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Emotional Intelligence And Caring Behaviors: Is There A Relationship?

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Emotional Intelligence and Caring Behaviors: Is There A Relationship?

by

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Abstract

Caring for others is stressful work. Research has shown that nurses are leaving practice

and have identified job-related stressors which lead to burnout as a primary cause. A

review of literature revealed that burnout is common in nursing and that this syndrome

decreases the quality of care, produces negative outcomes, and leads to a decline in

displaying caring behaviors. Studies identified that people who possess high levels of

emotional intelligence (EI) experience less burnout in their jobs. EI, a rising field of

study that includes the recognition, understanding, expression, and management of

emotions, may offer plausibility for effectively navigating occupational stress with the

goal of diminishing burnout and maintaining caring behaviors. The question was raised

as to whether or not a relationship exists between the level of emotional intelligence in

nurses and their ability to demonstrate caring behaviors in the clinical setting.

A quantitative, correlational study was conducted among a convenience sample of 100

nurses (n=100) in a mid-sized tertiary care center. Data was collected using Schutte's

Assessing Emotions Scale and Coates's Caring Efficacy Scale. Sixty-six percent of the

nurses surveyed placed in the top quartile on total scoring for emotional intelligence and

caring efficacy. Results revealed a positive statistically significant positive correlation ($r = 0.26$, $p < 0.007$) between the level of emotional intelligence in nurses and their ability

to demonstrate caring behaviors.

Keywords: emotional intelligence, burnout, caring, caring behaviors

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people have tremendous intrinsic value. It is with this in mind that I continue on in my

journey.

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CHAPTER I

Introduction

Problem Statement

Nursing has long been viewed as a nurturing profession with the concept of caring at its core (Peery, 2010). Caring for others is stressful work. Research has shown that within the first three years of practice, 30%-50% of all new registered nurses (RNs) either change positions or leave nursing altogether (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Aiken's study has remained relevant as evidenced in the American Association of Colleges (2010) projection that the nursing shortage may exceed 260,000 RNs by 2025. Studies have identified that the physical and emotional stress of the job, high patient acuity, inadequate staffing, perceptions of lack of respect, and little to no autonomy are reasons that nurses are less effective and find little satisfaction in their practice (Sumner & Townsend-Rocchiccioli, 2003).

Job-related stressors such as workload, time pressure, and role conflicts contribute to the phenomena known as burnout (Peery, 2010). Three primary themes that help to identify factors leading to burnout are: unfriendly work environments, emotional distress related to patient care, and fatigue and exhaustion (MacKusick & Minick, 2010).   The syndrome of burnout decreases the quality of care, produces negative outcomes, and imposes a decline in the demonstration of caring behaviors (Tellie, 2008). Emotional intelligence (EI), a rising field of study that includes the recognition, understanding, expression, and management of emotions, may offer plausibility for effectively navigating occupational stress with the goal of diminishing burnout and maintaining caring behaviors in the clinical setting. This study was designed to determine if a

relationship exists between the level of emotional intelligence in nurses and their ability to display caring behaviors in the midst of stressful factors.

Significance

At its historical roots, nursing has been grounded in an obligation to care and the majority of nurses join the profession because of an inner need to help others. This distinguishes nursing as an emotional work which is born out of intimate sharing moments with another at a vulnerable time. The intrinsic need to care often collides with the reality that nursing is dominated by medicine. Society has placed greater value on the knowledge of body processes than the ability to actually take care of the diseased body (Sumner & Townsend-Rocchiccioli, 2003). Modern healthcare, which is driven by productivity, reimbursement, technology, and increased workloads, has produced a huge gap between present-day nursing and its roots, leading to burnout and an inability to display caring behaviors in the clinical setting (Adair & Franklin, 2014).

Burnout and compassion fatigue are two distinct phenomena that explain consequentially why nurses are unable to provide quality care (Lachman, 2016). Tension arises as nursing tasks override the nurse's innate sense of caring and desire to connect with patients on a more holistic level. This tension becomes a breeding ground for stressful work environments. The American Nurses Association (ANA) asserted that stressful work environments provide high risk for burnout and compassion fatigue (ANA, 2010). Suboptimal work environments have serious implications that impact patient outcomes, increase the emotional and psychological stress for the nurse, and diminish the display of caring behaviors (Lowe, 2013). Further consequences that arise from burnout

are low morale, increased absenteeism, decreased effectiveness, lower job performance, less effective patient care, and higher nurse turnover (O'Mahony, 2011).

Emotional intelligence (EI), the ability to blend thoughts and feelings in order to effectively build meaningful, respectful relationships and make optimal decisions, may offer understanding in effectively coping with burnout and stressful situations. Nurses who possess better coping skills remain patient-centered in their daily work, interact more effectively, and have more positive outcomes. Training in EI has the potential to enhance self-awareness and bring about an increased sense of choice in thoughts, feelings, and actions. Growth in these areas could improve communication skills, give clarity in decision-making, and promote resilience in nurses collectively (Adair & Franklin, 2014). The tensions produced from competing values and agendas in healthcare would be better recognized and managed by those who possess high levels of EI (Rankin, 2013). Enhancing emotional intelligence in the nurse may serve to promote and maintain the nurse's ability to demonstrate true caring in the clinical arena.

Purpose

Nurses are leaving their jobs, as well as the nursing profession, in large numbers. Much of the departure has been attributed to emotional exhaustion. Research has indicated that high EI is correlated with low rates of emotional exhaustion and low rates of depersonalization in the clinical setting. Research suggests a strong correlation between high levels of EI and increased professional satisfaction, greater compassion, and more effective communication skills (Moraes, Wilson, Gajic, & Benzo, 2015). These findings have gained much attention in the scientific community as healthcare

personnel seek to understand how EI contributes to decline in burnout (Viachou, Damigos, Lyrakos, Channopoulos, Kosmidis, & Karavis, 2016).

The aging population in the United States calls for a larger number of providers of healthcare delivery. With this apparent need for delivery of care, it is necessary to build, maintain, and retain an effective, high-functioning nursing workforce. EI may be a critical link in training nurses to successfully navigate stressful situations while maintaining caring behaviors. EI is an indication of one's self-awareness, as well as awareness of others, that fosters strong relationships, interprofessional collaboration, and empathetic care delivery. The purpose of this study was to determine if a relationship exists between the level of emotional intelligence in nurses and their ability to demonstrate caring behaviors in clinical practice.

Conceptual Framework

Dr. Jean Watson's Theory of Human Caring served as the conceptual framework for this study. Watson stated that "caring begins with being present, open to compassion, mercy, gentleness, loving-kindness, and equanimity toward and with self before one can offer compassionate caring to others" (Watson, 2008b, p.xviii). Research indicates that as the connection between the patient and the nurse increases, the level of burnout decreases (Peery, 2010). Watson's theory capitalized on this and conceptualized nursing as a profession that moves the nurse beyond being a technician or skilled worker of medical technocure science (Watson, 2008a). Watson desired to illuminate the human caring process and inspire nursing to reintroduce love and healing into the clinical practice (Watson, 2012). She echoed the sentiments of Nightingale (1860) that the care of the body is not separate from the care of the soul. Watson illustrated the theory of

caring by stating that a nurse who performs tasks out of moral obligation is an ethical nurse, but that does not mean that the nurse cared about the patient (Watson, 2012). Watson denoted Caring Science as the foundation for the nursing profession (Watson, 2008a).

