This is a postprint version of the article published as:
Konow Lund, A. S., Heggestad, A. K. T., Nortvedt, P., & Christiansen, B. (2017). Developing mature empathy among first-year students: The learning potential of emotional experiences. Nordic Journal of Nursing Research, 2057158517722057.

Words 5174

Developing mature empathy among first year students – the learning potential of emotional experiences

Introduction

Nursing students are expected to develop the ability to care for patients and their immediate families in a sensitive and empathetic manner. The Norwegian National Curriculum for Nursing states that after graduation, students should have the capability to meet the individual patient and their next of kin with sensitivity, empathy and moral accountability[1]. Hoffman[2] emphasizes that the premise of mature empathy is that nurses are able to differentiate between themselves and others concerning emotional reactions in different situations. The student`s ability to develop mature empathic behaviour is particularly important in a profession like nursing, where one often meets people with disorders and emotional reactions that may seem alien and overwhelming. If nursing students are to develop a mature empathy, it requires emotional involvement, as well as the ability to work with their own emotional reactions. Thus their education has to provide students with the means to enhance their empathic potential[3, 4]. Clinical placements are important for the students' understanding of patients' reactions and emotional states[5].

Several studies have highlighted how nursing students are emotionally challenged by the patients' suffering[6-8]. In order to improve our understanding of how first year nursing students develop empathy in relations with patients and their next of kin, we conducted a qualitative study. This study is the first part of a longitudinal study on nursing empathy where the aim is to investigate students' empathic abilities at the onset of their nursing education, and how these develop as their studies progress.

Background

Empathy is a complex concept, often understood as the ability to comprehend and share the feelings of another person. Empathy has joint affective and cognitive components which interact with each other[9, 10]. Affective empathy, or "empathic distress" as the American moral psychologist Hoffman[2] describes it, refers to feelings of being upset upon observing someone in actual distress. Empathic distress is an involuntary and immediate emotional response, reflecting the experiential state of another person. As the phenomenologist Scheler states that when one sees the other`s kindness in an outstretched hand, the other`s grief in his tears, this is not based on reflection, but immediate experience[11, 12]. While affective empathy (empathic distress) involves how a nurse is affected emotionally, cognitive empathy discusses how nurses seek to understand their patient`s thoughts and feelings by putting themselves into the patient's situation, aiming at a true impression of the patients` experiences [10, 13]. Whether the nurse is able to act as a "mature empathizer" (which means taking the patient's perspective rather than their

own), depends on their ability to differentiate their own reactions from those of others, and thereby act as a subject in a given situation[2, 9, 14]. At times empathic distress can be so painful and intolerable for the observer that it is transformed into an intense feeling of personal distress or a state of “empathic over-arousal” which them forces the observer out of their empathic mode[2].

Nursing students’ ability to develop their own emotional qualities in caring for patients is usually associated with caring experiences in relation with patients and next of kin[1, 3, 15]. Hochschild[16] has shown what emotional work may involve for professionals in relationships that require dedication and empathy. Applied to nursing this work implies striving for a relationship between what one feels and what one expresses in a professional relationship (”deep acting”). Events in one’s own life that are of relevance to the situation may emerge spontaneously or may be deliberately recalled, and then act as an "as if" - repertoire of emotionally charged memories. Meanwhile, attention must be turned away from oneself, to view the patient from his/her own point of view [16]. Although this is an insight that can be transferred to student's learning processes, we seem to know little about how these processes manifest themselves during clinical placements in nursing education.

Studies related to nursing students and their levels of empathy have been largely quantitative studies which have identified students' empathic skills and abilities at various points in their education. McKenna, Boyle [17] conducted a study which assessed empathy

