.

Heritage, B., Pollock, C. and Roberts, L. D. (2015) Confirmatory factor analysis of Warr, Cook, and Wall's (1979) Job Satisfaction Scale, *Australian Psychologist,* 50(2), 122-129.

Higgs, M. and Dulewicz, V. (2014) Antecedents of well-being: A study to examine the extent to which personality and emotional intelligence contribute to well-being, *International Journal of Human Resource Management*, 25(5), 718-735.

Hills, D., Joyce, C. and Humphreys, J. (2012) Validation of a job satisfaction scale in the Australian clinical medical workforce. *Evaluation & the health professions*, *35*(1), pp.47-76.

Hinderer, K. A., VonRueden, K. T., Friedmann, E., McQuillan, K. A., Gilmore, R., Kramer, B. and Murray, M. (2014) Burnout, compassion fatigue, compassion satisfaction, and secondary traumatic stress in trauma nurses, *Journal of Trauma Nursing,* 21(4), 160-169.

Ho, W. H., Chang, C. S., Shih, Y. L. and Liang, R. D. (2009) Effects of job rotation and role stress among nurses on job satisfaction and organizational commitment, *BMC Health Services Research*, 9(1), 8.

Hogan, R. (1995) *Hogan Personality Inventory.* Tulsa, OK: Hogan Assessment Systems.

Hochschild, A. (1983) *The Managed Heart.* Berkeley, CA: University of California Press.

Hoeve, Y. T., Jansen, G. and Roodbol, P. (2014) The nursing profession: Public image, self-concept and professional identity. A discussion paper, *Journal of Advanced Nursing*, 70(2), 295-309.

Honda, H. M. and Homma, M. (2001) Job satisfaction of Japanese career women and its influence on turnover intention, *Asian Journal of Social Psychology,* 4(1), 23-38.

Hosie, P. J. and Sevastos, P. P. (2010) A framework for conceiving of job-related affective wellbeing, *Management Revue*, 406-436.

Humpel, N. and Caputi, P. (2001) Exploring the relationship between work stress, years of experience and emotional competency using a sample of Australian mental health nurses, *Journal of Psychiatric and Mental Health Nursing*, 8(5), 399-403.

Husserl, E., Moore, S.H., McCormick, P. and Elliston, F. (1981) *Pure Phenomenology, Its method and Its Field of Investigation*. USA: Scott H. Moore.

Ilies, R., Dimotakis, N. and De Pater, I. E. (2010) Psychological and physiological reactions to high workloads: Implications for well-being, *Personnel Psychology,* 63(2), 407-436.

Ingledew, D. K., Hardy, L., & Cooper, C. L. (1992) On the reliability and validity of the Locus of Control Scale of the Occupational Stress Indicator, *Personality and Individual Differences,* 13(11), 1183-1191.

Jacobsson, C., Pousette, A. and Thylefors, I. (2001) Managing stress and feelings of mastery among Swedish comprehensive school teachers, *Scandinavian Journal of Educational Research*, 45(1), 37-53.

Jahoda, C. (1958) *Current Concepts of Positive Mental Health.* New York: Basic Books.

James, W. (1890) *The Principles of Psychology*, vol. 2. New York: Dover.

Jeurissen, T. and Nyklíček, I. (2001) Testing the Vitamin Model of job stress in Dutch health care workers, *Work & Stress*, 15(3), 254-264.

Johnston, A., Abraham, L., Greenslade, J., Thom, O., Carlstrom, E., Wallis, M., and Crilly, J. (2016) Review article: Staff perception of the emergency department working environment: Integrative review of the literature, *Emergency Medicine Australasia,* 28(1), 7-26.

Johnston, D. (2016) Stressors, appraisal of stressors, experienced stress and cardiac response: A real time, real life investigation of work stress in nurses, *Annals of Behavioral Medicine,* 50(2), 1870-1970.

Johnson, S. J., Batey, M. and Holdsworth, L. (2009) Personality and health: The mediating role of Trait Emotional Intelligence and Work of Locus of Control, *Personality and Individual Differences,* 47, 470-475.

Jones, T. L. and Argentino, D. (2010) Nurse-to-nurse hostility, confrontational anxiety, and emotional intelligence: An integral, descriptive pilot study, *Journal of PeriAnesthesia Nursing,* 25(4), 233-241.

Josephson, M., Lindberg, P., Voss, M., Alfredsson, L. and Vingård, E. (2008) The same factors influence job turnover and long spells of sick leave a 3-

year follow-up of Swedish nurses, *European Journal of Public Health,* 18(4), 380-385.

Judge, T. A. and Bono, J. E. (2001) Relationship of core self-evaluations traits – self-esteem, generalized self-efficacy, locus of control, and emotional stability with job satisfaction and job performance: A meta-analysis, *Journal of Applied Psychology,* 86(1), 80.

Judge, T. A., Heller, D. and Mount, M. K. (2002) Five-factor model of personality and job satisfaction: A meta-analysis, *Journal of Applied psychology*, 87(3), 530.

Jeurissen, T. and Nyklíček, I. (2001) Testing the vitamin model of job stress in Dutch health care workers, *Work & Stress, 15(3), pp.254-264*.

Jung, C. G. (1953) *Psychological Types: Or the psychology of individuation*. New York: Pantheon.

Kahn, R. L., Wolfe, D. M., Quinn, R., Snoek, J. D. and Rosenthal, R. A. (1964) *Organizational Stress.* New York: Wiley.

Karademas, E. C. (2006) Self-efficacy, social support and well-being: The mediating role of optimism, *Personality and Individual Differences,* 40(6), 1281-1290.

Karasek, R. A. (1979) Job demands, job decision, Latitude and mental strain: implications for job redesign, *Administrative Science Quarterly, 24(2), 285-308.*

Kvale, S., (1996) The 1,000-page question, *Qualitative inquiry, 2(3), pp.275-284*.

Kashdan, T. B., Biswas-Diener, R., and King, L. A. (2008) Reconsidering happiness: The costs of distinguishing between hedonics and eudaimonia, *Journal of Positive Psychology,* 3(4), 219-233.

Kay, E. and Kingston, H. (2002) Feeling associated with being carrier and characteristics of reproductive decision-making in women known as carriers of X-linked conditions, *Journal of Health Psychology,* 7, 169-181.

Kim, M. J., Son, K. H., Park, H. Y., Choi, D. J., Yoon, C. H., Lee, H. Y., Cho, E. Y. and Cho, M. C (2013) Association between shift work and obesity among female nurses: Korean Nurses' Survey, *BMC Public Health*, 13(1), 1204.

Kinman, G. and Leggetter, S. (2016). Emotional labour and wellbeing: What protects nurses?, *Healthcare,* 4(4), 89).

Kirpal, S. (2004) Work identities of nurses: Between caring and efficiency demands, *Career Development International,* 9(3), 274-304.

Kitson, A.L. (1996) Does nursing have a future?, *BMJ*, 349, 1346-1442.

Kivimäki, M., Virtanen, M., Elovainio, M., Kouvonen, A., Väänänen, A. and Vahtera, J. (2006) Work stress in the etiology of coronary heart disease—a meta-analysis, *Journal of Work, Environment & Health,* 32(6), 431-442.

Klatt, M., Steinberg, B. and Duchemin, A. M. (2015) Mindfulness in motion (MIM): An onsite Mindfulness Based Intervention (MBI) for chronically high stress work environments to increase resiliency and work engagement, *Journal of Visualized Experiments,* 101, online, Jul 1. doi: 10.3791/52359

Kohn, M. L. and Schooler, C. (1982) Job conditions and personality: A longitudinal assessment of their reciprocal effects, *American Journal of Sociology (*87), 1257-1286*.*

Koivu, A., Saarinen, P. I. and Hyrkas, K. (2012) Does clinical supervision promote medical–surgical nurses' well-being at work? A quasi-experimental 4-year follow-up study, *Journal of nursing Management,* 20(3)*,* 401-413*.*

Kompier, M. and Cooper, C.L. eds. (1999) *Preventing Stress, Improving Productivity: European case studies in the workplace.* London, UK: Routledge.

Kramer, M. and Schmalenberg, C. (2008) Confirmation of a healthy work environment, *Critical Care Nurse*, 28(2), 56-63.

Kravits, K., McAllister-Black, R., Grant, M. and Kirk, C. (2010) Self-care strategies for nurses: A psycho-educational intervention for stress reduction and the prevention of burnout, *Applied Nursing Research* 23(3), 130-138.

Krohne, H.W., 1996. *Individual Differences in Coping*. New York: Wiley.

Kun, B., Urbán, R., Paksi, B., Csóbor, L.V., Oláh, A. and Demetrovics, Z. (2012) Psychometric characteristics of the Emotional Quotient Inventory, Youth

Version, Short Form, in Hungarian high school students, Psychological Assessment, 24(2), 518.

Kunert, K., King, M. L. and Kolkhorst, F. W. (2007) Fatigue and sleep quality in nurses, *Journal of Psychosocial Nursing and Mental Health Services,* 45(8), 30-37

Kuokkanen, L., Leino-Kilpi, H., and Katajisto, J. (2003) Nurse empowerment, job-related satisfaction, and organizational commitment, *Journal of Nursing Care Quality,* 18(3), 184-192.

Lahey, B. B. (2009) Public health significance of neuroticism, *American Psychologist,* 64(4), 241.

Lambrou, P., Papastavrou, E., Merkouris, A. and Middleton, N. (2015) Professional environment and patient safety in emergency departments, *International Emergency Nursing,* 23(2), 150-155.

Landa, J. M. A., López-Zafra, E., Martos, M. P. B. and del Carmen Aguilar-Luzón, M. (2008) The relationship between emotional intelligence, occupational stress and health in nurses: A questionnaire survey, *International Journal of Nursing Studies*, 45(6), 888-901.

Landy, F. J. (2005) Some historical and scientific issues related to research on emotional intelligence, *Journal of Organizational Behaviour*, 26(4), 411-424.

Lang, T. A., Hodge, M., Olson, V., Romano, P. S. and Kravitz, R. L. (2004) Nurse-patient ratios: A systematic review on the effects of nurse staffing on patient, nurse employee, and hospital outcomes, *Journal of Nursing Administration,* 34(7-8), 326-337.

Laposa, J. M., Alden, L. E. and Fullerton, L. M. (2003) Work stress and posttraumatic stress disorder in ED nurses/personnel (CE), *Journal of emergency nursing,* 29(1), 23-28.

Laschinger, H. K. S., Finegan, J., Shamian, J., and Casier, S. (2000) Organizational trust and empowerment in restructured healthcare settings: Effects on staff nurse commitment, Journal of Nursing Administration, 30(9), 413-425.

Lazarus, R. S. (1966) *Psychological Stress and the Coping Process.* New York: McGraw-Hill.

Lazarus, R. S. (1990) Theory-based stress measurement , *Inquiry*, 1(1), 3-13.

Lazarus, R. S. (1999) Hope: An emotion and a vital coping resource against despair, *Social Research*, 66(2), 653-678.

Lazarus, R. S. (2001) Relational meaning and discrete emotions, in K. R. Scherer, A. Schorr and T. Johnstone (Eds.), *Series in Affective Science. Appraisal Processes in Emotion: Theory, methods, research* (pp. 37-67). New York: Oxford University Press.

Lazarus, R. S. and Folkman, S. (1984a) *Stress, Appraisal and Coping.* New York: Springer.

Lazarus, R.S. and Folkman, S. (1984b) Coping and adaptation, in W. D. Gentry (ed.), *The Handbook of Behavioral Medicine*, pp. 282-325. New York.

Lazarus, R. S. and Lazarus, B. N. (1996) *Passion and Reason: Making sense of our emotions*. New York: Oxford University Press.

Leineweber, C., Chungkham, H. S., Lindqvist, R., Westerlund H., Runesdotter S., Alenius L. S. and Tishelman C. (2016) Nurses' practice environment and satisfaction with schedule flexibility is related to intention to leave due to dissatisfaction: A multi-country, multilevel study, *International Journal of Nursing Studies,* 58, 47-58.

Leineweber, C., Westerlund, H., Chungkham, H. S., Lindqvist. R., Runesdotter, S. and Tishelman, C. (2014) Nurses' practice environment and work-family conflict in relation to burn out: A multilevel modelling approach, *PLoS ONE,* 9(5), e96991. https://doi.org/10.1371/journal.pone.0096991

Leitner, K. and Resch, M. G. (2005) Do the effects of job stressors on health persist over time? A longitudinal study with observational stressor measures, *Journal of Occupational Health Psychology,* 10(1), 18.

Levi, L. (2000) *Guidance on Work-related Stress: Spice of life or kiss of death?* Office for Official Publications of the European Communities.

Lewin, K. (1938) *The Conceptual Representation and the Measurement of Psychological Forces*. Michigan: Duke University Press.

Lewin, K. (1951) *Field Theory in Social Science*. New York: Harper.

Lewis, N. J., Rees, C. E., Hudson, J. N. and Bleakley, A. (2005) Emotional intelligence medical education: Measuring the unmeasurable?, *Advances in Health Sciences Education,* 10(4), 339-355.

Light, I. and Bincy, R. (2012) Effects of stress management interventions on job stress among nurses working in critical care units, *Nursing Journal of India,* 103(6), 269-271.

Likupe, G. (2006) Experiences of African nurses in the UK National Health Service: A literature review, *Journal of Clinical Nursing,* 15(10), 1213-1220.

Lombardo, B. and Eyre, C. (2011) Compassion fatigue: A nurse's primer, *Online Journal of Issues in Nursing,* 16(1), p.3.

López, M. P. S. and Dresch, V. (2008) The 12-Item General Health Questionnaire (GHQ-12): Reliability, external validity and factor structure in the Spanish population, *Psicothema,* 20(4), 839-843.

Lu, K. Y., Chang, L. C. and Wu, H. L. (2007) Relationships between professional commitment, job satisfaction, and work stress in public health nurses in Taiwan, *Journal of Professional Nursing,* 23(2), 110-116.

Lu, K. Y., Chiou, S. L. and Chang, Y. Y. (2000) A study of the professional commitment changes from nursing students to registered nurses, *Kaohsiung Journal of Medical Sciences,* 16(1), 39-46.

Luft, J. and Ingham, H. (1955) The Johari Window, a graphic model of interpersonal awareness, in *Proceedings of the Western Training Laboratory in Group Development.* Los Angeles: University of California, Los Angeles.

Lum, L., Kervin, J., Clark, K., Reid, F. and Sirola, W. (1998) Explaining nursing turnover intent: Job satisfaction, pay satisfaction, or organizational commitment?, *Journal of Organizational Behavior,* 19(3), 305-320.

Lyne, K. D., Barrett, P. T., Williams, C. and Coaley, K. (2000) A psychometric evaluation of the Occupational Stress Indicator, *Journal of Occupational and Organizational Psychology*, 73(2), 195-220.

Lyne, K. D., Barrett, P. T., Williams, C. and Coaley, K. (2000) A psychometric evaluation of the Occupational Stress Indicator, *Journal of Occupational and Organizational Psychology*, *73*(2), 195-220.

MacCann, C. and Roberts, R. D. (2008) New paradigms for assessing emotional intelligence: theory and data, *Emotion*, 8(4), 540.

Mackenzie, C. S. Poulin, P. A. and Seidman-Carlson, R. (2006) A brief mindfulness-based stress reduction intervention for nurses and nurse aides, *Applied Nursing Research,* 19(2), 105-109.

Mahar, D. J., Iwasiw, C. L. and Evans, M. K. (2012) The mandala: First-year undergraduate nursing students' learning experiences. *International Journal of Nursing Education Scholarship*, 9(1).

Makikangas, A., Feldt, T. and Kinnunen, U. (2007) Warr's scale of job-related affective wellbeing: A longitudinal examination of its structure and relationships with work characteristics, *Work & stress,* 21(3), 197-219

Makowska, Z. and Merecz, D. (2001) Polish adaptation of David Goldberg's General Health Questionnaires: GHQ-12 and GHQ-28. *Assessment of Mental Health Status Using David Goldberg's Questionnaires: Guide for users of GHQ-12 and GHQ-28*]. Łódź: Nofer Institute of Occupational Medicine.

Mann, S., (2005) A health-care model of emotional labour: an evaluation of the literature and development of a model, *Journal of health organization and management, 19(4/5), pp.304-317.*

Marino, K. E. and White, S. E., 1985. Departmental structure, locus of control, and job stress: The effect of a moderator, *Journal of Applied Psychology*, 70(4), 782.

Martins, A., Ramalho, N. and Morin, E. (2010) A comprehensive meta-analysis of the relationship between emotional intelligence and health, *Personality and Individual Differences*, 49(6), 554-564.

Maslow, A.H. (1943) A theory of human motivation, *Psychological Review*, 50(4), p.370.

Matsudaira, K., Shimazu, A., Fujii, T., Kubota, K., Sawada, T., Kikuchi, N. and Takahashi, M. (2013) Workaholism as a risk factor for depressive mood, disabling back pain, and sickness absence, *PloS One,* 8(9), e75140.

Matthews, G., Deary, I. J. and Whiteman, M. C. (2003) *Personality Traits*. London: Cambridge University Press.

Matthews, G., Emo, A. K., Funke, G., Zeidner, M., Roberts, R. D., Costa Jr, P. T. and Schulze, R. (2006) Emotional intelligence, personality, and task-induced stress, *Journal of Experimental Psychology: Applied*, 12(2), 96.

Matthews, G., Roberts, R.D. and Zeidner, M. (2004) Seven myths about emotional intelligence, *Psychological Inquiry*, 15(3), 179-196.

Mauno, S., Ruokolainen, M. and Kinnunen, U. (2013) Does aging make employees more resilient to job stress? Age as a moderator in the job stressor well-being relationship in three Finnish occupational samples, *Aging & Mental Health,* 17(4), 411-422.

Mavroveli, S., Petrides, K. V., Rieffe, C. and Bakker, F. (2007) Trait emotional intelligence, psychological well-being and peer-rated social competence in adolescence, *British Journal of Developmental Psychology*, 25(2), 263-275.

Mayer, J. D. and Salovey, P. (1997). What is emotional intelligence?, in P. Salovey and D. Sluyter (eds), *Emotional Development and Emotional Intelligence: Implications for educators* (pp. 3–31). New York: Basic Books.

Mayer, J. D., Caruso, D.R. and Salovey, P. (1999) Emotional intelligence meets traditional standards for an intelligence, *Intelligence*, 27(4), 267-298.

Mayer, J. D., Gaschke, Y.N., Braverman, D. L. and Evans, T. W. (1992) Mood-congruent judgment is a general effect, *Journal of Personality and Social Psychology*, 63(1), p.119.

Mayer, J.D., Salovey, P. and Caruso, D.R. (2002) *MSCEIT User's Manual.* Toronto, ON: Multi-Health Systems.

Mayer, J. D., Salovey, P. and Caruso, D. R. (2004). Emotional Intelligence: Theory, findings, and implications, *Psychological Inquiry*, 15(3), 197-215.

McCrae, R. R. and Costa, P. T. (1985) *The NEO Personality Inventory Manual*. Odessa: Psychological Assessment Resources.

McCrae, R. R. and Costa, P.T. (2003) *Personality in Adulthood: A five-factor theory perspective*. New York: Guilford.

McCrae, R. R., Costa Jr, P. T., Terracciano, A., Parker, W. D., Mills, C. J., De Fruyt, F. and Mervielde, I. (2002) Personality trait development from age 12 to age 18: Longitudinal, cross-sectional and cross-cultural analyses, *Journal of Personality and Social Psychology*, 83(6), 1456.

McGrath, J. E. (1976) Stress and behaviour in organisations, in M. Dunnette (ed), *Handbook of Industrial and Organisational Psychology,* pp. 1351-1395. Chicago: Rand McNally.

McHugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloane, D. M. and Aiken, L. H. (2011) Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care, *Health Affairs,* 30(2), 202-210.

McKay, C., Cox, T., Burrows, G. and Lazzerini, T. (1978) An inventory for the measurement of self-reported stress and arousal, *British Journal of Social and Clinical Psychology*, 17(3), 283-284.

McVicar, A. (2003) Workplace stress in nursing: A literature review, *Journal of Advanced Nursing,* 44(6), 633-642*.*

Mikolajczak, M. and Luminet, O. (2008) Trait emotional intelligence and the cognitive appraisal of stressful events: An exploratory study, *Personality and Individual Differences*, 44(7), 1445-1453.

Mikolajczak, M., Luminet, O., Leroy, C. and Roy, E. (2007a) Psychometric properties of the Trait Emotional Intelligence Questionnaire: Factor structure, reliability, construct, and incremental validity in a French-speaking population, *Journal of Personality Assessment*, 88(3), 338-353.

Mikolajczak, M., Menil, C. and Luminet, O. (2007b) Explaining the protective effect of trait emotional intelligence regarding occupational stress: Exploration of emotional labour processes, *Journal of Research in Personality*, 41(5), 1107-1117.

Mikolajczak, M., Petrides, K. V. and Hurry, J. (2009) Adolescents choosing self-harm as an emotion regulation strategy: The protective role of trait emotional intelligence, *British Journal of Clinical Psychology,* 48(2), 181-193.

Moeller, S. B., Bech, P., Kessing, L., Mortensen, E. L., Austin, S. F. and Bukh, J. O. D. (2015) A psychometric validation analysis of Eysenck's Neuroticism and Extraversion scales in a sample of first time depressed patients, *Journal of Depress Anxiety,* 4(4), 2167-1044.

Montes-Berges, B. and Augusto, J. M. (2007) Exploring the relationship between perceived emotional intelligence, coping, social support and mental health

in nursing students, *Journal of Psychiatric and Mental Health Nursing*, 14(2), 163-171.

Moore, L. W., Leahy, C., Sublett, C. and Lanig, H. (2013) Understanding nurse-to-nurse relationships and their impact on work environments, *Medsurg Nursing,* 22(3), 172.

Morgan, D. L. (1998) Practical strategies for combining qualitative and quantitative methods: Applications to health research, *Qualitative Health Research*, 8(3), 362-376.

Morgan, D.L., (2014) *Pragmatism as a paradigm for mixed methods research. Integrating qualitative and quantitative methods: A pragmatic approach*. Thousand Oaks, CA: Sage.

Morris, J., and Feldman, D. C. (1997) Managing emotions in the workplace, *Journal of Managerial Issues,* 9, 257-274.

Morrison, J. (2008) The relationship between emotional intelligence competencies and preferred conflict-handling styles, *Journal of Nursing Management*, 16(8), 974-983.

Moustaka, E. and Constantinidis, T. (2010) Sources and effects of work-related stress in nursing, *Health Science Journal,* 4(4), 210-216.

Moustakas, C. (1994) *Phenomenological Research Methods*. Thousand Oaks, CA: Sage.

Mroczek, D. K. and Almeida, D. M. (2004) The effect of daily stress, personality, and age on daily negative affect, *Journal of Personality*, 72(2), 355-378.

Muncer, S., Taylor, S., Green, D. W. and McManus, I. C. (2001) Nurses' representations of the perceived causes of work-related stress: A network drawing approach, *Work & Stress,* 15(1), 40-52.

Murensky, C. L. (2000) The relationships between emotional intelligence, personality, critical thinking ability and organizational leadership performance at upper levels of management, *Dissertation Abstracts International: Section B: The Sciences and Engineering,* 61(2-B), 1121.

Murray, M. K. (2002) The nursing shortage: Past, present, and future, *Journal of Nursing Administration*, 32(2), 79-84.

Murta, S.G., Sanderson, K. and Oldenburg, B. (2007) Process evaluation in occupational stress management programs: A systematic review, *American Journal of Health Promotion*, 21(4), 248-254.

Nam, S. and Lee, S. J. (2016) Occupational factors associated with obesity and leisure-time physical activity among nurses: A cross-sectional study, *International Journal of Nursing Studies,* 57, 60-69*.*

Nasseh, M., Ghazinour, M., Joghataei, M. T., Nojomi, M. and Richter, J. (2011) A Persian version of the Social Support Questionnaire (SSQ), *Social Welfare Quarterly*, 11(41), 251-266.

Nasseh, M., Jalilvand, J. and Vahdani, M.R. (2012) Relationship between personality dimensions and job burnout of nurses, *Modern Care,* 9, 87-94.

Nelis, D., Quoidbach, J., Mikolajczak, M. and Hansenne, M. (2009) Increasing emotional intelligence: (How) is it possible?, P*ersonality and Individual Differences,* 47(1), 36-41.

Newman, D. A., Joseph, D. L. and MacCann, C. (2010) Emotional intelligence and job performance: The importance of emotion regulation and emotional labor context, *Industrial and Organizational Psychology*, 3(2), 159-164.

Newsome, S., Day, A. L. and Catano, V. M. (2000) Assessing the predictive validity of emotional intelligence, *Personality and Individual Differences*, 29(6), 1005-1016.

NHS (2005) *Agenda for Change: NHS Terms and Conditions of Service Handbook.* London: NHS Employers.NHS (2014) *Zero-hours Employment Contracts*. London: NHS Employers.

NHS Digitals (2018) *NHS Vacancy Statistics England, February 2015 - September 2017*, Provisional Experimental Statistics https://digital.nhs.uk/.../nhs.../nhs-vacancy-statistics-england-february-2015-september... accessed 23/1/2018.

NHS Digitals (2017) *NHS Workforce Statistics***,** https://digital.nhs.uk/data-and.../nhs.../nhs-workforce-statistics-december-2017 accessed 23/1/2018.

NMC (2018a) *Standards of Proficiency for Registered Nurses*. Retrieved from: https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf

NMC (2018b) *Pre-2018 Standards*, available at https://www.nmc.org.uk/standards/standards-for-nurses/ Pre-2018 Standards (still used by programmes across the UK): last updated 16/05/2018, accessed 23/1/2018

Nolan, P. and Smojkis, M. (2003) The mental health of nurses in the UK, *Advances in Psychiatric Treatment*, 9(5), 374-379.

Noorbakhsh, S. N., Besharat, M. A. and Zarei, J. (2010) Emotional intelligence and coping styles with stress, Procedia-Social and Behavioral Sciences, 5, 818-822.

Nuikka, M. L., Paunonen, M., Hänninen, O. and Länsimies, E. (2001) The nurse's workload in care situations, Journal of Advanced Nursing, 33(3), 406-415.