Core Principles/Practices: From Carative to Caritas

Watson's 10 carative factors served as the foundation for caring. These emerged into caritas processes to more accurately depict the connection between caring and love (Watson, 2008a). Caritas comes from the Latin word meaning to cherish, to appreciate, or to give special attention to. Charity, compassion, and generosity of spirit are embodied within the definition of caritas. Five core principles distinguish the differences in the process from carative to caritas and lay the groundwork for the future by connecting caring, healing, and human consciousness. The five core principles are: (1) practice of loving-kindness and equanimity; (2) authentic presence – enabling deep belief of other; (3) cultivation of one's own spiritual practice – beyond ego; (4) "being" the caring-healing environment; and (5) allowing for miracles (Watson, 2008a).

These principles served as the conceptual framework for understanding the correlation between EI and the demonstration of caring behaviors by the nurse in the clinical setting. Studies in Midwestern rural hospitals demonstrated that Watson's concepts of transpersonal caring relationships and caring moments are crucial for quality healthcare and delineate caring as positive connectedness, professional knowledge and skill, and attentiveness to others (Tanking, 2010).

Caritas Processes used in the Conceptual Framework

The concepts of Watson's Theory of Human Caring and the concepts of EI are closely linked. The Caritas Processes that are the body of Watson's work lend themselves toward the transpersonal and hold value when looking at nurse-patient interactions. Highlights of the Caritas Processes are:

- Practicing loving-kindness and equanimity for self and other

- Being authentically present: enabling, sustaining, honoring deep belief system and subjective world of self and other

- Cultivating one's own spiritual practices: deepening self-awareness; going beyond the ego

- Developing and sustaining a helping, trusting, authentic caring relationship

- Being present to and supportive of the expression of positive and negative feelings as a connection with the one being cared for

- Creative use of self and all ways of knowing, being, and doing as part of the caring process

- Engaging in genuine teaching and learning experiences within the context of a caring relationship

- Creating a healing environment at all levels

- Reverentially and respectfully assisting with basic needs

- Opening and attending to spiritual dimensions of life, death, and suffering (Watson, 2008a).

Watson's Theory of Human Caring as seen in these Caritas Processes is applicable to all populations and fosters true care at an intimate level. This offers a sense

of satisfaction and fulfillment to all parties in the experience. The increase in professional satisfaction correlates with greater compassion and increased manifestation of caring behaviors. A sense of fulfillment breeds a healthy work environment and may ultimately move nursing closer to its historical roots of caring. Through the caritas processes, Watson (2007) asserts that caring is the essence of nursing and the central focus of nursing practice.

Dimensions of Nurse Caring

Wolf, Giardino, Osborne, and Ambrose (1994) studied Watson's carative factors and consolidated the 10 factors into five dimensions of nurse caring: assurance of human presence, respectful deference, professional knowledge and skill, positive connectedness, and attentiveness to other's experiences. These human-to-human interactions are more easily carried out in healthy work environments that are patient-centered. As Watson has iterated, caring is intrinsic to the nurse-patient process and produces therapeutic results in the person being served (Watson, 1979).

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Thesis Question

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The following question was addressed in this study: Does a relationship exist between the level of emotional intelligence in nurses and their ability to demonstrate caring behaviors in clinical practice?

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Definition of Terms

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EI refers to the ability to identify and manage self and reaction to others' emotions (Mayer, Salovey, & Caruso, 2008). It consists of a four-branch model that includes the ability to perceive emotion, the ability to use emotion to facilitate thought, the ability to understand emotions through analysis and prediction, and the ability to

manage emotions (Rankin, 2013). EI simply stated is a characteristic of personality that people possess which enables them to recognize, understand, express, and manage emotions appropriately (Petrides & Furnham, 2000).

Caring is the central feature within the metaparadigm of nursing knowledge and practice in Watson's theory. It consists of the Caritas Processes and is the foundational core of the nursing profession (Watson, 2008a). Human caring is more than an emotion, concern, attitude, or benevolent desire. Caring is the moral ideal of nursing that results in protection, enhancement, and preservation of human dignity (Gadow, 1984). Nightingale was clear in her assertion that nursing is a calling and as such, caring is intrinsic in that calling (Watson, 2008a).

Caring behaviors include touching, listening, accepting differing beliefs and cultures, connecting and forming relationships, expressing empathy, and effectively communicating. Another aspect of caring behavior is the ability to provide a presence of serenity when entering a room. For the purposes of this study, the nurse's ability to demonstrate such behaviors will be measured by a self-efficacy rating scale.

Burnout is a three-dimensional syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment (Schaufeli & Enzmann, 1998). It occurs in settings where people work with other people. Individuals feel overextended and depleted emotionally, resulting in a detachment from others. In the clinical setting this would be the nurse detaching from the patient as well as co-workers. This emotional depletion and detachment causes feelings of incompetence and lack of success.

Summary

Modern healthcare delivery has produced a huge gap between the nurse's desire to care at a transpersonal level and the overarching task-driven work at the bedside. This dichotomy has produced tension that has led to burnout of nurses in the clinical setting. The population growth in the United States mandates a greater number of healthcare providers illustrating the significance of building, maintaining, and retaining a strong nursing workforce. EI is an avenue that has gained much interest for those in the healthcare arena who are searching to discover the relationship between nurse dissatisfaction, burnout, declining displays of caring behaviors, and positive patient experiences. Measuring and developing EI in nurses may be an answer to increasing the satisfaction of nurses, decreasing their levels of stress and burnout, and increasing their ability to demonstrate caring behaviors. Training in EI has the potential to enhance self-awareness and bring about an increased sense of choice in thoughts, feelings, and actions. Growth in these areas could improve resilience in nurses, ease the current tensions which exist in the clinical setting, and return nursing to its historical core of caring.

CHAPTER II

Literature Review

The purpose of this chapter was to present a comprehensive review of the literature relevant to emotional intelligence (EI), burnout, and caring behaviors in nurses. While research has demonstrated correlation between some of the related factors, few studies have approached the inter-relational aspect of these three concepts. The plausibility for exploring if a relationship exists may offer guidance in improving the delivery of healthcare.

Research has shown that nurses are leaving practice and have identified job-related stressors that lead to burnout as a primary cause. Studies have revealed that burnout in nursing decreases the quality of care and leads to a decline in caring behaviors. Research has suggested that people who possess high levels of EI experience less burnout. This raises the question of whether the EI level in nurses has a relationship with their ability to display caring behaviors in the clinical setting. The Cumulative Index for Nursing and Allied Health Literature (CINAHL) was used to search these concepts. The keywords burnout, caring, caring behaviors, and emotional intelligence were explored in the search.

Burnout in Nurses

Burnout, a psychological condition resulting from ineffective coping strategies and prolonged stress in the work environment, has been named as a major contributor to nursing shortages in acute care hospitals and clinics. This phenomenon affects the entire healthcare sector. Edward and Hercelinskyj (2007) conducted a literature review study and offered that the literature suggested a correlation between moral distress and burnout

in nurses which affected recruitment and retention. Burnout was demonstrated by chronic fatigue, exhaustion, cynicism, depression, suspiciousness, and feelings of helplessness oftentimes brought about by role conflict and role ambiguity. This produced ongoing stress and frustration in nurses. They further suggested that the caring aspect in nursing may carry with it an emotional burden for the nurse and bring about workplace fatigue.