levels and regard for specific medical conditions in undergraduate nursing students, and found that students demonstrated acceptable empathy levels, while findings in another longitudinal study over one year showed a statistically significant decline of empathy amongst nursing students in periods where they were exposed to patients encounters during study periods[18]. Similar findings are also seen in an interdisciplinary studies of pharmacy, law, and nursing students where the nursing students showed a decline in empathy, in relation to the other students[19]. Other studies have found that although nursing students have a cognitive perception of ideal palliative nursing close to death, the actual experiences of patient death and dying scared them[7, 8]. Findings in an Israeli study showed that nursing students coped with emotional strains by distancing themselves[6]. However Ouzouni and Nakakis [20] also found that 6th semester nursing students displayed more emphatic abilities than the 1st semester students. Results from a Norwegian qualitative study showed that role-playing among nursing students appears to have potential for learning how to handle the tension between being emotionally involved but not overwhelmed, and to relate to patients in a personal way without being overly self-centered[15]. In another qualitative study among third year medical students in Norway, findings showed that the students struggled with handling their emotions. The findings indicated that cynicism was used as a strategy to handle the demanding feelings when facing the suffering of a patient[21].

Although themes concerning the development of empathy have been addressed in earlier studies, few qualitative studies have investigated how nursing students develop the ability to empathize with patients and how this ability evolves during their education.

Aim

Drawing on data from the first part of the study, this article addresses the characteristics of situations that evoke strong emotions among the students, as well as the learning potential of these experiences. The research questions were: What characterizes situations in a nursing home that evoke strong emotional reactions in first year students? What is the learning potential of these experiences?

Method

Design

The study has an interpretive and explorative design. Qualitative interviews are well suited to provide insight into characteristics of situations that students experienced as emotionally challenging, and that affected them personally[22]. We used in-depth interviews as we wanted the students to give voice to how they reacted and handled such situations.

Participants

Eleven students, who were in their first practical placement in a nursing home, were recruited in February 2013 through purposive sampling in collaboration with teachers at the Nursing Faculty. Four teachers were asked to introduce the research project to students they were supervising in four different nursing homes. The students who wanted to participate were asked to sign a list which was given to the researchers. Nine women and two men volunteered (age range 20-32). The researchers provided further written information about the aim and background of the project. Before their first placement in the nursing home the students had passed a course in ethics and communication. The communication course primarily focused on skills training while the ethics course contained theory lessons.

Data collection

The interviews were conducted in Mars and April 2013 both during, and right after the students' first practical placement in a nursing home. We used a semi-structured interview guide that also allowed the informants to describe their experiences in their own terms[23]. At the beginning of each interview, we asked the students to describe situations with patients` that had affected them emotionally. The aim of this first open question was to gain as rich descriptions as possible, thus reducing the influence by our prior understandings of the theme. The situations the students described were followed up by

elaborative questions from the interview guide: *What did you feel in the situation? What did you think? What was it in the situation that affected you? Can you describe how you were affected? How did you act in the situation?*

Two of the participants had met the primary author through previously supervision, and were therefore interviewed by the secondary author. Each in-depth interview lasted from one to one and a half hours. The interviews were held in the nursing home where the students had their placement, or in a meeting room at the faculty of Nursing. All interviews were audio recorded and transcribed verbatim by a professional transcriber.

Data analysis

A hermeneutic approach to data analysis was used, where the research question was the basis of a reflective interpretation[22]. Two researchers analysed the transcripts following Kvale & Brinkmann's[23] three-level interpretation method. The first level reflected the self-understanding of the informants. At this level of analysis the transcripts were read as openly as possible, trying to gain a sense of the whole. Initial meaning units that derived from the data were identified by colour-coding, and involved a search of the entire material for similar and contrasting utterances. The second level, critical common-sense understanding, included a wider frame of understanding than the self-understanding of the informants. Discussions in the research group uncovered nuanced meanings related back to the initial meaning units. Thus the meaning units were restructured and condensed

into preliminary categories across all interviews. Further discussions and re-reading of the content of each category was a process where three themes eventually emerged:

1) *Characteristics of situations that evoke strong emotions*
2) *See themselves in the patient's situation*
3) *Alternative ways of dealing with such situations*

This level of interpretation is reflected in the presentations of findings. Quotations from the transcribed material underpin and exemplify our interpretations. The third level of interpretation supersedes common-sense understandings by using theoretical frameworks and previous research, and is reflected in the discussion[23].

Ethical considerations

Approval for the study was obtained from the Norwegian Social Science Data Services (NSD) and from the dean of the nursing faculty. The students received written information on the background and aim of the study, including information about their right to withdraw from the study at any time. Written informed consent was collected prior to the data collection.