Nursing Times (2019) Nurses criticise BBS for overlooking their primary care role, available at: https://www.nursingtimes.net/news/primary-care/nurses-criticise-bbc-for-overlooking-their-primary-care-role-09-05-2019/, accessed on 28.01.2020.

Nylén, L., Melin, B. and Laflamme, L. (2007) Interference between work and outside-work demands relative to health: Unwinding possibilities among full-time and part-time employees, *International Journal of Behavioral Medicine,* 14(4), 229-236

Office for National Statistics (2017) *Suicide by Occupation, England: 2011–2015*. Public Health England.

Oginska-Bulik, N. (2005) Emotional intelligence in the workplace: Exploring its effects on occupational stress and health outcomes in human service workers. *International Journal of Occupational Medicine and Environmental Health*, 18(2), 167-175.

Orly, S., Rivka, B., Rivka, E. and Dorit, S. E. (2012) Are cognitive–behavioral interventions effective in reducing occupational stress among nurses? *Applied Nursing Research,* 25(3), 152-157.

O'Connor, K.P. and Hallam, R.S., (2000) Sorcery of the self: The magic of you, *Theory & Psychology, 10(2), pp.238-264.*

O'Sullivan, M. (2005) Emotional intelligence and deception detection: Why most people can't read others, but a few can, in *Applications of Nonverbal Communication,* pp. 215-253.

Padron, A., Galan, I., Durban, M., Gandarillas, A., Rodriguez-Artalejo, F. (2012) Confirmatory factor analysis of the GHQ-12 in Spanish adolescents, *Qual. Life Research,* 21(7), 1291-1298.

Palmer, B. and Stough, C. (2001) *Workplace SUEIT: Swinburne University emotional intelligence test–technical manual.* Hawthorn, Australia: Organisational Psychology Research Unit, Swinburne University.

Palmer, B. R. (2003) An analysis of the relationship between various models and measures of emotional intelligence. Unpublished doctoral dissertation, Swinburne University of Technology, Melbourne.

Palmer, B. R. (2007) Models and measures of emotional intelligence, *Organisations and People*, 14(2), 3.

Palmer, B. R., Gardner, L. and Stough, C. (2003) Measuring emotional intelligence in the workplace with the Swinburne University Emotional Intelligence Test, in *Proceedings of the First International Conference on Contemporary Management: Emotional Intelligence in Organizations,* September, Swinburne University of Technology, Australia.

Palmer, B. R., Manocha, R., Gignac, G. and Stough, C. (2003) Examining the factor structure of the Bar-On Emotional Quotient Inventory with an Australian general population sample, *Personality and Individual Differences*, 35(5), 1191-1210.

Palmer, B. R., Stough, C., Harmer, R. and Gignac, G. (2009) *The Genos Emotional Intelligence Inventory: A measure designed specifically for workplace applications*. In Assessing emotional intelligence (pp. 103-117). Boston, MA: Springer.

Palmer, B. R., Stough, C., Harmer, R. and Gignac, G. (2009). The Genos Emotional Intelligence Inventory: A measure designed specifically for workplace applications, in *Assessing Emotional Intelligence* (pp. 103-117)., Boston, MA: Springer.

Paoli, P. and Merlie, D. (2001) *Third European Survey on Working Conditions 2000.* Dublin: European Foundation for the Improvement of Living and Working Conditions.

Parker, S. K., Griffin, M. A., Sprigg, C. A. and Wall, T. D. (2002) Effect of temporary contracts on perceived work characteristics and job strain: A longitudinal study, *Personnel Psychology,* 55(3), 689-719

Payne, R. (1988) Individual differences in the study of occupational stress in C. L. Cooper and R. Payne (eds). C*auses, Coping and Consequences of Stress at Work*. Chichester: Wiley & Sons.

Pearlin, L. I. and Bierman, A. (2013) Current issues and future directions in research into the stress process, in *Handbook of the Sociology of Mental Health* (pp. 325-340). Dordrecht: Springer.

Pearlin, L. I. and Schooler, C. (1978) The structure of coping, *Journal of Health and Social Behaviour,* 19(2-21), 337-356*.*

Penley, J. A. and Tomaka, J. (2002) Associations among the Big Five, emotional responses, and coping with acute stress. *Personality and Individual Differences*, 32(7), 1215-1228.

Pérez, J. C., Petrides, K. V. and Furnham, A. (2005) Measuring trait emotional intelligence, in R. Schulze and R. D. Robe (eds), *Emotional Intelligence: An international handbook,* pp. 181-201. Cambridge, MA: Hogrefe & Huber

Perrewé, P. L., Halbesleben, R. B. and Rosen, C. C. (2012) Organizational politics and stress: The development of a process model, in G. R. Ferris and D. C. Treadway (eds), *Politics in Organizations: Theory and research considerations,* p. 213*.* New York: Routledge/Taylor & Francis.

Peters, V., Houkes, I., de Rijk, A. E., Bohle, P. L., Engels, J. A. and Nijhuis, F. J. N. (2016) Which resources moderate the effectors of demanding work schedules on nurses working in residential elder care? A longitudinal study, *International Journal of Nursing Studies,* 58, 31-46.

Petrides, K. V. (2009) Psychometric properties of the trait emotional intelligence questionnaire (TEIQue), in *Assessing Emotional Intelligence* (pp. 85-101). Boston MA: Springer.

Petrides, K. V. (2010) Trait emotional intelligence theory, *Industrial and Organizational Psychology*, 3(2), 136-139.

Petrides, K. V. and Furnham, A. (2000a. On the dimensional structure of emotional intelligence. *Personality and Individual Differences*, 29(2), 313-320.

Petrides, K. V. and Furnham, A. (2000b) Gender differences in measured and self-estimated trait emotional intelligence, *Sex Roles*, 42(5-6), 449-461.

Petrides, K. V. and Furnham, A. (2003) Trait emotional intelligence: Behavioural validation in two studies of emotion recognition and reactivity to mood induction, *European Journal of Personality*, 17(1), 39-57.

Petrides, K. V. and Furnham, A. (2009) Technical Manual for the trait Emotional Intelligence Questionnaires (TEIQue). London: London Psychometrics Lab, UCL.

Petrides, K. V., Furnham, A. and Mavroveli, S. (2007) G. Matthews, M. Zeidner, and R. D. Roberts (eds), *The Science of Emotional Intelligence: Knowns and unknowns* (pp. 151–166). New York: Oxford University Press.

Petrides, K. V., Frederickson, N. and Furnham, A. (2004) The role of trait emotional intelligence in academic performance and deviant behavior at school, *Personality and Individual Differences*, 36(2), 277-293.

Petrides, K. V., Mikolajczak, M., Mavroveli, S., Sanchez-Ruiz, M. J., Furnham, A. and Pérez-González, J. C. (2016) Developments in trait emotional intelligence research, *Emotion Review*, 8(4), 335-341. Available at http://hdl.handle.net/2078.1/180665

Petrides, K. V., Pérez-González, J.C. and Furnham, A. (2007) On the criterion and incremental validity of trait emotional intelligence, *Cognition and Emotion*, 21(1), 26-55.

Petrides, K. V., Pita, R. and Kokkinaki, F. (2007) The location of trait emotional intelligence in personality factor space, *British Journal of Psychology*, 98(2), 273-289.

Petrides, K. V., Vernon, P. A., Schermer, J. A., Ligthart, L., Boomsma, D. I. and Veselka, L. (2010) Relationships between trait emotional intelligence and

the Big Five in the Netherlands, *Personality and Individual Differences*, 48(8), 906-910.

Pietkiewicz, I. and Smith, J. A. (2014) A practical guide to using interpretative phenomenological analysis in qualitative research psychology, *Psychological Journal*, 20(1), 7-14.

Pines, A. M. and Keinan, G. (2005) Stress and burnout: The significant difference, *Personality and Individual Differences,* 39, 625-635.

Pishghadam, R. and Sahebjam, S. (2012) Personality and emotional intelligence in teacher burnout, *The Spanish journal of psychology, 15(1), pp.227-236*.

Podsakoff, N. P., LePine, J. A., and LePine, M. A. (2007) Differential challenge stressor-hindrance stressor relationships with job attitudes, turnover intentions, turnover, and withdrawal behavior: A meta-analysis, *Journal of Applied Psychology,* 92(2), 438*.*

Pompili, M., Rinaldi, G., Lester, D., Girardi, P., Ruberto, A. and Tatarelli, R. (2006) Hopelessness and suicide risk emerge in psychiatric nurses suffering from burnout and using specific defense mechanisms, *Archives of Psychiatric Nursing,* 20(3), 135-143.

Por, J., Barriball, L., Fitzpatrick, J. and Roberts, J. (2011) Emotional intelligence: Its relationship to stress, coping, well-being and professional performance in nursing students. *Nurse Education Today*, 31(8), 855-860.

Pravettoni, G., Cropley, M., Leotta, S. N. and Bagnara, S. (2007) The differential role of mental rumination among industrial and knowledge workers, *Ergonomics* 50(11), 1931-1940.

Prosser, D., Johnson, S., Kuipers, E., Dunn, G., Szmukler, G., Reid, Y., Bebbington, P. and Thornicroft, G. (1999) Mental health, burnout and job satisfaction in a longitudinal study of mental health staff, *Social Psychiatry and Psychiatric Epidemiology*, 34(6), 295-300.

RCN (2017) Campaign so far: Close the gap, available at: https://www.rcn.org.uk/nursingcounts/nursing-pay/campaign-so-far, November, accessed 30/11/2017.

RCN (2019) Nursing student numbers are still falling Short, available at: https://www.rcn.org.uk/news-and-events/news/uk-nursing-student-numbers-are-still-falling-short-150819, accessed 28.01.20

RCN (2020) Gender and Nursing as a profession: valuing nurses and paying them their worth, Oxford Brooks University and RCN Publication

Rees, D. and Cooper, C. L. (1992) Occupational stress in health service workers in the UK, *Stress and Health*, 8(2), 79-90.

Reid, K., Flowers, P. and Larkin, M. (2005) Exploring lived experience: An introduction to interpretative phenomenological analysis, *Psychologist*, 18(1), 20-23.

Rhodes, J.E. (2004) Family, friends and community: The role of social support in promoting health*,* in P. M. Camic and S. Knight (eds), *Clinical Handbook of Health Psychology* (pp. 289-296). New York: Hogrefe and Huber.

Richardson, K. M. and Rothstein, H. R. (2008) Effects of occupational stress management intervention programs: A meta-analysis, *Journal of Occupational Health Psychology,* 13(1), 69*.*

Robert, B. W. and Mroczek, D. (2008) Personality trait change in adulthood, *Current Directions in Psychological Science*, 17, 31-35.

Roberts, S. J. (2000) Development of a positive professional identity: Liberating oneself from the oppressor within, *Advances in Nursing Science,* 22(4), 71-82.

Robson, C. (2002) *The Analysis of Qualitative Data*. Oxford: Blackwell.

Robson, F. M. (2002) 'Yes!—A chance to tell my side of the story': A case study of a male partner of a woman undergoing termination of pregnancy for foetal abnormality, *Journal of Health Psychology*, 7(2), 183-193.

Ryff, C. D. (1989) Happiness is everything or is it? Explorations on the meaning of psychological wellbeing, *Journal of Personality and Social Psychology,* 57, 1069-1081.

Ryff, C. D. and Keyes, C. L .M (1995) the structure of psychological wellbeing revisited, *Journal of Personality and Social Psychology,* 69, 719-727.

Saber, D. A. (2014) Frontline registered nurse job satisfaction and predictors over three decades: A meta-analysis from 1980 to 2009, *Nursing Outlook,* 62(6), 402-414.

Sailaxmi, G. and Lalitha, K. (2015) Impact of a stress management program on stress perception of nurses working with psychiatric patients, *Asian Journal of Psychiatry,* 14, 42-45.

Sainsbury Centre (2007) *Mental Health at Work: Developing the business case.* Policy Paper 8. Sainsbury Centre for Mental Health.

Saksvik, I. B. and Hetland, H. (2011) The role of personality in stress perception across different vocational types, *Journal of Employment Counselling*, 48, 3-16.

Saksvik, P. Ø. and Gustafsson, O. G. (2004) Early retirement from work: A longitudinal study of the impact of organisational change in a public enterprise, *Policy and Practice in Health and Safety*, 2(2), 43-55.

Sala, F. (2002) *Emotional Competence Inventory (ECI): Technical manual.* Boston: Hay/McBer Group.

Salovey, P. and Grewal, D. (2005) The science of emotional intelligence, *Current Directions in Psychological Science*, 14(6), 281-285.

Salovey, P. and Mayer, J. D. (1990) Emotional intelligence, *Imagination, Cognition and Personality*, 9(3), 185-211.

Salovey, P., Mayer, J. D., Goldman, S. L., Turvey, C. and Palfai, T. P. (1995) *Emotional Attention, Clarity, and Repair: Exploring emotional intelligence using the Trait Meta-Mood Scale.* Available at Psycnet.apa.org (Downloaded 6th February 2018)

Sarid, O., Berger, R. and Segal-Engelchin, D. (2010) The impact of cognitive behavioural interventions on SOC, perceived stress and mood states of nurses, *Procedia Social and Behavioural Sciences*, 2, 928-932.

Schmidt, Louis, Todd, A. and Riniolo, C. (1999) The role of neuroticism in test and social anxiety, *Journal of Social Psychology,* 139(3), 394-395.

Schmitz, N., Neumann, W. and Oppermann, R. (2000) Stress, burnout and locus of control in German nurses, *International Journal of Nursing Studies*, 37(2), 95-99.

Schulz, K. F. and Grimes, D. A. (2002) Allocation concealment in randomised trials: Defending against deciphering. *Lancet*, 359(9306), 614-618.

Schutte, N. S. and Loi, N. M. (2014) Connections between emotional intelligence and workplace flourishing, *Personality and Individual Differences*, 66, 134-139.

Schutte, N. S., Malouff, J. M., Bobik, C., Coston, T. D., Greeson, C., Jedlicka, C., Rhodes, E. and Wendorf, G. (2001) Emotional intelligence and interpersonal relations, *Journal of Social Psychology*, 141(4), 523-536.

Schutte, N. S., Malouff, J. M., Hall, L.E., Haggerty, D. J., Cooper, J. T., Golden, C. J. and Dornheim, L. (1998) Development and validation of a measure of emotional intelligence, *Personality and Individual Differences*, 25(2), 167-177.

Schutte, N. S., Malouff, J. M., Simunek, M., McKenley, J. and Hollander, S. (2002) Characteristic emotional intelligence and emotional well-being, *Cognition & Emotion*, 16(6), 769-785.

Schutte, N. S., Malouff, J. M., Thorsteinsson, E. B., Bhullar, N. and Rooke, S. E. (2007) A meta-analytic investigation of the relationship between emotional intelligence and health, *Personality and Individual Differences*, 42(6), 921-933.

Schulz, K. F. and Grimes, D. A. (2002) Generation of allocation sequences in randomised trials: Chance, not choice, *Lancet*, 359(9305), 515-519.

SCIE Social Care Online (2017) *Rising Pressure: The NHS workforce challenge, workforce profile and trends in England*. London: Health Foundation.

Selye, H. (1956) *The Stress of Life*. New York: McGraw Hill.

Selye, H. (1976) The stress concept, *Canadian Medical Association Journal*, 115(8), 718.

Sevastos, P., Smith, L. and Cordery, J. L. (1992) Evidence on the reliability and construct validity of Warr's (1990) well-being and mental health measures, *Journal of Occupational and Organizational Psychology*, 65(1), 33-49.

Shader, K., Broome, M. E., Broome, C. D., West, M. E. and Nash, M. (2001). Factors influencing satisfaction and anticipated turnover for nurses in an

academic medical centre, *Journal of Nursing Administration, 31(4), 210-216.*

Shanahan, M.J. and Bauer, D.J., 2004. Developmental properties of transactional models: The case of life events and mastery from adolescence to young adulthood, *Development and psychopathology, 16(4), pp.1095-11*17.

Sheldon, K. M. and Elliot, A. J. (1998) Not all personal goals are personal: Comparing autonomous and controlled reasons for goals as predictors of effort and attainment. *Personality and Social Psychology Bulletin*, 24(5), 546-557.

Sheward, L., Hunt, J., Hagen, S., Macleod, M., and Ball, J. (2005) The relationship between UK hospital nurse staffing and emotional exhaustion and job dissatisfaction, *Journal of Nursing Management,* 13(1), 51-60.

Shields, M. A. and Ward, M. (2001) Improving nurse retention in the National Health Service in England: The impact of job satisfaction on intentions to quit, *Journal of Health Economics*, 20(5), 677-701.

Shinebourne, P. (2011) The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis*, 22(1).

Shinebourne, P. and Smith, T. A. (2009) Alcohol and the self: An interpretative phenomenological analysis of the experience of addiction and its impact on the sense of self and identity, *Addiction Research & Theory*, 17(2), 152-167.

Siegling, A. B., Nielsen, C., and Petrides, K. V. (2014) Trait emotional intelligence and leadership in a European multinational company*, Personality and Individual Differences,* 65, 65-68*.*

Silverman, D. (2015) *Interpreting Qualitative Data.* London: Sage.

Sjölund, M. and Gustafsson, H. (2001) *Outcome Study of a leadership Development Assessment and Training Program Based on Emotional Intelligence: Educating people to be emotionally intelligent*. Sandton, South Africa: Heinemann.

Sjostedt, E., Dahlstrand, A., Severinsson, E. and Lutzen, K. (2001) The first nurse-patient encounter in a psychiatric setting: Discovering a moral commitment in Nursing, *Nursing Ethics,* 8(4), 313-327.

Salovey, P., Mayer, J. D., Goldman, S. L., Turvey, C. and Palfai, T. P. (1995) *Emotional Attention, Clarity, Repair: Exploring emotional intelligence using the Trait Meta-Mood Scale, i*n J. W. Pennebaker (ed.), *Emotion, Disclosure, and Health*, pp. 125-154. Washington DC: American Psychological Association, doi:10.1037/10182-006

Slaski, M. and Cartwright, S. (2003) Emotional intelligence training and its implications for stress, health and performance, *Stress and Health*, 19(4), 233-239.

Smith, J. A. (2004) Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology, *Qualitative Research in Psychology*, 1(1), 39-54.

Smith, J. A., Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis: Theory, method and research publishing.* London: Sage.

Smith, J. A., Jarman, M. and Osborn, M. (1999) Doing interpretative phenomenological analysis, in Dans M. Murray and K. Chamberlain (eds), *Qualitative Health Psychology: Theories and methods* (pp. 218-240). London: Sage.

Smith, J. A. and Osborn, M. (2004) Interpretative phenomenological analysis, in G. M. Breakwell (ed.), *Doing Social Psychology Research* (pp. 229-254). Leicester: Blackwell/British Psychological Society.

Smith, J. A. and Osborn, M. (2007) Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain, *Psychology and Health*, 22(5), 517-534.

Smith, K. B., Profetto-McGrath, J., and Cummings, G. G. (2009) Emotional intelligence and nursing: An integrative literature review, *International Journal of Nursing Studies,* 46(12), 1624-1636*.*

Smith, T. W. and Rhodewalt, F. (1986) On states, traits and processes: A transactional alternative to the individual differences assumptions in type A behaviour and psychological reactivity, *Journal of Research in Personality*, 20, 229-251.

Snelgrove, S. R. (2014) Conducting qualitative longitudinal research using interpretative phenomenological analysis, *Nurse Researcher*, 22(1), 20.

Snowden, A., Stenhouse, R., Young, J., Carver, H., Carver, F. and Brown, N. (2015) The relationship between emotional intelligence, previous caring experience and mindfulness in student nurses and midwives: A cross-sectional analysis, *Nurse Education Today*, 35(1), 152-158.

Sonnentag, S. and Frese, M. (2003) Stress in organizations, in W. C. Borman, D. R. Ilgen, & R. J. Klimoski (eds), *Handbook of Psychology*, *vol. 12: Industrial and Organizational Psychology*. New York: John Wiley.

South, B. (2007. Combining mandala and the Johari Window: An exercise in self-awareness, *Teaching and Learning in Nursing*, 2(1), 8-11.

Spector, P. E. (1988) Development of the work locus of control scale, *Journal of Occupational Psychology,* 61(4), 335-340*.*

Spector, P. E. (2008) *Industrial and Organizational Psychology: Research and practice* (5th edn). Hoboken, NJ: Wiley. .

Spector, P. E. and Jex, S. M. (1998) Development of four self-report measures of job stressors and strain: Interpersonal conflict at work scale, organizational constraints scale, quantitative workload inventory, and physical symptoms inventory, *Journal of Occupational Health Psychology,* 3(4), 356.

Spector, P. E., Zapf, D., Chen, P. Y. and Frese, M. (2000) Why negative affectivity should not be controlled in job stress research: Don't throw out the baby with the bath water, *Journal of Organizational Behavior,* 21(1), 79-95.

Spence, G., Oades, L. G. and Caputi, P. (2004) Trait emotional intelligence and goal self-integration: Important predictors of emotional well-being? *Personality and Individual Differences,* 37(3), 449-461*.*

Steiler, D. and Paty, B. (2009) Developing a French version of the Occupational Stress indicator (OSI), *Revue europeenne de psychologie appliquee,* 59, 113-122.

Steptoe, A. (2000) Psychosocial factors in the development of hypertension, *Annals of Medicine,* 32(5), 371-375*.*

Steptoe, A. and Cropley, M. (2000) Persistent high job demands and reactivity to mental stress predict future ambulatory blood pressure, *Journal of Hypertension,* 18(5), 581-586.

Stone, P. W., Mooney-Kane, C., Larson, E. L., Horan, T., Glance, L. G., Zwanziger, J. and Dick, A. W. (2007) Nurse working conditions and patient safety outcomes, *Medical Care,* 45(6), 571-578.

Sutton, J. M., Mineka, S., Zinbarg, R. E., Craske, M. G., Griffith, J. W., Rose, R. D., and Mor, N. (2011) The relationships of personality and cognitive styles with self-reported symptoms of depression and anxiety, *Cognitive Therapy and Research,* 35(4), 381-393.

Suzuki, E., Itomine, I., Kanoya, Y., Katsuki, T., Horii, S. and Sato, C. (2006) Factors affecting rapid turnover of novice nurses in university hospitals, *Journal of Occupational Health,* 48(1), 49-61.

Sveinsdóttir, H., Biering, P. and Ramel A. (2006) Occupational stress, job satisfaction, and working environment among Icelandic nurses: A cross-sectional questionnaire survey, *International Journal of Nursing Studies,* 43(7), 875-889.

Swami, V., Begum, S. and Petrides, K. V. (2010) Associations between trait emotional intelligence, actual–ideal weight discrepancy, and positive body image. *Personality and Individual Differences*, 49(5), 485-489.

Tabachnick, B. G. and Fidell, L. S. (2001) *Using Multivariate Statistics*. Boston: Allyn & Bacon/Pearson Education.

Taris, T.W. and Schaufeli, W. (2015) Individual well-being and performance at work: A conceptual and theoretical overview, in M. Van Veldhoven and R. Peccei, *Well-being and Performance: The Role context.* Available at http//:books.google.co.uk (downloaded 6th February 2018).

Tajvar, A., Saraji, G.N., Ghanbarnejad, A., Omidi, L., Hosseini, S.S.S. and Abadi, A.S.S., 2015. Occupational stress and mental health among nurses in a medical intensive care unit of a general hospital in Bandar Abbas in 2013. Electronic physician, 7(3), p.1108.

Ten Hoeve, Y., Castelein, S., Jansen, G. and Roodbol, P. (2017) Dreams and disappointments regarding nursing: Student nurses' reasons for attrition and retention. A qualitative study design, *Nurse Education Today*, 54, 28-36.

Tennant, C. (2000) Work stress and coronary heart disease, *European Journal of Cardiovascular Risk*, 7(4), 273-276.

Tennant, C. (2001) Work-related stress and depressive disorders, *Journal of psychosomatic research,* 51(5), 697-704.

Thoits, P. A. (1987) Gender and marital status differences in control and distress: Common stress versus unique stress explanations, *Journal of Health and Social Behavior*, 28, 7-22.

Thoits, P. A. (1995) Stress, coping, and social support processes: Where are we? What next? J*ournal of Health and Social Behavior*, extra issue: Forty Years of Medical Sociology: The State of the Art and Directions for the Future 28(1), 7-22. DOI: 10.2307/2137137

Thomas, B. (1997) Management strategies to tackle stress in mental health nursing, *Mental Health Care*, 1(1), 15-17.Thomsen, S., Soares, J., Nolan, P., Dallender, J. and Arnetz, B. (1999) Feelings of professional fulfilment and exhaustion in mental health personnel: The importance of organisational and individual factors*, Psychotherapy and Psychosomatics*, 68(3), 157-164.

Thorndike, E. L. (1920) Intelligence and its uses. *Harper's Magazine*, 140, 227-235**.**

The Guardian (2019) *Record numbers of NHS staff quitting due to long hours,* available at https://www.theguardian.com/society/2019/feb/17/nhs-staff-quit-record-numbers-work-life-balance, accessed on 28.01.2020

The King's Fund (2013) *The Francis Inquiry Report*, available at: https://www.kingsfund.org.uk/projects/francis-inquiry-report, accessed on 28.01.2020

Togari, T. and Yonekura, Y. (2015) A Japanese version of the Pearlin and Schooler's Sense of Mastery Scale, *SpringerPlus,* 4(1), 1-4.

Traynor, M. (2014) Caring after Francis: Moral failure in nursing, *Journal of Research in Nursing,* 19(7-8), 546-556.

Trinkoff, A. M., Le, R., Geiger-Brown, J., Lipscomb, J. and Lang, G. (2006). Longitudinal relationship of work hours, mandatory overtime, and on-call to musculoskeletal problems in nurses, *American Journal of Industrial Medicine,* 49(11), 964-971.

Tupes, E. C., and Christal, R. E. (1961) *Recurrent Personality Factors Based on Trait Ratings*, Technical Report NoASD-TR-61-97, Lackland Air Force Base, TX: US Air Force.