A qualitative study conducted among members of a trauma team allowed them the opportunity to share perceptions of compassion fatigue and burnout syndrome as related to stress triggers and coping strategies. The study uncovered that both of these concepts were present among their unsuspecting team. Findings revealed that one-third of the team scored at high levels of burnout (Berg, Harshbarger, Ahlers-Schmidt, & Lippoldt, 2016). Previous studies acknowledged that these high levels of burnout are closely associated with job satisfaction and are correlated with the nurse practice environment. A study that included four Belgian hospitals went a step further and reported that variation in the practice environment coupled with feelings of burnout were predictors of outcomes and quality (Van Bogaert, Clarke, Roelant, Meulemans, & Van de Heyning, 2010).

One of the elements of burnout is compassion fatigue and like burnout, it also is characterized by exhaustion and distress. Research has shown that burnout and compassion fatigue in nurses decreases the quality of care delivered, tends toward negative outcomes, and imposes diminished ability to connect with others (Tellie, 2008). These factors serve as predictors for nurses leaving practice. MacKusick and Minick (2010) discovered three major themes when investigating why nurses are leaving the profession. Fatigue and exhaustion were listed in these themes with nurses often alluding

to the fact that they felt too tired to continue on in their practice. New graduate nurses also experienced burnout in relationship to their work environments which was demonstrated through emotional exhaustion (Laschinger, Finegan, & Wilk, 2009). Displays of emotional exhaustion were evident in their cynicism toward their work, their colleagues, and their low efficacy levels with patients.

Leiter and Maslach (2009) conducted a study to gain insight into the relationship between burnout and the intention of nurses to leave their job. As predicted, nurse workloads were strongly correlated with the burnout dimension of exhaustion. A surprising result of this study revealed that the clearest predictor of turnover intention was the dimension of cynicism. Cynical beliefs hold that people are generally selfish and dishonest so it was intriguing that this dimension carried the most weight. It provided practical implications for practice from nurse administrators. In Ireland, research was conducted among emergency nurses to determine if the exhaustion and burnout in these nurses were related to their work environment. Findings revealed that over half of the nurses surveyed experienced high levels of burnout, as demonstrated through exhaustion and depersonalization, and that it was directly related to the nature of the work environment. This correlation suggested that the better the working environment, the less burnout experienced (O'Mahony, 2011).

This literature review demonstrated correlations between burnout and the nursing shortage. Recruitment and retention of nurses for the provision of safe, high-quality care was revealed as being directly affected by the work environment. The quality of the care delivered was impacted by the syndrome of burnout, and if left unchecked, may lead to cynicism in bedside nurses.

Caring Behaviors

The concept of caring has always been at the core of nursing (Peery, 2010). A majority of nurses join the profession because of an inner need to help others. The intrinsic need to care often collides with modern healthcare, which is driven by productivity, reimbursement, technology, and increased workloads. This has produced a huge gap between present-day nursing and its roots. This type of tension has been linked to the phenomenon of burnout and an inability to display caring behaviors in the clinical setting (Adair & Franklin, 2014). As shown previously, work environments significantly affect burnout in nursing. Studies have also demonstrated that suboptimal work environments have serious implications that impact patient outcomes, increase the emotional and psychological stress for the nurse, and diminish the display of caring behaviors (Lowe, 2013).

Peery (2010) conducted a study to examine the relationship between carative factors and a nurse's level of burnout in a large group of nurses in North Carolina. Results indicated several positive correlations. Nurses who developed a relationship with patients and families showed a decrease in emotional exhaustion and a decrease in depersonalization. This act of connective caring increased job satisfaction which also decreased burnout. It was noteworthy that as the number of patients assigned to the nurse and their acuity increased, depersonalization also increased. This finding may indicate that nurse's personal satisfaction increases more as their connections with patients increase, not as they perform tasks. Returning to its roots of caring may provide nursing with a sense of fulfillment that is not given by technical tasks in the current medical model of care delivery.

In the United States, the Institute of Medicine's published report on the future of nursing was met with positive media coverage which accelerated the implementation of their recommendations supporting the professionalism of nursing (Institute of Medicine, 2011). Nurses in England have not received such support. Studies revealed that they have been labeled as uncaring and public support toward them has been unfavorable. The Prime Minister went so far as to accuse them of having uncaring attitudes and dismissed recommendations for them to obtain bachelor's level of education. As a result, Aiken, Rafferty, and Sermeus, (2014) joined forces to analyze the quality storm hitting the European nurses. Their research indicated that nurses in England were not uncaring, but rather were burdened by excessive workloads and an inadequate skill mix. Nurses' reports revealed that 44% of nurses who worked in hospitals in the National Health System in England scored in the high burnout range. Despite the high levels of burnout, no evidence was found that the attitudes of nurses towards their patients were negative. Nurses in England actually ranked higher than all others surveyed in the dimension of caring what happened to their patients. Results revealed that demanding workloads may be the best explanation of the uncaring perception as two-thirds of the hospital nurses reported no time to educate, talk with, or comfort patients. Chana, Kennedy, and Chessell (2015) reinforced the impact of work stressors on nurses in England and emphasized the importance of support of the well-being of the nursing staff to reduce burnout and improve the quality of caring behaviors.

In the medical model of healthcare delivery, caring has taken a backseat to skills and technology. The pendulum has begun to swing toward the caring factor as nurse caring and physician/nurse communication have become important quality indicators. A

correlational study conducted in the southwestern United States demonstrated statistically significant relationships between nurse caring and compassion satisfaction, nurse job satisfaction, stress, and burnout. Compassion satisfaction, the satisfaction derived from professional care-giving, was the greatest determinant in nurse caring variability. This was indicative of the reality that nurses who were happy in their work environment and found their work meaningful experienced higher levels of patient satisfaction in the caring dimension (Burtson & Stichler, 2010). However, it is important to recognize that one limitation in studies on caring is the difficulty in quantifying caring due to varied definitions and its somewhat elusive nature (Peery, 2010).

Emotional Intelligence

The literature search revealed that the majority of the research on EI has been associated with psychology and business. It has only been in the last few years that the healthcare professions have demonstrated interest in this concept. Kaur, Sambasivan, & Kumar (2013) demonstrated that EI, spiritual intelligence (SI), psychological ownership (PO), and burnout (BO) played a significant role in effecting caring behaviors in nurses. This was one of the few articles found connecting EI and caring in any manner. The research was carried out to identify factors that affected caring behaviors. Caring behavior was defined as the physical and affective care of nurses that provided physical and emotional comfort to patients. Results revealed that; (1) spiritual intelligence influenced EI and PO, (2) EI influenced PO, BO, and caring behavior of nurses, (3) PO influenced BO and caring behavior of nurses, (4) BO influenced caring behavior of nurses, (5) PO determined the relationship between SI and caring behavior and between EI and caring behavior of nurses, and (6) BO determined the relationship between SI and

caring behavior and between PO and caring behavior of nurses. It was determined that SI, EI, PO, and BO played a significant role in effecting caring behavior of nurses.