Methodological considerations

In accordance with Kvale & Brinkmann[23], we understand validity as being linked to the entire research process. Concerns about validity were salient when we decided not to

include our own students we dealt with in practical placements. If we included our own students, this might have played a part in how and what the students said in the interviews. Although emphasis was placed on allowing the participants to talk freely in concrete form on the themes in focus, the fact that both of the interviewers were teachers may have influenced the course of the interviews to some degree. The conducting and analysing of qualitative interviews is always influenced by the prior understanding of the researchers. However, the validity of this work was strengthened during the analytic process because we then were four researchers with variations in prior understanding. According to Kvale & Brinkmann[23], different interpreters are sources of fruitfulness and virtues of interview research. We did not perform respondent validation and return transcripts to the students as an opportunity for the respondents to engage with and add to transcriptions and interpreted data[24], however we emphasized the clarification of meaning during the initial interviews.

Findings

Characteristics of situations that evoke strong emotions

All the students described situations in which they had been affected by the patients' diseases and suffering. A common feature of the situations was that they aroused strong emotional reactions among the students. One example was situations that in one way or

another were related to death and dying. It seemed that students were unprepared for the changes they would see in the patient`s condition, and to meet family members in mourning. Students appeared to be emotionally overwhelmed, which made it difficult for them to comprehend what had happened:

> E: When I came in and saw that she was dead, I was shocked, because I had seen her a week before in good shape (...). I was a bit afraid (...) It was difficult to understand it. That she was lying here. (...) I feel very sure that it is sad for their next of kin.

The students also described how they were filled with sadness when faced with patients who in different ways exemplified death and expressed a lack of motivation for continued living. The students were usually unprepared for these conversations, when they suddenly had to relate to the patient's personal loss and their wish for life to come to an end:

> R: I'm usually happy and satisfied here, but when it comes to residents who say: "Oh, life is unbearable. I am old and frail, I can`t bear to live any longer". So I think it's quite sad. (...). When they are 95 years old and everybody around them has died. Maybe one person in their family is left, and lives on the west coast….

Situations where patients suffered from pain during procedures also aroused strong emotions among the students. Despite their intense desire to help, experiences like this made students feel as though they were doing something wrong, and led to feelings of

inadequacy and guilt, and/or a bad conscience. In one example, a student told about her reactions when she participated in a morning care routine with patient with a large decubitus (bed sore):

> F: (...) I feel that I inflict her pain (...) I feel simply naughty when I go in there ... it's not a good feeling to help her. (…) I don`t have any good conscience when I leave that room...

Other students also described how they got frustrated and irritated when they thought the staff should have done more to alleviate pain among nursing home patients:

> S: (...) I'm actually a little irritated (…) I think that she could have received more pain relief. (...) She has so much pain every day. (...) There is something about being as old as she is, and then to end your life having so much pain every day… I do not think that anyone deserves it. Although there are so many educated nurses here, I think maybe they ignore pain relief a little…

Besides the fact that situations related to death and pain were mentioned by several students, they also described other challenging situations that resulted in strong emotional reactions among them. In many of these situations they could feel insecure and perplexed. A few students described how they reacted when faced with patients who suddenly changed their behaviour. One student described how a male patient's unstable and to some

extent aggressive behaviour affected her and made her unsure about what she did was right or wrong:

> L: (...) I experienced that the first time I was going into his room he was in a bad mood and yelled at me. And I was really not quite prepared for it, so I struggled a lot with it. I took it very personally, all that he said (…) you feel ... You are not so confident in what you are doing. So one becomes a little ….. Unsecure.

Another student described an episode where a pleasant conversation about a patient's personal photos suddenly changed when the photos reminded the old man of the loss of his wife who had died a few years earlier:

> E: It was a very nice photo so I asked who the woman was (…). He said it was taken at the cabin he had built himself, and that it was his wife who had died six years ago. (...) He began to cry and I felt that it was very tough and I didn`t know what to say, I felt very sorry for him, and it affected me.

