Inteligencia Emocional y variables relacionadas en Enfermería

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Universitat de Barcelona

Tesis Doctoral

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Abril 2013

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A toda mi familia,
por su apoyo y ayuda en estos años
en los que he podido compartir con todos ellos
ilusiones, incertidumbres y dudas.

A Juan Carlos que confió en mí y
siempre pensó que sería posible.

A Andrea y Mario por su amor incondicional
y su paciencia en los momentos
en los que estaba ausente.

A todos ellos, muchas gracias por estar ahí.

Encauzar las emociones es darles un sentido,
el sentido más idóneo para que la humanidad progrese
y que la convivencia entre las personas no se deteriore

Victoria Camps
El gobierno de las emociones

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ÍNDICE GENERAL

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I.

RESUMEN / ABSTRACT

RESUMEN

La Inteligencia Emocional (IE) hace referencia a las habilidades para percibir, comprender y gestionar los estados emocionales. Desde su popularización, el constructo de la IE ha constituido uno de los conceptos más investigados y difundidos en la literatura científica.

En el ámbito de la enfermería, la investigación formal de la IE es todavía un fenómeno reciente. No obstante, diversos autores afirman que la IE constituye una competencia fundamental para los profesionales de enfermería y defienden que para establecer relaciones terapéuticas es necesario identificar y comprender las emociones propias, así como las emociones de los pacientes y sus familiares. Asimismo, consideran que los profesionales de enfermería han de saber gestionar eficazmente las emociones que suscitan el contacto continuado con la enfermedad y la muerte. Sin embargo, a pesar de estas valoraciones, el entrenamiento en habilidades emocionales no ha estado suficientemente considerado en la formación superior de estos profesionales y no está integrado en gran parte de los currículos formativos.

Esta tesis doctoral pretende aportar conocimientos empíricos sobre la relación entre la competencia emocional de los enfermeros y su labor asistencial, así como la relación con otras variables, específicamente aquellas que evalúan el impacto que la muerte causa en estudiantes y profesionales, como la ansiedad, depresión, miedo y obsesión ante la muerte. Asimismo, se pretende aportar evidencia científica para desarrollar un programa de educación emocional que facilite el afrontamiento de los conflictos emocionales en los futuros profesionales de enfermería.

Los objetivos generales de este estudio fueron: profundizar en el conocimiento de las características y componentes de la IE, así como, analizar las características de los principales instrumentos existentes para su evaluación; revisar la literatura científica disponible sobre este constructo en el ámbito de la enfermería; analizar las relaciones existentes entre la IE y otras variables socioemocionales relacionadas con el impacto que produce el fenómeno de la muerte en estudiantes y profesionales de enfermería; analizar las propiedades psicométricas de la Trait Meta-Mood Scale, instrumento que evalúa la inteligencia emocional percibida (IEP), en el ámbito de la enfermería y, finalmente, proponer un modelo de competencias socioemocionales para la formación de futuros profesionales de enfermería.

Participaron, en los diferentes estudios empíricos, una muestra de 1544 estudiantes de enfermería y 209 enfermeras que respondieron, de forma voluntaria y anónima, a un cuestionario con datos sociodemográficos, la forma española de la Trait Meta-Mood Scale (TMMS-24), para evaluar la IEP en sus tres dimensiones (claridad, atención y reparación emocional), así como, diferentes instrumentos, según los objetivos específicos de cada uno de los estudios. Las variables e instrumentos utilizados, en sus versiones españolas, en la totalidad de estudios que aparecen en esta tesis doctoral, son: ansiedad ante la muerte (Death Anxiety Inventory-Revised – DAI-R; Death Anxiety Scale - DAS), depresión ante la muerte (Death Depression Scale-Revised – DDS-R), miedo a la muerte (Collet-Lester Fear of Death Scale – CLFDS), obsesión ante la muerte (Death Obsession Scale – DOS), riesgo suicida (Plutchik Suicide Risk Scale – SRS), depresión (Zung Self-Rating Depression Scale – SDS), ansiedad (Trait scale of the State-Trait Anxiety Inventory – STAI-T), alexitímia (Toronto Alexithymia Scale – TAS) y autoestima (Rosenberg Self-Esteem Scale – RSES).

Los principales resultados obtenidos sugieren que el Trait Meta-Mood Scale (TMMS-24), en su versión española, es un instrumento válido y fiable para evaluar la IEP en el contexto de enfermería. Asimismo, los resultados indican que los estudiantes que prestan más atención a sus emociones, tienen más dificultades para afrontar la idea de la muerte y presentan niveles más altos de ansiedad y miedo. Por el contrario, una mejor comprensión y gestión de los procesos emocionales disminuye el distrés emocional que causa el impacto de la muerte. En esta línea, las enfermeras con niveles más altos de comprensión y gestión emocional, presentan menor ansiedad ante la muerte y altos niveles de autoestima. Por otra parte, los resultados indican que un 14% de los estudiantes de enfermería presentan un riesgo suicida sustancial y que la depresión y la atención emocional son predictores significativos del mismo. En este sentido, parece imprescindible implementar programas de detección precoz de transtornos mentales, especialmente de signos y síntomas de depresión.

A la luz de los resultados, podemos concluir que las habilidades emocionales de los estudiantes y profesionales de enfermería forman parte fundamental del cuidado de los enfermos y de las decisiones de la práctica asistencial y deberían incluirse en los programas de formación de la profesión. Las habilidades asociadas con la IE, ayudarían a los futuros profesionales a afrontar eficazmente las emociones que suscita el contacto continuado con la enfermedad y el sufrimiento ajeno y

promover, a su vez, habilidades que permitan un crecimiento personal y bienestar profesional.

ABSTRACT

Emotional Intelligence (EI) refers to the ability to perceive, understand and manage emotional states. Since its popularization, the construct of EI has been one of the most researched and disseminated concepts in scientific literature.

In the field of nursing, formal research into EI is still a recent phenomenon. However, several authors claim that EI is a core competency for nurses and argue that establishing therapeutic relationships is necessary for them to identify and understand their own emotions and the emotions of patients and their relatives. They believe that nurses need to know how to effectively manage the emotions that result from continued contact with disease and death. Nevertheless, emotional skills training has not been sufficiently considered in the advanced training of these professionals and neither is it integrated in their training programs.

This doctoral thesis aims to provide empirical knowledge about the relationship between emotional competence of nurses and nursing care, and the relationship with other variables, specifically those that assess the impact that death has on students and professionals, such as death anxiety, death depression, fear of death and death obsession. It also seeks to provide scientific evidence to develop an education program that facilitates coping with emotional conflicts for future nursing professionals.

The general aims of this study were: to increase knoledge about the characteristics and components of EI, as well as to analyze the characteristics of the main instruments for assessing EI; to review the available scientific literature on this construct in the field of nursing, to analyze the relationship between EI and other socio-emotional variables related to the impact that the phenomenon of death has on nursing students and professionals; to analyze the psychometric properties of the Trait Meta-Mood Scale, an instrument that assesses perceived emotional intelligence (PEI), in the field of nursing, and ultimately, to propose a model of socio-emotional skills for training future nurses.

The different empirical estudies have involved a sample of 1544 nursing students and 209 nurses who responded, voluntarily and anonymously, to a questionnaire about sociodemographic data, the Spanish form of the Trait Meta-Mood Scale (TMMS-24), to evaluate the PEI in its three dimensions (clarity, emotional and attention), as well as different instruments, according to the specific objectives of each of the studies. The variables and instruments used, in their Spanish versions, in all studies reported in this thesis are: death anxiety (Death Anxiety Inventory-Revised - DAI-R; Death Anxiety Scale - DAS), death depression (Death Depression Scale-Revised - DDS-R), fear of death (Collet-Lester Fear of Death Scale - CLFDS), death obsession (Death Obsession Scale - DOS), suicide risk (Plutchik Suicide Risk Scale - SRS), depression (Zung Self-Rating Depression Scale - SDS), anxiety (Trait scale of the State-Trait Anxiety Inventory - STAI-T), alexithymia (Toronto Alexithymia Scale - TAS) and self-esteem (Rosenberg Self-Esteem Scale - RSES).

The main results obtained suggest that the Trait Meta-Mood Scale (TMMS-24), in its Spanish version, is a valid and reliable instrument for assessing the PEI in the context of nursing. The results also indicate that students who are more aware of their emotions have more difficulty coping with the idea of death as well as having higher levels of anxiety and fear. However, a better understanding and management of emotional processes decreases emotional distress caused by death impact. In this way, the nurses with higher levels of understanding and emotional management have lower death anxiety and higher levels of self-esteem. Moreover, the results indicate that 14% of nursing students present a substantial suicide risk, and depression and emotional care are significant predictors of the same. In this sense, it seems essential to implement prevention programs for mental disorders, especially with the signs and symptoms of depression.

In light of the results, we can conclude that students' and nurses' emotional skills are an essential part of patient care and clinical practice decisions, and they should be included in professionals' training programs. The skills associated with EI help future professionals to deal effectively with the emotions aroused by continued contact with the disease as well as the suffering of others and it promotes, in turn, skills that enable personal growth and professional welfare.

II

MOTIVACIÓN PERSONAL Y LÍNEA DE INVESTIGACIÓN SOBRE LAS EMOCIONES

MOTIVACIÓN PERSONAL

Uno de los aspectos que ha marcado mi trayectoria desde el punto de vista profesional, tanto desde la perspectiva docente como investigadora, ha sido la experiencia como profesora en la asignatura de “Enfermería en Cuidados Paliativos”.

Mi objetivo fundamental como docente en esta materia ha sido siempre ofrecer una visión de la muerte como un proceso natural que debe ser integrado en la vida, además de procurar conocimientos sobre los cuidados que una enfermera debe prestar a los pacientes al final de la vida y a sus familiares. No obstante, he podido observar, a lo largo de estos años, que los estudiantes muestran temor a hablar sobre la muerte y, específicamente, a verbalizar o reflexionar sobre sus creencias, experiencias y emociones sobre este fenómeno.

El impacto que la muerte causa en los estudiantes, la dificultad que presentan para comunicarse con los enfermos en esta situación y con sus familiares, y la vivencia personal de la muerte de los enfermos durante sus prácticas clínicas, como una situación emocionalmente muy intensa y angustiosa, hizo que me planteara la necesidad de evaluar empíricamente el impacto emocional y las habilidades emocionales de las que disponían los futuros enfermeros para enfrentarse a estas situaciones. Las habilidades comunicativas y socioemocionales son una parte fundamental para el cuidado efectivo de pacientes y familiares y constituyen, sin duda, un elemento que otorga calidad a sus cuidados.

Las emociones juegan un papel fundamental en nuestras vidas y las enfermeras hemos de aprender a vivir con ellas. En las instituciones sanitarias nos encontramos con muchas personas enfermas que están sufriendo dolor, que están muy tristes por su situación o muy ansiosas ante un posible diagnóstico fatal. En muchas ocasiones, los profesionales se enfrentan a este ambiente, emocionalmente intenso, en condiciones adversas y en ámbitos de asistencia muy complejos como son las situaciones de urgencia, los entornos muy especializados, que requieren rapidez de respuesta, o los contextos de falta de personal y otros recursos, como en estos momentos de crisis económica.

Todos estos aspectos han incrementado mi interés por evaluar la Inteligencia Emocional, tanto en estudiantes como en profesionales, en el ámbito de Enfermería, y

analizar las posibles relaciones entre la Inteligencia Emocional y las variables relacionadas con el impacto que puede causar la muerte. Con esta tesis se pretende aportar evidencia científica relevante para diseñar programas educativos específicos en el Grado de Enfermería que desarrollen habilidades socioemocionales. La implementación de programas de formación específicos de Inteligencia emocional en enfermería proporcionaría a los estudiantes habilidades emocionales y estrategias para ofrecer mejores cuidados y, a su vez, les ayudaría a enfrentarse mejor a las emociones propias y a las de sus pacientes y familiares.

LÍNEA DE INVESTIGACIÓN SOBRE LAS EMOCIONES

Como he comentado con anterioridad, la línea de investigación personal sobre las emociones en enfermería se inició hace ya unos 10 años. A lo largo de este tiempo se han realizado diversas investigaciones sobre el tema que configuran lo que llamamos los estudios preliminares de la tesis doctoral cuyos resultados ayudaron al diseño de la misma y al establecimiento de los objetivos específicos. En concreto, además de estos estudios preliminares especificados en esta tesis, las investigaciones sobre las emociones y la docencia durante estos años han dado lugar a 17 artículos publicados en revistas nacionales e internacionales, en colaboración con distintos autores; 45 comunicaciones orales y posters presentados en congresos y 9 colaboraciones en manuales y libros sobre la materia.

Por otro lado, durante el desarrollo de la tesis se ha hecho realidad en nuestras universidades la adaptación de los estudios al Espacio Europeo de Educación Superior. Los resultados de las investigaciones previas sobre la inteligencia emocional aportaron argumentos para diseñar una línea curricular de formación en competencias socioemocionales en el Grado en Enfermería, cuyo planteamiento se describe en las publicaciones derivadas de la tesis. Paralelamente, se han realizado otros estudios que profundizan en las relaciones entre la Inteligencia emocional y otras variables tan relevantes en la relación enfermera-paciente como la empatía.

A continuación se puede observar en la Figura 1 los estudios preliminares de la tesis, los estudios presentados para su valoración y los estudios que se han llevado a cabo de forma paralela a la misma

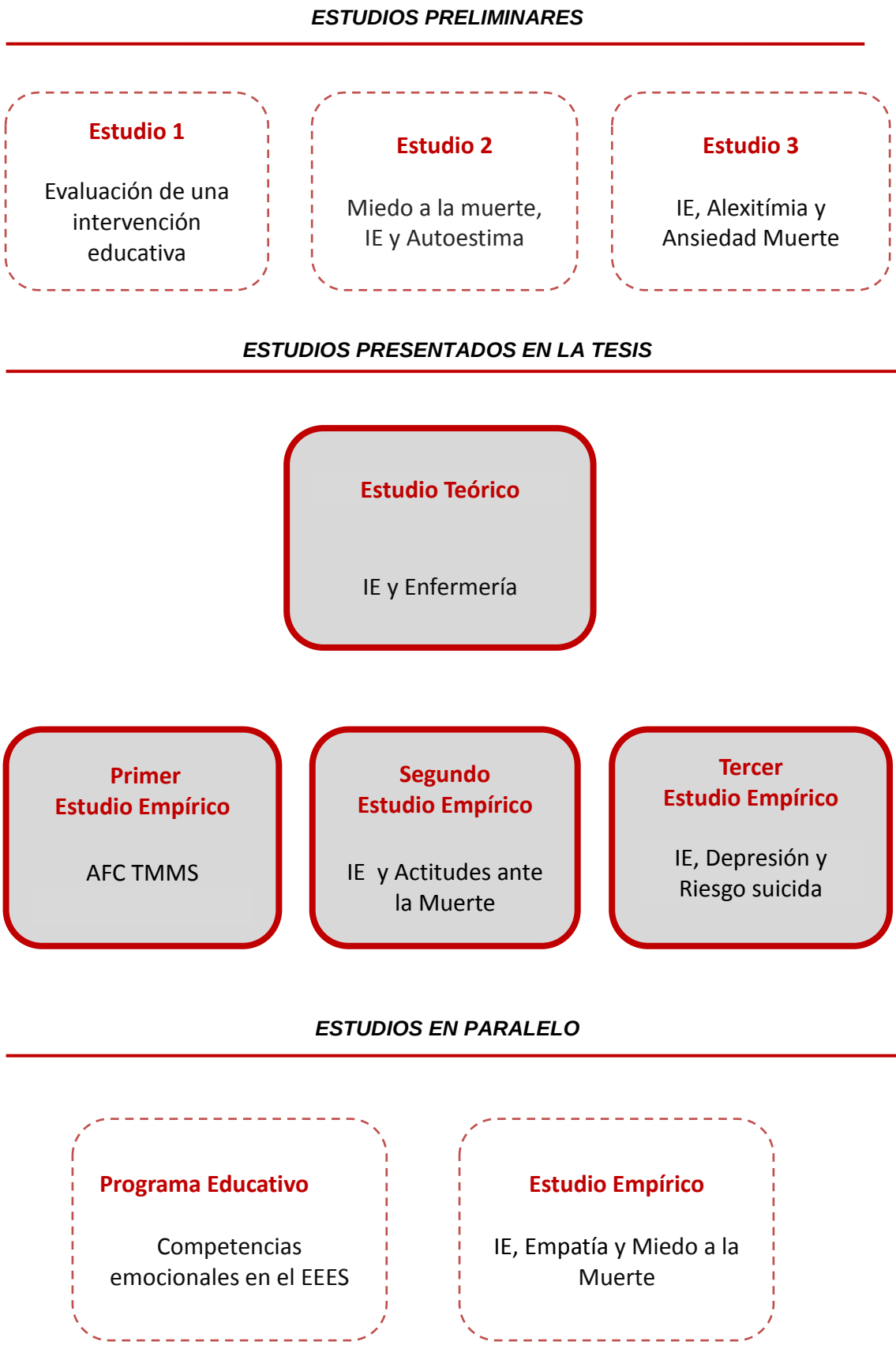

Figura 1. Secuencia de los estudios preliminares, los presentados en la tesis y los realizados en paralelo.