Rankin (2013) examined the relationship between EI and clinical and academic performance and retention in student nurses. Amidst concerns regarding a lack of compassionate care and values-based selection procedures, EI was studied as a potential factor to aid with these concerns. Results demonstrated a significant predictive index between EI, practice performance, academic performance, and retention. Nursing students experienced the emotional distress that arises from competing values in healthcare. This study proposed that those with higher EI would be better able to navigate and manage priorities. Results of the study demonstrated a significant correlation between academic performance and total EI scores. Perception of emotion and management of one's own emotions were both significantly correlated. Managing others' emotions and utilization of emotions were not significantly correlated. This study demonstrated a predictive relationship between scores on the EI survey and persistence, clinical performance, and academic achievement at the end of the first year of nursing studies. These findings suggested that academic institutions use EI scores to help determine suitability of candidates. This study was limited by the fact that it was only carried out in one institution and the institution's curriculum may have addressed EI.

Doas (2013) explored the potential outcomes of integrating emotionally competent behaviors into the care of psychiatric patients through a descriptive study of inpatient psychiatric nurses interactions. Emotional competence was defined as the ability to appropriately manage and express one's emotions without suppressing the emotions of others. The purpose of the study was to gain understanding of the

psychiatric nurse's level of emotional competence and to determine the degree to which it was demonstrated in interactions with psychiatric patients. Content analysis revealed deficits in self-awareness, mood management, and managing relationships. Since psychiatric patients regularly encounter stressful, clinical situations, researchers noted the importance of developing emotionally competent nurses.

McQueen (2004) conducted a literature search of EI and emotional labor to determine if EI had value in nursing for its potential benefits to patient care and staff welfare. Results revealed that EI plays an important role in forming successful human relationships and that emotional labor is necessary in establishing therapeutic nurse-patient relationships. Some considerations from this paper were the importance of understanding the value of EI with respect to nurses' emotional work, the need for development of EI in preparing nurses for their professional work, and the necessity for further research on EI in the healthcare arena.

Nurses provide care to those who are suffering and emotions are often heightened. Compassion is essential in effectively working with these patients. In order to be compassionate with others, nurses must first embrace self-compassion, the ability to be compassionate to one self. A descriptive, correlational study was conducted in New York to examine the relationship between self-compassion and EI. Results indicated a positive relationship between the two. An essential element in displaying compassion is recognition of emotions and their effect on behaviors. Emotions and the resulting behaviors affected the quality of the nurse-patient interaction. A study was conducted to gain insight into the level of EI of mental health nurses in the Netherlands. Results revealed that the nurses surveyed scored significantly higher in EI level than the general

population. Interestingly, females scored higher than males on subscales of empathy, social responsibility, interpersonal relationship, emotional self-awareness, self-actualization, and assertiveness (Van Dusseldorp, Van Meijel, & Derksen, 2010). This may bear significance in examining high stress situations in the clinical setting.

The role of EI and emotional labor on the well-being of nurses has also been examined. Findings supported the hypothesis that EI and emotional labor have significant effects on nurses' well-being and perceived job stress (Karimi, Leggat, Donohue, Farrell, & Couper, 2013). In adopting values of more holistic care, nurses have been encouraged to communicate more openly with patients. Nurses need proficiency in walking the thin line between expressing and managing their emotions. EI has been identified as a factor that contributes to nurse competency in this area.

Strengths, Limitations, and Gaps

A review of the literature illustrated the need for nurses to understand the phenomenon of burnout and its contributing factors in order to develop healthy work environments. Nurse administrators can use the results of this body of research in assessing workloads and processes in the clinical setting. Correlations have been determined between burnout, nursing retention, and the nursing shortage. With this growing body of research, programs and processes can be designed to diminish nursing burnout.

Limitations on studying caring behaviors have been the result of its elusive nature. Definitions of caring are diverse and may be linked to culture and social mores. This can be alleviated by clearly defining caring behaviors in each research study. Studies have shown a correlation between work environments, workloads, and displays

of caring in the hospital environment. Further research is needed to distinguish how to make improvements.

Connection has been shown between burnout and emotional intelligence. Little has been studied in healthcare in relationship to EI and its effect on caring behaviors. This topic could prove to be an important area for future research in looking at quality indicators involving caring behaviors.

Summary

Research data has been reviewed to predict the continued increase in the present nursing shortage. Studies have been conducted that revealed a correlation between nurse retention, nurse shortage, and burnout. Research has identified job-related stressors such as poor environment, excessive workload, and emotional labor in influencing diminished quality and less than favorable outcomes. Burnout has been shown to have a correlation with a decline in the demonstration of caring behaviors. Research has suggested that people who possess high levels of EI are better able to navigate stressful situations and experience less burnout. It has been demonstrated that nurses who develop therapeutic relationships with patients, experienced lower levels of exhaustion and depersonalization. EI has been linked as a factor in building successful relationships.

CHAPTER III

Methodology

Caring for others is stressful work. A strong correlation has been shown between job-related stressors and burnout in the clinical setting. Burnout caused a decline in the demonstration of caring behaviors. High levels of emotional intelligence strongly correlated with decreased emotional exhaustion and increased expression of compassion (Peery, 2010). The purpose of this study was to determine if a relationship exists between the level of emotional intelligence in nurses and their ability to display caring behaviors. This chapter presents the design, setting, sample, methods, and considerations regarding protection of human subjects, instruments, data collection procedure, and data analysis procedure used in this study.

Design

A quantitative, correlational design was used to examine the relationship between the level of emotional intelligence in registered nurses and their ability to demonstrate caring behaviors in the clinical setting.

Setting

This study was conducted in a 240-bed tertiary care center in the southeastern United States that employs over 700 registered nurses. The facility began as a small community hospital that has grown into a mid-sized tertiary care center over the last several years. Nursing services include medical/surgical, cardiac, progressive, intensive care, cardiothoracic intensive care, endoscopy, interventional radiology, emergency, observation, and perioperative. The expansion of service lines has resulted in a more diverse nursing population as well as an increasing patient population. In this fast-paced

clinical setting with service expansion and increasing volume, factors leading to burnout have increased. Has the nurses' level of emotional intelligence influenced their ability to display caring behaviors in this clinical setting?

Sample

A convenience sampling of the 700 nurses currently employed at the tertiary care center was used. A power analysis was completed using an estimated effect size and a two-tailed test. The analysis was based on an alpha of 0.05 with a power of 0.95 and it was determined that 76 participants were needed to complete the surveys. One hundred twenty-five nurses from various areas within the hospital, including observation, emergency, medical/surgical, cardiac, critical care, and peri-operative were approached about participating in the study. All of the nurses who were approached accepted the surveys and agreed to participate by completing the two questionnaires and returning them to a neutral, centralized location to ensure anonymity.

Methods

The study investigator approached 125 nurses from various areas of the tertiary care center, delivered a short script of instructions, and requested voluntary participation in the study for the purpose of obtaining a measure of perceived perception of their level of emotional intelligence, and also to measure perception of their ability to display caring behaviors in the clinical setting. Implementation of the study took place over a 10 day period. The study investigator individually distributed the surveys to a convenience sample of nurses during this ten day period. Each nurse that agreed to participate was given an unmarked manila envelope containing instructions, in the form of an informed consent (Appendix A), and two surveys. The surveys in each envelope were coded with

a corresponding number for correlational purposes. There were no identifiers other than the matching code numbers associated with the surveys. Nurses were asked to complete the surveys during breaks or non-work times in an effort to refrain from interrupting their daily assignments. Nurses were asked to return the completed surveys to a designated drop-off box in the administrative supervisors' office housed within the nursing administration offices of the facility.