Seeing themselves in the other`s situation

For several of the students the situations seemed to evoke associations from their own lives:

> K: It has happened several times where I've experienced patients that for example have looked like my mother, or talked like my mother.
>
> E: I just thought, "I wonder if this person has young grandchildren at the same age as me when I lost my grandparents". I remember I thought it was very tough and sad.

For some the immediate recognition could arouse such strong feelings and memories that the distinction between the student's individual experiences and the patient's situation was blurred:

> V: Then there was a man two weeks ago, he was told that he had recovered from cancer (…) no spread of cancer. He was so happy! He began to cry. Then I really had to struggle to hold back my tears (...). Because I have a mother who also has had cancer. I sort of know what it is like to receive the message that there is no spread of cancer, and having had that fear too.

Other students imagined feelings they assumed the patient had. In one example, a student described how she reacted in a morning care situation where the patient received help with personal hygiene and dressing. The elderly woman was asleep and unprepared when the caregiver without warning pulled off her duvet. The patient became distressed and angry and struck the caregiver:

O: If I had been treated in the same a way, I would have beaten the caregiver too (...) I do not like it if my husband comes and takes the duvet off ', then I'll be really angry. (...). But I don`t like others to touch me or pull of my duvet, or my clothes. It's very like that, (…) I feel a bit like … not completely safe. I do not like it, it's my body, and it's private.

Ways of dealing with such situations

Most of the students expressed a strong desire to help the patient, but were unsure about what they should say or do. This could lead to a passive behaviour because they did not know what was "right" to do in the situation. An example was the student who chose not to follow up the patient's initiative to explore thoughts about death because he felt insecure about what the patient's was best, and where the conversation would lead them.

Other students described different ways to handle situations. Three students who had experienced the same patient with great pain, as well as weak hearing and vision, described how they tried to divert the patient's attention during a complicated morning care situation with a painful wound procedure:

F : (...) I heard she was fond of singing, so I tried to sing along with her, but she doesn`t hear very well, so you almost have to sing into her ear. Sometimes it helps

> a bit, and she begins to sing along with you (...). I always try to tell her what I'm doing before I do it. I don`t know how much effect it has, but I do it anyway… so you just have to be very, very, very careful, trying to have a gentle hand (...).

Several students also described that they observed how nurses handled situations before they chose a way to proceed. Sometimes they were critical of the way the nurse handled situations. A student expressed that he would not adapt to ways of talking about a dying patient because according to the student, some of the employees seemed indifferent. Other times observation of nurses gave support to how they would act in similar situations, in order to protect not only the patient, but also themselves. A student told about a patient with major mood swings, who both scared and hurt her. Observing how a nurse handled the situation, and reading literature, had increased her understanding of the patients' reactions and helped her to protect herself in the situation:

> L: (...) it affected me a lot, everything he said. Then I read a little about the disease, and all the other diseases of his, and learned not to take it personally (...).the previous time I was there I just watched what the nurse did, (...). Then I saw that he (the patient) was a bit, like, in a bad mood, but she handled it very well. (...), they told me you just have to respond (…) say that no, you're not allowed to talk to me like that. It`s not pleasant.

To experience the same kind of situation several times was described as an important part of developing confidence and a greater repertoire of actions in challenging situations. One example illustrates how a student handled a situation related to death, the second time round:

> E: (...) so many feelings came the first time that I was overwhelmed by what happened. While the second time, it was strange in the same way, but I was able to put what I felt aside and focus on the patients` sadness. It wasn`t they who should comfort me. Now I had to try to support them instead of being sad. (...) I believe that the third time I might handle it more professionally than I did the second time (…).

By experiencing challenging situations several times, it appears that the students experienced more "control" with their feelings, which in turn gave them greater autonomy and a sense of being "professional".