Turner, R.J., 2010. *Advances in the Conceptualization of the Stress Process: Essays in honor of Leonard I. Pearlin*. New York: Springer.

Twigg, D. and McCullough, K. (2014) Nurse retention: A review of strategies to create and enhance positive practice environments in clinical settings, *International Journal of Nursing Studies*, 51(1), 85-92.

Van de Ven, B., Jonge, J. and Vlerick, P. (2014) Testing the triple-match principle in the technology sector: A two-wave longitudinal panel study, *Applied Psychology,* 63(2), 300-325.

Van den Berg, T. I., Elders, L. A., and Burdorf, A. (2010) Influence of health and work on early retirement, *Journal of Occupational and Environmental Medicine,* 52(6), 576-583.

Van Den Tooren, M., and De Jonge, J. (2008). Managing job stress in nursing: What kind of resources do we need? *Journal of Advanced Nursing,* 63(1), 75-84.

Van der Klink, J. J., Blonk, R. W., Schene, A. H. and Van Dijk, F. J. (2001) The benefits of interventions for work-related stress, *American Journal of Public Health,* 91(2), 270.

Van Katwyk, P. T., Fox, S., Spector, P. E. and Kelloway, E. K. (2000) Using the Job-Related Affective Well-Being Scale (JAWS) to investigate affective responses to work stressors, *Journal of Occupational Health Psychology*, 5(2), 219.

van Veldhoven, M., Taris, T. W., de Jonge, J. and Broersen, S. (2005) The relationship between work characteristics and employee health and well-being: How much complexity do we really need?, *International Journal of Stress Management*, 12(1), 3.

Vitaliano, P. P., Russo, J., Carr, J.E., Maiuro, R. D. and Becker, J. (1985) The ways of coping checklist: Revision and psychometric properties, *Multivariate Behavioural Research,* 20, 3-26.

Vitello-Cicciu, J. M. (2002) Exploring emotional intelligence: Implications for nursing leaders, *Journal of Nursing Administration*, 32(4), 203-210.

Wagner, C. M. (2007) Organizational commitment as a predictor variable in nursing turnover research: Literature review, *Journal of Advanced Nursing,* 60(3), 235-247.

Wall, T. D., Bolden, R. I., Borrill, C. S., Carter, A. J., Golya, D. A., Hardy, G. E. and West, M. A. (1997) Minor psychiatric disorder in NHS trust staff: occupational and gender differences, *British Journal of Psychiatry,*171(6), 519-523.

Wall, T. D, Jackson, P.R., Mullarkey, S. and Parker, S.K. (1996) The demand-control model of job strain: A more specific test, *Journal of Occupational and Organizational Psychology,* 69, 153-166.

Wallace, J. C., Edwards, B. D., Arnold, T., Frazier, M. L. and Finch, D. M. (2009) Work stressors, role-based performance, and the moderating influence of organizational support, *Journal of Applied Psychology*, 94(1), 254.

Ware Jr, J.E., Kosinski, M. and Keller, S.D. (1996) A 12-Item Short-Form Health Survey: Construction of scales and preliminary tests of reliability and validity, *Medical Care*, 34(3), 220-233.

Ware, J. E., Sherbourne, C. D. and Davies, A. R. (1992. Developing and Testing the MOS 20-Item Short-Form Health Survey, in Anita L. Stewart and John E. Ware, Jr. (eds), *Measuring Functioning and Well-Being: The Medical Outcomes Study Approach,* pp. 277-290. Durham, NC: Duke University Press.

Warr, P. B. (1987) *Work, Unemployment, and Mental Health*. New York: Oxford University Press.

Warr, P. B. (1990a) The measurement of well-being and other aspects of mental health, *Journal of Occupational Psychology,* 63, 193-210.

Warr, P. B. (1990b) Decision latitude, job demands and employee well-being, *Work and Stress* 4, 285-294.

Warr, P. B. (1994) A conceptual framework for the study of work and mental health, *Work & Stress*, 8(2), 84-97.

Warr, P. B. (1996) Employee well-being. *Psychology at Work*, 1, 224-253.

Warr, P. B. (2007) A conceptual framework for the study of work and mental health Available at http:// doi.org/10.1080/02678379408259982

Warr, P. B. (2011) Jobs and job holders: Two sources of happiness and unhappiness, in *Work, Happiness, and Unhappiness*. Ebooks: Taylor & Francis.

Warr, P. B. and Clapperton, G. (2010) *The Joy of Work?: Jobs, happiness, and you*. Hove, UK**:** Routledge.

Warr, P. B., Cook, J. and Wall, T. (1979) Scales for the measurement of some work attitudes and aspects of psychological wellbeing, *Journal of Occupational Psychology,* 52(2), 129-148*.*

Warr, P. B. and Inceoglu, I. (2012) Job engagement, job satisfaction, and contrasting associations with person-job fit, *Journal of Occupational Health Psychology*, 17(2), 129.

Werneke, U., Goldberg, D. P., Yalcin, I. and Ustun, B. T. (2000) The stability of the factor structure of the GHQ, *Psychol. Med.,* 30(4), 823-829.

Whitworth, L., Kimsey-House, K., Kimsey-House, H. and Sandahl, P. (2007) Co-active Coaching: New skills for coaching people toward success in work and life (2nd edn). London: Nicholas Brealey.

Williams, L. J., and Hazer, J. T. (1986) Antecedents and consequences of satisfaction and commitment in turnover models: A reanalysis using latent variable structural equation methods, *Journal of Applied Psychology,* 71(2), 219.

Williams, M. A. (2015) Psychometric properties and factor structure of the General Health questionnaire as a screening tool for anxiety and depressive symptoms in a multi-national study of young adults, *Journal of Affective Disorders,* 187, 197-202.

Williams, P. and Goldberg, D. P. (1988) *A User's Guide to the General Health Questionnaire.* Berkshire: NFER/Nelson.

Williams, S. and Cooper, C. L. (1998) Measuring occupational stress: Development of the pressure management indicator, *Journal of Occupational Health Psychology*, 3(4), 306.

Willig, C. (2001) *Qualitative Research in Psychology: Adventures in theory and method*. Buckingham: Open University Press.

Willig, C. (2013) *Introducing Qualitative Research in Psychology*. UK**:** Open University Press, McGraw-Hill Education.

Willig, C. (2015) *Introducing Qualitative Research in Psychology* (3rd edn). Maidenhead: Open University Press.

Wright, T. A., Cropanzano, R. and Bonett, D. G. (2007) The moderating role of employee positive well being on the relation between job satisfaction and job performance, *Journal of Occupational Health Psychology*, 12(2), 93.

Zadeh, S., Gamba, N., Hudson, C. and Wiener, L. (2012) Taking care of care providers: A wellness program for pediatric nurses, *Journal of Pediatric Oncology Nursing,* 29(5), 294-299.

Zapf, D. and Holz, M. (2006) On the positive and negative effects of emotion work in organizations, *European Journal of Work and Organizational Psychology*, 15(1), 1-28.

Zapf, D., Seifert, C., Schmutte, B., Mertini, H. and Holz, M. (2001) Emotion work and job stressors and their effects on burnout. *Psychology and Health,* 16, 527–545.

Zeidner, M., Matthews, G. and Roberts, R. D., (2012) The emotional intelligence, health, and well-being nexus: What have we learned and what have we missed?, *Applied Psychology: Health and Well-Being*, 4(1), 1-30.

Zeidner, M., Matthews, G. and Roberts, R. D. (2004) Emotional intelligence in the workplace: A critical review, *Applied Psychology*, 53(3), 371-399.

Zeidner, M. and Shani-Zinovich, I. (2011) Do academically gifted and nongifted students differ on the Big-Five and adaptive status? Some recent data and conclusions. *Personality and Individual Differences*, 51(5), 566-570.

Zeller, J. M., and Levin, P. F. (2013) Mindfulness interventions to reduce stress among nursing personnel: An occupational health perspective, *Workplace Health & safety,* 61(2), 85-89.

Zhang, R. P. and Tsingan, L. (2014) Extraversion and neuroticism mediate associations between openness, conscientiousness, and agreeableness and affective well-being, *Journal of Happiness Studies*, 15(6), 1377-1388.

APPENDICES

Appendix 1. Written Informed Consent

WRITTEN INFORMED CONSENT

Written Informed Consent
Psychology Dept., Middlesex University, Town Hall, The Burroughs,
Hendon, London NW4 4BT

Title of study: Trait Emotional Intelligence: A Strategy for Managing Nurses' Affective Wellbeing at Work
Researcher: Chrysi Leliopoulou
Supervisor *(only for students)*: Dr Tracey Cockerton and Prof Michael Traynor

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.
I have been given contact details for the researcher in the information sheet.
I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.
I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.
I give my consent for the conversation session to be taped. Yes No
(Please indicate your response)

_____ _____

Print name Sign Name

date: _____

To the participant: All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The Middlesex Psychology Department's Ethics Committee have reviewed this proposal.

Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Health and Education Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

Appendix 2. Information Sheet

INFORMATION SHEET

Psychology Dept., Middlesex University, Town Hall, The Burroughs, Hendon, London NW4 4BT

Title: Trait Emotional Intelligence: A Strategy for Managing Nurses' Affective Wellbeing at Work

Dear Participant,

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

This research study aims to assess nurses' wellbeing at work. The attached self-report questionnaire contains questions about your emotional responses to work situations on a daily basis. Once you have completed the questionnaire, you may be asked to participate in a short interview/conversation session with Chrysi Leliopoulou. This interview/conversation session may be audio recorded with your permission.

Once you have completed this part, the researcher, Chrysi Leliopoulou, will give you a follow-up questionnaire in a stamped-addressed envelope to put in the post to her in 4-6 weeks after your interview/conversation session with Chrysi. Participants are reminded that their involvement is purely VOLUNTARY and on an ANONYMOUS basis as no identifying details are required when completing

questionnaires or in the interview/conversation session. Any information you give will be treated in the STRICTEST CONFIDENCE.

However, I would like to be able to contact you in 4-6 weeks' time, hence, if you can leave me a contact number and/or email address to contact you on (this will be stored separately from any other information you provide i.e., completed questionnaires, audio recorded conversations).

If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form; however, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

The Middlesex Psychology Department's Ethics Committee have reviewed and accepted this research. If you have any queries please do not hesitate to contact me either by phone on 07766 241248 or email chrysi1@mdx.ac.uk or Dr Tracey Cockerton (supervisor), Middlesex University at t.cockerton@mdx.ac.uk 020 8411 5464. Prof Michael Traynor (supervisor) Middlesex University at m.traynor@mdx.ac.uk 020 8411 2536.

Your help is much appreciated and thank you.

Chrysi Leliopoulou Date:

Appendix 3. The Questionnaire

Health and Education
Middlesex University
The Royal Free Campus
Pond Street, Hampstead
London NW3 2QG

Trait Emotional Intelligence:

A Strategy for Managing Nurses'

Affective Wellbeing at Work

Chrysi Leliopoulou

Dr Tracey Cockerton

Professor Michael Traynor

SECTION A: ABOUT YOU

1. Gender (please tick ☑) Male [ ] Female [ ]

2. Age: [ ] years

3. Ethnicity (please tick ☑)

White (British)	[ ]	Mixed White/Asian)	[ ]	Pakistani	[ ]
Irish	[ ]	Black (British)	[ ]	Bangladeshi	[ ]
White (other)	[ ]	Caribbean	[ ]	Asian (Other)	[ ]
Mixed (White/Black Caribbean)	[ ]	African	[ ]	Chinese	[ ]
Mixed (White/Black Caribbean)	[ ]	Black (Other)	[ ]	Other	[ ]
Mixed (White/Black African)	[ ]	Indian	[ ]		

4. Marital status (Please tick ☑)

Single	[ ]	Married	[ ]
Divorced	[ ]	Cohabiting	[ ]
Widowed	[ ]		

5. Number of Children (please tick ☑)

None [ ] How many: [ ]

How many are under 16 living with you? [ ]

6. Religion (please tick ☑)

Christian	[ ]	Muslim	[ ]	Hindu	[ ]
Atheist	[ ]	No religion	[ ]	Other	[ ]

SECTION B: WORK EXPERIENCE & EDUCATION

Work Experience: Please list all the jobs you have done starting from the most recent ones including job title and Band.

Job Title & Band	**Length of Time in Post**		**Full time**	**Part time**
	Years	**Months**		
			□	□
			□	□
			□	□
			□	□
			□	□

Education: Please list your diploma and/or degrees and qualifications including any specialist qualifications i.e. Clinical Nurse Specialist, Community Nurse and any other Degree you may hold.

EDUCATION

SECTION C: ABOUT YOUR HEALTH

General Health

We would like to know about your general well-being over the last few weeks. Please answer ALL the questions by placing a circle around the response that you think most nearly applies to you. Remember that we want to know about present and recent well-being. It is important that you try to answer ALL the questions

'In the past few weeks have you.....'

1	Been able to concentrate on what you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	Felt you are/were playing a useful part in things?	More so than usual	Same As usual	Less useful than usual	Much less useful
4	Felt capable of making decisions about things?	More so than usual	Same As usual	Less so than usual	Much less capable
5	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6	Felt you couldn't overcome your difficulties	Not at all	No more than usual	Less than usual	Much less than usual
7	Been able to enjoy your normal daily activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8	Been able to face up to your problems?	More so than usual	Same as usual	Less so than usual	Much less than usual
9	Been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
1	Been losing confidence in yourself	Not at all	No more than usual	Less than usual	Much less than usual

1	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
	Been feeling reasonably happy all things considered	More so than usual	About same as usual	Less so than usual	Much less than usual

General Health

This section asks questions related to how you feel and behave. Please circle a response that best describes your feelings.

	Almost Never	Quite Seldom	Quite Often	Almost Always
1. Do you like plenty of excitement and bustle around you?	1	2	3	4
2. Does your mood go up and down?	1	2	3	4
3. Are you rather lively?	1	2	3	4
4. Do you feel “just miserable” for no good reason?	1	2	3	4
5. Do you like mixing with other people?	1	2	3	4
6. When you get annoyed do you need someone friendly to talk to?	1	2	3	4
7. Would you call yourself happy go lucky?	1	2	3	4
8. Are you troubled about feelings of guilt?	1	2	3	4
9. Can you let yourself go and enjoy yourself a lot at a lively party?	1	2	3	4
10. Would you call yourself tense or “highly strung”?	1	2	3	4
11. Do you like practical jokes?	1	2	3	4
12. Do you suffer from sleeplessness?	1	2	3	4

Wellbeing

This section concerns your level of well-being at work over the last few weeks.

How much of the time has your job made you feel the following over the past few weeks?

Please circle your response for each item.

	Never	Occasionally	Some of the time	Much of the time	Most of the time	All of the time
1. Tense	1	2	3	4	5	6
2. Uneasy	1	2	3	4	5	6
3. Worried	1	2	3	4	5	6
4. Calm	1	2	3	4	5	6
5. Contented	1	2	3	4	5	6
6. Relaxed	1	2	3	4	5	6
7. Depressed	1	2	3	4	5	6
8. Gloomy	1	2	3	4	5	6
9. Miserable	1	2	3	4	5	6
10. Cheerful	1	2	3	4	5	6
11. Enthusiastic	1	2	3	4	5	6
12. Optimistic	1	2	3	4	5	6
13. Anxious	1	2	3	4	5	6
14. Comfortable	1	2	3	4	5	6
15. Motivated	1	2	3	4	5	6

Coping

This part is concerned with how you generally cope with problems at work. Please circle your response for each item, the way you generally handle situations at work.

	Never	Rarely	Sometimes	Often	Always
1. I try to change the situation to get what I want	1	2	3	4	5
2. I make an effort to change my expectations	1	2	3	4	5
3. I try to let off steam	1	2	3	4	5
4. I focus my efforts on changing the situation	1	2	3	4	5
5. I tell myself the problem was unimportant	1	2	3	4	5
6. I try to turn my attention away from the problem	1	2	3	4	5
7. I try to relieve my tension somehow	1	2	3	4	5
8. I work on changing the situation to get what I want	1	2	3	4	5
9. I try to adjust my expectations to meet the situation	1	2	3	4	5
10. I tell myself the problem wasn’t so serious after all	1	2	3	4	5
11. I try to get it off my chest	1	2	3	4	5
12. I try to adjust my own standards	1	2	3	4	5
13. I tell myself that the problem wasn’t such a big deal after all	1	2	3	4	5
14. I try to avoid thinking about the problem	1	2	3	4	5
15. I try to keep my mind off the problem	1	2	3	4	5

16. I eat more	1	2	3	4	5
17. I drink more alcohol	1	2	3	4	5
18. I smoke more than usual.	1	2	3	4	5

Section D: NURSING PRACTICE

Job Satisfaction

This section concerns your satisfaction with various aspects of your job. Please indicate how satisfied/dissatisfied you feel with each aspect of your present job. Please circle your response for each item.

Items	Extremely Dissatisfied----------→Extremely Satisfied					
1. The physical work conditions.	1	2	3	4	5	6
2. The freedom to choose your own method of working.	1	2	3	4	5	6
3. Your fellow workers.	1	2	3	4	5	6
4. The recognition you get for good work.	1	2	3	4	5	6
5. Your immediate boss.	1	2	3	4	5	6
6. The amount of responsibility you are given.	1	2	3	4	5	6
7. Your rate of pay.	1	2	3	4	5	6
8. The opportunity to use your abilities.	1	2	3	4	5	6
9. Relations between management and workers in your job.	1	2	3	4	5	6
10. Your chance of promotion.	1	2	3	4	5	6

11. The way you are managed.	1	2	3	4	5	6
12. The attention paid to the suggestions you make.	1	2	3	4	5	6
13. Your hours of work.	1	2	3	4	5	6
14. The amount of variety in your job.	1	2	3	4	5	6
15. Your job security.	1	2	3	4	5	6

Interaction with colleagues

This section is about your interaction between your superior and colleagues.

Please circle your response for each item.

How often:	Not at all	Once or twice	Three or four times	Several times	Most of the time	All of the time
1. have you been able just ‘to talk’ to someone	0	1	2	3	4	5
2. have you been able to give excess workload to someone else	0	1	2	3	4	5
3. were you aware that someone else had spotted any emotional problems of yours	0	1	2	3	4	5
4. have you been able to give work to someone else, because you did not feel it was in your area of expertise	0	1	2	3	4	5
5. have you been able to ‘let off steam’	0	1	2	3	4	5

6. have people at work been too interested in their own ambitions, rather than help you with your work	0	1	2	3	4	5
7. have you had sympathy from people at work when you have made a mistake	0	1	2	3	4	5
8. have people at work helped you get the information to do your work	0	1	2	3	4	5
9. have your colleagues and/or superiors made your job more difficult by careless work	0	1	2	3	4	5
10. have you been able to confide in someone at work	0	1	2	3	4	5
11. have you been let down by your colleagues and /or superiors	0	1	2	3	4	5
12. have you been told by your colleagues and/or superiors that they have confidence in your work	0	1	2	3	4	5
13. have you been told by your colleagues and/or superiors that they value your ideas concerning work	0	1	2	3	4	5

Control at Work.

Please circle one response that indicates how strongly you agree or disagree with each statement.

1. I have little control over the things that happen to me.	Strongly Agree	Agree	Disagree	Strongly Disagree
2. There is really no way I can solve some the problems that I have.	Strongly Agree	Agree	Disagree	Strongly Disagree
3. There is little I can do to change many of the important things in my life.	Strongly Agree	Agree	Disagree	Strongly Disagree
4. I often feel helpless in dealing with the problems of life.	Strongly Agree	Agree	Disagree	Strongly Disagree
5. Sometimes I feel that I'm being "pushed around" in life.	Strongly Agree	Agree	Disagree	Strongly Disagree
6. What happens to me in the future mostly depends on me.	Strongly Agree	Agree	Disagree	Strongly Disagree
7. I can do just about anything I really set my mind to do.	Strongly Agree	Agree	Disagree	Strongly Disagree

Emotional Intelligence at Work

Instructions: Please answer each statement below by putting a circle around the number that best reflects your degree of agreement or disagreement with that statement. Do not think too long about the exact meaning of the statements. Work quickly and try to answer as accurately as possible. There are no right or wrong answers. There are seven possible responses to each statement ranging from "Completely Disagree" (number 1) to "Completely Agree" (number 7).

1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . .6 7
Completely Disagree Completely Agree

1. Expressing my emotions with words is not a problem for me.	1	2	3	4	5	6	7
2. I often find it difficult to see things from another person's viewpoint.	1	2	3	4	5	6	7
3. On the whole, I'm a highly motivated person.	1	2	3	4	5	6	7
4. I usually find it difficult to regulate my emotions.	1	2	3	4	5	6	7
5. I generally don't find life enjoyable.	1	2	3	4	5	6	7
6. I can deal effectively with people.	1	2	3	4	5	6	7
7. I tend to change my mind frequently.							

1 2 3 4 5 6 7

8. Many times, I can’t figure out what emotion I'm feeling.

1 2 3 4 5 6 7

9. I feel that I have a number of good qualities.

1 2 3 4 5 6 7

10. I often find it difficult to stand up for my rights.

1 2 3 4 5 6 7

11. I’m usually able to influence the way other people feel.

1 2 3 4 5 6 7

12. On the whole, I have a gloomy perspective on most things.

1 2 3 4 5 6 7

13. Those close to me often complain that I don’t treat them right.

1 2 3 4 5 6 7

14. I often find it difficult to adjust my life according to the circumstances.

1 2 3 4 5 6 7

15. On the whole, I’m able to deal with stress.

1 2 3 4 5 6 7

16. I often find it difficult to show my affection to those close to me.

1 2 3 4 5 6 7

17. I’m normally able to “get into someone’s shoes” and experience their emotions.

1 2 3 4 5 6 7

18. I normally find it difficult to keep myself motivated.

1 2 3 4 5 6 7

19. I'm usually able to find ways to control my emotions when I want to.

1 2 3 4 5 6 7

20. On the whole, I'm pleased with my life.

1 2 3 4 5 6 7

21. I would describe myself as a good negotiator.

1 2 3 4 5 6 7

22. I tend to get involved in things I later wish I could get out of.

1 2 3 4 5 6 7

23. I often pause and think about my feelings.

1 2 3 4 5 6 7

24. I believe I'm full of personal strengths.

1 2 3 4 5 6 7

25. I tend to back down even if I know I'm right.

1 2 3 4 5 6 7

26. I don't seem to have any power at all over other people's feelings.

1 2 3 4 5 6 7

27. I generally believe that things will work out fine in my life.

	1	2	3	4	5	6	7
28. I find it difficult to bond well even with those close to me.							
	1	2	3	4	5	6	7
29. Generally, I'm able to adapt to new environments.							
	1	2	3	4	5	6	7
30. Others admire me for being relaxed.							

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE.

Appendix 4. The interview guide* for the exploratory study

1. Can you give me an example of a recent event that you found particularly difficult or challenging for you? What happened? What did you do? How did you feel at the time? How did you feel afterwards? Did you discuss this with anyone?
2. Can you describe how your role in this has affected your life at present?
3. Can you tell me about a time when you felt the best about yourself? When was it? How did you see yourself? What was it like? Was this related to your work?
4. Can you tell me about a time when you felt the worst about yourself? When was it? How did you see yourself? What was it like? Was this related to your work? How did you cope?
5. How do you describe yourself as a person? What do you like about yourself? What do you dislike?
6. What image would you use to describe yourself?
7. Has the way that you see yourself changed over time? In what ways? How do you feel about these change
8. What would be for you a positive development? How can you situation improve? Can you imagine what it would feel like?
9. How do you think others see you? Partner, family friends, work colleagues
10. How do you see yourself in the future?

*This interview guide was generated from the work of Shinebourne P. and Smith J.A. (2009) Alcohol and the self: an interpretative phenomenological analysis of the experience of addiction and its impact on the sense of self and identity, *Addiction Research & Theory,* 17(2) pp152-167.

Appendix 5. Discussion group agenda

The purpose of this focus group is to explore nurses' views on quality of work life and wellbeing of nurses.

Thank you for agreeing to participate in a focus group at RF at… in room … this Thursday the …. Please note that all information will be treated in the strictest confidence and will remain anonymous

Discussion group agenda:

What is it like to be working as a nurse?
Which aspects of your job you consider stressful?
Can you give me a couple of examples?
How much control over these situations do you feel you have?
Do you feel you receive adequate support from work?
Are you happy with your work right now?
Are you happy with your life outside of work right now?
Have you considered a change of direction in your career?

Appendix 6. Transcript example of a discussion group

Interviewer: Welcome and thank you for taking part in this discussion and for helping me out with this research… The first thing I would like to ask you is: What do you think it is like to be working as a nurse today?

Interviewee 1: Very different now to what it was… when I first started training, the last ten years has changed out of sight …. in some ways better… our opinions are more respected, erm, doctors are more aware of the wealth of knowledge that nurses have, so that's nice. However, there are less of us, the resources are more pushed now… When I started nursing, nursing was a job for life, it was unthinkable that there would never be hospitals … always a job there. And now with the changes that have gone on so recently you just think ok…it's not a job for life… although for me is not so much in an effect but for the new nurses coming through now…

Interviewer: yes… that's very, very interesting, but in terms of your job, your everyday job are there any other aspects of your job that have changed?

Interviewee 1: there is more paperwork … The risk of legislation is always there now…documentation, documentation, documentation, but that's on top of the physical care we have always provided you find though now the trained nurses, the more senior` staff get roped into paperwork instead of providing physical care which is what we want to do instead of filling bits of paper ….assessment, slip trips, nutrition, pressure areas, discharge planning…

Interviewer: How much of your time you think you spend on paper work out of your daily sort of workload?

Interviewee 1: 50% It's a hell of a lot, and organising social services, MDTs, you know, getting all these people together just takes up tons of your time probably it takes up possibly more than 50% of your time.

Interviewer: Okay, how about other aspects of the job? For example, the teaching aspect of the job? Do you have more students to look after? Or is it the same as before?

Interviewee 1: We've got more students and they're are harder work...and they just don't…

Interviewee 2: There are more difficult with different backgrounds and cultures we didn't have that in the past…sometimes just to get put off the language barriers are difficult... there are talking about the patient and they say he, he, he… they don't even understand what is the Surname and what is

their Christian name so these cultural differences are very, very... they can cause problems and sometimes you can't understand what they are saying…

Interviewee 1: Sometimes it can cause conflict with the patient as well, because the patients think that someone is being rude when they are called by their surnames…and the elderly can't understand them.