ESTUDIOS PRELIMINARES

A continuación se presenta un breve resumen de los estudios preliminares:

- **Estudio 1** Aradilla-Herrero, A., & Tomás-Sábado, J. (2006). Efectos de un programa de educación emocional sobre la ansiedad ante la muerte en estudiantes de enfermería. *Enfermería Clínica*, 6, 321-326.

  El primer objetivo planteado en relación al estudio de la IE y las relaciones con otras variables fue el de evaluar una intervención educativa de desarrollo de la IE en la asignatura de "enfermería en cuidados paliativos", asignatura optativa, en el año 2005, del último curso de la titulación de Enfermería. El impacto que la muerte causa en los estudiantes y los profesionales puede condicionar sus cuidados y su bienestar psicológico. En este estudio se diseñó un estudio transversal antes-después, en el que los participantes respondieron a un cuestionario que contenía, además de datos sociodemográficos, el inventario de Ansiedad ante la Muerte (DAI) y la escala de Inteligenca Emocional Percibida *(TMMS-24)*. Los resultados del estudio muestran que cuando aumenta la comprensión emocional del significado de la muerte y su asunción como un proceso natural, se produce una disminución de la ansiedad ante la muerte. Los resultados apoyan los planteamientos de numerosos estudios acerca de que los profesionales de enfermería se sienten incómodos y, en ocasiones, desbordados emocionalmente cuando cuidan a pacientes al final de la vida y atienden a sus familiares, y necesitan formación específica que les permita elaborar estrategias de afrontamiento eficaces para disminuir la ansiedad que les produce estos procesos.

Posteriormente se iniciaron otros estudios cuyo objetivo era establecer las relaciones entre la IE y otras variables, en muestras de enfermeras y estudiantes de enfermería, la investigación de estas relaciones dio lugar a las siguientes publicaciones:

- **Estudio 2** Aradilla-Herrero, A., Tomás-Sábado, J., Monforte-Royo, C., Edo Gual, M., & Limonero, J. (2010). Miedo a la muerte, inteligencia emocional y autoestima en estudiantes de enfermería. *Medicina Paliativa*, 17(supl I), 110.

  Participaron en este estudio 120 estudiantes de enfermería, 104 mujeres y 16 hombres, con una edad media de 23,58 (DT=4,2) que respondieron de forma voluntaria a un cuestionario autoadministrado que contenía, además de datos sobre sexo y edad, las formas españolas de las siguientes escalas: Escala de Miedo a la Muerte de Collet-Lester, la Escala de Inteligencia Emocional Percibida (TMMS-24) y la Escala de Autoestima de Rosenberg. Se obtuvieron correlaciones positivas y significativas entre la autoestima y dos dimensiones de la IE, comprensión y regulación emocional. Mientras que se obtuvieron correlaciones negativas y significativas con la autoestima y tres de las cuatro subescalas de miedo a la muerte. Asimismo, las correlaciones fueron negativas y significativas entre la compresión emocional y las cuatro subescalas de miedo a la muerte. Estos resultados contribuyen a la explicación de que personas con mayores habilidades emocionales poseen mejores estrategias de afrontamiento a los procesos de muerte, perspectiva esencial en el diseño de los programas de formación de los futuros enfermeros.

- **Estudio 3** Aradilla-Herrero, A., Tomás-Sábado, J., Gómez-Benito. J., & Limonero, J. (2009). Inteligencia emocional, Alexitimia y Ansiedad ante la Muerte en enfermeras españolas. En: P. Fernández-Berrocal y otros (Coords). *Avances en el estudio de la Inteligencia Emocional* (pp.161-165). Santander: Fundación Marcelino Botín.

  El objetivo de este trabajo fue estudiar las relaciones entre la IE, la alexitímia y la ansiedad ante la muerte en una muestra de enfermeras españolas. Participaron un total de 111 profesionales de enfermería, 7 hombres y 104 mujeres, que respondieron un cuestionario anónimo y autoadministrado que contenía la escala de Inteligencia Emocional Percibida (TMMS-24), la Escala de Alexitimia de Toronto (TAS-20) y el Inventario de Ansiedad ante la Muerte (DAI). Los resultados muestran una fuerte correlación negativa entre las puntuaciones de alexitímia y los componentes claridad y reparación de la inteligencia Emocional. Asimismo, las puntuaciones de ansiedad ante la muerte correlacionaron de forma significativa y positiva con la alexitímia y de forma no significativa con los tres componentes de la IE.

Estas tres publicaciones configuran los estudios preliminares cuyos resultados ayudaron a definir los objetivos de la tesis doctoral y confirmaron la necesidad de establecer programas formativos dirigidos al personal de enfermería que faciliten el desarrollo de estrategias de afrontamiento y habilidades emocionales.

ESTUDIOS PRESENTADOS EN LA TESIS

Posteriormente al análisis de los resultados de los estudios empíricos preliminares se definen los objetivos de la tesis y en base a ello se realizan las siguientes publicaciones, presentadas como compendio de artículos:

Estudio Teórico Aradilla-Herrero, A., & Tomás-Sábado, J. (2011). The Role of Emotional Intelligence in Nursing. In: C.E. Wergers (Ed). *Nursing Students and Their Concerns* (pp.131-154). New York, NY: Nova Sciences Publishers.

Primer Estudio Empírico Aradilla-Herrero, A., Tomás-Sábado, J., & Gómez-Benito, J. (in press). Perceived emotional Intelligence in nursing: Psychomeric properties of the Trait Meta-Mood Scale. *Journal of Clinical Nursing.* doi:10.1111/ jocn.12259

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ESTUDIOS EN PARALELO

Paralelamente a la realización de esta Tesis, con la incorporación de los estudios universitarios al Espacio Europeo de Educación Superior, se diseña en el Grado de Enfermería un programa formativo para desarrollar competencias relacionadas con la IE.

- Aradilla-Herrero A., Edo-Gual M. y Tomás-Sábado J., (2011). Modelos de competencias emocionales en Enfermería en el contexto del Espacio europeo de Educación Superior. En: P. Fernández-Berrocal y otros (Coords). *Inteligencia emocional: 20 años de investigación y desarrollo* (pp. 525-529). Santander: Fundación Marcelino Botín.

Asimismo, dado que en el ámbito de los profesionales de la salud, y específicamente, en enfermería la empatía es una competencia emocional relevante para establecer de forma efectiva el vínculo entre profesional-paciente, se diseñó y se llevo a cabo un estudio para establecer la relación entre la empatía, la IE y el miedo a la muerte.

- Aradilla-Herrero A., Tomás-Sábado J. y Limonero J. (2011). Inteligencia emocional, empatía y miedo a la muerte. En: P. Fernández-Berrocal y otros (Coords). *Inteligencia emocional: 20 años de investigación y desarrollo* (pp. 355-360).Santander: Fundación Marcelino Botín.

Los resultados obtenidos muestran relaciones negativas y significativas entre los tres componentes de la IE y el Distrés Personal, dimensión de la empatía, evidenciando que aquellas personas que presentan un menor malestar personal ante la presencia de experiencias negativas de otros, presentan mayores habilidades emocionales, en la misma línea que otros autores.

1.
MARCO TEÓRICO

1.1. APROXIMACIÓN A LAS EMOCIONES

Las emociones son parte fundamental en nuestras vidas y se construyen individualmente en un contexto social. Nos permiten obtener información de las personas de nuestro alrededor y, en la mayor parte de las ocasiones, nos facilitan las interacciones sociales. Durante las dos últimas décadas, la investigación científica sobre las emociones ha experimentado un considerable avance y ha aportado considerable evidencia respecto a la contribución de las mismas en los procesos racionales (Damasio, 1999; Ekman & Davidson, 1994; LeDoux, 1999). Damasio (1996) fue uno de los primeros investigadores en afirmar, y comprobar empíricamente, que las emociones son esenciales en todo juicio y ayudan en el proceso de razonamiento, en lugar de perturbarlo, como era la creencia común. A partir de sus investigaciones, Damasio (1996) sugiere que determinados aspectos de la emoción son indispensables en la racionalidad, que nos ayudan en la toma de decisiones y en la planificación de nuestras acciones futuras. Sin duda, los racionalistas como Platón, Kant o Descartes matizarían hoy sus reflexiones sobre la soberanía de la razón, si hubieran dispuesto de los conocimientos actuales acerca del papel que desempeñan las emociones en nuestros juicios (Asensio, García Carrasco, Núñez Cubero & Larrosa, 2006).

Los avances registrados durante estos años en el conocimiento de las emociones se han debido en gran parte al desarrollo de las distintas ramas de la neurociencia y a su interacción con la psicología experimental (Aguado, 2005). Las aportaciones de estos campos han permitido, en primer lugar, conocer que las emociones pueden ejercer una influencia, tanto positiva como negativa, sobre nuestra salud mental y física, a través del control que el cerebro ejerce sobre sobre los diferentes sistemas orgánicos; asimismo, también se ha avanzado considerablemente en el conocimiento de cómo las emociones pueden afectar al funcionamiento cognitivo, e influir en la percepción, la atención, el razonamiento o la memoria.

La aproximación científica del estudio de las emociones ha dado lugar a diferentes teorías y corrientes: la biológica, conductual, cognitiva y social (Bisquerra, 2009). Las distintas teorías y reformulaciones se deben fundamentalmente a los avances en el estudio de las emociones, la neurociencia cognitiva, el desarrollo de las ciencias clínicas, así como por la evolución de la psicología social y de la personalidad.

1.2. CONCEPTO DE INTELIGENCIA EMOCIONAL

El estudio de las relaciones entre la emoción y la cognición, han dado lugar a lo que en las últimas dos décadas llamamos *Inteligencia Emocional*. El proceso evolutivo de este fenómeno tiene su origen en los estudios relacionados tanto con la emoción como con la inteligencia. Se considera que los antecedentes más próximos a la inteligencia emocional son la introducción del concepto de *Inteligencia Social* por Thorndike (1920) y la *Teoría de las Inteligencias Múltiples*, desarrollada por Gardner (1983).

El concepto de Inteligencia Emocional (IE) fue definido por primera vez por los psicólogos Salovey y Mayer en 1990, aunque quién popularizó posteriormente el concepto fue Goleman, quien en 1995 publicó su libro "Inteligencia Emocional" donde afirma que la IE permite predecir el éxito académico y/o laboral con mayor exactitud que las medidas clásicas de inteligencia, afirmación que continúa investigándose en la actualidad.

En la revisión teórica de la literatura científica sobre el constructo, se observa que la IE es un constructo estudiado desde diferentes perspectivas, que ha suscitado una gran controversia y discusión entre los expertos (Conte, 2005; Daus & Ashkanasy, 2003; Landy, 2005; Locke, 2005; Petrides, 2011; Waterhouse, 2006; Zeidner, Roberts, & Matthews, 2008). Esta dificultad en la conceptualización ha llevado a Locke (2005) a considerar la IE un concepto inválido, porque afirma que no es un tipo de inteligencia y está conceptualizado de una forma demasiado amplia. Aunque hay otros autores que afirman que el constructo de la IE es reciente y que se encuentra en un primer estadio de aproximación al desarrollo teórico, de manera que la generación de diferentes aproximaciones teóricas puede considerarse un signo de vitalidad de la investigación y no tanto una debilidad (Cherniss, Extein, Goleman, & Weissberg, 2006) y que la popularidad del concepto en el ámbito de la organizaciones puede ser un aspecto estimulante para seguir investigando en este ámbito (Ashkanasy & Daus, 2005).

Una de las definiciones más ampliamente aceptada es la que considera la IE como *"la habilidad para percibir y valorar con precisión las emociones, la habilidad para acceder y/o generar sentimientos cuando éstos facilitan el pensamiento; la habilidad para comprender la emoción y el conocimiento emocional, y la habilidad para regular las emociones que promueven el crecimiento emocional e intelectual"* (Mayer &

Salovey, 1997, p.10). Sin embargo, esta definición no está universalmente aceptada por los investigadores en este ámbito, ya que las definiciones varían substancialmente en cada una de las aproximaciones teóricas al concepto.

1.3. MODELOS DE IE

Existe una gran dificultad para establecer una clara distinción entre los diferentes modelos teóricos debido a que no existe un consenso de los expertos sobre la definición de la IE, aunque en la revisión de la literatura podemos observar mayoritariamente tres modelos de aproximación conceptual a la IE: el modelo de habilidad, el modelo de rasgo y los llamados modelos mixtos (Tabla 1).

Tabla 1. Modelos de IE.

	Modelo de habilidad	**Modelo de rasgo**	**Modelos mixtos**
Concepción de la IE	Capacidad mental de procesamiento cognitivo	Rasgos de personalidad, autopercepción de los procesos mentales	Competencias socioemocionales, aspectos motivacionales y competencias emocionales cognitivas
Medidas	Ejecución o rendimiento máximo	Auto-Informe	Auto-informe
Autores representativos	Mayer y Salovey (1997)	Petrides y Furnham (2001)	Goleman (1995) Bar-On (2006) Boyatzis (2009)

a. Modelos de habilidad

Los modelos de habilidad, también llamados de procesamiento cognitivo, enfatizan el uso adaptativo de las emociones como facilitadoras de un razonamiento más efectivo (Mayer, Roberts, & Barsade, 2008). En este modelo, la IE se define como la habilidad para percibir y expresar las emociones, la capacidad de usar las emociones para facilitar el pensamiento, comprender y razonar con emoción y, finalmente, regular las propias emociones y la de los otros (Mayer & Salovey, 1997). Es el llamado modelo de las cuatro ramas: la percepción, valoración y expresión de la emoción; la facilitación emocional del pensamiento; la comprensión y análisis de las emociones y, finalmente, la regulación reflexiva de las emociones para promover el crecimiento emocional e intelectual.

En esta concepción teórica, la IE se evalúa mediante medidas de habilidad o de ejecución, que no se basan en la estimación subjetiva del sujeto sobre sus habilidades emocionales, sino que implican evaluar su ejecución o rendimiento en diversas tareas emocionales (Caruso, Mayer, & Salovey, 2002). Desde esta concepción teórica, la IE engloba un conjunto de habilidades relacionadas con el procesamiento mental de la información. Según sus autores, el modelo de habilidad mental cumple los criterios de una inteligencia estándar y realiza predicciones importantes para la vida social (Mayer, Salovey, Caruso, & Sitarenios, 2001; 2003).

b. Modelos de rasgo

En el modelo de rasgo, la IE se refiere a una constelación de disposiciones conductuales y autopercepciones sobre la propia capacidad para reconocer, procesar y utilizar la información cargada de emociones (Petrides, Frederickson, & Furnham, 2004; Pérez, Petrides, & Furnham, 2005) y se evalúa mediante instrumentos de auto-informe. Esta aproximación conceptual se refiere a lo que se podría llamar “metaemoción”, un aspecto más de lo que los psicólogos cognitivos denominan “metacognición”, es decir, la capacidad para contemplar introspectivamente nuestros procesos mentales y reflexionar sobre ellos (Aguado, 2005).