Protection of Human Subjects

Permission to conduct the study was obtained from the organization's Nurses Scientific Advisory Committee and Institutional Review Board, as well as the Institutional Review Board of the university. This study was considered exempt due to minimal risk to participants. Prior to completing the surveys, each nurse was informed that the completion of the survey was considered as consent to participate. All participation was voluntary. No identifying data was placed on the surveys prior to research implementation. Upon completion, surveys were turned in at a drop-off box in a central location to maintain anonymity. Results were analyzed based on findings from the total number of participants. No individual results were reported. There were no risks to the nurses associated with this project and there was no associated penalty with refusal to participate. Results from this study, paper and the electronic flash drive, were stored in a secured location at the School of Nursing at the University for a period of three years. The electronic results were stored on a password protected computer.

Instruments

The Schutte Assessing Emotions Scale (Appendix B) was used to determine characteristic emotional intelligence. The scale was created and based on Salovey and Mayer's (1990) model of emotional intelligence. The original model proposed that there were four tenets to emotional intelligence: appraisal of emotion in self and others, expression of emotion, regulation of emotion in self and others, and utilization of emotion in solving problems. The original model described emotional intelligence as a mixture of traits and abilities. Mayer, Salovey, & Caruso, (2004) later refined their study and stressed an ability conceptualization of emotional intelligence. Other researchers focused on a trait approach that draws on self and other reports to glean information regarding the display of emotional intelligence characteristics in daily life (Neubauer & Freudenthaler, 2005). Schutte held both traits and abilities as significant aspects of emotional intelligence (Schutte, Malouff, & Bhullar, 2009).

The Schutte Assessing Emotions Scale consists of a 33-item self-report inventory that focuses on typical or trait emotional intelligence. Participants rate themselves on each item using a five-point scale. Scores can range from 33 to 165. Higher scores indicate higher trait emotional intelligence (Schutte et al., 2009). Schutte et al. (1998) determined the internal consistency of the scale to be .90 as measured by Cronbach's alpha. Numerous studies have derived that the mean alpha across the study samples is .87.

The Caring Efficacy Scale (Appendix C) was used to determine the perception of caring behaviors of the nurses. The scale, based on Watson's (1985) carative factors for forming caring relationships and responding to human need, was developed by Dr.

Carolie Coates in 1997. The original Caring Efficacy Scale demonstrated high consistency as noted in the Cronbach's alpha coefficient of .88 (Coates, 1997). It has been used in a variety of organizations to evaluate caring efficacy. Researchers across the world have used Coates' tool to evaluate caring in diverse healthcare settings. Dr. Jean Watson, author of the Theory of Human Caring, has recommended this tool as a measurement scale to assess nurses' beliefs about their ability to care. The scale, consisting of 30 items, rates items from "strongly disagree" to "strongly agree," with corresponding numerical values. Total scores range from 30 to 180 with higher scores indicating stronger caring efficacy.

Data Collection

Prior to completing the surveys, each nurse participant was given a brief explanation of the study and its purpose. The participants were informed that their answers were anonymous and that no identifiable markers were used in the surveys. They were instructed that the numbers on the surveys were strictly for correlational purposes and were not tied to any identifiable markers. Nurses were informed that completing the surveys was a voluntary action and upon agreement to participate, each nurse was given a manila envelope containing an instruction sheet for completing the surveys, Schutte's Assessing Emotions Scale, and Coates' Caring Efficacy Scale. Each participant was informed that completion of the surveys was considered as their consent to participate in the study.

Surveys were distributed by the research investigator to a convenience sample of nurses working in different areas of the tertiary care center. Areas included in the distribution of the surveys were medical/surgical units, cardiac units, intensive care units,

observation units, perioperative units, and the emergency department. Each participant

was asked to answer the survey questions based on their recent interactions with patients.

The participants were instructed to return the completed surveys in the manila envelope

to a drop-off box at a centralized location, the Administrative Supervisor office, in the

nursing administration office.

Data Analysis

The data was analyzed based on total score comparison of the surveys. The

Schutte Assessing Emotions Scale rated the 33-items using a five-point scale. Total scale

scores were calculated by reverse coding items 5, 28, and 33, and then summing all of the

items. Scores ranged from 33 to 165. Higher scores indicated higher trait emotional

intelligence.

The Caring Efficacy Scale rated the 30 items with responses from "strongly

agree" to "strongly disagree." Scores on items that were rated in the negative sense on

the Caring Efficacy Scale were reversed so that totals across items would have meaning.

Responses of "strongly agree" were coded as "6" and responses of "strongly disagree"

were coded as "1". Total scores ranged from 30 to 180 with higher scores indicating

stronger caring efficacy.

The data of the total scores was inputted into a Microsoft Excel worksheet by

placing the total score of each Assessing Emotional Intelligence Inventory in column B

and the total score of each Caring Efficiency Scale in column C. The data analysis

package in Microsoft Excel was used to determine the correlation and the statistical

significance of the relationship among the variables. Pearson's correlation coefficient

was used to determine if a relationship existed between the level of emotional

intelligence and the perception of caring demonstrated through the caring efficacy scale.

Regression analysis was used to determine the statistical significance through the p value.

CHAPTER IV

Results

The purpose of this study was to determine if a relationship exists between the level of emotional intelligence in nurses and their ability to demonstrate caring behaviors in the clinical setting. Surveys were distributed to 125 registered nurses over a period of 10 days. The surveys served as a tool for measuring the nurses' perceived perception of their level of emotional intelligence, and also to measure perception of their ability to display caring behaviors. Each nurse received two surveys, Schutte's Assessing Emotions Scale and Coates's Caring Efficacy Scale. The nurses returned the completed surveys to a drop box in a neutral location to maintain anonymity in the study. Coding and reverse coding, as indicated by the authors of the surveys, were used to calculate total scores on the surveys. Data analysis was conducted on the total scores using Pearson's correlation and regression statistics for statistical significance to determine if a relationship existed between these two concepts.

Sample Characteristics

One hundred and twenty-five surveys were distributed to nurses working in various areas of the hospital and 107 surveys were returned to the drop box in the nursing supervisor's office in nursing administration for an 86% participation rate. Seven of the individual surveys contained one unanswered question each. Those surveys were deemed incomplete and were removed from the calculations and omitted from the sample size. The surveys with corresponding numbers were also omitted in each of these instances since no relationship could be determined. The final sample size for the study after omissions was 100. The primary investigator scored each survey by using the

instructions of the survey authors on coding and reverse coding of the answers to the

questions. Data analysis was conducted to obtain Pearson's correlation (*r*), which

determined if a relationship existed between the total scores on the corresponding

surveys. Regression statistics was used to analyze all data and calculate the *p* value for

statistical significance.

Major Findings

The Schutte Assessing Emotions Scale contained 33-items that were rated using a

five-point scale. Total scale scores were calculated by reverse coding specific items as

instructed by the author of the survey, and then summing all of the items. Scores can

potentially range from 33 to 165. For participants in this study, scores ranged from 105

to 156. Higher scores indicated higher trait emotional intelligence. Anyone scoring over

132 rated in the top quartile for EI. Of the 100 survey participants, 66 scored in the top

quartile (66%) (Appendix D).