Interviewer: So a number of issues there and you have to deal with this and you've got a situation...

Interviewee 1: And trying to explain either side is pretty much a no win situation because whoever you talk to is going to be offended the student because you are commenting on their accent or the fact their English language although it's far better than my grasp of their language would be, unfortunately because of the situation we are in..

Interviewee 2: And that's not just the students it's the team you are working with as well, and their work ethics can be very different and that's very difficult then when you are actually following on from someone and taking over from them and attitudes and work attitudes.

Interviewee 1: I find that less noticeable because I have been in it and watching it change all the way through whereas you've just come in and looking at it with...

Interviewer: Can you give me an example?

Interviewee 2: Well, I had a nurse who had a patient who was dying, this trained nurse with a patient who was dying and needed regular turning and she turns round and says "I'm not going to break my back because she is dying so I'm not going to turn her" that's an awful attitude to have.

Interviewer: Of course it is.

Interviewee 2: It's disgusting. But you're up against that and they seem to spend more of their day trying to find out how to get out of doing a job rather than just getting on to do the job…

Interviewer: Right. How do you explain this attitude?

Interviewee 1: It's really difficult because you don't know…

Interviewee 2: You can't say anything because then they say you have been racist so you don't say anything so you feel frustrated because things are happening…

Interviewee 1: But that...

Interviewee 2: If the…and don't say much because you never know when the cards are going to be turned on you…

Interviewer: True

Interviewee 2: And the issue is not going to be about what they are doing, but about you are saying something

Interviewer: Yes..

Interviewee 2: That's what I find very difficult and am always stepping around…

Interviewer: Do you agree? Do you find the same?

Interviewee 1: Not to that extreme, I am experiencing…if anyone on our ward had said something like that I'd rather…. dealt with that or…

Interviewee 2: It's more health care assistants are experiencing that rather than staff nurses… And you've got a patient asking for a commode "It's all right you got the pad just wee in the pad"

Interviewee 1: What is your ward manger doing?

Interviewee 2: She is so laid back as a ward manager she will take on anybody…

Interviewee 1: The trouble is you can't be laid back as the ward manager. You got to be in some situation…

Interviewee 2: The junior sister will say something but she is never backed up…

Interviewee 1: So then say to her if you don't deal with it we will go over your head to the lead nurse.

Interviewee 2: It's often you came on to work and say "Thank god you are on" or even have the palliative care team saying "Are you looking after so and so? Yes, good, good"

Interviewer: Right, okay...

Interviewee 1: but even if you say so that doesn't actually mean that things are getting done…

Interviewer: Why though?

Interviewee: 1: Because we've had issues with members of staff over the years and they have been confronted and there have been long talks, ong sort of "look, this what is been said, what have you got to say? What are you going to do to change your practice?" and it was a big defence. "This was a racist attack"

Interviewee 1: Yea… and I can get away with saying but actually that isn't racist attack this is t…

Interviewer: Yeah. It is a real shame when people are so defensive. It's a shame.

Interviewee 1: It's a nonsense I am not looking at the colour of somebody's skin if they are not doing what they are supposed to be doing, or if they are treating somebody badly, it doesn't matter whether they are scarlet and pink with polka dots, they shouldn't be doing that...

Interviewee 2: We get it the other way around…there more sort of, on our ward we have got these Nigerian sisters and there are so many of them that now they have actually stopped us so that they can't ring home of the weekend, because that's what they used to do.

Interviewee 1: That was a recognised problem in this hospital as well …because mmm…they stopped a lot of the outside calls.

Interviewee 2: You can't bring mobiles on the ward now without going through your manager.

Interviewer: So they used to call outside to…to…

Interviewee 2: Yea. Home. Nigeria. They all sat there Saturday and Sunday and just phoned home.

Interviewee 1: That was a problem throughout the whole of the NHS.

Interviewer: can you explain please?

Interviewee 2: It wasn't a five minute chat it was an hour long chat

Interviewer: This is not very good isn't it??

Interviewee 1: It's lack of respect for this country as well and it's a lack of respect for other cultures and that goes all the way round. You know, white, blacks, scarlet and pink, Asian, whatever. Having a lack of understanding and respect for other cultures and like the person who didn't even respect the woman who was dying enough to turn her. That's just unforgiveable. Which is absolutely…

Interviewee 2: That's what I found more frustrating in the job is that side of it. Not actually dealing with…

Interviewee 2: If it was my family I'd have got that nurse out reported her to the NMC.

Interviewee 1: But then what a lot of them are saying now is that everyone is responsible for their own practice, aren't they? So we are individual practitioner so that means to say you can pass the buck? But then you are walking to a patient whose confused or got dementia say "Do you want to wash?" and they'll say "no" every day of the week but you still wash her. But their excuse is "the patient refused".

Interviewee 2: No, they still have a duty of care.

Interviewee 1: But that…

Interviewer: Right

Interviewee 1: It's fair enough if the patient refuses aggressively and it's just….

Interviewee 2: But then they will use any excuse not to do a day's work. My attitude is you are there from when you start to when you finish and you are there to work.

Interviewer: Do you say there are a lot of these nurses on the wards?

Interviewee 2: Not always. Quite often… It's just... It's certainly on my ward it's a small minority of people who have… an attitude problem, should we say and I have to say I don't particularly experience it because they are not like that when I am around… probably because I wouldn't tolerate it and I wouldn't actually let them get away with that so… I'm not backwards in coming forwards. But, I know a lot of wards it's this you know…

Interviewer: so how do you manage?

Interviewee 2: Oh well, you know when you follow certain people you will be working a lot more than other people.

Interviewee 1: Well, that's why 12 hour shifts in some ways are better because you've got the whole day to watch somebody and there are no excuses not to.

Interviewer: so what's like to be working as a nurse today?

Interviewee 2: What's it like to be working as a nurse? It can be very frustrating. Not enough hours in the day. You get to do all the bits you have to do, practical and the paper work not necessarily in that order. But the time we use to have for talking to people is cutting to. That… that's what suffered, with the increasing paper work

Interviewee 1: You are ingrained into you, isn't it? If you haven't written it down you haven't done it.

Interviewer: Ok, yes…

Interviewee 2: If you have a conversation, if you don't record it, it doesn't count or you are open to complaint or disciplinary if there is a problem in the future.

Interviewer: Right, ok, so what does that mean for nurses? Ticking boxes?

Interviewee 1: No, if it was ticking boxes, it would be a lot quicker but it's writing it's just constant writing it's like essay writing everyday isn't it?

Interviewee 2: Mmm

Interviewer: Oh dear, okay. Right.

Interviewee 1: You get some nurses who are far better at doing the paper work than actually looking after the patients.

Interviewer: Okay, but you know, a nurse's job should be looking after the patient isn't it?

Interviewee 2: Yeah

Interviewer: So, what you are saying to me is that the job we had in mind has changed an awful lot…

Interviewee 2: Significantly

Interviewer: Yes

Interviewee 1: But some people just write about it don't actually do the work. "Oh yes, this patient had a wash, and this patient had this and this"

Interviewee 2: It does but it's not that person who has written it who's done it because …well half the time you can't or you reliant on other people to help you out…which the burden falls quite often on the healthcare assistants and I know where I work ours HCAs are great, well, most of them are, and we are very lucky…

Interviewee 1: We not very good at looking after each other though are we?

Interviewee 2: No

Interviewee 1: If I have a bank nurse or anybody who is working with me I always introduce myself, I always introduce them to all the patients and always thanks at them at the end of the shift.

Interviewee 2: Absolutely, it's courtesy

Interviewee 1: A lot of people don't. Common courtesy seems to have gone out of the window for nurses. Which is sad.

Interviewer: It is, yes.

Interviewee 1: We are supposed to be in a caring profession…

Interviewee 2: But we don't care about ourselves enough. Although I mean I can moan but I am lucky in comparison. I have got a very good ward manager, very good leaders, who happen to be friends of mine as well so I've known them for a very long time. But our senior nurse is very proactive in getting a team that not only works well but does all the bit, but if there is any friction or any problems she will deal with it immediately. There is no sitting festering, she get things sorted there and then that's it. Over and done with and then move on. We and try to get conflict resolution sorted straight away and we try and keep an environment where people, if you have an issue come and say it doesn't matter who you have that issue with could be the lead nurse, it could be me it can be any of the other sisters or the other staff. If there is a problem, say it, get it out, air it, and try to sort it there and then.

Interviewer: So the ward culture is different to perhaps your ward and it sound to me that it's really down to the person who leads that ward

Interviewee 2: It is, yeah

Interviewee 1: Our ward manager, senior manager, she is fantastic, she is so laid back but she won't deal with any conflict or sort anything else

Interviewer: She may be lovely but she is not doing her job.

Interviewee 1: No, so therefore the ones who get together, they hate any change anything that happens

Interviewee 2: Unfortunately the NHS is all about changes at the moment

Interviewee 1: Everything is an issue. And it gets tiresome

Interviewee 2: It's not perfect but we try and because we had huge amount of problems, because in the last five years we moved from a satellite unit into the R---- F--- amalgamated with another team and we had massive conflict and we had to learn. This hasn't been an easy process, it's been a very, very painful process over a relatively short space of time where we had to learn to get on and communicate and work as a team otherwise all was going to go horribly, horribly wrong and so when the team came first together, oh, god, it was… I used to go home and cry every night and I think most of the staff did.

Interviewer: What was the most difficult thing there? What was the problem?

Interviewee 2: It was the fact that it was... We knew… We worked in a specialist ITU and we come over… our unit was shut down and we moved up here and to join the HIV services here. We were basically… people assumed because we come from a small unit that we were unskilled which was untrue but ignorance is bless and they made this assumptions and it got to the point we even... the patients were being asked about us in the outpatients clinics if we were providing decent care. If we were looking after them properly…and patients would coming back and telling us this… and yeah it was… I mean it was massive…

Interviewer: It was quite bad then..

Interviewee 2: And it from the stroke management down and not from my lead nurse but from the HIV services, from their doctors and consultants, all the way through on that side and it was very, very unpleasant. We had a team building day that just ended nearly being a massacre it was just... I mean I will never ever, ever go on a team building day again.

Interviewer: what do you mean?

Interviewee 2: In my life. I will never go back again….it was the hardest thing in the world for me not to burst into tears and am not exactly a teary person… I am not exactly a shrinking violet. But the hardest thing I had to do was sit there for that afternoon and watch crucify my manager at the time,

who's now retired, that was it for her. But, it was so upset at how vicious and bloody-minded and ignorant these people were. And I went to the pub and I got absolutely pissed as a newt… and my boss came down to see me because we were all meeting anyway and "How are you? How was it?" And I just burst into tears and couldn't stop crying and she's known me for fifteen years and never ever seen me crying and the first thing she did was to send me to a counsellor because she was so worried about me. And I was like, "That's it, I'm off" and that was one day.

Interviewer: Yes, yeah

Interviewee 1: I think the ward manager should pick up on it on an individual's personal agenda what they are actually bringing to work if they've got problems but they don't do they?

Interviewee 2: No..

Interviewee 1: I think they should because if they did they'll pick up more things than what they do

Interviewer: Unless they feel they don't have the authority.

Interviewee 1: I think that things have changed so quickly.

Interviewee 2: …occy health and that sort of things. It's a house of cards. Because I was going to a counsellor and I had an awful time going through a divorce. My husband is an alcoholic, and I divorced him. My son's got problems since 21 with drugs and drink and I was under so much stress but I still used to go to work and put it all behind me, but occasionally it just get me and then I started having chest pains and I ignored them for so long, but it's all psychosomatic. They frightened me because I had an ECG and abnormal changes and thought "oh, my God". And my dad had had a bypass when he was my age, I'm like "oh"… and then failed an exercise tolerance test! If I'd had someone to talk to it wouldn't have got so out of hand.

Interviewer: I see..

Interviewee 2: It was very difficult. It was embarrassing and you don't want to admit you have got a problem but I was having phone calls at work from the police and all sorts and I am thinking I can't deal with this.

Interviewer: Yes, and sometimes it's hard when you are in a situation to go and ask for help

Interviewee 1: Exactly

Interviewee 1: Oh, we've have been lucky. Most of our people who have had problems, we've picked up. Even the ones who had sort of little niggling ones that have turned out to be major health disasters

Interviewer: Right

Interviewee 2: I always think I will always try to be there for someone else. It's like, one of the sisters is going away for six weeks and I was off and I rang her up just to say, "well, bon voyage, have a lovely time" and she goes, "oh, you are so sweet to ring up and remember that I am going on a holiday" and I thought little things make a difference

Interviewer: Oh yeah, absolutely. Exactly

Interviewee 2: I don't feel let down but I felt embarrassed that it got so out of hand that I didn't realise

Interviewee 2: Sometimes, I'll go into work and I have been up all night with Jack or whatever, problems with the police or whatever, and I used to get at the end of my tether but now I am really… I needed someone to actually to do it for me I think.

Interviewee 1: To recognise…

Interviewee 2: To recognise it for me. Because I kept on ignoring it and all I was getting was this chest pains.. I still didn't feel… I made an appointment to go to occupational health and see a counsellor but then I cancelled it. I couldn't go through with it. Because I felt that they would judge me as a nurse...

Interviewee 1: No, they don't

Interviewer: No, they don't but I probably would have felt the same way.

Interviewee 1: The only reason I went was because my boss had made the appointment otherwise.

Interviewer: How did she know?

Interviewee 1: Yeah, well it was a bit difficult to miss!

Interviewer: As nurses I suppose we want to show to people that we are strong, that we can cope, and we can look after other people.

Interviewee 1: But you can't absorb emotions for evermore, you have to have an outlet and if you don't have… find an outlet that works for you then you're gonna pop… you're gonna get chest pains or your hair's going to fall out or…

Interviewee 2: Well, I had days when I went into work and I had the patients going on and I said f** off… Shut up. You don't know what's going on. You don't know the half of it!

Interviewer: I understand..

Interviewee 1: My flare up, that flash point was that was that team building day... that sounds like a dirty word, honest to God, it was just so... I mean I'd been having problems at home for quite a long time before that and that day was just the flash point for it…

Interviewer: Sometimes it can't be helped.

Interviewee 2: Sometimes you can see it with some of the other nurses I say 'You're not having a good day today are you? Don't worry, leave it, go home, you're allowed not to have a good day now and again and but it's not the end of the world and it's not a crime".

Interviewee 1: Somebody recognising that you've got problems it goes miles down the line to helping someone. "Oh, good, I'm not going mad."

Interviewee 2: It's remembering tiny little personal details about someone and just asking about it. Just shows that you're interested. If somebody asks you. A minor detail like 'How's your grandson, is he alright?' Tiny details.

Interviewer: Interesting. How about patients? Do they get to talk to you easily?

Interviewee 2: You get some patients who will talk to you about everything and nothing. And they spend the whole time skirting around whatever it is... that little…well, big usually

Interviewer: How do you manage them?

Interviewee 1: They don't tend to spell out to you how they're feeling, because they don't know themselves

Interviewee 2: 'Fine' isn't actually a feeling or an emotion, you say you feel fine. I don't know what it stands for, but it means you don't feel fine!

Interviewee 1: I am still here I still haven't killed anyone yet. No one's killed me yet. I don't do killing patients. Death with dignity, yes. Absolutely, I'm a very, very strong advocate of that because I can't bear the thought of somebody being on their own.

Interviewee 2: That's one of my big bug bears. Everybody deserves a dignified death. Absolutely.

Interviewer: I mean, it's, gosh, this is the biggest thing.

Interviewee 2: Still a lot of people still don't understand that they're or even acknowledge that they're gonna die. It's said that the only two things you'll ever do in life is pay your taxes and die.

Interviewee 1: Nope three things: Birth, Death and Income tax.

Interviewer: Right, okay well guys thank you very much that was really good, that was really good what we've said so far. So I think from what we said in the last 5-10 minutes, we also covered a second question "what aspects of your job do you find most demanding or stressfull?"

Interviewee 1: Students. Finding time to fill in their bl***y forms. It's the time to sit down and talk to them. If it's little niggly things then yes, "look why are you always coming in half an hour late?" "No you can't go down to the bl***y library, this is your clinical time, not your library time you do that in your own time".

Interviewee 2: But if they had ten minutes at the end of each shift for some reflection…

Interviewee 1: No, but they're off out the door at ten past 8 whilst you're still doing hand over

Interviewee 2: Not just the students, but everybody It would be at that time to get things aired, to sort stuff out and it should be part of your job. It should be, but no one ever does it because no one has time.

Interviewer: The time factor is a big issue, isn't it?

Interviewee 1: Nine times out of ten I'm late leaving the ward.

Interviewee 2: I go in early on my late shift, so that I can sort everything out.

Interviewee 1: I leave at half six in the morning and that's early enough! I can't face getting up any earlier. And I don't get home until half ten, if I get out on time… so.

Interviewer: We talked about when your start, how about the shift work? Does that bother you?

Interviewee 3: I have done all of the shifts over the years, still going, and for me, now, I have got children. From a finance point of view I can't afford to do anything really apart from long days because apart from the fact it gives me more time at home with my children, more quality time rather than "oh I'm just going off to work now", or "I've just come back from work, quick have some food and go to bed" I get whole days to spend with them. It's also from a financial point of view it's less time with child minders.
It works for me. And where I am now, I'm at a point now where I can't afford to go up and onwards, because up and onwards is a 9-5 job but not the pay to go with it.
I would actually take quite a dramatic pay cut, even if I went up two grades now if I did 9-5. And I earn more than the 7 bands. It's outrageous really.

Interviewer: How about you?

Interviewee 3: I came to myself when I realised what the pay was and worked it out, and I thought "no, I think I'll stay where I am" I'll have more time with my family.

Interviewee 1: They're my priority. And no matter how much I like my job, that's my job. They're my family. They're my flesh and blood and I have more of a responsibility to them than to here. Three or Four days a week works for me, whereas other people, people who live closer maybe it's maybe better, but personally I hated ten day stretches.

Interviewee 2: I think we're going onto long days, but mind you our long days before were just too long, we were doing 7 until 9.30.

Interviewee 1: No, that's too long. It's illegal, you can't work more than 12.5 hours.

Interviewee 2: But they didn't pay us the 12.5

Interviewee 1: It's still illegal.

Interviewee 2: They didn't pay us the 12.5 even though you were there for 14…

Interviewee 3: It's a long day

Interviewer 4: It's something to do with civil rights isn't it?

Interviewee 1: We were only allowed do two in a row. Two in a row?! You'd have been carried out of there on a stretcher.

Interviewee 2: I once did 16 hours and that was killer.

Interviewee 1: I don't do any of that stuff anyway when I get home. It's half past ten at night. I go in and I sort of just manage to make myself a drink, water, cold drink, slug it, bed. To get up at half past five.

Interviewer: how about your areas?

Interviewee 4: what I don't like with our shifts is that some people do long days, some people don't. It's only the odd couple do long days. We start at 7, and we half an hour break in the morning so you can go for break from half past nine until ten, you're supposed to finish at three, but you don't finish until four, but you don't have a lunch break.

Interviewee 1: I think you shifts are appalling.

Interviewee 2: The doctors, and all the occy health officials, everybody goes for lunch except for us. I get home at four o'clock sometimes and sometimes you don't have the time to do your paperwork during the day so you end up after the shift has finished doing your paperwork and by the time you get home you feel as though your throat has been cut!
It's horrible. And you're so thirsty because they've stopped us drinking water on the wards.

Interviewer: Why?

Interviewee 2: Because you're not allowed to drink while you're on the ward at the nurse's station it's… you're not allowed to have drinks, and when it's over 100 and the air con has stopped and we've had two nurses who've had to have stents put in when they've had kidney problems.
And it's pathetic isn't it. It's saying 'do no drink at the nurses station'. Alright, I can see their point when they say don't have take-away pizzas and things like that. But water? No. Are you allowed to drink water?

Interviewee 1: Oh God yes, we do!

Interviewee 2: We do, but if the matrons come round. That's pathetic isn't it?

Interviewee 3: It's a human right, and it's an infringement of a human right for God's sake!

Interviewee 2: Say if you started at 9 o'clock in the morning until half past nine, that's the last time you've had something to eat or a hot drink it's 4 o'clock in the afternoon.

Interviewee 2: That's if you get a break. The odd day you don't get a break. Sometimes you'd have a late break at 1 o' clock.

Interviewee 4: Years ago I did agency in your hospital and it was like that, it's horrendous.

Interviewee 3: I have to say I am not that dedicated to nursing. I insist on breaks. Unless there is an emergency which is totally different kettle of fish, no matter how busy it is go on your breaks. Hand it over to the other people in your team…

Interviewee 1: I've learnt though, you won't get anything at our place. You have to look after number one first.

Interviewee 2: You have to prioritise as well. If you are doing audits or things like that, they're taking you away from patient care and you have to be selfish for learning and everything.

Interviewee 1: Audits, benchmarking. That's the only way it gets done. Slips, trips, all of that.

Interviewee 4: Even appraisals, they're meant to happen yearly aren't they?

Interviewer: One of you talked about demanding students, can you give me an example please?

Interviewee 1: A student who didn't know what paracetamol was. Well, her mentor came and… I noticed her but I didn't really know her because I'd just come back from annual leave and she was quite inappropriate. It was a bit like the playground, rather than the ward. And she was a 3rd year student, and the nurse came up to me and said 'please would you mind talking to the student because a) her attitude sucks and you're better at being sensitive…and also because I'm just really concerned about her knowledge'. I was like 'fine, okay then' so I started talking to her about medications so I said 'okay let's start with the essentials that everybody knows, what's paracetamol for?' Didn't have a clue. Started giggling, and thought it was just funny that she didn't know. And I was livid, and I was livid at the fact that she had so little respect for the fact that she didn't know.

Interviewee 2: So she's been going on the ward for three years and didn't bother to ask anyone…

Interviewee 1: I said have you never been to a chemist in your life? I said if you have a headache what do you take? I'm sorry, but you are very stupid, and I said and you are very unsafe, and we actually… I tore a strip off her. I said that this is not a game. In six months-time you are going to be responsible for people's lives. You're not passing the buck to anyone else. The responsibility stops with your qualification. I said, and how would you feel if someone was looking after your mother or your grandmother and came up to you... or you went up to the nurse and asked 'what are her drugs for' and you went (fake laughter noises) and she was like 'oh, oh, oh' and it hadn't even occurred to

her that this is actually real, and real life and she had no concept at all and she's not the only one, there are others, and although she was extreme. We refused to sign her PAT tool.
We wouldn't sign it. And we said 'right, you have to do this, this, this and this to be able to get your PAT tool, and we will not sign it until you have done that. You come back and you show us evidence and you prove to us that you have learned these things. And she never came back. She never came back to get her PAT tool signed. We phoned up the University who didn't know what we were talking about so we phoned them a few more times, and then we got our lecturer practitioner involved in it. And we never heard any feedback.
We never got any feedback back from the University but my colleague actually looked her name up on the student role, and she was no longer on it, so we presume that she left. But we don't know. Even though we contacted the University saying this girl is useless. And we've had a few who we've not signed the PAT tool and they've never come back to us, we've told the University and there's no feedback to us.

Interviewee 4: It's terrifying to think that if she falls through the cracks now and then can write a couple of good essays, then she's going to be qualified.

Interviewee 1: I don't want her looking after me and mine thank you very much. But she would have gone back to having a couple of assessments on the ward.

Interviewee 1: They need to have more clinical practice on the wards. Because the staff on the wards haven't got the time to do it.

Interviewee 1: and then they'll go hide and you haven't got time to go looking for them. It's like one student disappeared. One of our students disappeared for three hours the other day. And we asked "'where the bl**** hell were you?' I tore a strip off her as well, I said 'look, ultimately I'm in charge, I'm responsible if there was a fire and I don't know where you are… Have you got no idea, no concept of responsibility? You can't just wander on and off at will. You need to tell us and if you're disappearing for hours on end, you have no excuse. You're supposed to be here.

Interviewee 2: It does make you wonder why they're there though, don't they, because they ignore the patients. This is the reason why…

Interviewee 1: This is a lesser spotted pa.. this thing here? Patient.

Interviewee 3: If they talk to them, they will tell you more about their illness and more than you can learn in a book. Absolutely.

Interviewer: why do you think may be?

Interviewee 3: Some of them it's obvious, it's money, but they're not interested in people. They don't find out anything about that, you know, what they did, how many children they've got, where they live. I'm nosy. I want their whole life history! Family tree going back to the 17th century! One option... it's spill the beans! But it is, some of them are so fascinating hearing their stories from what they were doing in the war and this and all the rest of it, and it makes you appreciate as well what they've gone through to get to where they are… what put them in that bed

Interviewee 1: They actually become people not patients

Interviewee 2: I learnt my people skills as a student talking to patients.

Interviewee 4: Maybe they should do an essay on that. They're doing computer skills, but not on patient skills. All they do is go in to the library and find as many references as they can possibly get

Interviewee 6: They should get, have to do one on a life history of a patient. They have to sit down with a patient

Interviewee 1: Yes. But there is an ethical, there's confidentiality issues.

Interviewee 2: Well, then they should ask the patient first. Ask the patient first.

Interviewee 4: Even when they're admitting a patient they're doing it from the notes they don't go and talk to the patient.

Interviewer: They do that?

Interviewee 2: Oh yes, I tell them go over there, there's the patient, you don't need all this gumph here.

Interviewee 1: The only thing that is useful from the notes is the name and address and next of kin and the doctor, and then check with the patient.

Interviewee 2: But they seem to copy everything out of the medical notes or the nursing notes.
Interviewee 1: They copy all the ADLs from the notes. They copy out medical terms, they haven't got a clue what they mean.

Interviewees: yeah.. (nodding all in agreement)

Interviewee 2: Do they get counselled half way through their training, so 'look, do you really want to do this?'

Interviewer: They meet with their personal tutors regularly but they are not asked directly that question...

Interviewee 2: Try them six months down the line, try them a year down the line, "'what are you getting out of this?" "Do you really want to still carry this on?" You need to get in there and open the gates.