La propuesta de Petrides y Furnham (2001) diferencia entre la IE rasgo (o autoeficacia) y la IE capacidad (o capacidad cognitivo-emocional). La distinción entre estas dos concepciones de la IE está basada en el método de medida utlilizado para evaluar el constructo (Pérez et al., 2005). Los autores de este modelo han construido un cuerpo considerable de pruebas que demuestran que la IE rasgo es un constructo válido que tiene validez discriminante y validez de criterio en comparación con las dimensiones de personalidad existentes (Petrides & Furnham, 2001; Petrides, Pérez-González, & Furnham, 2007 Pérez et al., 2005). Sin embargo, las principales críticas recibidas por este modelo subrayan el solapamiento del instrumento de medida con las escalas que evalúan personalidad como el *Big Five o Cinco Grandes Factores de Personalidad* y dudan de que realmente se puedan considerar medidas diferenciadas de las anteriores (Mayer, Salovey, & Caruso, 2008; Mayer, Salovey, Caruso, & Cherkasskiy, 2011). A pesar de las críticas recibidas, estudios recientes demuestran que aunque la IE evaluada con un instrumento de autoinforme, como el *Trait Emotional Intelligence Questionnaire* (TEIQue), diseñado por Petrides y Furnham (2001), muestra una mayor asociación con las dimensiones de personalidad, ambas formas de entender la IE, habilidad y rasgo, presentan una contribución incremental y significativa en la predicción de la salud mental (Davis and Humphrey, 2012a). Con respecto a la validez discriminante, los investigadores han demostrado que la IE rasgo se correlaciona con las dimensiones de personalidad, pero no lo suficiente para ser un constructo redundante (Petrides et al., 2007).

c. Modelos mixtos

En este apartado de la clasificación encontramos los modelos de la IE que entienden la IE desde una concepción más global e incluyen en su concepción teórica diversas competencias socioemocionales, aspectos motivacionales, competencias emocionales cognitivas y rasgos de personalidad. Entre los modelos existentes, principalmente podemos considerar los de Bar-On (2006), Goleman (1995) y Boyatzis (2008) entre otros.

1.4. INSTRUMENTOS DE MEDIDA DE LA IE

En la revisión de la literatura aparecen fundamentalmente dos procedimientos para evaluar la IE: mediante medidas de auto-informe o medidas de habilidad, también llamadas de ejecución.

a. Medidas de auto-informe para evaluar la IE

A continuación, se describen brevemente las medidas de auto-informe más utilizadas en la literatura científica para evaluar la IE.

Uno de los primeros instrumentos para evaluar la IE es el denominado *Trait Meta Mood Scale* (TMMS), basado en el modelo original de Salovey y Mayer (1990). Esta medida consiste en una escala de rasgo de metaconocimiento emocional que evalúa la percepción de los individuos sobre sus propias habilidades emocionales y su capacidad para regularlas (Salovey, Mayer, Goldman, Turvey, & Palfai, 1995). En su versión original, contiene 48 ítems con respuesta tipo Likert que evalúa tres dimensiones de la IE: atención, claridad y reparación. También existe una versión reducida en castellano, el TMMS-24 (Fernández-Berrocal, Extremera, & Ramos, 2004) que ha demostrado buenas propiedades psicométricas para poder ser utilizado en muestras de habla hispana.

Otro de los instrumentos más utilizados para evaluar la IE, basado también en el primer modelo de Salovey y Mayer es el *Shutte Self Report Inventory* (SSRI) desarrollado por Shutte et al. (1998), también denominado *Assessing Emotions Scale*. El SSRI se compone originalmente de una escala de 33 ítems que evalúa aspectos intrapersonales e interpersonales. Esta escala ha estado sometida a diferentes estudios cuyos resultados postulan diversas aproximaciones factoriales. Shutte et al. (1998) recomiendan usar la escala como unifactorial, sin embargo, Ciarrochi, Chan y Bajgar (2001) sugieren una estructural factorial de 4 factores: percepción de las emociones, gestión de las propias emociones, gestión de las emociones de los otros, y utilización de las emociones. Posteriormente, otro grupo de investigadores (Austin, Saklofske, Huang, & McKenney, 2004) desarrollaron una versión de 41 ítems, con mejores propiedades psicométricas, que comprende tres factores: evaluación emocional, utilización de las emociones y regulación emocional. Finalmente, Gignac,

Palmer, Manocha y Stough (2005) seleccionaron 28 de los 33 ítems que han demostrado un mejor ajuste al modelo de Salovey y Mayer (1990).

Petrides y Furnham (2003), por su parte, diseñaron el *Trait Emotional Intelligence Questionnaire* (TEIQue), que se ajusta a la operacionalización de su teoría sobre la IE rasgo (Petrides & Furnham, 2001, Petrides, Furnham, & Mavrovelli, 2007). La última versión del instrumento contiene 153 ítems, 15 subescalas que responden a cuatro factores (bienestar, autocontrol, emocionalidad y sociabilidad) y que además ofrece una puntuación global de la IE rasgo (Petrides & Furnahm, 2003). El cuestionario también dispone de una versión corta de 30 ítems, el llamado Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF), que está basado en la versión completa del instrumento. Está compuesto por 2 ítems de cada una de las 15 subescalas del TEIQue con respuesta tipo Likert de 7 puntos y que ofrece una puntuación global de la IE rasgo. Existen diferentes estudios que apoyan la validez convergente, discriminante e incremental del constructo (Kluemper, 2008; Petrides & Furnahm, 2003; Petrides et al., 2007). Se ha demostrado que la IE rasgo predice satisfacción vital (Petrides et al, 2007; Petrides, Pita, & Kokkinaki, 2007), felicidad (Furnham & Petrides, 2003), creatividad (Sánchez-Ruiz, Hernández-Torrano, Pérez-González, Batey, & Petrides, 2011) y absentismo escolar en adolescentes (Petrides et al., 2004). En muestras clínicas, la IE rasgo predice algunos trastornos de personalidad y depresión (Petrides et al., 2007). Existe controversia acerca de si la IE rasgo demuestra suficiente validez discriminante con varias medidas de personalidad como el *Big Five o Cinco Grandes Factores de Personalidad* (MacCann, Matthews, Zeidner, & Roberts, 2003). Sin embargo, Petrides et al. (2007) defienden que es cierto que el TEIQue muestra una alta correlación con medidas de personalidad, pero no lo suficiente para poder considerarse un mismo constructo.

Finalmente, existen dos instrumentos que han tenido un auge muy importante en el desarrollo y evaluación de la IE en la empresa y organizaciones.

En primer lugar, The *Bar-On Emotional Quotient Inventory* (EQ-i), desarrollado por Bar-On (1997), es una de las medidas auto-informadas más ampliamente utilizada en la literatura para evaluar la IE. En su versión original consiste en una escala de 133 ítems, con 7 o 9 ítems para cada componente conceptual: inteligencia intrapersonal, inteligencia interpersonal, adaptación, gestión del estrés y humor general. Está designado para utilizarse en individuos mayores de 17 años, aunque también se ha desarrollado una versión para utilizarse en niños y adolescentes (Bar-On & Parker,

2000), el llamado *Emotional Quotient Inventory: Youth Version* (EQ-i: YV), y otra versión abreviada de 51 ítems (Bar-On, 2002).

Por último, el *Emotional Competence Inventory* (ECI) desarrollado por Boyatzis, Goleman y Rhee (2000). El ECI se diseñó para evaluar competencias emocionales y comportamientos sociales positivos (Boyatzis, Goleman, & Rhee, 2000; Goleman 1998; Boyatzis & Sala, 2004), comprende 110 ítems y evalúa 20 competencias que están organizadas en 4 grupos: Autoconciencia emocional, conciencia social, autogestión, y habilidades sociales. Posteriormente, se desarrolló el Emotional and Social Competency Inventory (ESCI) que evalúa 12 competencias organizadas en 4 grupos: autoconciencia, autogestión, conciencia social y gestión de las relaciones. La última versión del ESCI propone un instrumento de 360° para evitar la distorsión personal de los instrumentos autoinformados y la deseabilidad social (Boyatzis & Goleman, 2007). El ESCI está diseñado fundamentalmente para evaluar las competencias sociales y emocionales en organizaciones laborales y está contemplada una autoevaluación, una evaluación de los compañeros y una evaluación del supervisor (Boyatzis, 2009).

b. Medidas de habilidad para evaluar la IE

El instrumento más reconocido para evaluar el modelo de habilidad de Salovey y Mayer (1997) es el *Mayer-Salovey-Caruso Emotional Intelligence Test* (MSCEIT; (Mayer et al., 2003) desarrollado a partir de la revisión de un instrumento anterior de los mismos autores, el denominado *Multifactor Emocional Intelligence Test* (MEIS; Mayer, Caruso, & Salovey, 1999). Se han desarrollado dos versiones, el MSCEIT v1.1. y el MESCEIT v.2.0 (Mayer, Salovey, & Caruso, 2001). La escala del MSCEIT se compone de 141 ítems, con cuatro ramas y ocho subescalas. Las puntuaciones del test se obtienen a través de dos criterios normativos de comparación: el criterio consenso y el criterio experto. Existe una versión en castellano del instrumento que demostrado unas adecuadas propiedades psicométricas (Extremera, Fernández-Berrocal, & Salovey, 2006).

Los autores de la propia escala reconocen que el instrumento tiene importantes limitaciones (Mayer et al., 2008) sobretodo en relación a la evaluación de la percepción emocional y afirman que la estructura factorial permanece abierta a discusión y futuras

investigaciones (Palmer, Gignac, Manocha, & Stough, 2005), aunque creen firmemente que el MSCEIT es un instrumento válido y fiable para evaluar la IE conceptualizada como una habilidad mental (Mayer et al., 2003). A su favor, en relación a las medidas de auto-informe, el MSCEIT demuestra una mínima correlación con el *Big Five o Cinco Grandes Factores de Personalidad* (Energía, Afabilidad, Tesón, Estabilidad Emocional y Apertura Mental) (Brackett & Mayer, 2003).

1.5. INSTRUMENTOS DE AUTO-INFORME VERSUS INSTRUMENTOS DE HABILIDAD

Algunos autores afirman que las medidas de habilidad o de ejecución presentan una serie de ventajas frente a las medidas de auto-informe. Su principal fortaleza es que los resultados obtenidos se basan en la capacidad actual de ejecución o de conocimiento emocional de la persona en una tarea y no sólo en su creencia sobre tal capacidad (Extremera & Fernández-Berrocal, 2007). Sin embargo, Gohm (2003) afirma que las percepciones, creencias y expectativas sobre nuestras habilidades determinan su uso. Es decir, que los individuos que no confían y no creen en sus propias capacidades no las utilizan adecuadamente. Estos dos aspectos, a priori contrapuestos, sugieren que estas dos aproximaciones de medida de la IE pueden ser consideradas complementarias y aportar información valiosa según los objetivos propuestos por la investigación. Sin olvidar que las medidas de habilidad no están exentas de limitaciones y también presentan dificultades a la hora de proporcionar un índice de la habilidad real, no intencionada de procesamiento y regulación de las emociones del individuo (Fernández-Berrocal y Extremera, 2005).

Extremera y Fernández-Berrocal (2007) describen una serie de aspectos que sería necesario analizar antes de elegir un instrumento u otro. Entre las características que pueden suponer una ventaja de las medidas de auto-informe sobre las de habilidad se destaca que:

- Son fáciles de administrar, las instrucciones suelen ser más sencillas y se pueden obtener los resultados y las puntuaciones totales de forma rápida,

por el contrario, las medidas de habilidad suelen ser más complejas de administrar, la mayor parte son instrumentos estandarizados que una vez cumplimentados por los participantes, se debe enviar una plantilla de resultados a las editoriales que los comercializan para que realicen la baremación y posteriormente te envíen los resultados.

- La mayoría de pruebas auto-informadas son gratuitas, se pueden utilizar libremente en la investigación y son accesibles a través de las publicaciones científicas o solicitándolas directamente a sus autores, sin embargo, la mayoría de instrumentos de habilidad están comercializados y se requiere un previo pago para su utilización.

- Si el tiempo que se dispone para realizar la evaluación es limitado, quizá una prueba de auto-informe pueda ser la mejor opción ya que, por ejemplo, el TMMS requiere de unos 10 minutos para su cumplimentación, en contraposición con el MSCEIT que requiere de 45 minutos a 1 hora. Aspecto muy importante a tener en cuenta, tanto en estudiantes como en profesionales de enfermería, que en muchas ocasiones no disponen de ese tiempo para cumplimentar los cuestionarios en las aulas o dentro de su jornada laboral, en el caso de los profesionales.

- Cuando el tiempo de cumplimentación es tan largo, como en el caso de las medidas de ejecución, se podrían producir problemas de sesgo debido al cansancio de los sujetos, aspecto casi inexistente en las pruebas de auto-informe, excepto en las baterías que incluyen más de una escala. En este caso, se deben realizar estimaciones previas del tiempo requerido para la cumplimentación total de la batería de pruebas.

Entre las desventajas de las medidas de auto-informe respecto a las de ejecución se encuentra que:

- Las medidas de auto-informe proporcionan una estimación, una creencia o percepción de la autoeficacia personal sobre las propias capacidades emocionales y no una evaluación de las habilidades mentales de procesamiento de la información emocional. Según Mayer et al. (2011), las medidas de auto-informe se basan en percepciones e impresiones del manejo

emocional del individuo, mientras que las medidas de ejecución, como el MSCEIT, tienen la ventaja que representan el nivel de rendimiento individual en cada habilidad (percepción, asimilación, comprensión y regulación emocional).

- Las medidas de auto-informe pueden facilitar los problemas de sesgo derivados de la deseabilidad social. Es decir, que el individuo intuya el objetivo de la prueba y responda los ítems con un fin predeterminado distorsionando la realidad. Este aspecto también puede condicionar, según Extremera y Fernández-Berrocal (2007), las respuestas de las medidas de habilidad en alguna dimensión, como en la regulación emocional, ya que evalúan el conocimiento de las estrategias emocionales y no su ejecución real.

- La crítica más frecuente a este tipo de instrumentos auto-informados es que la evaluación de algunas habilidades emocionales se solapa con variables de personalidad e inteligencia verbal (Mayer et al., 2008; Zeidner et al., 2008)

Extremera y Fernández-Berrocal (2007) afirman que la toma de decisiones sobre qué medida utilizar para evaluar la IE va a depender del evaluador, sus creencias sobre el constructo, y sus intereses de investigación. El amplio conocimiento de los distintos instrumentos nos permitirá saber cuál es el más útil y apropiado para cada situación. Neubauer y Freudenthaler (2005) señalan que tanto la conceptualización de la IE como habilidad, medida con instrumentos de ejecución, como la de rasgo, que utiliza medidas de auto-informe, pueden aportar información científica relevante y, por tanto, constituir dos formas complementarias y de apreciable valor para los investigadores y para la sociedad en general.