Coates's Caring Efficacy Scale consisted of 30-items containing responses from

"strongly agree" to "strongly disagree." Responses of "strongly agree" were coded as

"6" and responses of "strongly disagree" were coded as "1". The author of the Caring

Efficacy Scale identified specific items that were rated in the negative sense and

instructed that these items be reverse coded so that totals across items would have

meaning. Total scores could range from 30 to 180 with higher scores indicating stronger

caring efficacy. In this study, the participants' scores ranged from 122 to 161. Those

scoring 143 or above placed in the top quartile for caring efficacy. Sixty-six of the 100

(66%) participants scored in the top quartile.

Pearson's correlation was conducted to determine if a relationship existed between the total scores on emotional intelligence and caring efficacy. Results demonstrated a positive, statistically significant correlation, $r = .26$, $p < .007$, (Appendix E), indicating that a relationship existed between the level of emotional intelligence and the ability to demonstrate caring behaviors.

Summary

Survey results from a convenience sampling of 100 nurses currently employed at a tertiary care center in the southeastern United States demonstrated that 66% of the nurses surveyed were in the top quartile on total scoring for emotional intelligence and caring efficacy. These results revealed a statistically significant positive correlation ($p < .007$, $r = .26$) between the level of emotional intelligence in nurses and their ability to demonstrate caring efficacy.

CHAPTER V

Discussion

Nursing is a profession with caring found at its core. However, caring for others is stressful work and studies have demonstrated that physical and emotional stress are contributing factors that make nurses less effective and lead to the phenomenon of burnout (Peery, 2010). Burnout decreases the quality of care, produces negative outcomes, and imposes a decline in the demonstration of caring behaviors (Tellie, 2008). Modern healthcare, driven by productivity, reimbursement, technology, and increased workloads, has played a significant role in burnout development and an inability to display caring behaviors in the clinical setting (Adair & Franklin, 2014). Burnout from the stress of the job has caused many to leave nursing altogether and has further increased the shortage of nurses to provide care. It has been demonstrated that burnout is impacted by EI (Kaur et al., 2013). EI, a rising field of study that includes the recognition, understanding, expression, and management of emotions may offer plausibility for effectively navigating occupational stress with the goal of diminishing burnout and maintaining caring behaviors in the clinical setting. The purpose of this study was to discover if a relationship exists between the level of emotional intelligence in nurses and their ability to demonstrate caring behaviors.

Implication of Findings

Over the past four or five years, the healthcare professions have begun to show an interest in the role that emotional intelligence plays in the healthcare arena. One of the few studies connecting EI and caring behaviors demonstrated that EI, spiritual intelligence (SI), psychological ownership (PO), and burnout (BO), contributed

significantly to effecting caring behaviors in nurses (Kaur et al., 2013). Caring behavior was defined as the physical and effective care of nurses that provided physical and emotional comfort to patients. This previous research linking EI and caring behaviors has been enhanced by this research study that demonstrated a positive, statistically significant correlation, $r = .26$, $p < .007$, between the level of emotional intelligence in nurses and their ability to demonstrate caring behaviors. This finding implies that since a correlation exists, enhancing emotional intelligence in nurses may positively impact caring behavior and care outcomes.

Application to Theoretical Framework

Peery (2010) indicated that the level of burnout in nurses decreases as the connection between the patient and the nurse increases. Watson's Theory of Human Caring (2008) which conceptualizes caring and personifies the caring relationship, served as the framework for this study. The body of Watson's work is found in the Caritas Processes which lend toward the transpersonal and find value and meaning in nurse-patient interactions. Watson (1979) iterated that caring is an intrinsic reality in the nurse-patient relationship which produces therapeutic outcomes in the person being served. Watson (2007) asserted that caring is the essence of nursing and the central focus of nursing practice.

One highlight in the Caritas Processes is cultivating one's own spiritual practices which go beyond the ego and deepen self-awareness. A second process builds on this and encourages the nurse to be present and supportive of positive and negative feelings when connecting with the one being cared for. These two processes reveal the significance of EI and its impact on human interactions. The Theory of Human Caring

aids in giving expression and meaning to human interaction and validates the importance of transpersonal caring moments.

Human caring is more than emotions, attitudes, concerns, or benevolent desires. Gadow (1984) depicted caring as the moral ideal of nursing that protects, enhances, and preserves human dignity. Nurses who deliver caring at this level possess the ability to perceive, express, understand, and manage emotions appropriately. Training in this ability, referred to as EI, has the potential of enhancing the nurse's sense of choice in thoughts, feelings, and actions, which would improve resilience in nurses and provide greater opportunity to express caring.

Limitations

While the data demonstrated a positive, statistically significant relationship between EI in nurses and their ability to demonstrate caring behaviors, its strength is not overwhelmingly strong. This may have been limited by the fact that both surveys were based on the self-perception of the nurses. Nurses who possessed lower EI may not have accurate perceptions of themselves or others. Nurses who scored lower and demonstrated less self-awareness also possessed less awareness of others. This diminished awareness affects the quality of the nurse-patient interactions.

More meaningful data may have been obtained if those who work with the nurses who participated in the study had also completed a survey on their perception of those nurses and their interactions with others. This would have enabled the investigator to compare self-scores with scores of others and enhance the depth of the survey. Due to the constraints of time and expense, it was not feasible for the researcher to obtain the additional input from others.

A second limitation of this study was that no demographic data was obtained on the participants as to how long they had been in nursing, their level of nursing education, their job satisfaction, or their level of stress on the job. Based on previous research, this information may have added other dimensions to this study and offered a broader range of understanding. Constraints of time and resources once again prevented this researcher from exploring these added dimensions within this study.

Despite these limitations, this study demonstrated a positive relationship between EI in nurses and their ability to demonstrate caring behaviors in the clinical setting and laid a foundation for additional research in the future. Hopefully, the findings from this study will offer a rationale for future research initiatives to examine the extent of effect that these concepts offer to the nursing workforce. Owing to the mentioned limitations, the researcher will suggest some recommendations for future research which will expand on the findings demonstrated in this study.

Recommendations

The findings of this present study offer guidance for maintaining and retaining a professional nursing workforce. The positive relationship that has been demonstrated provides inspiration for future healthcare delivery through the development of EI in the nursing profession to provide patients with caring interactions. It is recommended that additional studies be conducted that add others perceptions of nurses and their interactions to this new body of knowledge to add depth and dimension to existing results.

Since a positive correlation has been demonstrated between these concepts, it would be interesting to develop a training program geared toward nurses to assist in

enhancing EI. One nursing unit in a hospital could be utilized to conduct the study. Prior to implementation of the study, patients and nurses on the unit would be surveyed to obtain a baseline on perception of EI and caring behaviors by the nursing staff. The program would begin with a standard series of interview questions that gauge EI in nursing applicants followed by an orientation that includes EI training. Interactive quarterly workshops on various aspects of EI would also be held on the unit. At the end of one year, surveys of nurses and patients would be repeated to compare pre and post scores on these concepts. Evaluation could also be conducted to determine the impact on nurse retention and burnout rate in light of the training. Demographic data could be included to inform length of the careers of the nurses and their satisfaction with their work. It is important to note that all training should revolve around the theory of caring and its impact on personal interactions and outcomes.