Interviewer: Thank you for this, what other aspects of your job can be challenging?

Interviewee 6: One thing with the medical teams as well, when they don't treat you with respect and not realising that you've got some expertise. And they're just dismissive. We had a team, and luckily they've gone now, the consultant she's terrible and it comes from her but this team... they had a patient admitted with a cast over the lung and he came in earlier and they found out he was the main carer for his wife, he had to stay in over Christmas, and I came in, I had been away for a few days and they said, 'oh, he's going to go down for a scan because they're going to do a pleural tap on him' And I took one look and I thought 'my god, if they take him off the ward, he's going to arrest'. And the… one of the daughters had come over from Ireland but there was another three children that hadn't been called in. The wife was very anxious, she was lovely she was, they took one look at him and said 'he's not safe to go downstairs'. But they insisted on taking him down there without the crash trolley. So we got down there then they brought him back up and they said 'no, he's too ill for a scan, for a tap'. This time he's still full of numbness, the consultant hadn't spoken to the family, he'd been in for about four or five weeks, I took one look at him and like, he could die at any minute and the day before they'd actually told her and she'd decided to call in the rest of the children, so then the consultant…He was written up for some more morphine he was in pain, so I gave him only 2.5mg, so I gave him some, the consultant came about an hour and a half late took all the family off the ward had a sit down and had a chat with them, they stopped chain stoking, so then, before that I said to the reg. I said he's getting really distressed. Please can I give him some more ….. she goes 'he is not terminal, what do you think you're doing' She didn't even get off her arse and go and see the patient. And I was so cross. And I said, 'I think you should go and have a look at this patient instead of sitting there.' And she just looked at me and she was so dismissive. And I went back in there, and I said 'well, I'm going to go and get the relatives now to come and sit with him while he dies, because he's dying now. Not tomorrow, next week or next month, when it suits you, now. They're in there being told that he's got cancer, he's probably going to be terminal and he's dying now.' So I went and got the relatives out, and he died five minutes later.

Interviewee 1: What did they say? The doctors I mean.

Interviewee 6: Oh, they just looked at me.

Interviewee 6: Exactly. They seem to think they know best. I mean, how long have you been qualified? What's that, 5 minutes? Maybe a nurse with twenty-years of experience might actually have something useful to…

Interviewee 2: Well, I had this patient who was just about to arrest and the house officer's been on the ward and I've said "he's a bit sicker… if I were you….." And she came over and asked "where's the pain?' Do you think he can tell you where the pain is?"

Interviewee 3: That's when your stress levels shoot up. I had similar thing a few weeks back. I had a patient… I came on duty he had a GCS in his boots and he was very, very not well. And I got his Reg up eventually after making the mistake of relying on somebody else to do it and they didn't. And the Reg arrived. And I said 'Thank God, you can come up and see your man. How's he doing?' And she was like 'What man? Where?' And she hadn't been told about him. He had a GCS of about five and I was like 'Oh, for Christ sake just get over there and do something, make a decision, we need a decision' and I went over and I was about to catheterise him and I was thinking that 'I don't really got time to do this'. So I went over and got the resus box, we have these black boxes with these ET tubes round the back with stuff in, went and got the black box. It's was like… 'erm, doctor', she was sitting at the desk saying 'who am I going to call' and I said 'it's a resus. Are you going to make a decision? You've got about two minutes to make it. He's either for resus or not, you need to call it now, otherwise he's going to start being resussed'. His sats dropping. His breaths are going down His blood pressure is going down. I'm thinking 'och' And it was about five minutes later and he was just there or thereabouts sats were on the mid 70s, and I had to go on the rebreather and all the rest of it and she made a decision. ITU. So then we had four hours of ITU, intubating him on the ward because he was that flat. That we were having to manually bag him. And we had to get a portable ventilator because we thought he had temporal artoritis and they thought he'd had a subdural and he's full active or full active up till. 'Oh God, will you get somebody who will make a decision. So we end up… she was the reg.

Interviewer: how did you manage the situation?

Interviewee 3: well it was like "you need to make this call", and "you need to make this decision and you need to make it now" and in the end it was like because she couldn't make the decision to do a DNR she got the… she put it out to ITU and ITU because we really didn't really know what was going on with him even though he was like 900 years old and all the rest of it he… he… they decided to go for it. So we treated him I think he was intubated on the ward for three hours and while we were waiting for a CT scan his stats are still dropping, his pulse is dropping, his blood pressure is going up and I'm thinking 'oh God'. Crash trolley proper is on the ward next door and I'm thinking… I'm looking at him and I'm looking at them and I'm thinking 'should I just go and get the crash trolley now'. What a good idea. And I just got it back to the end of the bed and he went. Even already intubated, already… everything he had outlines in, we'd been putting lines in every orifice

whilst we were waiting, and he crashed anyway. And we brought him back, about 4 or 5 times but his son was the end of the bed crying. And it was in a bay with a man in a bed next to him who had just been diagnosed with cancer. And it was awful. It was absolutely the worst place, because it was so noisy.

Interviewee 3: I think that's well difficult as well The most stressful situation that I've been in is because of the doctors.

Interviewee 1: It's always the doctors.

Interviewee 2: We had a patient who she came in with a sore hip and then all of a sudden she had a spinal cord compression. But they didn't know that at the time, they said we'd paralysed her. They said by immobilising her we'd paralysed her. Who was on duty? Who was it? What have you done? And then….Then they found out she had cord compression, I mean they just. They were actually pointing at us saying 'what have you done to this patient?' And then they…

Interviewer: okay..

Interviewee 2: They said we'd paralysed her and that we'd been rolling her and all sorts, it was awful, and they never even sent her to radiotherapy. And she was only 60 and she's come in with a sore hip. They didn't even know where the primary was. Before they'd finished with her within three months she was dead. Awful.

Interviewee 1: Exactly. Or even a plain spine neck tray would have shown the compression. So you would have had a collapse of whatever.

Interviewee 2 The worst thing was that straight away all the fingers went out. And we all of you nurses had to write statements and we want to know what was going on here.

Interviewee 1: That's outrageous

Interviewee 2: But that was the consultant. I actually told the registrar on the ward round to f ***off. In the middle of the ward.

Interviewer: what happened?

Interviewee 2: He went off sick with stress because he had one of the other reg, she left him there. She cried. He was absolutely horrendous. I've never met someone horrible in my life and we've still got him.

Interviewee 1: We temporarily… we've just changed specialities so hopefully I'll never meet this creature again… but most of our consultants are quite well trained on our ward, they respect the nurse they have to. They have to communicate with us, they have to tell us what's going on and they're really good. And we had one, a couple of consultants from one specific speciality and they were the rudest, most ignorant, arrogant so and so's. I met one of them once and they were… 'my patient's critically ill, she's got skin failure.' No, she's got flare up of her psoriasis because she's grieving because her husband's died. And you didn't actually help her and suggest that maybe bereavement counselling would help her deal with her grief and therefore reduce the severity of her psoriasis. Because you're such a single minded….

Interviewee 2: We had a registrar and her bleep went on the ward and she's stormed, she'd answer the bleep. And whoever bleeped her must have walked away from the phone. She was waiting there and she was like "look nurse, if you bleep me you do not walk away from the phone, you stay". It was a doctor. "No, it's me so and so, doctor so and so" ,"Oh that's all right then dear". Two faced cow.

Interviewee 1: The patient would have been dead

Interviewee 1: It's very difficult, I mean sometimes when things… I mean I was on the other day and a young chap was diabetic. And they had been messing around... he'd only recently been diagnosed and they'd been messing around with his insulins and the night before he'd vomited a couple of times but then he was fine so then they … I was on late shift. In the morning., he'd had three pluses for key tones but he was not excessively high but quite high, but then I took over and his BMs were fine they were within normal limits, and he wasn't vomiting, he was eating, he felt fine he went downstairs with his parents, and then overnight he started vomiting again and then in the morning he was really quite ill he was going into keptaocidosis, and the SHO came up and he went ballistic. And he did an IR1 form because the day before he's had three pluses at key tones and nothing had been done. I said, but I looked after him and his BMs were fine. Usually his BMs are under 15 then you check the urine, he was fine. He had no vomiting, he was eating and drinking he didn't feel unwell. So I said, alright then I could have tested his urine I said but that... if I'd called the on call team officer up over the weekend and said he's got three they wouldn't have done anything. So I said, but you've done an IR1 form you put this… "this is meant to end in chronology ward, how has this happened?" I thought 'fine'

Interviewee 2: But some of them would rather chat with each other, they don't actually do their work. And then if you ask them more than once they get ratty. So then they leave it and then the on call team have to pick it up and they don't nag because this should have been done.

Interviewee 5: When the doctors put you in that position don't they, with the social workers, the OTs, the physios. They put you there as a first line of defence.

Interviewee 2: It's supposed to be working as a team, but that doesn't seem to be happening yet.

Interviewee 4: It's still very difficult to have a family and do nursing. Most nurses as soon as they have children can't combine the two. There wasn't the childcare then. And I thought it would have changed a lot but it hasn't. Not for shift works.

Interviewee 1: They've got a lovely nursery there. How many nurses have actually got their children in that, who work full time? None, because it opens 9-5. Or 9-4. Or 8-4. It's no good for shift work. They kept banging on about this nursery, why don't you put your children in the nursery. No. Why would I cart them halfway across London to put them in a nursery that doesn't even open… it's all for the office workers, or you can only go in it as a nurse if you work part time and that's if you can get a place. Even though they've increased the number of places it's… there's still a waiting list, or there was…

Interviewee 2: They tick the boxes to say they're doing it but they're not really doing it. They've increased the amount of child places but are they unusable for nurses? No. Not unless you go part time. And how many wards are going to be able to take part time nurses?

Interviewer: Well, thank you very much for your time and effort. I really, really appreciate that and apologies for taking a bit longer than planned but it's been fascinating talking to you all. Thank you again.
THE END

Appendix 7. Transcript example of a discussion group

Interviewer: Hello, my name is Chrysi Leliopoulou, as I explained earlier this group discussion and we're all in agreement, will be tape recorded. So what is it like to be working as a nurse in the NHS?

All: Mmm hmm. Yeah.

Interviewee 2: Well, it can be quite stressful and it's frustrating because erm… a lot of dependence on computers and if the computer goes down then basically you know… all of your work is back logged up.

Interviewer: Okay.

Interviewee 2: You have insufficient staff to do what is the proper standard. You're expected to take on increasing amounts of GP work.

Interviewer: Okay

Interviewee 2: For what they're getting paid for. Erm. And at the same time it can be very, very satisfying.

Interviewer: Yes, can you please tell me more?

Interviewee 2: That you're in patient's homes and looking after them on a one to one basis and their time and your time is protected.

Interviewee 3: Erm, erm, I find that erm, I think that things are moving so fast that especially secondary care pushing patients out, you know without perhaps sometimes er, spending, you know, taking time to make sure that the discharge is proper. But it all fails, you know, insufficient resources to give, you know, to organise the care, and they end up back in hospital because, you know, it wasn't properly sorted out and this idea that everything must be out, out, out in the community.

Interviewer: Can you please tell me more on this?

Interviewee 3: you know… that every day in hospital counts and erm… sometimes a discharge is not as good because if they'd actually spent a bit more time organising it would have, you know, it wouldn't have had the er, the problems.

Interviewer: Why do you think that they do that though? I'm sorry, but why do you think that…

Interviewee 3: Because there's this culture now that everything should be straight out of hospital.

Interviewer: Right, okay. Do the rest of you feel the same?

Interviewee 4: When I go into hospitals, and I think that hospital nurses are busier. They are used to taking on board…

Interviewee 3: I'm not saying it's their fault

Interviewee 4: I think you have to see it both ways, discharge planning is a nightmare so for the ward nurses to start doing because they are so busy doing all the day to day tasks like IVs and so on…

Interviewee 3: They're turn over so fast that people don't… you know… the problems and the issues don't get resolved and… and the nurses on the wards are very stressed and busy that… that they can only cope with what they're doing and you know.

Interviewer: okay

Interviewee 4: There's a lot of pressure from above to get people…out of hospital

Interviewee 3: To get people out. Yeah. That's the trouble.

Interviewee 4: sometimes people are discharged maybe too quickly before the services are ready to accept them.

Interviewee 1: We also have to look at the fact that so many hospital beds have been decreased, there's a big push in the past ten years and hospital beds have halved to what they were ten years ago.

Interviewer: Yes..

Interviewee 1: So you can't pull a bed on a social admission for a month.

Interviewee 2: As we have to do perhaps, sometimes, as well.

Interviewee 5: Going back to the social admission I don't work, sort of, like out in the community, I work in the walk in centre so if I see a little old lady that's got a fracture, who's at home, but

because she's got a break in her hand so she can't cook. So, then I have to think of the care that she's going to get at home and in the old days I could ring up social services, get meals on wheels over there and delivered, but now the service is withdrawn which is… really horrible because then I have to go up to the community nurses, knowing that they are really pushed anyway, but to have something so simple as meals on wheels that we cannot go out, and we have to admit her because social services checked that she did not fall under the right criteria to get meals on wheels.

Interviewer: Alright, okay…

Interviewee 3: The continuing care. I've got a lady at the moment that I've had to send back in because the continuing care is now so difficult to get there's… the lady herself is not being very realistic either and says she can cope. She comes out and then she gets really ill, you know she's terminally ill, and there's no care, so I have to send her in and keep saying to them…

Interviewer: How does that make you feel, though because you're…

Interviewee 3: Terrible, it makes you feel inadequate in a lot of ways.

Interviewer: Right

Interviewee 3: But it's not your fault because the services and the way they're… it's not fair any more.

Interviewee 4: I think there's an unrealistic portrayal of what care's available. Like all the advertising about people being able to die at home and you'll be able to see a nurse every day all those things, when in reality it doesn't happen. There's not the funding really for it.

Interviewee 1: The disadvantages that community nurses have in relation to hospital nurses is that hospital nurses can say their beds are full. District nurses have to admit and admit and admit ad infinitum with insufficient staff which then make it very dangerous.

Interviewer: I understand...

Interviewee 1: And you can't go to the next ward to get the nurse. It's paying Peter… robbing Peter to pay Paul!

Interviewee 5: …Change beds to move more people into hospital

(Laughter)

Interviewee 1: Exactly. Staff…Even if they're full … most of the time they're really short by one nurse as well.

Interviewee 3: I'm short by four. That is a significant difference. I've got four nurses short, so that's over 70 hours.

Interviewee 1: Why are you always short?

Interviewee 3: Because of promotion or because the jobs…

Interviewee 4: We've been short for ages…

Interviewee 1: Yeah, but to me if the funding's there for a position, you apply, you advertise and you fill it.

Interviewee 3: And I sat… I've done two lots of ad… erm… interviewing now and you sit there and people are confirmed

Interviewee 2: And they don't turn up

Interviewee 3: and I sat there for a whole day. Two people turned up for Heathcare Assistants role out of ten so the whole day was ruined. Erm… and the Band Five jobs I think we had four out of twelve. Erm.

(Confusion of voices)

Interviewee 1: But I think that's a recruitment issue isn't it? Yeah the recruitment issue not the job.

Interviewee 2: …ITU. And I'm 14 Band Sixes short and four Band Fives for an Intensive Care Unit. So …. Trying to fill them. Be in my shoes and try and be 14 Band Sixes!

Interviewer: So, okay, why is it difficult to get people in to do the jobs?

Interviewee 1: Because it's hard work!

Interviewer: Right okay, so have you actually had nurses who came into a job did for example a year or two and then went?

Interviewee 1: Not even that!

Interviewer: Right. Okay.

Interviewee 6: I think partly bureaucracy because…

Interviewee 3: It takes longer to recruit then it does…

Interviewer: One at a time please

Interviewee 6: I think it's more bureaucracy because I mean …some people who are…in terms of the requirements, they don't meet the requirements, I mean I've had seen one of them has not taken the mentorship course, that's right, some people are qualified to do… but they cannot be shortlisted because they haven't done the mentorship course. But their work is very good and they have qualified clinically. But we've had that experience before. Sometimes… I think in the past because you rely more on the status of how you see the nurse works in the ward more than how you see… Now there are so many rules and regulations that you have to follow, and that includes… that's why we have this problem as well of how do we get the District Nurses to do this meal for meal because when we ring the phone they're not very helpful. I ring the phone and you get a response in about… it's seems to be improving because before the response would be after two hours. Then you would find out it's some other woman and I will let the nurses know in the morning and then we'll ring you back.

Interviewee 3: Excuse me, the District Nurses, it's not the responsibility for District Nurses to do meals on wheels.

Interviewee 6: No, no, no, what about… (real confusion as it seems to kick off a bit!!)

Interviewer: Okay, can I just… Right… I think what… you're trying to say, if I understand here, is that the team that you have behind you, or the people you're working with to sort out a problem, in this case meals on wheels aren't always available.

Interviewee 1: This is just one example. If it's a leg fracture then it's care for getting up the stairs and so on.

Interviewee 3: So social services in other words. You know.

Interviewee 1: So if social services doesn't take it on board, it goes to you guys. I mean, we can't just let them go… they get admitted to beds as well. I've had to admit them to beds because there's been no other option. But they are not ill. They've just broken a bone that needs time to heal.

Interviewer: Right.

Interviewee 2: The danger of getting patients admitted which are not ill is that they can get hospital an nfection in the hospital.

Interviewee 4: Absolutely

Interviewer: Yes, yes. And I'm sure that the patient wouldn't like that either. ..

Interviewee 1: That's costing a lot of money.

Interviewer: Okay, so are you telling me that working with other people can be difficult? Or perhaps…

Interviewee 3: An organisation

Interviewer: An organisation. Right. And what is the main difficulty? Is communication?

Interviewee 3: Social Services.

Interviewer: Right, but in what way? Yes?

Interviewee 1: They like passing the buck between the agencies.

Interviewer: Passing the buck?

Interviewee 1: Nobody wants to know and they keep saying ring this, ring this, ring this.

Interviewer: Okay.

Interviewee 1: You're on the ward and a lot of your time is trying to call this one that they suggest and you're just going around in circles.

Interviewer: Thank you. What do you mean by passing the buck? Do you think it is lack of responsibility?

Interviewee 1: Authority

Interviewer: Can you please explain this for me?

Interviewee 1: yes, as the girls were saying here I agree with that, there's a lack of staffing for a start. So, it's very difficult for all these multi agencies to supply to your demand or to meet your demand because they are also constricted and restricted by changes in government policy which is cut out the budgets. So every single area under that umbrella has suffering. And I think as a result every single one of them are frustrated. Not just the…

Interviewer: So would you say that the patient suffers from this situation?

Interviewee 1: Absolutely.

Interviewee 3: Absolutely.

Interviewer: How does that make you feel though? Do you think about all these things that happen at work when you go back home?

Interviewee 2: Try not to.

Interviewer: Okay but do you find yourself thinking about work at home?

Interviewee 4: Sometimes, yeah.

Interviewee 2: Sometimes, when you've been dealing with a particularly difficult situation.

Interviewer: Can you give me an example?

Interviewee 4: If you're managing a case load of patients and it's really busy and there are things that you haven't managed to do then sometimes you go home and you think "'oh, I should have done that" and you wake up and you know…

Interviewer: Yes, yeah. .

Interviewee 2: I dream about it sometimes.

(Laughter)

Interviewer: Do you? Dream about it?!

Interviewee 2: Yeah

Interviewer: Like, a good dream or…

Interviewee 2: If I'm subconsciously worried about a patient then they'll be in my dreams, they'll always appear in my dreams.

Interviewer: Okay, alright, that's interesting. Thank you. Yes, yeah. So…

Interviewee 1: I think also nurses feel they're not as represented as other areas, for instance they're top heavy in management and whereas the people doing the nursing care and the acute care are run off their feet therefore, I mean, like one thing… there are always risks of making mistakes or drug errors or whatever. And because they are so short staffed everyone is kind of depending on everyone else. And that's at ward level probably, but also out in the community. Um. A lot of nurses work in isolation because… because of the shortage of staff.

Interviewer: is that what might happen also in the community?

Interviewee 2: Well, I suppose that, yeah, they've always got the doctor.

Interviewee 1: Er, Practice Nurses for instance, there's someone at the…

Interviewer: How is it working on your own in the community, how does that feel?

Interviewee 3: You have to make decisions.

Interviewer: Right. Tell me a little bit more about this.

Interviewee 3: Well, you know, if you come across sick patient you have to decide whether you going to, you know, send them in or keep them at home erm… what.. you know… whether you should… you know… you know… keep them at home and try and get the support or… or send them in.

Interviewer: Right, so what happens if you can't make the decision? Who do you go to ask for help?

Interviewee 2: But some of that is to do with GPs that will work in the community. I mean you can have some very good GPs who are very responsive and then you can ring them up and say "Look, you…", you can interrupt their surgery and they'll make time for you… erm, and you can say "look, this is the situation what do you want me to do "'. And they will tell you. There are other doctors that you can't get hold of, they're like mercury.

(Laughter)

Interviewer: So other than the GP, who else can you call upon for help and advice?

Interviewee 2: Well, we have a line manager.

Interviewer: Right.

Interviewee 2: And if you're not satisfied with the line manager we have the general manager for the Trust then you can go on up.

Interviewer: How does it feel when you don't get the right support?

Interviewee 3: Very stressful. There was a patient who needed erm, daily intensifying injections. The… she was in a residential home, the residential home had promised to get the drug but they hadn't, er, so that on Saturday morning there was no intensifier to give. Erm. I had to find out from the… well, the nurse told me in feedback that she couldn't give it. I had to find out from erm… pharm doc who was the on call doctor who would give the general prescription. Got the prescription, and had to go for an hour, to drive up and get it bring it back to the chemist. No chemist had it in stock.

Interviewer: Okay.

Interviewee 3: So I then asked pharm doc, erm, I said "Look, how important is this injection if it's missed for a day", no it had to be given that day. So I then had to think about my options. Erm. I didn't have much option of support. The pharm doc suggested that I phoned every chemist in the area which I didn't have time for. So I then went to the… I went straight to the general manager because nobody was on call. I should have gone to the... gone to line manager on call. Erm, and we had to actually get that patient into hospital by ambulance to have the injection come home with a supply for Sunday.

Interviewer: Right

Interviewee 1: Couldn't you have gone to the hospital to get it?

Interviewee 3: Who?

Interviewee 1: Could you or somebody else have gotten it from the hospital? Or the ward?

(Confusion of answers)

Interviewee 3: They wouldn't prescribe it unless they had been seen and all that protocol went through.

Interviewee 2: Yeah, all the bureaucracy.

Interviewer: How about the rest of you? Do you agree with the comments?

Interviewee 1: I think now that the pressure is on to keep people out of hospital so erm… nurses like community specialists have to be… have to make a decision and they have to be prepared to defend that decision whether they've kept someone out of hospital or admitted them because they may admit them and the GP might say because they're saving money or, you know, they've been directed to have so many admissions and so many referrals every day then that nurse is in a situation where he or she has to be able to defend strongly their decision to admit that… that patient.

Interviewer: Okay. Can I quickly change the focus of the discussion? How much autonomy do you think you can exercise in your jobs?
Interviewee 2: I think most nurses would say they work along guidelines because if we do not do that then direct repercussions come back on yourself and you stand alone, but if you work within the guideline of whatever your Trust is that should cover you so I… I… I think that is how we nurses do work.

Interviewer: Yes

Interviewee 3: If you worked within the guideline, you just start quoting the guideline then everybody backs off.

Interviewee 2: That is how we do our safe practice and also to cover ourselves when we… Or another issue is careless liability because if you don't work within the guidelines… yeah... yeah… so whatever position you make with people is the guidelines.

Interviewer: Okay. Okay, that's a question to everybody then. So do you feel you actually exercise your professional judgement?

Interviewee 2: Oh absolutely. Yes.

Interviewer: And do you have autonomy?

Interviewee 2: Yes. We have that autonomy but you still…But you're still held within, as X says, you're still bound by those professional guidelines.

Interviewer: Do you find that okay?

Interviewee 2: Yeah. Not necessarily. Er. I mean guidelines are there to guide you but they don't need to be the end of all.

Interviewer: yes, they're only guidelines.

Interviewee 2: Yeah, only guidelines so if you do decide to over-ride those guidelines you have to have a really good reason or some backing, you know, that can… evidence to show why you've not followed the guidelines.

Interviewer: Right

Interviewee 2: But guidelines are only there. But at the end of the day we are all very vulnerable. I'm in a job that patients do feel ill???, so even though we know that perhaps we could go out of the guidelines we don't tend to.

Interviewer: Yes

Interviewee 2: We are limited by that.

Interviewer: what do you mean?
Interviewee 5: We have adequately autonomy in working but the thing is we get managers that are not nurses. And that is something…

Interviewee 3: Hmmm. That's right.

Interviewee 5: Okay, I don't want to be quoted but during a meeting we were told running is like a business. That's the kind of pressure, I think in the community as well. You can make your own decisions but if your manager is pressured by this business idea of the run… of how to run the hospital you end up arguing (laughs). Something like that. I think it happens in the community as well.

Interviewee 3: Oh yes.

Interviewee 5: Yeah, because I mean during our meetings, we have this staff meeting every Friday they try to ask us why we're late and especially the four hour targets. Or whatever you call it. And sometimes the… this manager will tell me "Why hasn't the patient been warded because they've been asking, is the patient sick? Is the patient needs care? Does the patient… general… is there…

are repairs? And that will make the bed manager … All of these politics. We call it politics. But I think it's because they're not nurses and, like, before we had a manger that is a nurse and now we're told because they will be more efficient you're going to have someone who is not a nurse so that we can see from a business tactical view. That was years ago.

Interviewer: Yes

Interviewee 5: And I think our previous manager was one of the high… you know her, she's from the one in Islington. That used be our A… our manager. But after her all the managers were non nurses so…

Interviewer: Okay

Interviewee 5: You end up talking like they caught… I know they've got their job to do, they don't know anything about clinical but they ask you about things about patient care while in fact they're not nurses.

Interviewer: Right, okay.

Interviewee 5: They're just taking it on their own…

Interviewee 2: Let's say… we have got targets. The government have set the targets for our matrons or whatever. The only thing is they forget that what these targets are about is not machines. These are people.