1.6. INTELIGENCIA EMOCIONAL Y ENFERMERÍA

En Enfermería, ámbito específico en el que se desarrolla esta tesis doctoral, la IE permite a las enfermeras desarrollar relaciones terapéuticas efectivas y facilita la interacción con otros profesionales de la salud (Reeves, 2005). Sin embargo, en ocasiones, las enfermeras muestran una carencia en este tipo de de habilidades y verbalizan que no han recibido suficiente capacitación a lo largo del currículo formativo (Bellack, 1999; Hurley, 2008). En su labor asistencial diaria, las enfermeras mantienen un contacto continuado con la enfermedad, el dolor, el sufrimiento y la muerte, momentos en los que el desarrollo de habilidades emocionales resultan esenciales, con el fin de minimizar los problemas que se derivan de éstos, tales como altos niveles de estrés, burnout, ansiedad acerca de la muerte o conductas de evitación que pueden afectar la calidad de la atención de enfermería (Akerjordet Severinsson, 2004; Hurley, 2008; Montes-Berges & Augusto, 2007).

En este sentido, enfermería es considerada como una profesión muy exigente y estresante (Jones & Johnson, 2000), ya que implica una interacción social constante con personas enfermas, familiares y otros profesionales de la salud, en el que se debe realizar un esfuerzo diario constante para regular las propias emociones y las de los demás. Asimismo, son varios los estudios que han comprobado empíricamente que los niveles elevados de estrés, experimentado por los estudiantes de enfermería en sus prácticas clínicas, han contribuido a su inseguridad, baja autoestima, irritabilidad, depresión, trastornos somáticos, trastornos del sueño y agotamiento físico y psicológico (Chan, Creedy, Chua, & Lim, 2011; Montes-Berges & Augusto, 2007; Por, Barriball, Fitzpatrick, & Roberts, 2011; Watson, Dreary, Thompson, & Li, 2008), aspectos que afectan a su bienestar personal y pueden influir de forma negativa en su futuro desarrollo profesional.

En este sentido, la influencia de la inteligencia emocional en la salud mental y física ha sido investigada por numerosos autores, en diferentes contextos, con resultados alentadores. Dos recientes metaanálisis sobre los efectos de la IE en la salud concluyeron, en ambos casos, que la inteligencia emocional está relacionada con la salud y el bienestar de las personas (Martins, Ramalho, & Morin, 2010; Schutte, Malouff, Thorsteinsson, Bhullar, & Rooke, 2007). Específicamente, Martins et al. (2010) muestran que la IE, evaluada con medidas de autoinforme, está más

fuertemente asociada con la salud (*r* = 0,34) que cuando se evalúa con una medida de capacidad (*r* = 0,17). Los hallazgos en este sentido apoyan la consideración de que la IE puede constituir un predictor fiable del estado de salud de los individuos.

Los estudios empíricos en enfermería sobre la IE y su relación con otras variables han ido aumentando de forma creciente desde el año 2000 hasta la actualidad. En los primeros años mayoritariamente las publicaciones sobre el tema eran reflexiones teóricas, pero posteriormente podemos encontrar estudios empíricos de la IE relacionados con diversos temas relevantes en el ámbito de la enfermería (salud mental, aplicación de la IE a la gestión, educación, resolución de conflictos, salud y bienestar). Asimismo, se observa que los estudios utilizan instrumentos de las diversas conceptualizaciones teóricas de la IE descritas con anterioridad. Ejemplo de ello se puede observar en la Tabla 2 con publicaciones de los últimos cinco años.

En este contexto, los objetivos principales de esta tesis doctoral aparecen en el siguiente apartado y se llevaron a cabo a través de las publicaciones presentadas en este compendio.

Tabla 2. Investigaciones empíricas sobre la IE realizadas en el ámbito de enfermería.

Autores	Instrumento de medida de la IE	Muestra	Principales resultados
Fernández et al. (2012)	TEIQue-SF	81 estudiantes de enfermería	La conciencia y comprensión emocional tienen un impacto positivo en los resultados académicos
Benson et al. (2012)	Bar-On EQ-i	52 estudiantes de enfermería	A lo largo de la carrera no se encontraron diferencias significativas en las puntuaciones de IE
Chan et al. (2011)	TMMS	112 estudiantes de enfermería	La IEP muestra relación positiva con el estado de salud
Por et al. (2011)	SEIS	130 estudiantes de enfermería	Los resultados muestran correlaciones positivas entre la IE y el bienestar y la competencia percibida y negativas con el estrés.
Beauvais et al. (2011)	MSCEIT	87 estudiantes de enfermería	La IE se relaciona positivamente con el rendimiento
Benson et al. (2010)	Bar-On EQ-i;Short	100 estudiantes de enfermería (25 por curso)	Los estudiantes presentaban una adecuada capacidad social y emocional. Las puntuaciones de los estudiantes en todos los cursos fueron mayores de 98 puntos.
Heffernan et al. (2010)	TEIQue-SF	135 enfermeras	Los resultados confirman una correlación positiva entre la IE y la autocompasión (r = 0.55)
Van Dusseldorp et al. (2010)	Bar-On EQ-i	98 enfermeras	No se encontraron diferencias entre hombres y mujeres en relación a la IE, ni en relación a la edad, ni a la experiencia en el ámbito de salud mental.
Augusto Landa et al. (2009)	TMMS	135 estudiantes de enfermería	Los resultados mostraron correlaciones positivas entre la claridad y la reparación con todos los componentes del autoconcepto.
Codier et al. (2009)	MSCEIT	350 enfermeras	Las enfermeras con mayores puntuaciones de IE demostraban un mejor rendimiento y una mayor retención del empleo.
Morrison (2008)	ECI	94 enfermeras	La IE correlaciona positivamente con el estilo de colaboración de resolución de conflictos y de forma negativa con la acomodación

Bar-On EQ-i - BarOn Emotional Quotient Inventory; ECI – Emotional Competency Inventory; MSCEIT – Mayer-Salovey-Caruso Emotional intelligence Test; SEIS – Shutte Emotional intelligence Scale ; TEIQue-SF – Trait Emotional Intelligence Questionnaire – Short Form; TMMS – Trait Meta Mood scale.

2.
OBJETIVOS DE LA INVESTIGACIÓN

2.1. OBJETIVO GENERAL

El objetivo de este trabajo es, en primer lugar, profundizar en el conocimiento de la IE en el contexto de enfermería y su relación con las variables socioemocionales relacionadas con el impacto que produce el fenómeno de la muerte en estudiantes y profesionales de enfermería, y que pueden afectar a la calidad de los cuidados proporcionados a pacientes y familiares.

2.2. OBJETIVOS ESPECÍFICOS

A continuación se describen los objetivos específicos que se han llevado a cabo en el ámbito de la enfermería, tanto en muestras de estudiantes como de profesionales, y que han sido abordados progresivamente en los diferentes apartados de esta tesis doctoral.

Los objetivos específicos propuestos fueron:

1. Realizar una revisión exhaustiva de la literatura científica de la IE en el ámbito de la enfermería.

2. Determinar si la estructura factorial de la Trait Meta-Mood Scale, instrumento que evalúa la IEP, es consistente con la propuesta por los autores originales de la escala en una muestra de estudiantes y profesionales de enfermería.

3. Determinar si existen diferencias de género y diferencias entre estudiantes y profesionales, en relación con las diferentes dimensiones de la IE, en el ámbito de la enfermería.

4. Analizar la relación entre las tres dimensiones de la IEP (atención, claridad y reparación) con las actitudes ante la muerte (ansiedad, miedo, depresión y obsesión ante la muerte) en enfermería.

5. Finalmente, explorar la relación entre la IEP, la depresión y el riesgo suicida.

2.3. HIPÓTESIS

Las hipótesis planteadas, a la luz de la revisión de la literatura sobre el tema y del análisis de los resultados de los estudios preliminares llevados a cabo en el ámbito de enfermería, fueron las siguientes:

1. El Trait Meta Mood Scale, en su versión española (TMMS-24), es un instrumento válido y fiable para evaluar la IEP en el ámbito de la enfermería en muestras de habla hispana.

2. Las mujeres muestran puntuaciones mayores de IEP que los hombres en el ámbito de enfermería.

3. Los estudiantes de enfermería perciben menos habilidades emocionales que los profesionales.

4. La atención emocional (variable de la IEP) positivamente con las actitudes ante la muerte (ansiedad, depresión, obsesión y miedo), mientras que la claridad y la reparación correlacionan negativamente con las actitudes ante la muerte.

5. La atención emocional correlaciona de forma positiva con la depresión y con el riesgo suicida en estudiantes de enfermería, mientras que con la claridad y la reparación correlacionan negativamente.

3.
RESULTADOS

3.1. ORGANIZACIÓN

A continuación se observa en la Figura 2 la organización de los estudios presentados en la Tesis:

Figura 2. Organización de los objetivos y estudios de la Tesis

Tal y como acabamos de describir, el primer objetivo específico (**Objetivo 1**) que se propuso fue el de realizar una revisión de la literatura científica de la IE en el ámbito de la enfermería. El resultado de este objetivo se materializa en el **Estudio 1** que lleva por título *The Role of Emotional Intelligence in Nursing* en el que se describen los estudios empíricos que se han realizado en el contexto de enfermería.

Posteriormente, se pretende analizar si la estructura factorial del TMMS, en el ámbito de enfermería, se corresponde con la propuesta por los autores originales y determinar si existen diferencias de género y diferencias entre estudiantes y profesionales de enfermería en relación a las diferentes dimensiones de la IE (**Objetivos 2 y 3**). Estos objetivos se resuelven en el **Estudio 2** titulado *Perceived emotional Intelligence: Psychometric properties of the Trait Meta-Mood Scale.*

Con el **Objetivo 4** se pretende analizar si existe relación entre las dimensiones de la IE y las variables que evalúan las actitudes ante la muerte, principalmente ansiedad,

miedo, depresión y obsesión. Para ello se diseñó el **Estudio 3** (*Death attitudes and emotional intelligence in nursing students*), en el que se describen estas relaciones.

Finalmente, el **Objetivo 5** pretende explorar las relaciones entre la IEP, la depresión y el riesgo suicida y evaluar si la IE puede modular el riesgo suicida en estudiantes de enfermería, ya que la revisión de la literatura ponía de manifiesto que los profesionales de enfermería son una población de riesgo. Este objetivo se materializa en el **Estudio 4** titulado *Death attitudes and emotional intelligence in nursing students.*

3.2. PUBLICACIONES DEL COMPENDIO

Esta tesis doctoral se presenta bajo la modalidad de compendio de publicaciones. Los estudios y trabajos desarrollados para la realización de esta Tesis Doctoral han dado lugar, antes de su defensa pública, a las siguientes publicaciones:

1. Aradilla-Herrero, A., & Tomás-Sábado, J. (2011). The Role of Emotional Intelligence in Nursing. In: C.E. Wergers (Ed). *Nursing Students and Their Concerns* (pp.131-154). New York, NY: Nova Sciences Publishers.
   ISBN: 978-1-61761-125-4

2. Aradilla-Herrero, A., Tomás-Sábado, J., & Gómez-Benito, J. (in press). Perceived emotional Intelligence in nursing: Psychometric properties of the Trait Meta-Mood Scale*. Journal of Clinical Nursing.* doi:10.1111/jocn.12259

   ISI Journal Citation Reports® Ranking: 2011; 30/97 (Nursing)

   Impact Factor: 1,118 Quartile: Q2

3. Aradilla-Herrero, A., Tomás-Sábado, J., & Gómez-Benito, J. (2012-2013). Death attitudes and emotional intelligence in nursing students**.** *OMEGA*, 66 (1), 39-55. doi. 10.2190/OM.66.1.c

   ISI Journal Citation Reports® Ranking 2011; 96/125

   (Psychology, Multidisciplinary)

   Impact Factor: 0.436 Quartile: Q4

4. Aradilla-Herrero, A., Tomás-Sábado, J., & Gómez-Benito, J. (under review). *Emotional Intelligence, Depression and Suicide Risk in nursing students. Nurse Education Today.*

   ISI Journal Citation Reports® Ranking 2011; 19/97

   (Nursing) Impact Factor: 1,241. Quartile: Q1

3.3. ESTUDIO TEÓRICO I:
The Role of Emotional Intelligence in Nursing

Aradilla-Herrero A & Tomás-Sábado J. (2011). The Role of Emotional Intelligence in Nursing. In: C.E. Wergers (ed). *Nursing Students and Their Concerns*. New York: Nova Sciences Publishers. Pp131-154.

En este estudio se procede a una revisión en profundidad de la literatura científica sobre la IE, su conceptualización y el análisis de los estudios realizados en el campo de la Enfermería.

Se realiza una breve descripción del constructo de la IE y de algunos de los diferentes modelos teóricos. Asimismo, se resumen las controversias existentes en relación al constructo y a los numerosos instrumentos de medida aparecidos en los últimos años.

Posteriormente, se analizan los estudios sobre la IE realizados en el contexto de enfermería. Principalmente los estudios analizados se relacionan con los siguientes aspectos: la relación entre la IE con el burnout, las estrategias de afrontamiento y la adaptación a situaciones estresantes en enfermería; la relación entre IE y liderazgo; la IE en la educación en Enfermería y, finalmente, la IE en el contexto de los cuidados paliativos.

Por último, se describe un proyecto de educación por competencias en el Grado de Enfermería para el desarrollo de las habilidades emocionales en los futuros profesionales.

In: Nursing Students and their Concerns
Editor: Colin E. Wergers
ISBN: 978-1-61761-125-4

Chapter 4

THE ROLE OF EMOTIONAL INTELLIGENCE IN NURSING

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ABSTRACT

Emotional intelligence is essential in establishing therapeutic nurse-patient relationships. Nurses should develop competencies to assess patient's responses to their illness and to interact with their families. The objective of this chapter is to describe the concept and to analyse the relation between emotional intelligence and effective care competencies. Emotional intelligence is the ability of an individual to perceive, assess and manage emotions of his/her own self and of other people. The original definition of emotional intelligence is a set of interrelated abilities. Every nursing intervention is affected by these emotional abilities. It is not enough to care for a patient using the technical procedures without also considering the person and their emotions and beliefs. In this review we used data from different studies to analyse the relation between emotional intelligence and different important topics in nursing: effective education strategies, leadership skills, successful communication and conflict resolution. Theoretical and scientific literature confirms emotional intelligence to be essential to the practice of nursing. Additionally, we have described some models of emotional intelligence in nursing and analysed the different methods of assessing emotional intelligence competencies.

INTRODUCTION

The nursing profession is devoted to caring for people. Through contact with the patient and their family therapeutic relationships are established. According to Peplau (1997), the

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patient-nurse relationship lies at the centre of the practice of nursing. This type of relationship includes the need to identify and understand one's own emotions as well as those of others, as well as the ability to use these to initiate a caring relationship which is suitable and focused on the patient's needs (Gastmans, 1998). To achieve this, it is fundamental to effectively manage the emotions caused by continuous contact with the illness and the suffering of the other (Aradilla-Herrero & Tomás-Sábado, 2006).

It is evident that social and emotional skills are essential characteristics and form part of the profile of basic competencies for health professionals (Epstein & Hundert, 2002). The art of caring cannot be dissociated from the ability to communicate, inform, create trust relationships with patients and their relatives, and collaborate with other professionals.

Many authors believe that emotional intelligence is a fundamental part of the skills of nursing professionals (Bulmer Smith, Profetto-McGrath, & Cummings, 2009; Epstein & Hundert, 2002; Freshwater & Stickley, 2004; Hurley, 2008b; Rochester, Kilstoff, & Scott, 2005). Epstein and Hundert (2002) define these professional skills as the habitual and sensible use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in the professional's daily practice. As regards emotions, they state that these are essential in every clinical judgement and decision. Damasio (2008) one of the first researchers to prove that emotions assist in the reasoning process rather than disturb it, as was commonly thought, describes this aspect in depth. This idea changes the historic belief that cognitive intelligence is the main factor behind success in academic performance and professional life. Currently, it is considered that emotional intelligence is also fundamental to achieving this success (Goleman, 1998; Reeves, 2005).