Conclusion

It is no secret that the professional nursing workforce is in a state of crisis. RNs have increasingly made the decision to leave the clinical field which has produced a shortage in those needed to provide quality, compassionate care. The American Association of Colleges (2010) projected that the nursing shortage may exceed 260,000 RNs by 2025. Unhealthy work environments, emotional distress related to patient care, fatigue, and exhaustion have been found to be primary reasons for this exodus. Modern healthcare delivery, driven by productivity, reimbursement, technology, and increased workloads, has contributed to burnout and turnover in a group of people who entered the profession to serve and care for others.

EI, a rising field of study in healthcare, has been defined as an indication of one's self-awareness as well as awareness of others that fosters strong relationships, interprofessional collaboration, and delivering empathetic care. Studies have determined that those with high EI have the ability to blend thoughts and feelings in order to effectively build meaningful, respectful relationships and make optimal decisions. Previous research has linked EI and positive outcomes. This study has added to that body of knowledge through demonstrating the positive relationship between the EI level in nurses and their ability to demonstrate caring in the clinical setting. Clearly seen is the idea that understanding and measuring emotional intelligence in the nursing workforce could impact nurse retention and influence caring behaviors. Dr. Jean Watson's Theory of Human Caring undergirded this study through the illumination of the human caring process and served as an inspiration to reintroduce love and healing into clinical practice. EI impacts caring, and caring is the foundation of the nursing profession. This present-day study practically applied the Theory of Human Caring in the clinical setting. Its results support previous research highlighting the effectiveness of EI in relationship to burnout and caring. The positive correlation between the concepts encourage the development of EI in the nursing workforce to positively impact caring behaviors one interaction at a time.

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Appendix A

Informed Consent

Dear Nurse,

As part of the requirements for the Master of Science in Nursing Degree, I am conducting a study on the emotional intelligence and caring behaviors of nurses. You are being invited to participate in this research study. Prior to participating, it is important for you to understand the purpose of the study and what participation entails.

The purpose of this research study is to determine if a relationship exists between the level of emotional intelligence in nurses and their ability to demonstrate caring behaviors in the clinical setting. You are being asked to complete the two surveys provided which will take 15-20 minutes total time. Based on your interactions with patients over the past thirty days, please select the responses that most closely describe your interactions.

There is minimal risk associated with your participation as there are no identifying markers included in the surveys. The numbers on the surveys are strictly for correlating the survey responses and do not identify you in any manner. Your participation is strictly voluntary and there is no penalty associated with refusal to participate. Completion of the survey will serve as your consent to participate.

There will be no direct benefits to you for participation in the study. My hope is that the information obtained from this study will be useful in adding to the body of nursing knowledge regarding demonstration of caring behaviors in the clinical setting.

The Institutional Review Board (IRB), a group of people who review research to ensure that participants' rights are protected, are involved in this process. If you have questions about your rights as a research participant, have concerns or questions, or would like additional information, you may contact the Chairman of the IRB at (704) 355-3158.

Should you have questions about this research study, please contact the primary researcher, Deborah Johnson, at djohnson17@Gardner-Webb.edu or Dr. Quanza Mooring at qmooring@Gardner-Webb.edu.

By returning the completed survey to the drop-off box in the Administrative Supervisor office, you are confirming that you have read and understand this information. Your return of the survey also confirms your consent and your understanding that your participation is voluntary.

Thank you for your participation and your commitment to the nursing profession.

Appendix B

The Assessing Emotions Scale

Directions: Each of the following items asks you about your emotions or reactions associated with emotions. After deciding whether a statement is generally true for you, use the 5-point scale to respond to the statement. Please circle the "1" if you strongly disagree that this is like you, the "2" if you somewhat disagree that this is like you, "3" if you neither agree nor disagree that this is like you, the "4" if you somewhat agree that this is like you, and the "5" if you strongly agree that this is like you.

There are no right or wrong answers.   Please give the response that best describes you.

1 = strongly disagree
2 = somewhat disagree
3 = neither agree nor disagree
4 = somewhat agree
5 = strongly agree

1. I know when to speak about my personal problems to others.   1   2 3 4 5

2. When I am faced with obstacles, I remember times I faced
      similar obstacles and overcame them.   1   2 3 4 5

3. I expect that I will do well on most things I try.   1   2 3 4 5

4. Other people find it easy to confide in me.   1   2 3 4 5

5. I find it hard to understand the non-verbal messages of other
      people.   1   2 3 4 5

6. Some of the major events of my life have Jed me to re-evaluate
      what is important and not important.   1   2 3 4 5

7. When my mood changes, I see new possibilities.   1   2 3 4 5

8. Emotions are one of the things that make my life worth   living.   1   2 3 4 5

9. I am aware of my emotions as I experience them.   1   2 3 4 5

10. I expect good things to happen.   1   2 3 4 5

11. I like to share my emotions with others.   I   2 3 4 5

12. When I experience a positive emotion, I know how to make it   1   2 3 4 5

13. I arrange events others enjoy.   1 2 3 4 5

14. I seek out activities that make me happy.   1 2 3 4 5

15. I am aware of the non-verbal messages I send to others.   1 2 3 4 5

16. I present myself in a way that makes a good impression on others.   1 2 3 4 5

17. When I am in a positive mood, solving problems is easy for me.   1 2 3 4 5

18. By looking at their facial expressions, I recognize the emotions people are experiencing.   1 2 3 4 5

19. I know why my emotions change.   1 2 3 4 5

20. When I am in a positive mood, I am able to come up with new ideas.   1 2 3 4 5

21. I have control over my emotions.   1 2 3 4 5

22. I easily recognize my emotions as I experience them.   1 2 3 4 5

23. I motivate myself by imagining a good outcome to tasks I take on.   1 2 3 4 5

24. I compliment others when they have done something well.   1 2 3 4 5

25. I am aware of the non-verbal messages other people send.   1 2 3 4 5

26. When another person tells me about an important event in his or her life, I almost feel as though I experienced this event myself.   1 2 3 4 5

27. When I feel a change in emotions, I tend to come up with new ideas.   1 2 3 4 5

28. When I am faced with a challenge, I give up because I believe I will fail.   1 2 3 4 5

29. I know what other people are feeling just by looking at them.   1 2 3 4 5

30. I help other people feel better when they are down.   1 2 3 4 5

31. I use good moods to help myself keep trying in the face of obstacles.   1 2 3 4 5

32. I can tell how people are feeling by listening to the tone of their voice   1 2 3 4 5

33. It is difficult for me to understand why people feel the way they do   1 2 3 4 5

Appendix C

Caring Efficacy Scale

30 items

Instructions: When completing these items, think of your work in clinical settings and/or similar experiences. Complete the following scale based on your work with clients or patients. Please indicate your degree of agreement with each item. (Circle the number which best expresses your opinion.)