Interviewer: Yes.

Interviewee 2: You can't say "I can't assess a patient in twenty minutes." It might be that patient is xxx and un-cooperative. Some patients come in particularly unwell, they can't help it if the patient needs to be calmed down, that will take an extra ten or twenty minutes. And they're discharging somebody, a business way of saying as well, and think the old saying. We as bed managers are trying to check why isn't the patient going yet. But like, we always say the day before we should check tablets, District Nurses, they should be informed 24 hours, they've got… this is all ideal. But of course a shortage of nurses and too much work is put upon them because we have taken so many tasks on board like cannulation… and all these extra tasks…

(General agreement)

To taking bloods, taking to the phlebotomy usually off the ward as well that is how we, say, ten twenty minutes off your time.

Interviewer: Absolutely.

Interviewee 2: So then you have your paperwork. Yes. To do all the proper things you need to for a discharge to work takes a lot. It's all a systems failure really.

Interviewee 3: Well, you're putting more and more jobs, more and more tasks on the nurse…

Interviewee 2: And less people.

Interviewee 3: Well, no extra resources. You know. You're doing a junior doctor's role…

Interviewer: Well, that's very interesting and thank you.

Interviewee 3: You know, I think most of us suffer… I don't… you know, the idea that patient is the first. And what would, how would you defend this in court? Are you always take it, you know, that's what you're sort of rule stick is because if you're standing up in court you want to have a damn good argument.

Interviewee 2: But at the end of the day it's still your licence.

Interviewer: Yes.

Interviewee 2: Before even, if the managers are saying discharge, just do whatever, you just make sure your back is covered at all times. I don't think nurses are ever truly autonomous because they always look at the guidelines, they always, regards the job, so I mean, when they say you're autonomous to a degree, but not truly in the full sense of the word in that we can work totally independent of anyone.

Interviewer: Yes. Yes.

Interviewee 2: Truly to… Doctors are truly autonomous but I don't think nurses are.

Interviewer: Even at your level?

Interviewee 2: Even at my level.

Interviewee 2: Because they wouldn't like… with my guideline and if I want to over-ride it I would seek a second opinion. I wouldn't do it on my own back. I think… I should do this… but you know, you need to get that other opinion as well and that is what…

Interviewer: To be sure?

Interviewee 2: To cover myself.

(End of tape) (restarted counter)

Interviewer: How important is that to a nurse you recon?

Interviewee 2: very and that's because we're risking so much litigation. I mean the medical profession has always been very…

Interviewer: Yes.

Interviewee 2: Powerful.

Interviewee 3: How many mistakes do doctors make and they never get any sanction or…or…

Interviewee 2: No never sanction

Interviewer: why do you think that?

Interviewee 2: Nurses don't have that at all.

Interviewee 1: Nurses stab each other in the back.

Interviewer: why do you say that?

Interviewee 5: I think peoples doesn't want to listen.

Interviewer: but why not?

Interviewee 2: It's interesting you say that… I think it's the union. I don't think… like I'm with the RCN, I don't think they're powerful enough for autonomous practitioners. We should be actually belonging to something like medical prevention, like the doctors are, because there are episodes where, you know … forward and you've gone to the union and the union haven't backed you up but if you were a doctor they're there with you, they stand in the dock…

Interviewer: Yes, they'll pay for the lawyers…

Interviewee 2: Yeah, the lawyers, they'll be in the discussion with your manager.

Interviewer: Yes.

Interviewee 2: So I…. pardon?

Interviewee 3: I've seen that a lot with nursing unions. They're not there.

Interviewee 2: That's what I'm saying, sometimes a faultless practitioner, I think our union do not match our autonomy. Whereas with the doctors if something was to go wrong er, they have the representative on day itself with the management whereas if something goes wrong it's you and the management having a discussion about it. And you'll want your union, and the union don't do much, you know.

Interviewer: Right, okay.

Interviewee 6: Well, they try and get… an appointment takes ages, you know, so, so you main insurance is very, very limited and that makes us more cautious, more wary.

Interviewee 3: We're employees though and the doctors are… sub-contractors aren't they? Yeah?

Interviewee 1: It was, no, it's just to say that essentially we'll be called, we're sort of lowly if you said something that …. it's like. If something that, whistle blowing they would call it. And here we'd actually call the erm, RCN, or whatever and he would ask what should we do in this situation? It's kind of more like they would code it, if you're going to whistle blow in the NHS Trust usually, it's not seen as something that, they would help you take on board the...some new thing that what is being done in practice at the moment is not safe.

Interviewer: Okay.

Interviewee 1: For the nursing.

Interviewer: So you think they label quickly? Do the rest agree?

Interviewee 3: Oh, yeah. I think if you go against the… what in nursing really, the new buzz word or the new thing… if you start speaking out against it you don't understand, you're old fashioned.

Interviewer: Okay, right. Who do you think would say that?

Interviewee 3: Your managers and that. So you have to tow the line.

Interviewer: Right. Okay.

Interviewee 3: If you don't tow the line you're old fashioned. Or you're… you don't understand.

Interviewee 2: In the NHS for the patients to complain is okay if a nurse was out of line. They would comment, you would move them.

Interviewer: Yes

Interviewee 2: Whatever, but the patient can be rude as hell to you. But it works because they are ill and you (the nurse) should understand.

Interviewer: Okay.

Interviewee 2: They give you hell at work, isn't it? And where are you supposed to go?

Interviewer: So you keep quiet about it?

Interviewee 5: Some people do this, the customer is always right.

Interviewee 5: Well it follows that ideal. It's all about bullying, aggression and all that stuff, and you are told that… it's like you're, like you're part of a business.

Interviewee 1: They don't practice what they preach.

Interviewee 5: The customer's always right. Because we focus that question at why… if we are being abused why can't we shout back?

Interviewee 3: There should be a zero policy on that kind of thing.

Interviewee 5: Yeah, there is a new one that they call customer care support. Where… I'm not too aware of it because it's still in planning stages.

Interviewee 3: What about zero tolerance?

Interviewee 5: They're meant to implement it by January, in the hospitals.

Interviewee 1: And your line manager won't support you, is that what you're saying?

Interviewee 5: The only way… I don't know the details yet because we have so many things to discuss.

Interviewee 3: Makes us sound like Marks and Spencers, doesn't it?

Interviewee 1: If you had an issue about anything…

Interviewee 5: Yeah, the thing is everything… you are not allowed to physically pipe back isn't it?

Interviewee 2: I think that's why it's hard to recruit people at the moment. Because most people are short of nurses and finding good long term nurses are really hard to actually get into the profession.

Interviewer: Because if you're good an conscientious you will burn out...

(Sounds of agreement.

Erm. Well, you know. Is that…

Interviewee 3: Also, we put up with a lot of these things that nurses go without breaks, they stay late and other professionals wouldn't do that, you won't get a secretary working through their coffee break.

Interviewer: So why do nurses do these things though?

Interviewee 3: Because we're conscientious.

Interviewer: is there anything else nurses are not expected to do as it goes against what they represent in the NHS?

Interviewee 5: It's like people… patients can be sick but it's hard to believe that nurses can go sick as well. What you've heard… when you heard that some whiles recruiting nurses for a long time, you think what's wrong with them?

Interviewer: Right.

Interviewee 5: Did they catch that from a patient? Did the patient come in sick, what's wrong with you?

Interviewer: I'm sorry, you wanted to say something?

Interviewee 2: Just thinking that we're painting a really bad picture of nursing and it's obviously something that making us stay in nursing.

Interviewer: That is true and thank you for highlighting this issue here. So what is it that keeps you going?

Interviewee 2: It's rewarding and… I think sometimes it's quite a privilege to have been the one person that helped the patient get better.

Interviewer: what else?

Interviewee 1: it may be that you can't do anything else, I'm too old now!

Interviewee 1: But there's always… Burn out. That is the danger of what we're doing. We're over working, we're at risk… we're risking our health. We're risking to burn out. And then our profession with… we've… we've lost it.

Interviewer: Yes. Yeah.

Interviewee 5: Maybe wages might be an idea. Because I mean, yesterday or the other day they were telling me that the forces, the ones in the… they were getting about 32% increase, and we only get 1.5 increase. We're… with all the work in the world, they're all sitting on their bums in the force. According to the media.

Interviewee 1: Well, staff rule and we do nothing about it. It's all very powerful.

Interviewer: why is that you recon? What are we doing wrongly as a profession?

Interviewee 3: I don't mean to be sexist but I think it's because it's a majority of women and we're not good at…

Interviewer: No, you're not sexist.

Interviewee 3: If there were more men in nursing, I think there would be.. there would be more changes.

Interviewer: You think that might be the reason? Do you think nursing is appealing to men?

Interviewee 3: I suppose. I don't know. When I think of who I trained with ten years ago I would say that the men in my course are in much more senior positions than the women. Maybe it's something to do with lifestyle, less commitments in the family life…

Interviewee 2: I was just going to say that as nurses we are lacking… involving the political side of NHS and nursing, women tend to be less interested in politics…

Interviewee 3: We talk about it.

Interviewer: Yes

Interviewee 2: But we don't like to get involved actively or politically.

(Sounds of agreement)

Exhibition making… er….you know…erm. Being vocal about our rights we… we tend to talk about these things in a small group and we don't take it up in the public arena. That's…that's what's lacking. Again, this is because we don't feel powerful in the job, in the status so…

Interviewer: Right

Interviewee 2: People don't always feel ready to speak up..

Interviewer: Okay, that's very interesting. Thank you.

Interviewer 3: We tell each other. Because of the … report, we tell each other.

Interviewee 2: *Indecipherable*

Interviewee 3: Even if they don't like the person or they (doctors) know that that person's in the wrong, they will support the profession as a whole, whereas with nurses you really don't get that, you end up you being the individual one.

Interviewer: Right.

Interviewee 3: Whereas in our the profession as a whole isn't supported.

Interviewer: Okay.

Interviewee 2: So you choose to stay passive and, you know…You don't take part in political leaning.

Interviewee 1: I…I….I find that female nurse managers very competitive and very unkind to the other and old women.

Interviewee 2: Yes, yes.

Interviewee 1: I mean I've had babies, I've had to go on maternity leave and things like that. The managers who is a woman doesn't sympathise, doesn't empathise, doesn't understand. "She's gone off to have another baby". I mean she's here, she was a baby you know I mean that is the whole thing. And… and when they become the manager you know, everything changes, and… and you don't have that support from them. And sometimes if you are a bit more vocal or want to take the public arena, trouble maker you are. Militant trouble maker. You get that stigma.

Interviewer: Yes.

Interviewee 1: Oh, she's very militant, she's a trouble maker. And… and women are very unkind to other women. And we… and we are the majority of the people there.

Interviewer: why do you think that's happening with women in senior positions?

Interviewee 1: I don't think you can point at just that issue. There would be like, some of the managers are young and not had children, and once they've had their children they can understand, but that doesn't help the people who were there.

Interviewer: Right, okay.

Interviewee 1: You know? And when the managers are not kind to them because they've gone on and the baby, then they sort of, oh yeah the shoes are reversed and others were unpleasant so….

Interviewee 2: I…I'm a manager as such, and I have lots of people off having babies. And I have chosen not to have children. What sympathy would you like me to give you? What support would you like me to give you? You're doing what women kind have done for millions of years and ask the world to not be…

Interviewee 1: Oh, no, no I'm not saying you as a manager.

Interviewee 2: No, but I'm asking you what would you like me…

Interviewee 1: Sometimes you want more friendly hours and that's a big issue. You have to battle for it…

Interviewee 2: But that's a Trust... do you know what I mean?

Interviewee 1: Yes, yes It's a policy, you are quoting the policy

Interviewee 2: You know it's much better now-a-days.

Interviewee 1: Yes it is. I mean my children are grown up, I had to go through all that really, yeah.

Interviewee 2: Yeah, you didn't have any of those options.

Interviewee 1: No.

Interviewee 2: But now-a-days there is. There is care issues...

Interviewee 1: You could even have a demotion because you didn't want to work full-time. I mean the skills were the same…

Interviewee 2: But the jobs are protected now.

Interviewee 1: The skills was the same, but…

Interviewee 2: You know the NHS has moved on.

Interviewee 3: That's… that's a positive.

Interviewer: Okay that's right. Yes. Okay. Yes.

Interviewee: 6: This is the human psychology, isn't it? If you work in an environment that you're not being supported at all, feel unsupported, then you…

Interviewee 3: Put politely you don't want to support them do you?

Interviewee 6: You don't want to, yes. This is it. Because you haven't learned what a supporting team working is all about. So of course this culture continues.

Interviewee 3: It's draconian all this. When you get to her level you're draconian to your…

Interviewee 6: And that's happening in nursing culture somehow. You know because being a… what's the word…

Interviewee 3: Draconian

Interviewee 6: Superior… errrr, you know being.

Interviewee 3: Hierarchical

Interviewee 6: Yeah, being part of a hierarchy, so you feel as part of the infrastructure.

Interviewer: Right, yes.

Interviewee 6: And this takes a lack of power, a lack of status on you. And then you have a bit of a promotion, if you're management level you become part of this.

Interviewee 3: They forget what it's like. If you join the club up there.

Interviewer: Sorry, one at a time please.

Interviewee 6: No, I just said that this is a complex situation somehow, it's linked to status, local power make us nurses get a hunch?, and then we become a danger to ourselves… Am I too far-fetched?

(silence, some nodding in agreement)

Interviewer: Thank you for such an honest contribution to the discussion from all of you here.

Interviewee 1: I think that the biggest change is probably professional in that we are taking on a lot of doctor's roles. Not being recognised for it as well. Not being paid in terms of money, money wise. You're doing in fact practically three quarter of a doctor's job. I mean, we're all trying to help the doctor, we're all on this course trying to be mini doctors.

(Sounds of agreement)

Interviewee 2: But we love it don't we?

Interviewee 1: We do love it, but we… yes yeah.

Interviewee 2: But we don't get the status that goes with it.

Interviewee 1: But professionally it has changed a lot.

Interviewer: Thank you.

Interviewee 6: …because you can do an OSCE if you're working on the ward actually looking after somebody, actually feeding somebody and that somehow makes me better than that person. But I actually…actually…

Interviewee 1: It doesn't, I agree with you but I'm just saying that nurses somehow we are willing to take on all these extra works. We're willing to do all the doctor's jobs because we think in that way we might have bit of a powering thing to the job.

Interviewer: Right.

Interviewee 2: I don't agree with that.

Interviewee 1: I don't agree with that.

Interviewer: Okay. I would like to hear from you, yes?

Interviewee 2: I think that we do it because nurses do it better.

Interviewee 1: Yes. I agree with you there.

Interviewer: Yes, you agree?

Interviewee 1: Yes, because, I mean, we don't get paid the money but when I used to work in A&E and we had the rotation every six months we would tell them what to do, we would do their jobs because the consultant didn't used to be there in the night, or the registrar, they'll would come and they'll ask you, and you could actually do the job. You didn't have the paper, but you could do the job, and sometimes it was quicker for you (the nurse) to do the job, but as you say we do it better. Absolutely. And some of the doctors we work agree that we do it better.

Interviewer: so why nurses shouldn't be doing it? What's missing?

Interviewee 1: They don't have the power or status.

Interviewee 2: I have lots of status.

Interviewer: Okay, you feel you've got lots of status. How about the rest of you? Yes?

Interviewee 3: I…I've just got a different… what's different today to what was before is… is now a days nurses… where… where the patient was paramount, we're now getting this sort of business concept coming in and sort of saying oh er… you know, like in the job I'm in at the moment, it's…it's reducing the sort of admissions. And that is more… you know. You've got a dichotomy there.

Interviewer: Okay.

Interviewee 3: You know, what…what's in the patient's best interest might not be what's the best interest of your role

Interviewer: Right, okay. Yes.

Interviewee 3: And I think this is happening in a lot of jobs. It's like the four hourly wait. It's not necessarily… you know, it might be better for the patient to stay and be observed. You know what I'm saying?

Interviewee: Yes

Interviewee 3: It's because it doesn't fit…

Interviewee 4: Yeah. Is it because we're trying to break the job into lots of little bits and put them in boxes and try to tick and measure and…

Interviewee 3: No, I just think that the aim of the business is different to the aim of the professionals.

Interviewee 4: There's a lot more targets now. There's always targets. I mean for our managers all they're interested in is the number of face to face contacts we have with patients, they're not interested in anything else.

Interviewee 3: Yeah.

Interviewee 4: All they want to know how many patients we're seeing in a day, face to face. So even if you're doing a lot of work on the phones or your referrals..

Interviewer: Don't they also count?

Interviewee 4: None of that counts, they're not interested. All they're interested in is face to face contact.

Interviewer: Can I just have one person talking at one time, please?

Interviewee 3: I was just saying that we count telephone calls as face to face.

Interviewer: Right, okay, so different systems apply to different places.

Interviewee 3: Yes.

Interviewee 4: There's a lot more pressure on recording data, and writing and all data collection because, you know, you know your job's at risk if your data's not good enough they can cut members of your staff and that.

Interviewer: So it has to look good on paper.

Interviewee 4: So you may have a busy day at work, then you have to stay later to make sure that the data's written up, you have loads written up so… that adds to your stress.

Interviewer: Right. I bet it does.

Interviewee 4: Yeah, we get told sometimes by the consultant, that you're not seeing enough patients this week. And then that has an effect on your morale.

Interviewer: okay so why is this so important to your role?

Interviewee 1: I think that what we need is quality not quantity. I think they're not being helped to maintain standards.

Interviewer: Right.

Interviewee 1: I mean, I did a bank shift in A&E 8 years ago there would have been patients on trolleys on beds and you wouldn't have been able to walk. Now they're all in there.

Interviewer: Right. Yes.

Interviewee 1: But also, every time a cannula gets infected now in the hospital, infection control come down like a tonne of bricks and I think that is good for the patients.

Interviewee 2: If I go on the counter at all and the nurses now because they're not that experienced take it off because it says 72 hours on the box even if you cannot read…

Interviewee 3: That's the problem with a nurse in a system.

Interviewee 2: You know, what I'm saying. Because what they have ingrained, or what they've been taught is just put the patient took 72 hours, it's a little bit of excess on the paper, otherwise they say why is this left in place, saying so and so.

Interviewer: Right.

Interviewee 2: They'd rather just tick it off and get somebody else to do it.

Interviewer: is life outside work good?

(General agreement in the positive)

Interviewer: Great!.

Interviewee 2: Less happy now!

Interviewer: Why is that?

Interviewee 1: I would say I was happy at work, but I put in too many hours to cover my work, yes. And the work of my work/life balance is very poor.

Interviewer: Right, okay. How about the rest of you here? Do you also put more hours after you finish your shift to complete the work?

(General agreement)

Interviewee 5: I feel satisfied with what I do. But they always want more.

Interviewer: Are you looking for other jobs? To leave nursing I mean?

Interviewee 1: Yes, always. I've seen…

Interviewee 4: I think you can only stay so long in the one area, and you have to keep moving.

Interviewee 1: It's not that long until I retire so…

Interviewer: Right

Interviewee 6: Nurses don't mind moving around.

Interviewee 1: But I've noticed as a practice nurse over the last five years, since QoF Targets have been introduced, they want a framework for the patients, because lots of patients are regularly seen, we'd be seeing regularly.

Interviewee 1: Which is very good, but once they work for the practice at the arms of a sub-contractors because they get the towering payments enhanced, we get grades, okay? But you still seeing the amount of patients, you're still have the same amount of nurses, but now you're expected to see all those patients.

Interviewee 1: And you still have the same ten minute time staff.

Interviewer: Right.

Interviewee 1: But in my practice they have 13 doctors and three nurses. Nurses still do most of the prep work.

Interviewee 1: Do the maths…

Interviewer: Would you say in general that nursing is moving up, getting better as a job, like would you send your children to become nurses?

(General response in the negative then laughter)

Interviewer: Now, why not?

Interviewee 6: Not even doctors. Because…

Interviewer: Not even doctors?

Interviewee 6: Because the NHS has gone down a bit.

Interviewee 4: Don't think the training is as… I think it's training.

Interviewee 2: Well, the responses that I think you've already had. The money, is not there. You can train to be a lawyer, or…time and duty make. You work hard at your training and you're probably on £60, 000.

Interviewer: Right.

Interviewee 2: You work hard at nurse training and you're on £14,000.

Interviewee 6: No, £20,000.

Interviewee 5: No, it's £20,000 now.

Interviewee: I thought it was £20,000.

Interviewee 2: Is it £20,000

Interviewer: Is it £20,000? I thought it was £25,000?

(Chorus of 'no')

Interviewee 5: Policemen earn more than us. Firemen earn more than use.

Interviewee 1: Soup drivers are on £20,000

Interviewer: Okay. You know, I thought it was £25,000.

(Another chorus of 'no's')

Interviewee 1: Nope, no. It's definitely for all starting under Band Five.

Interviewer: Band Five? Band Five.

Interviewee 1: Yep, Band Five.

Interviewee 2: And that includes Mental Health…

Interviewee 3: That's probably with London weighting you were thinking of.

Interviewee 3: If they were at Archway and they're in the inner London it would probably be twenty five.

Interviewer: Right. Okay.

Interviewee 2: My mum was a nurse and she begged me to not go into nursing.

Interviewer: Okay. So why did you go for nursing at the end?

Interviewee 2: Because that's… I don't know, that's where I that I saw as an ideal place to be as a woman, because the way I saw my mum she was a nurse she was a great mother and I just wanted to copy her.

Interviewer: why would you discourage someone to enter the profession?

Interviewee 1: I think what we talked about earlier, they (nurses) don't support each other.

Interviewee 4: Not really respected or seen as professionals, whereas like other careers, if you become a surgeon or… I don't know a teacher.

Interviewer: Right.

Interviewee 3: Or even a physio err… an OT.

Interviewee 2: And I think too it's… you're sending these, whatever, 18 year olds who are seeing death. Who are seeing the worst of society. They are seeing abuse and… I think I'd much rather send my child into university and doing a degree in art or something and get drunk and fall over and enjoy their friends and not know anything about death and what I've endured all these years.
But I alsoI think that it is in your blood, that you must truly want to be a nurse. All nurses are going to get paid a pittance.

Interviewer: Thank you all for your contributions. Much appreciated and this discussion will finish here. Thank you again.

THE END (part1a).

Appendix 8. Transcript example of the interpersonal awareness training (IPaT)

File: **-------3.WAV**
Duration: **00:56:08**

Interviewer: Hello M-------, so lovely to see you again. Today is the 4th July, 11:30 and here I have a little activity for you to do for me. Can you draw me a circle if I give you a pencil or pen?

interviewee: So what do you want me to do?

Interviewer: What you need to do is to draw a circle and then draw some vertical lines across the circle, each slice represents a part from your life, i.e. work, hobbies etc and then you need to score each part from 1(not happy)-10 (very happy)…

Interviewee :I don't really think about things, I just get on with each day. I don't think about time.

Interviewer: Okay, so what if I draw the circle for you and you identify the bits you think are important for you and then you try to give a number to each one of them. Let's start with hobbies, what would you give to that?

interviewee:We will put five.

Interviewer: Five? Okay, so five is fine. How about work or career? How happy you are with work right now? Another five maybe?

interviewee: No, work is zero.

Interviewer: Zero? Okay..so work and career is currently zero. Hobbies is a five and celebrating life is a nine. Which part would you like to look at?

interviewee:The work.

Interviewer: It is work, yes, okay so tell me a little bit more about it, why is

it a zero now? What would you say about work right now?

interviewee:I like people to communicate nicely.

Interviewer: Right, okay, that is what is not happening right now?

interviewee:Yes.

Interviewer: And you feel it has an impact on your work life?

interviewee:You see it won't affect the way, how I care with my patients.

Interviewer: No.

interviewee:But it affects how I feel inside about… Because if you work for an organisation, if a group of people in that organisation is supposed to be caring for you, and you feel that they don't care for you, it impacts on how you feel. But my motivation towards my patients, if you are talking on a work basis, it will be always be between eight and nine.

Interviewer: Yes, of course.

interviewee:Because that is what I come to work for, to care for my patient, and to do my best for the trust.

Interviewer: So you take a lot of satisfaction out of the work you do with the patients?

Interviewee:Patients, yes.

Interviewer: Yes, that is very, very clear to me. Right, so you talked about communication, so communication has got an impact on you right now?

Interviewee:Yes, at this moment.

Interviewer: Just about today, yes. Okay, so if I would say, What do you appreciate most in your life right now?" What would that be?

Interviewee:Life.

Interviewer: Life in general, can you be more specific?

Interviewee:It is affecting my life.

Interviewer: how?

Interviewee:Work makes me feel uncomfortable.

Interviewer: Uncomfortable?

Interviewee:Yes.

Interviewer: What is uncomfortable?

Interviewee:Lack of communication.

Interviewer: Right tell me a little bit more about this communication.

Interviewee:Communication, if you say “Good morning” and no one answers, that is not a problem, because everyone is grumpy first thing in the morning.

Interviewer: Yes.

Interviewee:But communication where it is going to affect the way your well being is at work.

Interviewer: Yes.

Interviewee:Then it affects how you feel in general.

Interviewer: Yes, yes. Okay, that is very good, thank you. So what do you want, if you were to change something right now, what would that be?

Interviewee:For people to be honest.

Interviewer: Honest?

Interviewee:If you have lost the communication or letter which you have got from me, or you have lost track of what you are supposed to be doing for me, just be honest and say, “I have forgotten what we are supposed to be doing for you.”

Interviewer: Yes.

Interviewee:“Sorry we have ignored you, but appreciate that we are busy and we have got thousands of members of people in the trust to care for.” I would prefer that.

Interviewer: Right, so you would prefer that?

Interviewee:Yes, rather than I have to chase communications, “Where is this,

where is that?” Then they expect you to be polite and perform.

Interviewer: Right.

Interviewee:To be polite and professional for them, but they are not being polite and professional for you.

Interviewer: How does that make you feel?

Interviewee:Uncomfortable.

Interviewer: Uncomfortable?

Interviewee:Because I think, “Am I a horrible person?” The answer is no, I am not a horrible person, because if I was a horrible person, I would…

Interviewer: Why would you say, “As if I am a horrible person.”? What makes you think?