In nursing, although Peplau's model of interpersonal relationships is more than 50 years old, formal research into emotional intelligence is still a recent phenomenon. Nevertheless, various authors confirm that emotions form a fundamental part of patient care and of clinical care decisions in the nursing practice, and should be included in training programmes of the profession (Akerjordet & Severinsson, 2007; Bulmer Smith, et al., 2009; Freshwater & Stickley, 2004).

The ability to manage one's own emotions, while at the same time understand those of others, is especially useful in the carrying out of the duties of nursing, since the ability to assess and distinguish between emotional responses can be decisive in establishing an effective nurse-patient relationship. However, social and emotional skills training has not been sufficiently considered in the training of these professionals; nor has it been included in many of the training curricula. In general, it is assumed that students acquire these competencies either by themselves or on the job, and it is considered, on many occasions, to be a skill that depends on the individual and innate characteristics of the person (Aradilla, Antonín, Fernández, & Flor, 2008). As a consequence, the academic training of health professionals does not sufficiently consider these aspects aimed at developing an effective clinical relationship.

One of the situations with which nursing professionals are frequently faced is caring for the terminally ill and their relatives. Without a doubt, this is one of the aspects that requires higher emotional skills in order to find strategies that respond with satisfaction to the needs that arise in these times (Wong, Lee, & Mok, 2001). Nevertheless, other situations also exist in which it is essential that the professionals have these emotional skills, such as for example, those that occur in emergency services, intensive care, out-of-hospital emergencies, and surgery.

Literature on the subject reveals that emotional intelligence is an essential part of the nursing profession in many situations. Empirical research focuses particularly on the field of management and leadership (Akerjordet & Severinsson, 2008; Herbert & Edgar, 2004; Muller-Smith, 1999a; Vitello-Cicciu, 2001, 2002; Vitello-Cicciu, 2003), education (Aradilla-Herrero & Tomás-Sábado, 2006; Bellack, et al., 2001; Cadman & Brewer, 2001; Chabeli, 2006; Freshwater & Stickley, 2004), mental health and wellbeing of health professionals and nursing students (Akerjordet & Severinsson, 2004; Farmer, 2004; Montes-Berges & Augusto, 2007; Morrison, 2005; Tjiong, 2000).

Below a detailed description of the concept of emotional intelligence and the different theoretical models related to the construct is outlined. Similarly, the most relevant research carried out in the field of nursing is reviewed, and a model of emotional competencies to be applied in the context of higher education is proposed.

WHAT IS EMOTIONAL INTELLIGENCE? DIFFERENCES IN THE CONCEPTUALISATION OF EMOTIONAL INTELLIGENCE

The concept of emotional intelligence was first defined by the psychologists Salovey and Mayer (1990) as "the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions". It was later popularised by Goleman (1995).

Mayer and Salovey (1997) later reformulated the original definition of the construct, believing that their first approach omitted the relation between feelings and thoughts. On the basis of this revision, the concept of emotional intelligence came to refer to the ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth.

Since then, the increase in publications, conferences and educational programmes has acquired exponential characteristics, developing different conceptual models which have triggered considerable academic controversies and discussions, about which full agreement is yet to be found (Cherniss, Extein, Goleman, & Weissberg, 2006; Mayer, Salovey, & Caruso, 2008; Petrides & Furnham, 2001; 2003; Salovey & Grewal, 2005; Vernon, Petrides, Bratko, & Schermer, 2008; Waterhouse, 2006; Zeidner, Roberts, & Matthews, 2008). This has occurred to such a point that the conceptual differences have lead to Locke (2005) considering that emotional intelligence is an invalid concept. However, other authors believe that it involves a recent construct in the first phase of theoretical development, in which the generation of different theoretical conceptualisations constitutes a sign of strength in the research and not a weakness (Cherniss, et al., 2006). Fernández-Berrocal and Extremera (2006) defend the advisability of developing different approaches towards the construct, since this facilitates research, especially into the two key aspects for which there is still no clear answer: the mechanisms of acquiring emotional skills and the role that emotional intelligence plays in personal and professional success.

It is evident that emotional intelligence is a multi-faceted construct which can be approached from many different perspectives (Zeidner, et al., 2008). In this regard, different classifications and models of emotional intelligence have been proposed. The most popular

classification is that which differentiates between ability models and mixed models (Keele & Bell, 2008; Petrides & Furnham, 2000; 2001) . The ability models (Caruso, Mayer, & Salovey, 2002; Mayer, Caruso, & Salovey, 1999; Mayer, Salovey, & Caruso, 2004; Mayer, Salovey, Caruso, & Sitarenios, 2001), also known as cognitive processing models (Petrides & A. Furnham, 2001), highlight the adaptive use of emotions as facilitators of a more effective reasoning (Mayer, et al., 2008). On the other hand, the mixed models understand emotional intelligence from a more global concept and include different socio-emotional skills, motivational aspects, cognitive emotional skills (Mayer, et al., 2008), and personality traits (Pérez, Petrides, Furnham, Schulze, & Roberts, 2005; Petrides & Furnham, 2001; Petrides, Furnham, & Frederickson, 2004; Petrides, Furnham, et al., 2007; Petrides, Pérez-González, & Furnham, 2007).

This differentiation is mainly based on the measurement method used. In the case of the ability models, performance-based ability measures are used to assess emotional skills, for instance the Mayer Salovey Caruso Emotional Intelligence Test (MSCEIT) (Mayer, Salovey, Caruso, & Sitarenios, 2003), while in the mixed or trait models, self-report measures, also known as self-judgement scales are used, as the Trait Emotional Intelligence Questionnaire (TEIQue) (Petrides, et al., 2007) and the Bar-On Emotional Quotient Inventory (EQ-i) (Bar-On & Parker, 2000).

Petrides and Furnham (2000; 2001; 2003) do not share this preliminary difference between the emotional intelligence models, arguing that the measuring method used, and not the theoretical conception, must be the differentiating characteristic between the ability and mixed models. Basically, they defend an emotional intelligence model that is based on personality traits, which does not fully apply to the mixed models, since these assume a wider theoretical conception of emotional intelligence which includes, among others, aspects such as motivation and happiness.

Boyatzis (2009) proposes a new classification which differentiates between ability measures (Mayer, et al., 1999; Mayer & Salovey, 1997), behaviour measures, based on 360º evaluation tools (Bar-On & Parker, 2000; Boyatzis, Goleman, Rhee, Bar-On, & Parker, 2000; Dulewicz, Higgs, & Slaski, 2003) and self-report measures (Law, Wong, & Song, 2004; Petrides & Furnham, 2001; Schutte, et al., 1998; Wong & Law, 2002).

MODELS OF EMOTIONAL INTELLIGENCE

As outlined above, various models of emotional intelligence exist, with their corresponding measuring methods. Table 1 contains a summary of the classification of the models of emotional intelligence, the authors who most defend them and the main tools used to assess them. Below, some of these models are described in more detail.

Table 1. Models of emotional intelligence according to measuring method

Theoretical model	Authors	Measures
Ability	Mayer, Salovey and Caruso	MSCEIT
Behavioral	Boyatzis and Goleman	ESCI-360
Self-report	Petrides and Furnham	TEIQue

Salovey and Mayer's Model

Mayer and Salovey (1997) present emotional intelligence as a model with four branches of basic competencies, arranged from greater to less complexity, in which each branch is characterised by four skills, which must develop gradually. The basic abilities that appear in the model are:

1. Perception, appraisal and expression of emotion.
2. Emotional facilitation of thinking.
3. Understanding and analysing emotions, using emotional knowledge.
4. Reflective regulation of emotions to promote emotional and intellectual growth.

Emotional perception. This skill refers to the ability to identify one's own different emotional states and those of others, and to the ability to express feelings and emotional needs in an appropriate way. The authors understand that recognising emotional states is the first step towards predicting someone's actions and thoughts.

Emotional facilitation of thought. This skill refers to the ability of emotional situations to help in the intellectual process and to direct the focus to the most important aspects. This ability also enables feelings to be anticipated, by means of a cognitive process in which emotions can be created, felt, manipulated and examined in order to better understand them before making a decision.

Emotional understanding. This refers to the ability to name the different emotions and to recognise the relation between emotions and the situations that cause them. It also involves both an anticipatory and retrospective activity, to recognise the causes of the mood and the consequences of our actions (Extremera & Fernández-Berrocal, 2009). Furthermore, it includes the ability to recognise the complex combination of emotions, such as love and hatred, or fear and surprise.

Emotional regulation. This consists of the conscious regulation of emotions in order to promote emotional and intellectual growth. This ability is the most complex of the four and enables emotions to be managed by diminishing negative ones and intensifying positive ones. Similarly, it refers to the ability to regulate the emotions of others, putting into practice different strategies which modify the emotions of the self and of others.

The most recognised measure for assessing the ability model of Mayer and Salovey (1997) is the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT) (Mayer, et al., 2003) developed on the basis of a review of a prior measure from the same authors, the Multifactor Emotional Intelligence Test (MEIS) (Mayer, et al., 1999). The first tool developed by the authors is the Trait Meta Mood Scale (TMMS) (Salovey, et al., 1995), a self-report measure which has been widely used and which provides an emotional intelligence assessment according to Salovey and Mayer's original model (Salovey & Mayer, 1990).

Model of Goleman and Boyatzis

Goleman (1998) defined emotional intelligence as the group of skills that enable a person to achieve excellent performance, which can be learned (Goleman, 2000) and which determine the way in which a person can look after him/herself and others, as well as the way in which a person cares for their life and their job (Boyatzis, Goleman, & Rhee, 2000). The model of emotional intelligence conceptualised by Boyatzis (2009) as a behaviour model, incorporates the works of Goleman (1995, 1998), Boyatzis (2000) and Boyatzis, Goleman and Rhee (2000). In this model four aspects are defined: self-awareness, self-management, social awareness and relationship management.

The basic characteristics of these four aspects are:

Self-awareness refers to knowing one's emotional states, preferences, resources, and intuitions. The self-awareness cluster contains three competencies:

- **Emotional awareness**: Recognising one's own emotions and their effects.
- **Accurate self-assessment**: Knowing one's strengths and limits.
- **Self-confidence**: A strong sense of self-worth and of abilities.

Self-management refers to managing one's emotional states, impulses, and resources. The self-management cluster contains six competencies:

- **Emotional self-control**: Keeping disruptive emotions and impulses under control.
- **Transparency**: Maintaining integrity, acting in accordance with one's values.
- **Adaptability**: Flexibility in dealing with change.
- **Achievement**: Striving to improve or meeting a standard of excellence.
- **Initiative**: Readiness to act on opportunities.
- **Optimism**: Persistence in pursuing goals despite obstacles and setbacks.

Social awareness refers to how people handle relationships and also to the awareness of others' feelings, needs, and concerns. The social awareness cluster contains three competencies:

- **Empathy:** Being sensitive to others' feelings and perspectives, and taking an active interest in their concerns.
- **Organisational awareness:** Reading a group's emotional currents and power relationships.
- **Service orientation:** Anticipating, recognising, and meeting customers' needs.

Relationship management concerns the skill or adeptness at triggering desirable responses in others. The relationship management cluster contains six competencies:

- **Developing others:** Being sensitive to others' development needs and encouraging their abilities.
- **Inspirational leadership:** Inspiring and guiding individuals and groups.

- **Change catalyst:** Initiating or managing change.
- **Influence:** Wielding effective persuasion tactics.
- **Conflict management:** Negotiating and resolving disagreements.
- **Teamwork & collaboration:** Working with others toward shared goals. Creating group harmony to pursue collective goals.

Boyatzis is one of the authors most interested in developing training programmes to increase emotional competencies in the professional field (Boyatzis, 2008b; Boyatzis, Bar-On, Maree, & Elias, 2007; Boyatzis, Ciarrochi, & Mayer, 2007; Boyatzis & Saatcioglu, 2008). Studies carried out in this field have revealed that emotional intelligence and social skills are significant performance indicators (Boyatzis, 2008a). According to Boyatzis (2000) three reasons explain why a person should develop their emotional intelligence: to increase their efficiency in work, to become a better person, and to help others to develop their emotional intelligence. In order to be able to assess these skills, they must be able to be observed, that is, the person must carry out actions that others can perceive, which can be identified as measurable behaviour (Boyatzis, 2009). The evaluation of this behaviour is carried out using 360º tools which constitute the grounds of Boyatzis' behaviour model. The first measure developed was the Emotional Competency Inventory (ECI) which assesses 18 skills using the answers given to 110 items (Boyatzis, Goleman, & Rhee, 2000). Later, the Emotional and Social Competency Inventory (ESCI) was developed, which assesses 12 competencies organised into four clusters: Self-awareness, self-management, social awareness, and relationship management. The latest version of the ESCI attempts to address the difference between coded behaviour from behavioural event interviews and from informant based 360 surveys (Boyatzis, 2009).

Model of Petrides and Furnham

For Petrides and Furnham (2000; 2001; 2003) the EI trait models refer to a sequence of behavioural dispositions and self-perceptions concerning the ability to recognise process and use emotional information. In this regard, the model is conceived as a group of self-perceptions related to emotional efficiency, which the authors consider to be stable personality traits (Petrides, Pita, & Kokkinaki, 2007).

EI understood as a trait, includes various aspects of the domain of the personality, such as empathy, impulsiveness and assertiveness. Moreover, it includes elements of social intelligence and personal intelligence which are assessed as self-perceived skills using self report measures.

Petrides and Furnham (2001) developed the Trait Emotional Intelligence Questionnaire (TEIQue), which contains 153 items with a Lickert-type format of 7 options with a structure of 15 subscales organised into 4 factors: well-being, self-control, emotionality, and sociability (Mikolajczak, Luminet, Leroy, & Roy, 2007).

BENEFITS OF EMOTIONAL INTELLIGENCE IN NURSING

Various works have been devoted to the study of the relation between emotional intelligence and different aspects of people's lives; wellbeing and healthy behaviour,the quality of interpersonal and organisational relationships , and education, among others. This section describes, using existing evidence, the influence of emotional intelligence on different fields of the nursing profession and it justifies the need to develop emotional competencies in order to optimise the quality of care provided to patients and families.

Literature on the subject reveals the importance of emotional intelligence in the professional development of nurses (Akerjordet & Severinsson, 2007; Bellack, 1999; Chabeli, 2006; Freshwater & Stickley, 2004; McQueen, 2004). Emotions are fundamental in the practice of nursing, since they are closely related to the way in which the professional relates to the patients, makes clinical decisions or works in interdisciplinary teams (Bulmer Smith, et al., 2009).

Akerjordet and Severinsson (2004) state that each clinical intervention by nurses requires high levels of emotional intelligence, qualified, at times, as the *heart of the art of nursing* (Freshwater & Stickley, 2004), the central nucleus from which the profession is developed. Moreover, emotional management is perceived as a skill essential to a nurse being considered a competent professional (Bellack, 1999; Cadman & Brewer, 2001).

Emotional intelligence enables nurses to develop therapeutic relationships and to interact with other health care professionals (Reeves, 2005), although on many occasions, nurses display a lack of these skills and state that they did not receive sufficient training (Aradilla-Herrero & Tomás-Sábado, 2006; Bellack, 1999; Hurley, 2008a). This aspect of training in emotional skills is fundamental in many areas. For example, it is essential regarding the effective operation of interdisciplinary health teams. Technical experience and cognitive intelligence are not sufficient to establish good teams; emotional skills such as emotional self-awareness, emotion management and social skills are also necessary for the effective operation of these groups (McCallin & Bamford, 2007).

The continuous contact nurses have with illness, pain, suffering and death is another of the aspects that requires the development of emotional intelligence, in order to minimise the problems that can derive from these, such as high stress levels, burnout, anxiety about death or avoidance behaviour which could affect the quality of the nursing care (Aradilla-Herrero, Tomás-Sábado, Gómez-Benito, & Limonero, 2009). Many studies relate emotional intelligence to these factors (Akerjordet & Severinsson, 2004; Aradilla-Herrero, et al., 2009; Hurley, 2008a; Montes-Berges & Augusto, 2007).