Rating Scale:

-3 strongly disagree	+1 slightly agree
-2 moderately disagree	+2 moderately agree
-1 slightly disagree	+3 strongly agree

	strongly disagree					strongly agree
1. I do not feel confident in my ability to express a sense of caring to my clients/patients.	-3	-2	-1	+1	+2	+3
2. If I am not relating well to a client/patient, I try to analyze what I can do to reach him/her.	-3	-2	-1	+1	+2	+3
3. I feel comfortable in touching my clients/patients in the course of care giving.	-3	-2	-1	+1	+2	+3
4. I convey a sense of personal strength to my clients/patients.	-3	-2	-1	+1	+2	+3
5. Clients/patients can tell me most anything and I won't be shocked.	-3	-2	-1	+1	+2	+3
6. I have an ability to introduce a sense of normalcy in stressful conditions.	-3	-2	-1	+1	+2	+3
7. It is easy for me to consider the multi-facets of a client's/patient's care, at the same time as I am listening to them.	-3	-2	-1	+1	+2	+3
8. I have difficulty in suspending my personal beliefs and biases in order to hear and accept a client/patient as a person.	-3	-2	-1	+1	+2	+3
9. I can walk into a room with a presence of serenity and energy that makes clients/patients feel better.	-3	-2	-1	+1	+2	+3
10. I am able to tune into a particular client/patient and forget my personal concerns.	-3	-2	-1	+1	+2	+3
11. I can usually create some way to relate to most any client/patient.	-3	-2	-1	+1	+2	+3
12. I lack confidence in my ability to talk to clients/patients from backgrounds different from my own.	-3	-2	-1	+1	+2	+3
13. I feel if I talk to clients/patients on an individual, personal basis, things might get out of control.	-3	-2	-1	+1	+2	+3

14. I use what I learn in conversations with clients/patients to
   provide more individualized care.   -3   -2   -1   +1   +2   +3

15. I don't feel strong enough to listen to the fears and concerns
   of my clients/patients.   -3   -2   -1   +1   +2   +3

16. Even when I'm feeling self-confident about most things, I still
   seem to be unable to relate to clients/patients.   -3   -2   -1   +1   +2   +3

17. I seem to have trouble relating to clients/patients.   -3   -2   -1   +1   +2   +3

18. I can usually establish a close relationship with my
   clients/patients.   -3   -2   -1   +1   +2   +3

19. I can usually get patients/clients to like me.   -3   -2   -1   +1   +2   +3

20. I often find it hard to get my point of view across to patients/
   clients when I need to.   -3   -2   -1   +1   +2   +3

21. When trying to resolve a conflict with a client/patient, I
   usually make it worse.   -3   -2   -1   +1   +2   +3

22. If I think a client/patient is uneasy or may need some help,
   I approach that person.   -3   -2   -1   +1   +2   +3

23. If I find it hard to relate to a client/patient, I'll stop
   trying to work with that person.   -3   -2   -1   +1   +2   +3

24. I often find it hard to relate to clients/patients from a
   different culture than mine.   -3   -2   -1   +1   +2   +3

25. I have helped many clients/patients through my ability to
   develop close, meaningful relationships.   -3   -2   -1   +1   +2   +3

26. I often find it difficult to express empathy with
   clients/patients.   -3   -2   -1   +1   +2   +3

27. I often become overwhelmed by the nature of the problems
   clients/patients are experiencing.   -3   -2   -1   +1   +2   +3

28. When a client/patient is having difficulty communicating
   with me, I am able to adjust to his/her level.   -3   -2   -1   +1   +2   +3

29. Even when I really try, I can't get through to difficult
   clients/patients.   -3   -2   -1   +1   +2   +3

30. I don't use creative or unusual ways to express caring to my
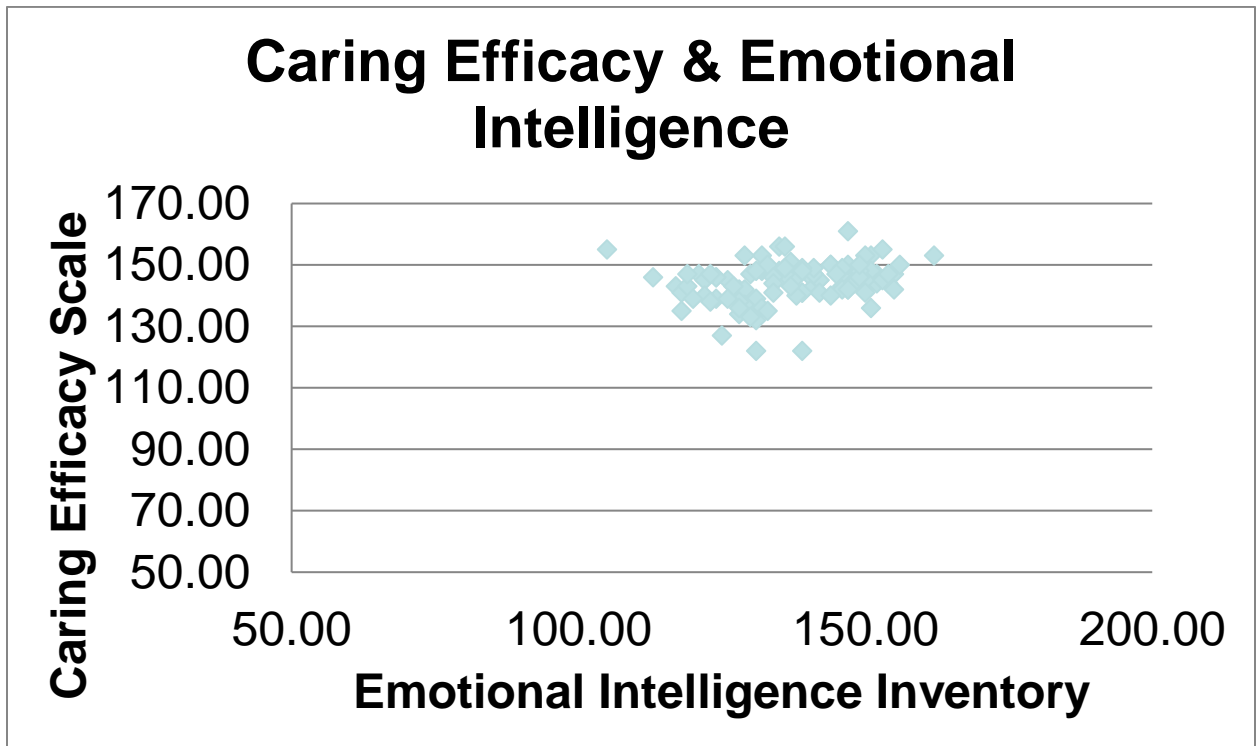   clients/patients.   -3   -2   -1   +1   +2   +3

Word file: CARINGB.SLF

Appendix D

Total Scores

Total scores on both surveys scored in the top quartile.

Caring Efficacy & Emotional Intelligence

Appendix E

Results Table

Results demonstrated a positive statistically significant correlation between level of emotional intelligence and caring efficacy.

SUMMARY OUTPUT

Regression Statistics	
Multiple R	0.264184
R Square	0.069793
Adjusted R Square	0.060301
Standard Error	6.376564
Observations	100

ANOVA

	df	SS	MS	F	Significance F
Regression	1	298.9742	298.9742	7.352928	0.007908
Residual	98	3984.736	40.66057		
Total	99	4283.71			

	Coefficients	Standard Error	t Stat	P-value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	123.5331	7.67392	16.09779	2.85E-29	108.3045	138.7618	108.3045	138.7618
EI Inventory	0.151209	0.055763	2.711628	0.007908	0.040549	0.26187	0.040549	0.26187