Interviewee:Well you only treat horrible people in horrible ways, and I fi was a horrible person I could understand.

Interviewer: Right.

Interviewee:The lack of communication to me. I am straightforward.

Interviewer: Is that how you?

Interviewee:How I interpret it.

Interviewer: Is that how you interpret it?

Interviewee:Yes.

Interviewer: Right, okay, okay. But you are not.

Interviewee:I am not a horrible person.

Interviewer: We know you are not.

Interviewee:Am I that?

Interviewer: So what is it you want really at this point in time?

Interviewee:What I want?

Interviewer: What do you want? Yes.

Interviewee:What I want is for people to just explain what it is they want me to do, and if they do not understand what they want me to do, just say, “We haven’t got a clear cut picture of how to care for you in this process.”

Interviewer: Yes.

Interviewee:“Or how to care for you while you are working for us.” Then say that, but don’t make it all hairy fairy, and saying that we are going to have a world-class organisation if certain people do not have world-class skills.

Interviewer: Right

Interviewee:You have to have world-class skills to look after your staff as well as your patients. If your staff are nurtured you have a happy work force.

Interviewee:Right, so you feel wanted?

Maureen: I don’t need to be pampered.

Interviewer: No.

Interviewee:I just need to be communicated to, be it by letter, email or just a quick conversation to say, “Sorry, I haven’t got time to talk to you, we will talk about this process in a month’s time.” Then I am relaxed, I can do what I am doing and feel peaceful.

Interviewer: Yes, I understand that, yes. So what would like to experience more as a feeling, this what you just said?

Interviewee:Closure.

Interviewer: Closure, yes.

Interviewee:Closure, and I don’t need any more stories or any fancy words, closure.

Interviewer: How long has this been going on?

Interviewee:Over a year.

Interviewer: Over a year?

Interviewee:Yes.

Interviewer: Yes. So it is a long time isn't it?

Interviewee:Yes.

Interviewer: A year is a very long time. So if you were to move this zero that you put down there for work… Because obviously you did say to me very clearly, "I put a zero there because of the communication." Nothing to do with the patients, nothing to do with the actual work you do here?

Interviewee:No.

Interviewer: It is to do with staff?

Interviewee:Yes.

Interviewer: But you didn't specify which people, are we talking about your peers?

Interviewee:No I am talking about management.

Interviewer: Management?

Interviewee:People who should know the structure of their organisation.

Interviewer: Right.

Interviewee:And who are supposed to be able to implement it competently, because they are in that position. If you can't communicate with me as an employee, how can you manage your workforce? It might be that I am not someone approachable to talk to?

Interviewer: Why do you say that?

Interviewee:No, because I am just thinking, if you can't communicate with me regularly by phone or by meetings or whatever, I have to always be chasing, then for you to do your job… You see I don't like this stuttering thing, I like to be peaceful. I come to work to do a job and just care for…

Interviewer: Thank you. So what number… This is all hypothetical, if you were to

feel peaceful, that is what you like to feel isn't it?

Interviewee:Yes.

Interviewer: What would that number be?

Interviewee:It only has to be five.

Interviewer: So if that number in that cycle, that area for work would have been a five?

Interviewee:Then I have got a full circle, where I am at an equilibrium with myself.

Interviewer: Yes. So if this zero was to be a five, would you have found yourself to be peaceful?

Interviewee:Yes, because I was peaceful before, yes I was peaceful.

Interviewer: Okay, so it… This is again hypothetical… Because I know you are still zero, but if you were to feel six?

Interviewee:If it was to feel nine, or eight.

Interviewer: Or nine, how would that feel?

Interviewee:Then I believe that the organisation is doing their best to make me feel comfortable as a member of staff.

Interviewer: Okay, let's forget about the organisation right now. Just focus on you, so how would you feel?

Interviewee:Just relaxed.

Interviewer: If you were to score nine you would have felt peaceful?

Interviewee:Yes, because I like to know I come to work, you might be busy, you might be stressed out, or whatever… But you know that the support network around you called management, who works above me... Are in some zone with myself.

Interviewer: Yes.

Interviewee:Maybe I am not giving enough, I don't know?

Interviewer: I'm sure you do, I understand what you are

saying. So if you were to move yourself from zero to five to nine, the difference, if I

understood, it would have been that when you are a nine you would have felt peaceful,

comfortable?

Interviewee:Yes.

Interviewer: Yes? Yes, okay, so…

Interviewee:Not to say that I am not peaceful now, it is just that one little section

of me is thinking about that rather than me just being relaxed and being able to focus. I

like to be able to focus, that is the word.

Interviewer: Okay.

Interviewee:It is drifting my thoughts onto a negative pathway, and I don't like

that.

Interviewer: Okay, of course. Can you tell me about a time when you felt the

best about yourself?

Interviewee:I am always feeling good about myself.

Interviewer: So describe that, describe… When was it, for starters?

Interviewee:Before I came here this morning.

Interviewer: Okay, right, and how did you see yourself, how would you describe

yourself when you arrived this morning?

Interviewee:I am happy.

Interviewer: Were you very smiley?

Maureen: Yes, happy, just happy, glad to be at work, giving God thanks that I

am here, and that I can bring a smile to others.

Interviewer: Right, bring a smile to others, is that important to you?

Interviewee:Of course.

Interviewer: Yes?

Interviewee:I don’t like people being miserable.

Interviewer: Okay.

Interviewee:If I have upset…

Interviewer: Why is that?

Interviewee:I don’t think people should be miserable, no.

Interviewer: Right, and how does that make you feel? If they are miserable how does that make you feel?

Interviewee:That I need to make them feel better.

Interviewer: Right.

Interviewee:Even if it is something that they are going through, like bereavement, or loss, separation.

Interviewer: Yes.

Interviewee:If I can take them out of that zone, for that moment of time.

Interviewer: You used “zone” as a word twice so far, what does that mean to you? Other ___[0:14:51] used this term.

Interviewee:A zone is where people can forget what their main problems are at work, or at home, or in the environment.

Interviewer: Yes.

Interviewee:They can just relax.

Interviewer: Okay.

Interviewee:I don’t know how to explain, but it is just a peaceful zone, and I like to put people in it.

Interviewer: Right, okay, very good. So do you think that is a need you have? Would you say, “This is something I need to do as a nurse or as a person. I need to make people feel happy, put them in that peaceful zone.”

Interviewee:I think it is my role.

Interviewer: Do you think that is your role as a nurse, or as a?

Interviewee: As a person.

Interviewer: Right, does that fit well with what you are doing as a job, being a nurse?

Interviewee: It does, because it normally works.

Interviewer: It normally works? When would you say it doesn't?

Interviewee:If I am not in that zone.

Interviewee:If you are not in that zone?

Interviewee:Yes.

Interviewer: You wouldn't necessarily try to bring somebody in?

Interviewee:Obviously if I am feeling like that, it is going to take the smile off my face isn't it?

Interviewer: Yes, and would that make any difference to how you are going to?

Interviewee:No not really, but I will be a bit more quiet, quieter.

Interviewer: Right. What image would you use to describe yourself, how do you see yourself?

Interviewee: How do I see myself?

Interviewer: Yes.

Interviewee:I don't understand.

Interviewer: Some people say to me, "Well I see myself more as a mother."

Interviewee:I am a nurturer, I am a nurturer.

Interviewer: Okay.

Interviewee:I love to nurture. I believe that everybody is my child.

Interviewer: Okay, like their mother?

Interviewee:Yes.

Interviewer: Is that how you see yourself? Right, do you have lots of nieces and

nephews?

Interviewee:I have lots of nieces, nephews, friends, children, yes.

Interviewer: So is that how you see yourself?

Interviewee:I like to care for people, I am a people person.

Interviewer: Okay.

Interviewee:When I experience things like that, then I believe that there is a part of my people person that is missing.

Interviewer: So has the way that you see yourself changed over time?

This nurturer that you describe?

Interviewee:I don't really, no.

Interviewer: The mother role?

Interviewee:No.

Interviewer: It hasn't you reckon?

Interviewee:No.

Interviewer: Okay, so as far as you remember yourself you have always been like that, from an early age?

Interviewee:From a very young… Because I did… The Queen's mother, the British Home for Incurables, I used to go there and just talk to the elderly.

Interviewer: Yes.

Interviewee:Or we used to, because a lot of them had incurable diseases, or incurable mind sets where they would put make up on, take it off, and that would happen throughout the whole day until they go to bed.

Interviewer: Okay.

Interviewee:Or you would have some people there that might have had polio, or TB, lots of different things.

Interviewer: Yes, and what did you do there?

Interviewee:Basically you just sat and talked with them.

Interviewer: Did you find that helped them?

Interviewee:Yes, because the lady that always took make up on and off, whilst I was talking to her she didn't do it.

Interviewer: Right, okay. How did you feel afterwards?

Interviewee:I felt good, because the matron said to me, "It is impossible to talk her without her putting her make up on and off."

Interviewer: Right, interesting.

Interviewee:While I was there that happened. So I felt from a young age that I had connection with people.

Interviewer: With people?

Interviewee:Yes.

Interviewer: Would you say that you have got that rapport with people?

Interviewee:I think so.

Interviewer: Yes, and is that what made you think to go into nursing? How did you come into nursing?

Interviewee:How did I come into nursing?

Interviewer: How did it all start?

Interviewee:Well I did secretarial, I did accounts, I did bookkeeping, then I thought I needed a profession, and nursing seems like a profession to go into.

Interviewer: Yes.

Interviewee:I was always caring for everybody anyway.

Interviewer: Yes.

Interviewee:So I tried it, and it was okay.

Interviewer: Lovely.

Interviewee:I made it a vocation rather than a job.

Interviewer: Yes.

Interviewee:So to me it wasn't about… Whereas my friends were earning more money than me.

Interviewer: Yes.

Interviewee:It was about doing something that I liked, and every day was a blessing to come into work.

Interviewer: Yes, and what it is that you really enjoy about this job? What are the things that you really love in this current job? Despite all that communication problems that you are talking about?

Interviewee:Meeting other patients, helping the staff to do things.

Interviewer: Tell me about meeting the patients, what is it that you enjoy about meeting the patient?

Interviewee:Every patient has a story. Sometimes I can see fear in their faces, and I will do everything possible to ensure that whatever is their fear.

Interviewer: Yes.

Interviewee:That it is alleviated before we start our tests. So if I see a patient being frightened I might say, "Hello, can you come over here for a minute?" I will take them to the room, and I will say, "I noticed that you look a little bit worried, is there anything that I can help you with?" They said, "I am worried about the test." I said, "Gosh, let me tell you all about it." They said, "But it is not my time yet." I said, "I will tell you about it, then you can stop worrying."

Interviewer: Yes, so that is what you enjoy?

Interviewee:Yes. So it is watching people's facial expressions, and trying to work out whether or not I am going to be interfering with somebody who really doesn't want to talk. Or if there is a little scope for me to go in before.

Interviewer: Right.

Interviewee:Normally I am right.

Interviewer: Yes, of course, I am sure you are. So this is something you would have taken from this job if you want to a whole different [Career 0:20:53].

Interviewee:Yes.

Interviewer: That is one thing. What was the other thing you said that you really enjoyed, perhaps you would have taken up this job?

Interviewee:Well my colleagues, even certain things are happening.

Interviewer: You look at a particular one? Are you looking at a particular person?

Interviewee:No, I can talk to all of them. All of them will come to me, and they will tell me what is happening with their children, with their life, with another member of staff. It is a story, so I have go the whole picture of everybody's story, but nobody will ever know what the other person has said to me. Even if…

Interviewer: Right, okay.

Interviewee:It will always be in my heart.

Interviewer: Yes.

Interviewee:I won't use it as a weapon against them as it were.

Interviewer: Yes, so this sort of interaction is what you would enjoy?

Interviewee:Yes, so confidentiality.

Interviewer: Yes.

Interviewee:So it doesn't just go beyond… It isn't just about the patient's confidentiality, it is about the staff's confidentiality.

Interviewer: Yes, what does that give you back, this story telling?

Interviewee:It feels like they trust me.

Interviewer: Right, okay. So you enjoy the fact that they trust you with their stories?

Interviewee:Or it could be that they want some information from me.

Interviewer: Okay, yes.

Interviewee:But it doesn't matter, I will give it, I am a free spirited person.

Interviewer: Yes, but you still enjoy it?

Interviewee:Yes.

Interviewer: It is part of the job that you do. Is there anything else that you would have like to include from this job then?

Interviewee:The old times.

Interviewer: Old times?

Interviewee:Yes.

Interviewer: What do you mean?

Interviewee:When I first started the job, it was nice.

Interviewer: What was nice about it?

Interviewee:Because when you trained somebody, or you taught something, everybody appreciated what you was doing.

Interviewer: Is that what you did then?

Interviewee:I still do it now, even though I know it hasn't been a good thing for me to do.

Interviewer: Yes.

Interviewee:I will still do it, because I believe in passing on knowledge.

Interviewer: Yes.

Interviewee:If the knowledge is correct.

Interviewer: So developing people, is that what you are talking about?

Interviewee:Yes, that is it.

Interviewer: Yes. You like to do that?

Interviewee:I like to learn from people as well.

Interviewer: You are a teacher in a way? Part of you is a teacher?

Interviewee:Yes.

Interviewer: You like teaching, mentoring perhaps people?

Interviewer: So these are three aspects of your job that you would really like to take away. If you were to go to another job?

Interviewee : Yes.

Interviewer: So if you were going to another job, what would you like that other job to have that perhaps this one doesn't have?

Interviewee:Honesty.

Interviewer: Right, tell me a little bit more about honesty, from whom?

Interviewee:The management.

Interviewer: The management?

Interviewee:Yes.

Interviewer: Honest about what?

Interviewee:Bity things, I don't like bity things.

Interviewer: What do you mean by bity things?

Interviewee:Bity things, maybe I shouldn't say bity things.

Interviewer: Give me an example.

Interviewee:What is bity to me?

Interviewer: Yes, what is bity to you? Because that is what I am interested in.

Interviewee : Bity for me is… "I have already explained that interview guideline for phase two, is on the desk, and it is on the right hand side." For example. Then you come back to me later and you say to me, "M-------, you did not tell me where the phase two guidelines are, where is it? I need it now."

Interviewer: Right.

Interviewee:I said, "I told you this morning that it was on the desk, on the right

hand side." "Well why don't you get it for me, because I need it right now." I would be in the middle of dealing with a patient, and you are talking to me on a level that I don't really like.

Interviewer: Right, so who is that person then is talking to you?

Interviewee:It could be anybody.

Interviewer: Anybody, like a peer?

Interviewee:A peer, a management, and you just interrupt me in the middle of dealing with a patient.

Interviewer: Right.

Interviewee:I see that as being maybe bity.

Interviewer: Bity, okay.

Interviewee :Because you could have said, "Excuse me, sorry to interrupt, but you made me that document, I can't find it on your desk."

Interviewer: Right.

Interviewee:So interrupting me in the middle of an injection to ask me about something.

Interviewer: So manners?

Interviewee:Yes manners.

Interviewer: So you wouldn't like to go to a job working with people who have that?

Interviewee:A little bit, we can't always.

Interviewer: A little bit?

Interviewee:Only a little bit, it doesn't have to be a lot.

Interviewer: You will be fine with a little bit

Interviewee:A little bit, excuse me please.

Interviewer: Right, what other things would you like from this new job? More

money perhaps, or responsibilities?

Interviewee:It would be nice to have more money, but it is not the money.

Interviewer: What do you want from this new job?

Interviewee:It is about feeling that, because you spend most of your working life at work.

Interviewer: Yes.

Interviewee:Therefore my work should be like I am being around my friends and my family. Not to say that they necessarily have to be my friends or my family.

Interviewer: Yes.

Interviewee:But to feel as though you go to work to feel a joy, there is something that makes your heart beat.

Interviewer: Right.

Interviewee:That you are coming to work, your enthusiasm, that is it. Enthusiasm, motivation.

Interviewer: If you were to go to a new job, is that what you would have liked to have?

Interviewee:Enthusiasm, motivation and somebody that if they feel that you are going off the driven path, they will say, “I am sorry M-------, but you know you was going to do such and such? I think you are deviating from that, can you come back to the right or the left?”

Interviewer: Okay, so some sort of guidance?

Interviewee:Guidance.

Interviewer: Direction, yes?

Interviewee:Maybe I think because they see as senior level uniform.

Interviewer: Yes.

Interviewee:They presume that you no longer need guidance, but I think that is the wrong thing to presume, because even management need guidance. I have worked

that out over a period of time.

Interviewer: I agree, yes.

Interviewee:Management need guidance.

Interviewer: Yes.

Interviewee:They can get guidance, I believe that you can learn from a child, and you can learn from somebody who isn't even in the workforce.

Interviewer: Yes.

Interviewee:They can see things that you might not see about yourself.

Interviewer: Yes.

Interviewee:So I would like people to pull me up, not in a nasty way, but in a nice way.

Interviewer: Yes.

Interviewer: Obviously you feel you are open to development?

Interviewee:Yes, constructive development.

Interviewer: You want people to contribute towards that, you want to grow as a person and as a professional?

Interviewee:Yes.

Interviewer: Yes, is that what you are saying?

Interviewee:As a professional. Rather than a person.

Interviewer: Yes, as a professional, yes. So in this new job, if this is your old job, in your right hand, and if we have your new job on your left hand… If you went to put them together, would that make your ideal job?

Interviewee:Yes, because you have learnt how not to treat people, and you have learnt how to treat people.

Interviewer: Yes.

Interviewee:You have learnt that not everybody can be positive, you have got

some people who are very negative all the time and you will never change them. You have got people like myself, who is inquisitive to know that if you say, “A is A” I want to know how did you come to A?

Interviewer: Yes.

Interviewee:So you have got the people who would question your question, and sometimes it can become… Some people might find it not a good thing to do, because they don’t know the answer, but they are too frightened to tell you that they don’t know the answer. Rather than saying, “Leave it with me, I don’t know the answer, I will ask one of my colleagues.” If I don’t know the answer to any of my work things, I will say, “I don’t know, but you know what, I will find out for you. If I can’t find out, I will put you through to someone who I think would be able to help you.”

Interviewer: Yes.

Interviewee:I have no problem with going to a junior member of staff and saying, “How do you do such and such?” “Oh yes, don’t you remember?” I said, “No that is why I am asking you.”

Interviewer: Yes.

Interviewee:Or I will say, “I have completely forgotten how to do such and such, can you tell me?” I can go to a senior person and ask them.

Interviewer: Do you think you can do that in your current job?

Interviewee:I do it, because I have to care for my patient.

Interviewer: Yes.

Interviewee:There is no opportunity to say, “I can’t ask that person.”

Interviewer: Yes.

Interviewee:Even if they are unapproachable, I will ask them.

Interviewer: Yes.

Interviewee:Even if they turn their back to me, like this, I will say, “Sorry so and

so, can I just have a word with you?" "Yes, you can talk to me." It is difficult for me to speak to your back.

Interviewer: Yes.

Interviewee:But if that is the way how you want to treat me, for me to speak to your back, I will speak to your back.

Interviewer: Is that how you feel some people treat you?

Interviewee:Yes, but I have got over it, because I am bigger and better than that.

Interviewer: How did you get over it?

Interviewee:I will just say to them, "I don't mind speaking to your back."

Interviewer: Is that what you say to them?

Interviewee:Yes, in my head. So I will change the tone of my voice.

Interviewer: Right.

Interviewee Because the voice might change I will say, "Excuse me I just need to find out whether or not I can go ahead and inject this patient." So because I have said…

Interviewer: How do you find these type of interactions?

Interviewee You have to do it, because if you just said, "Excuse me."

Interviewer: But obviously you don't like it.

Interviewee:No, I don't.

Interviewer: Do you like it?

Interviewee:No.

Interviewer: But you have to do it because of the patient?

Interviewee:Yes, because I need the speed, you need to have the speed in which to carry out the work.

Interviewer: Yes.

Interviewee:So if you have got an injection that you want to give straight away, or…

Interviewer: So what would you have liked that person who turns his back to you to have done?

Interviewee:If I have called you by your name, and said, “Excuse me so and so.” I expect you to stop what you are doing, or say, “Give me two minutes.” You finish writing what you are writing.

Interviewer: Yes.

Interviewee:Or I have had the decency to wait until you finish your dictation. I said, “Can I interrupt you before you do your next dictation or whatever?”

Interviewer: Yes.

Interviewee:I have called you by your name, I expect you to turn around. But to keep your back to me and say, “Yes, you can inject that patient. Yes, it will be fine.” I said, “Well can you sign this?” “Give me this.” Then they sign it, that to me is rude. But I can deal with that, because I have had to learn to deal with it.

Interviewer: You have had to learn to deal with it?

Interviewee:Yes.

Interviewer: How did you do that, how did you learn?

Interviewee:Because as I said I like a peaceful life, I like a peaceful zone, and rather than saying, rather than making an argument out of bity things.

Interviewer: Is that what you call a bity thing?

Interviewee:Yes. Before I would say, “Could you turn around while I am speaking to you?” I haven’t got time for that, you want to turn your back to me, it is fine. You want to take the paper from me from behind, it is fine. Because you are doing what I have asked you to do, to sign the papers so I can go and do my job, look after my patient.

Interviewer: Right, okay, and that is good enough for you?

Interviewee:Good enough for me.

Interviewer: Can you give me an example of some that you wouldn't tolerate?

Interviewee:I don't tolerate, I don't like people lying to me.

Interviewer: Right.

Interviewee:I don't.

Interviewer: You have said that to me before, tell me a little bit more about that.

Interviewee:As I said.

Interviewer: Give me a quick example.

Interviewee:A quick example.

Interviewer: Yes, from your work, yes.

Interviewee:Okay, supposing you know that you made a mistake with a patient, no… No I am not going to comment on that, no, it is another story, no I will take that one away.

Interviewer: Okay, fine.

Interviewee:Supposing… What was the question.

Interviewer: Give me an example of something that happened at work that you wouldn't tolerate, the way you tolerated perhaps that person who turned his back to you, or her back to you.

Interviewee:Right, if I am speaking to a patient, and you come in between me and the patient to get my attention without saying, "Excuse me", that I don't like. I say, "Excuse me, I was just talking to this patient." Or, "I was talking to this relative, whilst talking to my colleague, can you wait a minute?"

Interviewer: Yes, yes. Have you found yourself in that situation recently?

Interviewee:Yes I have, but I have dealt with it.

Interviewer: Yes.

Maureen: Or shouting at me, or telling me, “Sister, you didn’t inject the patient in the correct arm.” Then you are in the middle of the waiting room, and you have got patients around as to say, “Well what arm is she supposed to inject in?” You know, no manners.

Interviewer: Yes.

Interviewee:Not knowing your zones in which you speak to people.

Interviewer: How did you deal with that?

Interviewee:I said to them, “The patient had a left and a right arm.” They said, “Yes.” I said, “So when you say I injected them in the wrong arm, what did you mean?” “Because we have got the camera on this side we wanted them to be injected on that side.” I said, “If you had checked with patient, you would find that they have got a fistula on that side. So therefore you can’t inject on that side or take blood pressure, that is why I have injected them on that side.” “Okay.” No sorry, they are gone.

Interviewer: Right, okay.

Interviewee:So I am in front of a whole load of patients.

Interviewer: Yes.

Interviewee:Or other colleagues, and I don’t want to be embarrassed.

Interviewer: I understand now, yes.

Maureen: Because it is a little about…

Interviewer: It is about respect really?

Interviewee:Yes.

Interviewer: It is about more professionalism?

Interviewee: Belittling me.

Interviewer: How does that make you feel afterwards?

Interviewee No, because I have dealt with the situation, and I have dealt with it, I will leave it.

Interviewer: Yes.

Interviewee:But if the person had said anything more, I would say, “When you have got a moment I need to speak to you.” Or if I don’t feel as though it is settled, I will go back and say, “I didn’t like how you spoke to me in front of the patients this morning. You didn’t need to do that.”

Interviewer: Of course.

Interviewee:Because I try not to do it to others, I am not saying that I am perfect. So if pick up the phone and ring a ward and they say, “Yes.” I said, “Have I got through to such and such a ward?” They go, “Yes.” I said, “Who am I speaking to?” “One of the nurses.” “What is your name?” “So and so.” I said, “Okay, are you caring for such and such?” I said, “Remember, you are representing the hospital. You are not answering your home phone, so I don’t expect you to pick up the phone and go yes.” “I thought it was somebody else.” “No, you can never presume, because it is not all the time that you bleep somebody that they will be the next caller.”

Interviewer: How often would you say this happens at your workplace? From one to ten, ten very often, almost every day?

Interviewee:I would prefer not to answer that question.

Interviewer: Okay, that is fine. Okay, so how does that make you feel at the end of the day, after you have dealt with all these people? After you have cared for all these patients, how do you feel when you are actually leaving the ward, the hospital and going home, you are on the bus now.

Interviewee:I just say, “Thanks for letting me get through the day.”

Interviewer: Okay, and what else there is something else, what else?

Interviewee:“I survived.”

Interviewer: You say to yourself, “I survived.” Is that how you feel, a survivor?

Interviewee:Yes, it is survival, I have survived.

Interviewer: Thank you, that is interesting. Obviously it must be quite intense

then, or you feel it is quite intense?

Interviewee:I try to each morning.

Interviewer: Good. So how do you feel afterwards? When

you are sitting on your sofa now having your cup of tea?

Interviewee:I just say, “Wow, I got through that day, well done.” And I give myself a pat on the back. I have to, because if not you would be in trouble wouldn’t you?

Interviewer: Yes, yes. Do you have somebody to do that ___[0:37:44] other than

Interviewee? Do you have like a friend? Yes if I want to I have.

Interviewer: Yes. So do you get that from a friend, or from your mother, brother?

Interviewee:Anyone who I want to get it from I will.

Interviewer: Yes, so who is your… Who would you say is the person that you

count on in your life for when things go a bit too much, and you want to talk to that

person? Because you know that person will hear you.

Interviewee:It depends, it could be a colleague outside the department, it could

be a colleague…

Interviewer: So you don’t have a special one?

Interviewee:No, if I want to talk to my sister or my brother, I will talk to them.

Interviewer: Perhaps somebody who accepts you totally and you have no

problems talking to them?