Health care professionals must be able to identify and understand the emotional reactions of the patients, help them to manage their emotions and show that they are also able to do this (Strickland, 2000). In order to commence a therapeutic relationship with a patient, the nurse must first develop an understanding of his/her own beliefs and values and his/her ability to create relationships before he/she can respond to the needs of his/her patients (O'Connell, 2008). These emotional skills enable health professionals to provide care according to a patient-focused model (Birks & Watt, 2007).

a. Emotional intelligence and emotional wellbeing in nursing: adapting to stressful situations, coping and burnout

Emotionally intelligent people develop more effective coping strategies, they adapt to stressful situations with more ease, and they manage conflicts in a constructive manner (Morrison, 2008; Zeidner, et al., 2008). According to Goleman (1995), the key to wellbeing is in developing the ability to adapt to stressful situations.

Work-related stress is a subject of significant worry in the professional health context (DesCamp & Thomas, 1993). More specifically, work-related stress is described as a group of emotional and physical reactions which occur when the demands of the job exceed the expectations and abilities of the worker, triggering an imbalance between the demands of the professional exercise and the coping skills of the affected subject. In this regard, emotions play an important role as stress mediators, since a person will experience a greater or lesser ability to cope with stressful situations depending on their emotional state (Chang, D'Zurilla, & Sanna, 2009). many studies which, from different perspectives, have taken interest in the action of work-related stress on the physical and psychological health of workers have proven its influence in manifestations such as anxiety and depression (Molassiotis, van den Akker, & Boughton, 1995); sleeping problems, headaches, gastro-duodenal ulcers, changes in the menstrual cycle or blood pressure (Hatch, Figa-Talamanca, & Salerno, 1999; Ullrich & FitzGerald, 1990); and work-related problems such as professional dissatisfaction, absenteeism, accident rate and low productivity. Although the majority of professionals are susceptible to experiencing work-related stress at some stage, in general health professionals are one of the most vulnerable groups in terms of the possibility of suffering from this disorder (Limonero, Tomás-Sábado, Fernández-Castro, & Gómez-Benito, 2004).

There are many work-related stress factors for health care workers who have been shown to have an increased risk of stress and burnout, such as contact with suffering and dying patients, the need to hide negative emotional responses, role conflicts with other professionals, an increasing administrative workload and organisational changes. (Ruotsalainen, Serra, Marine, & Verbeek, 2008). Nursing, in particular, has been identified as a highly stressful occupation (Admi, 1997) due to the great polyvalence and complexity of the duties carried out.

Augusto-Landa, López-Zafra, Berrios and Aguilar-Luzán (2006), analysed the relation between emotional intelligence, stress and health in a sample of 180 nurses. The results indicate that people with high levels of clarity and emotional repair show less stress, while people with high levels of emotional attention have greater stress levels. These results are consistent with other similar studies (Limonero, et al., 2004). Salovey, Stroud, Woolery and Epel (2002) confirm that people with high levels of emotional attention show symptoms of anxiety and depression. Other authors state that an excess of attention to emotions, especially if this is continuous over time, is not always productive and may bring about negative brooding thoughts (Limonero, et al., 2004).

Coping refers to a person's ability to manage or control a situation viewed as stressful, or overtaxing, or as challenging one's individual coping resources (Folkman & Lazarus, 1988). The role of the coping style is important in relation to professional burnout. Narumoto et al. (2008) confirmed that higher emotion-oriented coping and higher neuroticism are associated with higher burnout. As regards burnout, the study by Gerits, Derksen, Verbruggen and Katzko (2005) reveals a clear relation between emotional intelligence and burnout with

significant differences depending on the gender of the professionals. The fewest symptoms of burnout were reported by female nurses with relatively high emotional intelligence profiles and relatively low social skills. In a similar study (Gerits, Derksen, & Verbruggen, 2004), men displayed higher stress tolerance and lower anxiety levels. On the contrary, women scored higher in aspects linked to interpersonal relations, such as empathy and social responsibility. As regards coping styles, similar results were obtained for men and women, with negative and significant relations between emotional intelligence and depressive reactions and an avoidance style of coping.

Although some studies have related these variables to nursing students, there is still little scientific evidence that enables predictive relations to be established between personality traits, professional stress and coping strategies.

A recent research project, carried out with nursing students (Montes-Berges & Augusto, 2007) revealed that students with high levels of emotional clarity are able to identify their emotions in a stressful situation with more ease and use cognitive resources which enable them to develop different coping strategies more effectively. These results support the need for training in these emotional skills, which will facilitate coping strategies in the professional field. Learning skills to manage stressful situations is an essential requirement for an emotionally competent and healthy practice (MacCulloch, 1999). Interventions such as talking, crying, laughing, and relating individually to one's clients are all forms of caring, which encourage resilient behaviour and effective coping strategies to develop (Warelow & Edward, 2007). In the field of management, findings confirm that health professional leaders display a better perception of their health and psychological well-being (Slaski & Cartwright, 2002) and confirm that emotional intelligence plays a very important role as a modulator of stress and personal resilience.

b. Emotional intelligence and leadership in nursing

The relation between emotional intelligence and leadership is one of the most studied fields in nursing (Akerjordet & Severinsson, 2008). Successful leaders use their emotional skills to understand how their employees or work teams are feeling during difficult times, and construct spaces of trust through active listening and empathy (Cummings, Hayduk, & Estabrooks, 2005). Successful leaders are those who are in tune with and connect with other people's feelings and channel them in an emotionally positive direction (Goleman, Boyatzis, & McKee, 2002).

The concept of emotional intelligence has become a relevant concept for nurses in leadership because the level and the quality of interpersonal relations between superiors and their employees influences the level of professional satisfaction of both, and is key to successful management (Feather, 2009; Güleryüz, Güney, Aydin, & Asan, 2008). A warm, friendly atmosphere, established by the nurse manager, encourages emotional work and enables a degree of flexibility in routines to assure individualised care (McQueen, 2000).

Emotionally intelligent health professional leaders have a positive influence on patients, motivating nurses to make high level clinical decisions, even in complex situations. Moreover, they establish positive relationships with their nurses and facilitate the acknowledgement of their work within the interdisciplinary team (Bulmer Smith, et al., 2009).

Various studies relate emotional intelligence to professional satisfaction and confirm that high levels of emotional intelligence generate higher levels of professional satisfaction (Ashkanasy & Dasborough, 2003; Güleryüz, et al., 2008; Wong & Law, 2002). This aspect is of vital importance in the current situation characterised by a serious international problem of a shortage of nurses, a situation which requires strategies to be implemented so that nurses do not abandon the profession because of professional dissatisfaction and overwork (Vitello-Cicciu, 2003). One of the factors that may decrease the number of nurses leaving the profession is commitment with the organisation. Humphreys, Brunsen and Davis (2005) proved that direct care workers who score higher in emotional intelligence and in emotional coping strategies, display a greater commitment to the institution in which they work.

Another aspect that generates professional satisfaction is the possibility of gaining empowerment. Access to empowerment produces high motivation, commitment and ability to innovate (Laschinger, 2008). Nurse managers with emotional intelligence anticipate their staff's needs and establish strategies so that nurses can have more control over their daily practice (Lucas, Laschinger, & Wong, 2008). Leaders must manage the team by decreasing their sphere of control and building an atmosphere of commitment, responsibility and mutual trust.

One of the skills that leaders in nursing must be able to develop is the ability to create healthy work spaces, which promote team work and produce high quality nursing care (Vitello-Cicciu, 2003). Emotional intelligence is one of the attributes of efficient leaders who, by nurturing personal relationships, manage to achieve that their workers carry out their duties better (Muller-Smith, 1999b; Snow, 2001). Organisations need leaders and workers with emotional intelligence who can adapt to change, take part in decision-making, and will commit to the company (Scott-Ladd & Chan, 2004).

Building effective emotional intelligence skills allows managers and leaders to continually maintain their social networks (Freshman & Rubino, 2004). This aspect is particularly important in the creation and maintenance of interdisciplinary teams in health. The members of a team need emotional intelligence skills in order to work effectively with their colleagues, as well as with users of the health service and their families (McCallin & Bamford, 2007). Nevertheless, study results are not always unanimous. In this way, for example, Quoidbach and Hansenne (2009) found, contrary to what was expected, that appraisal of emotion was negatively linked with the quality of the health care provided by teams. A possible explanation of this phenomenon could be that a team in which individuals are more sensitive to the emotions of others wastes time and energy in understanding the emotions of patients and families and devotes fewer resources to respecting the safety and quality of the procedures, although this is a preliminary explanation that should be proven by future studies.

Leaders must learn to recognise emotional signs in others and organisations must promote the learning of emotional skills through specific education programmes for their managers (Feather, 2009; Freshman & Rubino, 2002). However, some authors state that it is necessary to include leadership competencies in undergraduate curricula in order to facilitate the change in health organisations and improve effective work groups (Bellack, et al., 2001). The need to consider emotional intelligence as a hiring requirement is also suggested (Cadman & Brewer, 2001).

c. EI and education in nursing

Although traditionally education has focused mainly on increasing cognitive aspects through transferring knowledge, effective clinical practice is a combination of emotional and cognitive factors (Rochester, et al., 2005). In fact, literature on the subject reveals the need to incorporate emotional aspects in the training curriculum of nursing (Akerjordet & Severinsson, 2007; Aradilla-Herrero & Tomás-Sábado, 2006; Bulmer Smith, et al., 2009; Freshwater & Stickley, 2004). Bulmer Smith et al. (2009) highlight three fundamental aspects in preparing nursing students in emotional competencies: firstly, understanding the emotional nature of nursing, an essential aspect to create effective therapeutic relationships; developing emotional skills in order to provide quality nursing care, since competent care must provide cognitive, technical and relational quality; and, lastly, developing these skills in order to deal with complex and occasionally chaotic work environments, in which they must carry out their clinical practice.

The new teaching paradigm being considered establishes training in competency-based curricula. This training goes beyond the use of knowledge and know-how, and seeks to prepare the future professional to act in complex settings that demand the use of resources and emotional strategies.

To prepare and design the competency-training profiles, three models are described: those that highlight a technical preparation to enter the labour market, those that define skills and abilities to carry out a profession and include more global aspects such as the ability to problem-solve or the ability to be flexible and adapt to a setting, and, lastly, models that also include individual training aspects (Aradilla, et al., 2008). These last models understand that a person will carry out their responsibilities effectively, not only because of the specific training in the field, but also because they reveal individual skills that foster personal growth, professional development and professional commitment.

As regards the most appropriate methodology with which to approach this subject, there is a consensus that emotional education should be approached using a predominantly experiential methodology (Aradilla-Herrero & Tomás-Sábado, 2006; Spall & Johnson, 1997; Warne & McAndrew, 2008; Wasylko & Stickley, 2003). This methodology, also known as experience-based, centres its attention on developing emotional strategies in settings similar to reality, which create spaces to practice, repeat, and reflect on practice, and with the possibility of obtaining feedback from colleagues and professors (Aradilla-Herrero & Tomás-Sábado, 2006; Arranz, Ulla, Ramos, del Rincón, & López-Fando, 2005; Lanser, 2000; Rochester, et al., 2005; Rose, Leonard, & Courey, 2008).

Freshwater and Stickley (2004) propose a series of active learning methodologies which can be used in emotional skills education: reflective learning experiences; supportive supervision and mentorship; modelling; opportunities from creative work with the arts and humanities; focus on developing the self and developing dialogic relationships; forum theatre; narrative, reflective discussion and writing; art; drama; music; film; poetry; practicing listening skills; and the use of video for observation and feedback. Other authors use problem-based learning, an active learning methodology to develop communication skills, emotional skills and a critical mind (Austin, Evans, Magnus, & O'Hanlon, 2007; Bowman & Hughes, 2005; Jones & Johnston, 2006; Mok, Lee, & Wong, 2002). Kooker, Shoultz and Codier (2007) propose storytelling as a strategy, so that nurses examine their professional experiences and create stories or narratives through which they can analyse their clinical practice. In these stories the actions and feelings that drive clinical decisions are described;

this is very useful to facilitate the emotional expression that arises from contact with patients' suffering and professionals' clinical doubts. Reflective learning helps nursing students and professionals themselves to generate an analysis on the care provided and to identify cognitive and emotional limitations (Horton-Deutsch & Sherwood, 2008; Pfund, Dawson, Francis, & Rees, 2004).

Some authors also relate emotional intelligence to academic performance and to the stressful aspects of studying a university degree. This perspective is particularly interesting, since it has been confirmed that students with emotional intelligence cope more effectively with academic pressure (Bulmer Smith, et al., 2009). Moreover, students with a higher opinion of themselves, their abilities, opportunities, resources and limitations manage their emotions in a more effective manner (Augusto Landa, López-Zafra, Aguilar-Luzán, & Salguero de Ugarte, 2009), demonstrating lower stress levels and revealing themselves to be more effective at developing coping strategies (Montes-Berges & Augusto, 2007).

Other authors blame education institutions and their professors for limitations in emotional education and defend the need for future generations of professionals to be emotionally more competent and to be able to manage the increasingly complex demands of the health organisations (Bellack, 1999).

d. Emotional intelligence and palliative care in nursing

Caring for people in the last stages of their life and dealing with the death of others is one of the essential aspects of nursing in palliative care. These situations require high levels of emotional intelligence on the part of the professionals in order to manage the impact of continuous contact with death and dealing with loss (Aradilla-Herrero & Tomás-Sábado, 2006). It is evident that if nurses deal with these situations with anxiety, they may have difficulties managing the aspects related with the death of their patients and develop avoidance behaviour that has repercussions on the quality of the care (Mok, et al., 2002).

There is little evidence in literature about the relation between emotional intelligence and the variables related to death, such as anxiety or fear. Nevertheless, results from research carried out in this field, agree on considering the need for specific preparation in emotional management strategies, as well as the development of social and communication skills, which help nursing students and professionals to cope with emotionally stressful situations (Aradilla-Herrero & Tomás-Sábado, 2006; Dickinson, 2007; Hainsworth, 1996; Mallory, 2003).

Death is still a taboo in our society and anxiety about death reflects the fear this provokes in us. Some studies have proved that nurses with high levels of death anxiety show discomfort when dealing with this subject with patients and families (Deffner & Bell, 2005). Other works confirm that the care of terminally ill patients and their families is one of the main triggers of stress in students and professionals (Augusto Landa, López-Zafra, Berrios Martos, & Aguilar-Luzán, 2008; Gómez, Hidalgo, & Tomás-Sábado, 2007; Lees & Ellis, 1990).

Aradilla-Herrero, Tomás-Sábado, Gómez-Benito and Limonero (2009) analysed the relation between emotional intelligence, alexithymia and death anxiety in a sample of 111 nursing professionals. The results show, firstly, that there is a strong negative link between alexithymia and two of the components of emotional intelligence; clarity and repair. However, the link between alexithymia and the attention component is close to nil, in agreement with the results of other studies. (Landa, et al., 2006; Velasco, Fernandez, Paez, &

Campos, 2006). These results allow a hypothesis to be drawn; that those people with alexithymic traits will see their ability to understand and manage emotions being seriously affected. However, contrary to what was expected, the links between emotional intelligence and death anxiety does not show any significant relation, although positive links are observed with emotional attention, and negative links with clarity and repair. These data are in agreement with the results of other studies that relate emotional intelligence to variables related to anxiety about death.

On many occasions, the death of patients is experienced by professionals as a therapeutic error and not as a natural or irremediable situation. Faced with these situations, it seems evident that in order to be able to provide physical, emotional and spiritual care to patients at the end of their life, nurses have to receive solid training in palliative care that does not create negative emotions such as anxiety, fear or frustration (Beck, 1997). Nursing students believe that end of life care is one of the most difficult and unpleasant situations that nurses have to take on (Allchin, 2006; Fitch, Bakker, & Conlon, 1999) although they state that the quality of the relationships that are established between patients and nursing professionals is essential to being able to provide people with a dignified death.