Discussion

The development of emotional involvement as a caring quality among students is usually associated with experiences in relationship with patients[1]. Our findings show that some learning situations experienced by first year nursing students in a nursing home were extremely emotionally challenging in several ways. Hallmarks of the situations included

the students' encounters with the patients' helplessness, pain and death. The feelings experienced by the students included sadness, fear, inadequacy and guilt. Even if such situations require empathic, compassionate concern[2, 3], the students were overwhelmed by their own feelings, which rendered them less capable of acting in a way they wanted to. Other studies have showed that although the students at the beginning of their education had a cognitive perception about ideal nursing close to death and pain, they described their own insufficiency, lack of experience and fear of death[8, 25]. According to Nortvedt[10], the ability to become spontaneously and emotionally affected in situations where other persons suffers, is a first and necessary step towards knowing and expressing empathy towards another human being. On the other hand, being overwhelmed by their own feelings as our study largely describes, may be an expression of what Hoffman[2] has described as "empathic over- arousal". This is a state where the student's personal distress moves her/him out of the empathic mode entirely. As our findings showed, it may mean that students possibly withdraw or remain passive in situations that create discomfort or fear. Arieli[6] also found that students coped with emotional strain by distancing themselves.

Other findings in our study showed that emotionally challenging encounters with patients evoked memories and associations from the students' personal lives (lived experiences). Recalling relevant memories and experiences from their own lives supports the imagination of "as if", which may serve as a resource to feel and express more empathy[16].

Empathic imagination, or putting oneself in “the shoes of another”, is a central empathic ability which is related to a person`s emotional repertory, influenced by his or her biographical experiences with empathic response from intimate others. In this way, to have been met with empathy oneself, strengthens the ability to show empathy to others[10]. In a qualitative study from Finland, Mikkonen et al.[26] found that teachers’ empathic attitudes had a positive impact on their students’ professional development and their learning environment.

As mentioned above, awakening memories and feelings can be a source of sensitivity and compassion, but may also cause a blurred distinction between patients and students experiences. To address the right owner of feelings in a given situation is, according to Hoffman[2], a necessary exercise on the way to develop " mature empathy". As argued in other studies[15, 21] the students have to work on their emotions, particularly on how close or distant to be with patients and their families in critical times.

Other findings show that the first-year students tried out alternative ways of dealing with these challenging situations, even though they felt overwhelmed, insecure and in their own opinion, unable to act in a professional way. They utilized nurses as role models and sources of knowledge. Nevertheless the students were also critical about how some nurses handled vulnerable situations, and tried to find their own way of relating to patients. In a qualitative study among student nurses in the UK, Jack and Wibberley[27] found that the influence of other nurses on the students emotional coping whilst on clinical placement,

was reported as negligible or largely negative. In our study the students were also partly left to themselves and tried on their own to help patients to cope with pain, anxiety or grief. According to Benner, Tanner [28] and Alligood[4], testing different actions and behaviours in practice is essential for nursing students in order to develop relational qualities such as commitment and empathy. Even though students` direct experiences with patients and their next of kin is essential in their development of mature empathy, findings indicate that support from clinical nurses was sparse during this learning endeavour. As other studies have emphasized, students often want more supervision than they receive during clinical placements[5, 27, 29]. The findings of this and other studies should alert nurses (as well as teachers) to the importance of helping students develop empathy as part of their learning trajectory in nursing education.

Conclusion

This study has shown that facing emotionally challenging situations during their first clinical placement in nursing education aroused strong feelings and commitment among the students. Facing vulnerable and suffering patients evoked memories and feelings from their own lives, which may be a resource for developing empathy, but also contributes to an over identification with the patients. When the students are overwhelmed by their own emotions it is easier to react on behalf of themselves than the patient. They did however try to find ways to handle emotionally challenging situations both with support in scientific literature, as well as from experience. The nurses were important role models,

but could also exemplify characteristics of less empathic behaviour. Developing "mature empathy" requires emotional work so that the students learn to adapt themselves to what will be demanded of them as professional nurses. In that sense further knowledge as well as supervision from nurses and teachers may help the students to maintain the ability to be touched by patient suffering and conditions, but in a manageable way. Because nurses often are pressed for time in nursing homes, teachers should have a particular responsibility for helping the first year students to reflect on, and utilize, the learning potential of emotional experiences. The students would thereby be supported in their development of mature empathy, as well as receiving a personal and social grasp of the core concepts and skills of ethics and communication, as taught in their classes at the Faculty of Nursing.

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