Interviewee:No, but they will see both sides, I will speak to people who if I say

something, they will say, “M------- I disagree with you there.”

Interviewer: Right.

Interviewee:They will say to me, “Well I think you have done such and such. I

don’t think your approach was right.” So they will see it from both sides.

Interviewer: Right.

Interviewee:So they will pull it to pieces what I am saying.

Interviewer: Fine, do you like that?

Interviewee:Yes, I don't mind.

Interviewer: You don't mind, but you don't like it, do you?

Interviewee:It makes me grow to realise, "I never thought about that."

Interviewer: Right, okay, so it gives you a different perspective?

Interviewee:Yes. So sometimes if I am a bit worried about what somebody like management, when I say management it could be a doctor, or…

Interviewer: Yes, of course, yes.

Interviewee:If I worry about what they have said to me, and I might of… No in fact before the meeting or whatever it is, is finished, if I feel that I have spoken out of turn, I will apologise. I am not…

Interviewer: Yes.

Interviewee:But if I don't think I have spoken out of turn, when I say out of turn, like if I disagreed with you. If I disagreed with you that the sheet was red, and I said it was yellow, then I thought, "Hold on a second, if you look that way it is red you know." I will say, "You know what, remember we were talking earlier and you said to me the sheet was red? I do apologise, but I can see that the sheet is read now, it is not yellow."

Interviewer: Right.

Interviewee:So I will apologise before I leave, so therefore that is done.

Interviewer: Right, okay.

Interviewee:But if I don't think that what I am saying is wrong, I won't back down.

Interviewer: Okay, very good.

Interviewee:I won't.

Interviewer: Good for you. So if I go back to my last question, is there anyone in your immediate surroundings who accepts you totally and you can talk to that person freely, accept your bad points?

Interviewee:Most of my friends and my family.

Interviewer: So can you think of one person, two people?

Interviewee:I can talk to God, he is better, because he doesn't answer back.

Interviewer: Okay, so God is?

Interviewee:He is my foundation.

Interviewer: He is, yes?

Interviewee:Yes.

Interviewer: Okay.

Interviewee:I know if I…I suppose no I don't I just say to him, "Thanks for getting me through the day." I said, "That was hard, but thanks for getting me through it."

Interviewer: One last thing before we close the interview, can you think of… Before I go onto this, let me take you back, remember we looked at that job? The new job that you are going to go for?

Interviewee:Yes.

Interviewer: So you have got your current job, and all the things that you want to take away, and all the things that you want to find in this new job remember?

Interviewee:Yes.

Interviewer: So on your right is your current job, and you just take out all the good things about it, and on your left hand side you have got your new job you are going to go to. With all of the things that you want this job to have. You gave me a number of things, so if you went to put those two together, what would that be?

Interviewee:That would be a good circle.

Interviewer: A good job?

Interviewee:Yes.

Interviewer: A good cycle of what?

Interviewee:Because even from a negative you get a positive. Because I believe that you will always remember a negative and a positive. If a negative stays in your mind, you will always remember, never, ever, ever to treat somebody, or to speak to somebody, or to do that process in your next job. If you see somebody doing it, you will be able to say to them, “You know what, I have had an experience of something similar to what you have been doing or you have been saying, and it is not nice at all.”

Interviewer: What do you want to take from this current job?

Interviewee:That I remain strong, focused.

Interviewer: Right.

Interviewee:Have manners, respect and to be still nurturing, regardless.

Interviewer: So this is what you decide, so this is from this job?

Interviewee:This is from this job, just to ensure that whatever training that they are going to give, that they promise to give, that they fulfil it. Being around a group of people, working as a team. Teamwork, when it is working, it works well.

Interviewer: So take that one then.

: Teamwork.

Interviewer: What else do you like from the current job that you want to take?

Interviewee:People.

Interviewer: Yes, certain people you have in mind?

Interviewee :No, I meant being able to be myself and to talk… So making sure that whatever nice things that are in the role… Because they are not always negative, it is just that when you are feeling negative, you…

Interviewer: what else?

Interviewee:My skills.

Interviewer: Your skills that you have got and developed in the job, what else?

Interviewee:Yes, my skills that I brought to the job, and to develop the skills that

I have lost since I have been in the job. Caring for the patients. Motivated, and to use my skills, and for them to develop, more skills and to ensure that I work to my full potential, and not halfway.

Interviewer: Right, that is what the new job is about, yes? This is everything you

want.

Interviewer: So if you were to bring all those things together in your new job, how would you feel?

Interviewee: Blessed.

Interviewer: Blessed? How would you score this new job of yours?

Interviewee:Nine.

Interviewer: Yes? Would you go for a job like this you just described?

Interviewee: I can't think.

Interviewer: You can't think? Why can you not think?

Interviewee:I couldn't think beyond. Going to another to another job. I couldn't think.

Because I feel as though I am deskilled, because I haven't used all my skills that I came here with, and the knowledge or the wisdom.

Interviewer: But you can.

Interviewee:But I can, and I will.

Interviewer: Yes you will.

Interviewee:I will, because that is what they want.

Maureen: Because when you focus. And because my focus was… I am like a child, you have a vision, and my vision is to care for the patients, to reach to a thing. Because I feel as though I am deskilled, and I feel as though… The ___[0:51:25] to learn more, but I can learn more.

Interviewer: So what would happen if you are deskilled as you said?

Interviewee:You can skill yourself up, you can learn more.

Interviewer: and what wouldn't happen if you are deskilled?

Interviewee:What wouldn't happen?

Interviewer: Wouldn't happen if you are deskilled, what wouldn't happen

M------- if you are deskilled?

Interviewee:I don't know.

Interviewer: You don't know? What don't you know?

Interviewee :You wouldn't have to think about anything. I don't understand the

question. It doesn't matter if you are deskilled because you can learn more, is that what

you are saying?

Interviewer: Okay, I will think of another question. What would happen if you

weren't deskilled?

Interviewee:I would be fine.

Interviewer: You would be fine, in what way?

Interviewee:Because every job that I applied for I would get it.

Interviewer: Right, so what wouldn't happen if you weren't deskilled?

Interviewee: What wouldn't happen?

Interviewer: Well you told me you would get any job you like if you weren't

deskilled. So now you tell me what wouldn't happen if you weren't deskilled?

Interviewee:I would be fine, and I am fine. I am making a silly statement, I hear

what you are saying.

Interviewer: You would be fine.

Interviewee:I would be fine, because you only can be deskilled for a while,

because in the subconscious memory, the skills are still there.

Interviewer: Thank you and I think we can close this interview here unless you have a question or something?

Interviewee: no I'm good.

THE END

Appendix 9. Transcript example of the interpersonal awareness training (IPaT)

File: **----.WAV**
Duration: **00:50:30**

Interviewer: Hi T---. Hi there. Today is 13/8. As I explained before we're going to look at the wheel of life again and think of what parts of your life you appreciate most in your life right now? You need to draw some horizontal lines across the wheel and score each part. What sort of score would you give?

Interviewee : Well, I'll start with relationships because that's really important to me and I will give that a really high score because I feel really comfortable with my friendships. I feel very comfortable with my family relationships. I've seen some family this week and it was a real pleasure, and I feel very loved by them. I go on holiday next week with my Mum and my partner and it's good. It's as good as it always is, but it's a little bit better than usual, so, I'll give that a really high score.

Interviewer: great so what would be your score?

Interviewee:I'll give that a nine. But, I have a constant challenge with time, in terms of having time to do all the things that I would want to do. Not just the things that I have to do, and this is not just work. This is pretty much everything, but, because I work really hard at managing my time, I'm not someone who likes to not use time effectively. Although it's a constant challenge, I feel like I'm okay with it and will probably give it about seven or so.

Interviewer: Okay. Is there anything in particular that you would have liked to do and you feel time isn't there?

Interviewee: Honestly, if I had my choice I would like to consider working slightly less hours and change the balance so that I have more time for things that I really want to do and less time in my workplace. Just by percentage of about...if I could cut my work down by 20%

I would.

Interviewer: How could you do that?

Interviewee :If the time didn't affect my finances too much and I was able to negotiate coming down to four days a week rather than five, I would absolutely love that day to do all the things that I would... All my aspirations, all the things that I would really like to do.

Interviewer: Tell me one aspiration. One thing that...

Interviewee:What I would like to do?

Interviewer: yes.

Interviewee:I would like to paint.

Interviewer: Paint? Okay. Is it something that you've been doing?

Interviewee:No. I used to paint when I was younger. My family is very creative and they do design and art and... I've never pursued it since I was young and I was really good at it. I was always interested in art and I would like to just do it for me.

Interviewer:Yes, fair enough. Okay, that's good, thank you.What would be the next one?

Interviewee :With my work I'm in a bit of flux at the moment because of these changes that are going on. However, I am really working hard to maintain my...that presence in the job and even if the job changes, I will want my presence and my commitment to be the same, regardless of whether I'm working full time or part time.

My work is a really, really important driver in my life and even my family ask me

___[00:08:06-8] so, I appreciate, really, that a lot of my identity has been my work, so I feel still very confident that I can and do put into work and get out of work what I need. So, despite the flux, I will score this high because I think my skills and my presence are actually getting better and better.

Interviewer: Good.

Interviewee:Finances. I genuinely am not that worried, on the whole, about finances. I'm comfortable. I've worked hard in the past so that I'm not someone who's greatly indebted. I worked really hard, when I qualified, to save up the base for my mortgage so my mortgage is very, very low. So, I don't have great financial worries. I've got the general worries about future and the timing but if it meant homing down and down-

sizing, it's not a problem.

Interviewer: At this point in time you feel like you're in a good place.

Interviewee:Yes, I've got savings and I'm fine.

Celebrate and contribute is very important to me. I've seen...with working in health care, I've seen so many things happen. I've seen so many losses. People die young, people are injured and people have terrible illnesses. One of my biggest philosophies is to celebrate and to recognise what's good and what's beautiful at the time. Why wait? Without being hedonistic; I mean share, involve...

Every year... I've been with my partner now for 25 years, so, every year...

after five years we had a celebration ___[00:10:07] then we were going to wait ten years, then after eight years we said; "Well, why wait? What if something happens?" We did it then and actually, we've done it every year. Family, friends, colleagues, and they've got bigger and bigger. It's a really lovely way of touching base with all your friends and actually recognising what's good in life.

Interviewer: So you really enjoy that?

Interviewee:We really, really enjoy it. Also, all the little details. I like enjoying all the little things like, sending a text at the right time, sending a card to someone. You're just...touching people and acknowledging them. So, I'm a big advocate of that and I think that's one of the things that differentiates us as decent humans.

Interviewer: How does that make you feel?

Interviewee:It makes me feel really good.

Interviewer: Would you say, happy, as well?

Interviewee:Very happy. I like to do it and I like to do it well, and when I'm on the receiving end of it, I really like it as well. But, then, I don't expect it. It makes me feel really good. Really good.

Physical body is really important because I know that good health and wellbeing...physical wellbeing underpins everything. It goes back to what we were

saying about working in health and appreciating how important that is. I have been blessed with very good health and although I have got some health problems, I don't.-I still feel... People say, "Are you blessed with good health?", and I say "Yes, I am". I've got energy and I sleep well and I exercise. I've got all the energy I need to do all the things I want to do, so, I would score that high and I really value that. But today I am a little bit... Today, because today's the day we're finding out about the team and who's in and who's out, so...It doesn't matter. In some ways I thought, you know, it is what it is and being in here doesn't change anything. Although I'm very good a compartmentalising my emotions, usually, I'm a little bit, kind of, fluxy today. So...

Interview: are you okay to continue with this?

Interviewee: Well, sometimes, days like today, with this going on, I kind of think I've got...it feels like I've got the weight of the world on... What about this, what about this person and that person. I kind of worry about everybody. My partner said, "You know you can't take it all on. You can't take on everybody and everybody else's problems."

Interviewer: It's true.

Interviewee:But I feel for them.

Interviewer: Do you feel safe with your job?

Interviewee:I do feel safe and that doesn't make me feel good, because, when I feel safe and I know that colleagues of mine are feeling unsafe...I've been feeling this for a while to do with this reconfiguration. I'm feeling very guilty. I'm feeling guilty, I feel like I've let them down. I can't do the things I would normally do for them as a team leader.

Interviewer: How long has it been going on? Because I'm aware of it for the last two months, but I've...

Interviewee :It's been hanging over us for... We've known the changes were coming for about six months. The details... Well, I probably thought that there were going to be changes coming in before that, because there were subtle things in the wind and you could just

tell. Then, there was full discussion of the changes about six to eight months ago, but we didn't know what the details would be. Then as the details have come out, the detail's not what I anticipated, because we've been informed that there wouldn't be any jobs in jeopardy, but then when we were formally told a couple of months ago, we were told that there would be jobs in jeopardy. That's the first I heard of it and that was really hard as a departmental manager, when you've told your teams; "Don't worry because it's..."So, I have felt guilty about the whole thing and I've worried that they think I've been involved in the process when I haven't. They've kind of said, "No, we understand", but sometimes, the way they're reacting makes me feel that they're angry. Maybe they're just venting their anger at me because I'm there, but it makes me feel really uncomfortable. So when I'm churned up, it's because I've got all this stuff churning around. In a way...in some ways, I just want today to be over so that we can take the next step, or whatever.

Interviewer: I understand, do you know what started this up?

Interviewee :I think it's really financial. There's a quip attached to all these different departments and while that's being said, it's got to happen. It's different with different departments and it's kind of happening everywhere.

Interviewer: If you were to do something about it, what would it be, to change the way you feel?

Interviewee :About this particular issue?

Interviewer: Yes.

Interviewee :Well I think my next response is going to be in relation to what has happened; What decision is made. So, I really feel that I'm kind of in limbo. I know this limbo's going to come to an end any minute, because when I go back downstairs, they will have started to meet people and tell them what's what. The general management coming down and telling them.

Then I've got my own anxieties about moving forward, which is, if the new team is configured with these people, what will that mean for me, in terms of working, if it's configured with different people? Do you know what I mean? Whatever the future formula is will have a bearing on how my future relationships are. Not just in terms of

numbers of staff, but who the staff are. So I have got really mixed feelings about that. Feeling guilty about my job being safe, compared to other people not being safe, but I also really want to know what's going to happen, because I want to know what my future holds in terms of who I'll be working with. I know, in the scope of things, that this is really selfish. I feel really selfish for thinking of that. I do. I feel really selfish for thinking like that when my colleagues have got bigger problems.

Interviewer: Okay. So, how would you have felt if nothing of that had happened. Let's hypothesise here. Let's say that the team stays the way it is after this. How would that make you feel?

Interviewee : I'd feel good. I would feel good because...for two reasons...three reasons. I would feel good because it would, to some degree, describe how my future relationships will be and it'll be similar to what I've had before and I've really enjoyed that. I'd feel good because people I work with and I have become friends with, would be stable, so I'd feel good on their behalf, for them.

Interviewer: That would make it easier for you as well, wouldn't it? Okay, and the third one?

Interviewee: I don't know what to say about that.

Interviewer: That's fine.

Interviewee:I think I'd feel that those anxieties I had would just be lifted.

Interviewer: So what would happen if that doesn't happen. If they're laid off and gone. What would happen to you? What would you have to do now, you've got a new team to work with. What would that mean for you, working as a Nurse in Charge with a new team?

Interviewee:This is hard, because I've got my internal thoughts which I can share with you, and these are the kinds of thoughts that I can only share at home or in here. There is a very strong part of me that says; "Get this out. Get it done. Find out who's in and then rebuild and move forward with it." There's a big part of me that wants to know what that is because I'm biting at the bit, wanting to know. So then I can move into this, and this, and this. Bearing in mind that I won't be leading that team, but I want influence how that happens.

Interviewer :Why wouldn't you be leading that team?

Interviewee: Because my job is being disestablished and changing. So my job will go from being Charge Nurse to Nurse Practitioner and it's a good job.

Interviewer: What is good about it?

Interviewee: It's very clinical.

Interviewer: And what aren't you sure about? Because there's something you're not sure about.

Interviewee: What I'm not sure about is that if you take away the departmental manager and add a manager who's in charge of that area and another area, it's a little bit hands-off, a bit more senior, will it be a nice job description on paper, and it looks really good, but actually...

Interviewer: Obviously, you've read the job spec?

Interviewee: Yeah, but on a day-to-day basis, would it actually be the same; "Oh this is not working, that's not happening, we've got a problem with this". Will that really change or will I be able to say…

Interviewer: Other than the job spec, do you have any other issues; is that what the job's going to be, what it says on paper?

Interviewee: Not really.

Interviewer: Okay. What makes you think that it may not be what the paper says? Previous experience or have you seen it happening to others or yourself, personal experience?

Interviewee:I think it's because. Well I don't know. Maybe I'm worrying about it unnecessarily. I sometimes worry that I'm just worrying about this because I'm worried. This is how my worries are manifesting. I don't know that I've actually got any grounds for worrying about it, but I think it might be a problem, but I also think there's going to be a period of

transition, after which the re-shaping, then everything's going to settle down. Then it'll be how it should be.

Interviewer: So, how would you then feel, or think you are, if the job is exactly...let's say, in two months' time, you do the job and the job is exactly what the paper says. How would that make you feel?

Interviewee :I honestly think I'd love it...absolutely love it. I would be really focused and good at it. It's where my heart really is.

Interviewer: So, if it turns out to be exactly what the paper says, you would give it a ten.

Interviewee: Absolutely.

Interviewer: How would you feel If the job is a nightmare job, it's not what you actually planned for, or wanted or you had thought?

Interviewee: I think if it wasn't quite what I'd anticipated, but it gave me some of what I'd anticipate it would be a complete nightmare. I'd be really disappointed.
Interviewer: Okay, what else?

Interviewee: I would feel let down. I'd feel a bit stitched up and I would...I've said to myself that I would put a time-frame on things. If I really don't like it and it's really not good for me, and, if the quality of care has taken such a downturn that I'm not happy with it in terms of my own personal ethos, I would consider just saying; "Thank you very much, but it's not for me". I wouldn't say "Stuff it", or whatever, but I would look for jobs. I've kind of semi-looked and I don't think there is an awful lot but my career has got stronger and stronger. If it meant taking a break for a while, well, I'm financially stable enough to do that.

Interviewer: Right, so what you're saying to me is that, you've got a plan A and a plan B. Yes?

Interviewee :You haven't got the desperation that's attached to; "I have to do this, because I haven't got..." You know, the thought of not doing it is unthinkable and that's difficult, it

really changes your relationship to what you're doing. If you like, it becomes a complicated relationship. You need to have that...an element of choice, even if you don't deserve the choice.

Interviewer :And you think you do.

Interviewee: Yes, I do have it.

Interviewer: Yes, you do now. What about before?

Interviewee: Well, I think, before, I was so blinkered that I didn't actually explore it. So, my situation, in terms of my finances hasn't changed and my whatever hasn't changed.:No, the physicality hasn't changed. None of that has changed. What has changed is just the way I've been able to think it through; To really give it some thought. So I did a lot of soul-searching over the last twelve months, not really knowing what was coming.

Interviewer: Tell me a little about the soul-searching, what did you do?

Interviewee: I was on holiday, sitting on a beach and I was worrying about what may be coming, and I've really let my head go clear and think about what do I really...what would I like to do? What do I like in my job? What don't I like in my job? What do I like in my life? What don't I like in my life? And if I could do it all...

Interviewer: What do you really, really like about your life?

Interviewee: I really like working. I'm not ready to stop working. However, I looked at what working meant to me....

Interviewer: What does it mean to you?

Interviewee: It kind of means doing something useful and being involved that gives me the satisfaction of achievement and purpose, but also gives to the recipients something mutually beneficial.

Interviewer: What is the purpose of that, would you say?

Interviewee: Some of it's about self-actualisation and achievement. It can be on a basic, fundamental level.

Interviewer : so it is a human need for you.

Interviewee: It is, it's about social connection and social engagement.

Interviewer: And it's that purpose for you? Is that what you think work does for you? That's your purpose, yes?

Interviewee: Yes, and when I really looked at that and realised...I've always realised how much I get out of nursing and particularly nursing in my department, but it also allowed me to think about; If things were different, could I get the same qualities and features in other types of work or other types of activity which may not be conventionally classed as work? So I started to think around it.

Interviewer: Have you found any other job to make you feel the same?

Interviewee: Well, a couple of things came up. One was the possibility of my mother and sister run a children's nursery in East London and it's a very big family business and I wanted to have a conversation with them, that, if things really went belly-up, could they find a place for me, at any level, in any capacity that I could possible use some transferrable skills in? That was one avenue I wanted to explore as an option. Another one was, really, doing stuff that was more to do with the non-statutory services; Volunteering or coaching, something out in that kind of sector. Now I know there are jobs just as much in jeopardy, but I looked at qualities involved in them...very personal.

Interviewer: what exactly do you have in mind?

Interviewee :Well, like life coach, you know, that kind of...a lot of stuff to do with working with ex patients and chronic illness. That sort of stuff, that's on the softer end of things. But I wondered whether some of my skills would be...and even if I did that for a couple of days a week, that would be a really valuable use of my time and I feel I could bring something to the table.

Interviewer: So, you have clearly worked out options for you. there.

Interviewee : I started with...when I first got anxious, I started with a little filing cabinet and I had a single piece in the drawer which was called...it was called pensions, because that's where I keep my pension documents, but all it had was a pension statement. Then, when things got a bit complicated I started to call it my future jobs and pensions. For months it had nothing in it. When I'd look at it I'd feel disappointed because there wasn't anything in that drawer.

Interviewer: What made you start thinking about all this?

Interviewee: When they started talking about changing my job ...disestablishing my job. That was a real trigger for making me think about things in general. In a way, it's that old cliché about something that ___[00:34:06] can be an opportunity. I'm not a big changer and mover. I often do feel this effect and I rarely see it as an opportunity. However, I've found it in myself to see if it's not what I think it is on the can, what am I going to do? Am I just going to suck it up and moan and groan, and be embittered, angry, dispassionate, delivering something that I'm half-hearted at? I couldn't do that. I would almost rather take a sabbatical or a year out and just do something purely voluntary, and go and work in ___[00:34:48] for my skills and volunteer.

Interviewer: okay, that brings me to my next question...So what is it you want to experience more? What is it you want for now, and for the future? Or what would you like to experience more as a feeling?

Interviewee: What could be nice about this future job, and what's been whittled away in my current job, but over years, is that intimate, sharing, caring time with people who happen to be patients. When I'm feeling optimistic, I'm optimistic that this job will give me much more of that than actually... I can bring all that I have as a human, as a caring, generous, intelligent, articulate nurse and share in that with the patient and recognise them as an interesting human who's got health concerns or issues or worries, and work together on whatever needs...

Interviewer: So, onto my next question. If you were to put it in words, I mean, you have described this and it's really good. However, if I were to ask you; What is your goal, what is your next goal? What would that be, in one sentence? Or in one word, you choose. Instead of describing it, just label it for me.

Interviewee: It may be too many words, and it sounds like a cliché, but, I often think; To make a difference.

Interviewer: To make a difference? That's fine...

Interviewee : Yes, and I genuinely believe that the right people in the right circumstances really can make a difference.

Interviewer: Okay, I like that, but I want you to complete the sentence for me. To make a difference to whom?

Interviewee: To people.

Interviewer: To people in general? Not patients?

Interviewee: Well, I've actually started to step away from that now because I'm trying to make it a life philosophy. I really believe it's important with patients but I think it's as important when you're in the building to share that with colleagues, when you get on the bus...I know it sounds funny, but, just to share that love and kindness.

Interviewer: So, your goal in life, let's say, is to actually make a difference to people? So, are you talking more about feeling good about being a human being and connecting to other people. Is it the relationship you're talking about?

Interviewee: It's connecting with other people, but it's also through your actions, however simple those actions are. It's to have an impact.

Interviewer: So, to make a difference.. to connect, you say?

Interviewee: Yes. I mean, sometimes, it's a very superficial level, but I don't think you can under-value that superficial level. So, sometimes it is just making them feel good in that moment, about themselves or just about something. So, to give you an example; Someone who's very marginalised and is having a horrible day and they're

really at the lowest end of the pecking order and they're treated badly all the time. You just say something nice and you're kind to them, even if that's all you do with that person; I believe that makes a difference in their experience and it has an impact.

However, often, it's not just that, that you do. It's just your opener and actually then you, well, you dig deeper and deeper and you actually start to get to the nitty-gritty stuff and you make a bigger difference and a much more solid impact. It starts with...you have to start with the basics. The basics are just the first bit.

Interviewer: Okay, how does that make you feel, when people do those things to you? The little things, like a smile or...

Interviewee: It's great. It's really nice being on the receiving end. I don't fuss about things and I never expect that. When people do that and it's genuine, it means an awful lot. It's really nice. It makes the whole world seem nicer. It makes you feel cared for, makes you feel..

Interviewer: Tell me, where does it start, really?

Interviewee:You recognise it here, because you know, you see it. Often it's visual or it's auditory, so you hear it and then you go... But then, you just feel it...you feel it in your...

Interviewer: So, would you say it starts from your forehead and moves down to your chest?

Interviewee: Yes, you definitely feel it here...

Interviewer: In your chest, yes. How does it feel? How would you describe this feeling?

Interviewee: I don't know if it feels warm or if it just feels soft.

Interviewer: Soft?

Interviewee: Erm, just soft.

Interviewer:Just soft, and do you have a colour? Does it move?

Interviewee :No, it just stays here really. It's a very nice feeling I do.....I've never thought about what it is…So I can work on that really, which is a good skill for me to have to access this feeling.

Interviewer: So, your goal is to make a difference to people in general.

Would you say, to make them happy as well?

Interviewee: If happy is what they want.

Interviewer: Okay, that's interesting. If happy is what they want. Okay, what can that be then, if it's not happiness.

Interviewee: Sometimes people don't want happy, they want functional things, they want process; They want snappy; They want response, or whatever, and if that's what they want and you can do that, and you can get satisfaction in doing that. I know, now, that people / patients are very different. All sorts of spectrums of what people want. There's an art to judging and gauging what they want. I'm learning to take my cues from them.

Interviewer: That's great and thank you for your time today. We'll stop here. I'll turn this off.