Education programmes about palliative care should include the development of emotional skills that provide strategies to cope with death for students and nurses (Thompson, 2005), since end of life care is a habitual and painful professional situation in many care units such as ICU, emergency department, hospitalisation units, geriatric units and special palliative care units.

Another very important aspect in palliative care training programmes is the possibility of promoting inter-professional education, that is, offering interdisciplinary training strategies that facilitate team management and mutual knowledge between different health professionals who are looking after patients at the end of their life (Latimer, Kiehl, Lennox, & Studd, 1998). As previously described, interdisciplinary training later increases the effectiveness of team work and the quality of the care provided (McCallin & Bamford, 2007).

MODEL OF EMOTIONAL COMPETENCIES IN NURSING. DESCRIPTION OF THE PROGRAMME, DEVELOPMENT AND LEARNING STRATEGIES

Emotional education is understood to be a continuous and permanent process that aims to foster the development of these skills as an essential element of the integral development of a person. This understanding of social and emotional skills education as an essential element of training a person is an important aspect for professional growth in nursing.

In order to conceptualise the model of competencies for nursing which appears below, mixed models are taken as references. In these models social and emotional skills are widely defined, understanding these skills to be competencies that can be learned, that are focused on the person, and that enable the formation of individuals who are both self-aware and aware of others, are able to make responsible decisions, are socially competent, show respect towards others and respect social norms.

Table 2. Model of Emotional Competencies in Nursing

MODEL OF EMOTIONAL COMPETENCIES IN NURSING		
EMOTIONAL SKILLS	SOCIAL SKILLS	PERSONAL SELF-CARE SKILLS
a) Perception b) Comprehension c) Assimilation d) Emotional management	a. Empathy b. Assertiveness c. Active listening d. Conflict resolution e. Team work f. Basic social skills (greet people, thank people, apologise, ask others for help and be appreciative) g. Effective verbal and non verbal communication h. Communication in complex situations i. Respect towards others j. Acceptance of diversity	a. Self esteem b. Positive attitude c. Resilience d. Stress tolerance

The Model of Emotional Competencies in Nursing (Table 2), is structured in three dimensions: emotional skills, social skills and personal self-care skills. The proposal includes this last section separate to emotional and social skills, because it is considered that self esteem, positive attitude, resilience and tolerance towards stress are essential skills for nursing. Looking after oneself is an absolutely necessary aspect of carrying out the nursing practice, since it enables the resources of the professionals to be optimised in the long term.

Implementation and Learning Strategies

The teaching of emotionally intelligent responses primarily depends on practice, training and perfecting training, and not so much on verbal instruction, or transferring knowledge, since what is essential to learning is the exercising of emotional competencies in order to convert them into an adaptive response of the person to a setting (Ruiz-Aranda & Fernández-Berrocal, 2009). Therefore, learning strategies should be dynamic and should ensure active participation from the student.

In order to implement said model active learning strategies are proposed such as the emotional reflexive diary, role-playing, video recordings, visualisation and analysis of film scenes, relaxation and stress management techniques, problem-based learning, simulations of common conflict situations in the workplace in order to exercise problem solving techniques and the learning portfolio or folder.

Another requirement for emotional skills learning to be effective is to work in reduced groups, in which there is a tutor-professor who encourages participation, debate and discussion, and who is able to encourage and motivate the students.

Lastly, the training programme must be assessed in order to guarantee that the curricular sequencing and design is in line with the previously defined skills profile, that appropriate learning strategies are used to develop emotional skills and that the expected results are obtained.

CONCLUSION

Emotional intelligence is one of the new constructs of the last 20 years. Its implementation in the field of nursing has driven many publications that support the need to establish strategies to develop emotional intelligence in health care professionals.

In this chapter, a literature review regarding emotional intelligence and nursing has been carried out. Scientific evidence in this field is still very limited and should constitute a research field to be explored, due to the importance of the phenomenon and its repercussion in the clinical practice of nursing.

The incorporation of emotional intelligence in the nursing curriculum is an essential element in the development of emotional intelligence in care. These aspects have been confirmed as essential to establishing effective therapeutic relationships with patients and families, to promoting interdisciplinary team work, and to generating effective coping responses in professionals in complex situations of clinical practice.

Emotionally competent nurses are able to perceive and identify their own emotions and those of others, are understanding and empathetic in their relationships, manage their emotions effectively, show adequate levels of self-control, have an influence over others, show a high leadership ability, are motivators and responsible, and are able to encourage positive thoughts and behaviour both in themselves and others; in short, they are people who are skilled to provide high levels of nursing care and to work on a team and lead health organisations effectively.

Lastly, it is important to note the need to establish collaboration networks to generate evidence on the best strategies for developing and assessing emotional intelligence in nursing and foster the study of this phenomenon that seems to make up an essential part of professional growth.

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3.4. ESTUDIO EMPÍRICO I: Perceived emotional intelligence: psychometric properties of the trait meta-mood scale.

Aradilla-Herrero A., Tomás-Sábado J. y Gómez-Benito J. (en prensa). Perceived emotional Intelligence in nursing: Psychometric properties of the Trait Meta-Mood Scale. *Journal of Clinical Nursing.* doi:10.1111/jocn.12259

En este primer trabajo empírico se pretende examinar las propiedades psicométricas de la escala Trait Meta Mood Scale, en su versión reducida en castellano (TMMS-24) que evalúa la Inteligencia Emocional Percibida (IEP), en el ámbito de enfermería. El TMMS-24 es uno de los instrumentos de auto-informe más ampliamente utilizado para evaluar la IE. Asimismo se analizan las relaciones entre la IE, la autoestima, la alexitímia y la ansiedad ante la muerte.

Para ello, se diseñó un estudio transversal en el que participaron un total de 1417 individuos, de los cuales 1208 eran estudiantes de enfermería y 209 enfermeras que trabajan en el entorno hospitalario. Todos los participantes respondieron a un cuestionario autoadministrado, que además de variables sociodemográficas incluía la Trait Meta-Mood Scale (TMMS-24), en su versión reducida en castellano. Asimismo, aproximadamente la mitad de la muestra (n=707), con el objetivo de analizar la relación de la IE con otras variables, también respondieron a los los siguientes instrumentos en sus versiones validadas en castellano: la Escala de Alexitímia de Toronto (TAS), la escala de Autoestima de Rosenberg (RSES) y el Inventario Revisado de Ansiedad ante la Muerte (DAI-R).

Se llevó a cabo un análisis factorial confirmatorio mediante el programa LISREL 8.8. Se examinó la consistencia interna de la escala y la fiabilidad test-retest, en una submuestra de 57 individuos, así como la relación de la IEP con las otras variables mediante el análisis de los coeficientes de correlación de Pearson.

Los principales resultados del estudio confirman, en primer lugar, la estructura factorial de tres dimensiones propuesta por los autores originales de la escala (atención, claridad y reparación). Asimismo, el TMMS-24 muestra una adecuada consistencia interna y una estabilidad temporal satisfactoria. El análisis de la relación

entre la IE y las otras variables muestran que la atención emocional correlaciona de forma positiva con la ansiedad ante la muerte y con la dimensión de la alexitímia Dificultad para Identificar Sentimientos (DIF) y negativa con la autoestima; mientras que la claridad y la reparación correlacionan negativamente con la ansiedad ante la muerte y con todas las dimensiones de la alexitímia y correlaciona positivamente con la autoestima.

ORIGINAL ARTICLE

Journal of Clinical Nursing

Perceived emotional intelligence in nursing: psychometric properties of the Trait Meta-Mood Scale

Amor Aradilla-Herrero, Joaquín Tomás-Sábado and Juana Gómez-Benito

Aims and objectives. To examine the psychometric properties of the Trait Meta-Mood Scale in the nursing context and to determine the relationships between emotional intelligence, self-esteem, alexithymia and death anxiety.

Background. The Trait Meta-Mood Scale is one of the most widely used self-report measures for assessing perceived emotional intelligence. However, in the nursing context, no extensive analysis has been conducted to examine its psychometric properties.

Design. Cross-sectional and observational study.

Methods. A total of 1417 subjects participated in the study (1208 nursing students and 209 hospital nurses). The Trait Meta-Mood Scale, the Toronto Alexithymia Scale, the Rosenberg Self-Esteem Scale and the Death Anxiety Inventory were all applied to half of the sample (n = 707). A confirmatory factor analysis was carried out, and statistical analyses examined the internal consistency and test–retest reliability of the Trait Meta-Mood Scale, as well as its relationship with relevant variables.

Results. Confirmatory factor analysis confirmed the three dimensions of the original scale (Attention, Clarity and Repair). The instrument showed adequate internal consistency and temporal stability. Correlational results indicated that nurses with high scores on emotional Attention experience more death anxiety, report greater difficulties identifying feelings and have less self-esteem. By contrast, nurses with high levels of emotional Clarity and Repair showed less death anxiety and higher levels of self-esteem.

Conclusions. The Trait Meta-Mood Scale is an effective, valid and reliable tool for measuring perceived emotional intelligence in the nursing context. Training programmes should seek to promote emotional abilities among nurses.

Relevance to clinical practice. Use of the Trait Meta-Mood Scale in the nursing context would provide information about nurses' perceived abilities to interpret and manage emotions when interacting with patients.

Key words: alexithymia, confirmatory factor analysis, death anxiety, emotional intelligence, nurses, nursing students, self-esteem

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Introduction

Emotional intelligence is perceived as an essential skill for a competent nurse (Rochester *et al.* 2005, p. 187, Hurley 2008, p. 384, Bulmer-Smith *et al.* 2009, p. 1632). Being able to manage one's own emotions, while at the same time understanding those of others, is especially useful when carrying out nursing duties, as the ability to assess and

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distinguish between emotional responses can be decisive in establishing an effective nurse–patient relationship (Aradilla-Herrero & Tomás-Sábado 2011, p. 132), in making clinical decisions or when working in interdisciplinary teams (McCallin & Bamford 2007, p. 389). Despite this, however, formal research into emotional intelligence remains a recent phenomenon in the nursing context.

Since the concept of emotional intelligence became popular, various construct models and numerous measurement instruments have emerged. The most popular classification is that which differentiates between ability and trait models (Petrides & Furnham 2001, p. 426). In the trait model, emotional intelligence refers to a constellation of behavioural dispositions and self-perceptions concerning one's ability to recognise, process and use emotion-laden information (Petrides *et al.* 2004, p. 278), and it is measured by self-report instruments. In the ability model, by contrast, emotional intelligence is defined as the ability to perceive and express emotion, to assimilate emotion in thought, to understand and reason with emotion and to regulate emotion in oneself and in others (Mayer & Salovey 1997, p. 10), and here, it is assessed by means of performance tests.

The Trait Meta-Mood Scale

The Trait Meta-Mood Scale (TMMS) 'was designed to assess relatively stable individual differences in people's tendency to attend to their moods and emotions, discriminate clearly among them, and regulate them' (Salovey *et al.* 1995, p. 128), and it is the first self-report instrument to be developed for the assessment of perceived emotional intelligence. The scale is based on the preliminary model of Salovey and Mayer (1990, p. 189), and it evaluates three dimensions of emotional intelligence: Attention, Clarity and Repair. In its original version, the TMMS is a 48-item scale that uses a 5-point Likert format to evaluate the individual's perception of his/her own emotional abilities. However, the authors especially recommend a more efficient 30-item version (Salovey *et al.* 1995, p. 132). The scale has three subscales or factors: Attention to emotions (how much attention individuals pay to their inner feelings and emotional states), Clarity of emotional perception (the perceived ability to understand and discriminate among feelings) and emotional Repair (the perceived ability to regulate moods, repair negative emotional experiences and prolong positive ones). An important aspect to bear in mind when analysing the results is that the authors designed the scale to obtain a score on each individual subscale rather than a global score. The internal consistency of the TMMS in its 30-item version was high for the three factors: Attention, $\alpha = 0{\cdot}86$, Clarity, $\alpha = 0{\cdot}87$, and Repair, $\alpha = 0{\cdot}82$ (Salovey *et al.* 1995, p. 133).

The TMMS has been adapted and translated into various languages, including German (Otto *et al.* 2001, p. 178), Portuguese (Queirós *et al.* 2005, p. 199), Farsi (Bayani 2009, p. 198), Turkish (Aksöz *et al.* 2010, p. 2642), Chinese (Li *et al.* 2002, p. 202), Basque (Gorostiaga *et al.* 2011, p. 523) and Spanish (Fernández-Berrocal *et al.* 2004, p. 751). The Spanish version contains 24 items and maintains the three factors from the original scale (Attention, Clarity and Repair), with eight items for each of the dimensions. The Spanish TMMS-24 shows appropriate psychometric characteristics, similar to the original version, and has an internal consistency (Cronbach's alpha) of 0·90, 0·90 and 0·86 for Attention, Clarity and Repair, respectively (Fernández-Berrocal *et al.* 2004, p. 753).

Studies that have examined the factor structure of the TMMS report varied results, although this could be due to sample differences. Palmer *et al.* (2003, p. 156), in a study with Australian participants, suggest the existence of a fourth factor, although their confirmatory factor analysis (CFA) also showed a good fit for the three-factor structure of the original model. In a study using the Turkish adaptation of the TMMS, Aksöz *et al.* (2010, p. 2646) confirmed the three-factor structure of the scale, even though the distribution of items differed significantly from the original version. Martín-Albo *et al.* (2010, p. 485) conducted a CFA of the TMMS-24 with a sample of 368 athletes and concluded that the initial fit was inadequate. They therefore respecified the model, eliminating items 5 and 23 from the subscales Attention and Repair, respectively. Similarly, in a study involving Spanish adolescents, Salguero *et al.* (2010, p. 1205) confirmed the original three-factor structure but found that item 23 (from the Repair subscale) showed a different correlation pattern to the other items.

The Trait Meta-Mood Scale in the nursing context

As regards the relationship between emotional intelligence and stress, a study carried out with Spanish nurses (Augusto Landa *et al.* 2008, p. 896) showed that nurses with high scores on emotional Clarity and Repair report less stress, whereas those with high scores on Attention to emotions experience greater levels of stress. In a study conducted in Singapore, Chan *et al.* (2011, p. 3557) found that younger nursing students scored lower on Attention and also reported less social support and less stress than did older students. The authors also note that senior students obtained significantly higher stress scores related to clinical

practice than did younger students. These results are congruent with those of Deary *et al.* (2003, p. 78), who carried out a cohort study with nursing students and concluded that levels of stress and psychological morbidity among students increased with clinical experience. Clinical educators therefore need to identify students' needs, facilitate their learning in the clinical setting and develop effective interventions to reduce stress (Chan *et al.* 2009, p. 313).

Montes-Berges and Augusto (2007, p. 168) point out that nursing students with higher scores on emotional Clarity clearly identify a specific emotion during stress situations, spend less time paying attention to their emotional reactions and invest correctly the cognitive resources that enable them to achieve more adaptive coping strategies. As regards emotional Attention, the correlation analyses showed that Attention scores were positively associated with the search for social support as a coping strategy. In a similar vein, Ghom (2003, p. 595) reports that people who presented moderate levels of emotional Attention were also efficient at using the information obtained through their emotions. Attention to emotions is defined as the degree to which individuals notice and think about their feelings (Salovey *et al.* 1995, p. 128). However, higher scores on this dimension of the TMMS usually correlate with emotional maladjustment (Fernández-Berrocal & Extremera 2008, p. 36). Previous studies also suggest that high emotional Attention is associated with neuroticism (Extremera & Fernández-Berrocal 2005, p. 941) and depression (Salovey *et al.* 1995, p. 135), and a greater number of those with high Attention scores also report physical symptoms (Goldman *et al.* 1996, p. 122). By contrast, high scores on Repair and Clarity have been associated with fewer ruminations or intrusive thoughts (Ramos *et al.* 2007, p. 758), less social anxiety and depression, greater satisfaction with interpersonal and family relationships (Goldman *et al.* 1996, p. 121; Salovey *et al.* 2002, p. 615) and with better mental health and life satisfaction (Extremera & Fernández-Berrocal 2002, p. 56; Extremera & Fernández-Berrocal 2005, p. 944). In this regard, a study carried out by Augusto Landa *et al.* (2009, p. 807) in a sample of nursing undergraduates found that Clarity and Repair were positively related to self-concept and the ability to regulate emotional state, all of which appear to be essential features in the formation of self-image.

Regarding the relationship between emotional intelligence and variables related to death, Aradilla-Herrero *et al.* (2012–2013, p. 50) found, in a sample of nursing students, that those with high scores on Attention found it harder to cope with the idea of death. By contrast, those students who showed a better understanding and management of the emotional process reported lower levels of death distress. Obviously, caring for people in the final stages of life and dealing with the death of others are essential aspects of nursing in the palliative care context. These situations require an adequate emotional adjustment on the part of nurses to manage the impact of death (Aradilla-Herrero & Tomás-Sábado 2011, p. 143).

Aims

Although a number of studies have applied the TMMS in samples of nursing professionals and students, to the best of our knowledge, no study in this context has conducted a psychometric analysis that includes a CFA of the scale's dimensions. The lack of such an analysis in the nursing context limits the scope of the corresponding research findings. Consequently, the aims of the present study were:

1 To determine, in a sample of Spanish nursing professionals and students, whether the factor structure of the Spanish adaptation of the TMMS is consistent with that proposed by the scale's authors.
2 To evaluate the internal consistency and temporal stability of the TMMS.
3 To determine whether there are significant differences between men and women and between nursing professionals and students in the different dimensions of the TMMS.
4 Finally, to analyse the relationship between perceived emotional intelligence and alexithymia, self-esteem and death anxiety.

Thus, the study seeks to confirm the three-factor structure of the TMMS (Attention, Clarity and Repair) that has been demonstrated in previous research, and aims to provide support for comparison invariance across other samples, specifically in a nursing context. Furthermore, a better understanding of the relationship between perceived emotional intelligence and other variables, for which limited empirical data are currently available in the field of nursing, will add scientific evidence that can be used to improve the design of training programmes for future nurses.

Methods

Study design and subjects

The study used a cross-sectional and observational design, and a total of 1483 nurses (1250 nursing students and 233 hospital nurses) were originally invited to participate. They all received written information about the study objectives

and procedures prior to administration of the questionnaires.

To analyse the relationship with other variables, around half of the sample ($n = 707$) were also administered the Toronto Alexithymia Scale (TAS-20), the Rosenberg Self-Esteem Scale (RSES) and the Death Anxiety Inventory-Revised (DAI-R).

Measures

The Trait Meta-Mood Scale (*TMMS-24*), devised by Salovey *et al.* (1995, p. 152) and modified and adapted to Spanish by Fernández-Berrocal *et al.* (2004, p. 751), is a 24-item scale that uses a five-point Likert format (anchored by 1 = strongly disagree and 5 = strongly agree). The scale assesses people's beliefs or perceptions about their emotional skills, and its subscales (eight items each) address three dimensions of emotional intelligence: Attention to Feelings (e.g. 'I pay a lot of attention to how I feel'), Clarity of Feelings (e.g. 'I am usually very clear about my feelings') and Mood Repair (e.g. 'I try to think good thoughts no matter how badly I feel'). The internal consistency of the original subscales was 0·90 for Attention, 0·90 for Clarity and 0·86 for Repair. In the present study, alpha coefficients for the total sample were 0·87, 0·87 and 0·84 for the subscales of Attention, Clarity and Repair, respectively.

The Toronto Alexithymia Scale (TAS-20), developed by Bagby *et al.* (1994) and adapted to Spanish by Martínez-Sánchez (1996, p. 19), is a self-report instrument that is widely used to assess alexithymia. It contains 20 items that use a 5-point Likert format, and it has been shown to have adequate psychometric properties in different languages (Parker *et al.* 2003, p. 280). The TAS-20 comprises three factors: Difficulties Identifying Feelings (DIF: seven items), Difficulties Describing Feelings (DDF: five items) and Externally Oriented Thinking (EOT: eight items). Total scores range from 20–100 points. In this study, the internal consistency (Cronbach's alpha) of the TAS-20 total score was 0·85, while the values for the TAS-20 subscales were 0·86 (DIF), 0·70 (DDF) and 0·66 (EOT).

The Rosenberg Self-Esteem Scale, developed by Rosenberg (1965) and adapted to Spanish by Martín-Albo *et al.* (2007, p. 461), has 10 items that use a 4-point Likert format ranging from strongly agree to strongly disagree. There are five positively worded items (items 1, 3, 4, 7 and 10) that are scored 1 for totally disagree and 4 for totally agree, and five negatively worded items (items 2, 5, 6, 8 and 9) that are reverse-scored. The total score therefore ranges from 10–40, with 10 representing the lowest level of self-esteem and 40 the highest. The Spanish version of the RSES has shown adequate temporal stability and internal consistency ($\alpha = 0{\cdot}85$) (Martín-Albo *et al.* 2007, p. 465). In the present study, the Cronbach's alpha for the RSES was 0·85.

The Death Anxiety Inventory-Revised

The DAI-R is an inventory for assessing death anxiety, and although originally constructed in Spanish (Tomás-Sábado *et al.* 2005, p. 793), there are also versions in English (Tomás-Sábado & Gómez-Benito 2005, p. 111) and Arabic (Abdel-Khalek & Tomás-Sábado 2005, p. 161). The DAI-R contains 17 items (e.g. 'I think I am more afraid of death than most people') that use a 5-point Likert format, anchored by 1 (totally agree) and 5 (totally disagree). Possible total scores range from 17, indicating the minimum level of death anxiety, to 85, for the maximum level. The original scale presents an appropriate internal consistency ($\alpha = 0{\cdot}89$). The Cronbach's alpha coefficient in the present study was 0·88.

Ethical considerations

This study was approved by a university research ethics committee. All participants were given a written explanation of the study and were informed that their responses were anonymous and that participation was voluntary.

Data analysis

Descriptive statistics were used to characterise TMMS scores across the sample population by age, sex and status (i.e. nursing student or hospital nurse).

The dimensionality of the TMMS was assessed by CFA using the LISREL, version 8.8 program (Scientific Software International, Lincolnwood, IL, USA). The maximum-likelihood robust method was used for estimation, with polychoric correlations and their corresponding asymptotic covariance matrices being previously generated by means of the PRELIS, version 2.8 program (Scientific Software International). Goodness of fit was assessed with the following indices: the Satorra–Bentler scaled chi-square (S-B χ^2); the root mean square error of approximation (RMSEA) and its relative confidence interval; the non-normed fit index (NNFI); and the comparative fit index (CFI). Indicators of a good fit are that the S-B χ^2 is not significant, that the NNFI and CFI have values above 0·90 (Kaplan 2000, p. 110) and that the RMSEA index is close to 0·05; Browne and Cudeck (1993, p. 144) argue that RMSEA values below 0·05 indicate a good fit, values between 0·05–0·08 an acceptable fit and values between 0·08–10 a marginal fit.

The internal consistency of the scale was evaluated by calculating Cronbach's alpha coefficients. Test–retest reliability was assessed using Pearson's correlation coefficients and was examined in a convenience subsample of participants ($n = 57$) who completed the TMMS again six weeks after the first data collection.

The relationships between the TMMS and other measures (the TAS, the RSES and the DAI-R) were evaluated using Pearson's correlation coefficients.

Except for the CFA, all analyses were performed using SPSS for Windows, version 18.0 (SPSS Inc., Chicago, IL, USA).

Results

Demographics

Of the 1483 subjects who were initially recruited, 1417 (95·5%) completed the questionnaire correctly (1208 nursing students and 209 hospital nurses). Of these, 1263 were women (89·13%) and 152 men (10·72%), with two subjects failing to specify their sex. The mean age was 23·97 years (SD 8. 95; range 17–64).

Dimensionality of the TMMS

When testing the three-factor model proposed by the scale's authors, the results of the S-B χ^2 statistic showed that the fit was poor ($p < 0{\cdot}01$). However, because this index depends on sample size, and given that the data were not normally distributed, we followed the recommendation of Kaplan (2000, p. 109) and based the evaluation of fit on the alternative criteria mentioned above. The tested model showed a good fit according to these alternative indices: the NNFI and CFI both reached 0·96, well above the cut-off, and the value of the RMSEA was close to 0·05 (specifically, it was 0·067, which can be regarded as acceptable according to the criteria of Browne & Cudeck 1993, p. 144). All the factor loadings of the model were statistically significant ($p < 0{\cdot}05$), but they had a diverse effect size (see Fig. 1): applying Cohen's criteria (1988) to the 24 items indicated that the effect size was low for one item, medium for three and high for 20. Respecifying the model by eliminating the one item with a low effect size (item 23) yielded slightly better fit indices: a CFI value of 0·97 and a RMSEA value of 0·065 (the NNFI value remained the same). Given that these are nested models, their degree of fit can be compared using the chi-square difference test of lack of fit ($\Delta\chi^2$), where the significance of the difference in the chi-square of the two models compared, with degrees of freedom equal to the difference between the degrees of freedom of each model, suggests choosing the model with the lower chi-square value. The model without item 23 had a significantly lower chi-square value compared with the competing model ($\Delta\chi^2 = 270{\cdot}54$, $\Delta df = 22$), indicating that the former model should be selected as best representing the data. In this 23-item model, the factor loadings reach the same values as those shown in Fig. 1, with the exception of items 22 and 24 (whose values are 0·1 lower). All the loadings are now above 0·40, illustrating that all the items are relevant for defining the corresponding domain. Note also that the correlations between factors are also significant ($p < 0{\cdot}05$), although they range from −0·10 between Attention and Repair, which can be considered negligible, to 0·38 between Clarity and Repair, which is moderate. These data indicate discriminate validity between the subscales.

Two other models were also tested: a single-factor model (in which all the items were specified as indicators of a global factor, emotional intelligence) and a three-factor model that also included a global second-order factor. Both these models were rejected due to a lack of fit.

Reliability

The internal consistency of the TMMS subscales was satisfactory. All Cronbach's alphas, for both nursing students and hospital nurses, were above 0·84. Test–retest correlation coefficients were high and significant ($p < 0{\cdot}01$) on the three dimensions (see Table 1).

Contrasted group comparison

Table 2 shows that in the analysis by sex, women scored significantly higher than men on emotional Attention ($t = 3{\cdot}63$, $p < 0{\cdot}01$). The estimated effect size was $d = 0{\cdot}19$, which is small in magnitude according to the operational definition suggested by Cohen (1988, p. 83). There were no significant differences between nursing students and hospital nurses in any of the TMMS dimensions.

Relationship with other variables

Table 3 shows the Pearson's correlation coefficients for the TMMS dimensions (Attention, Clarity and Repair) in relation to the three factors of the TAS-20 (DIF, DDF and EOT), the DAI-R and the RSES. It can be seen that all the correlations with the DAI-R were significant, being positive with respect to Attention ($r = 0{\cdot}15$, $p < 0{\cdot}01$) and negative with Clarity ($r = -0{\cdot}10$, $p < 0{\cdot}01$) and Repair ($r = -0{\cdot}17$, $p < 0{\cdot}01$). The correlations with the RSES were also all significant, but in contrast to the results for the DAI-R, they

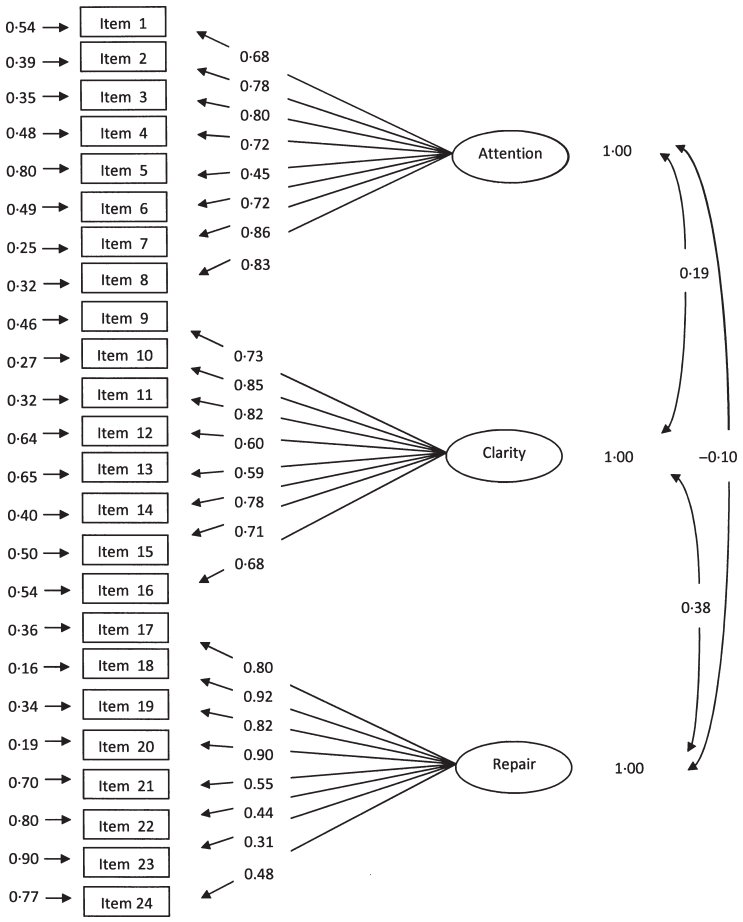

Figure 1 Path diagram of the confirmatory factor analysis of the Trait Meta-Mood Scale (TMMS-24).

Table 1 Descriptive statistics, Cronbach's alpha and test–retest reliability correlations for Trait Meta-Mood Scale (TMMS) subscales

	Nursing students (n = 1208)			Hospital nurses (n = 209)			Test–retest (r) (n = 57)
Variables	Mean	SD	α	Mean	SD	α	r
Attention	29·68	4·87	0·86	27·82	5·11	0·89	0·70
Clarity	28·28	4·81	0·86	30·34	4·61	0·88	0·80
Repair	28·13	5·15	0·84	30·58	4·81	0·84	0·67

were negative with respect to Attention ($r = -0{\cdot}15$, $p < 0{\cdot}01$) and positive with respect to Clarity and Repair, respectively ($r = 0{\cdot}41$, $p < 0{\cdot}01$; $r = 0{\cdot}42$, $p < 0{\cdot}01$). Finally, the correlations between the three subscales of the TAS-20 and the three TMMS dimensions were all negative, except for that between Attention and the DIF subscale of the TAS-20, which showed a positive and significant correlation ($r = 0{\cdot}22$, $p < 0{\cdot}01$). The correlations for Clarity and Repair were significant and negative with respect to all three subscales of the TAS-20.

Discussion

One of the main aims of this study was to examine, in the nursing context, the psychometric properties of the TMMS, including a CFA. The results obtained confirm

Table 2 Means, standard deviations and Trait Meta-Mood Scale (TMMS) contrasted group comparison

	Female (n = 1263)		Male (n = 152)			Nursing students (n = 1208)		Hospital nurses (n = 209)		
Variables	Mean	SD	Mean	SD	t	Mean	SD	Mean	SD	t
Attention	29·57	4·79	28·03	5·97	3·63*	29·68	4·87	27·82	5·11	−5·05
Clarity	28·52	4·83	29·15	4·86	−1·5	28·28	4·81	30·34	4·61	5·74
Repair	28·38	5·15	29·44	5·24	−2·3	28·13	5·15	30·58	4·81	6·40

*$p < 0·01$.

Table 3 Pearson's correlation coefficients between the TMMS subscales and the three TAS-20 subscales, the DAI-R and the RSES (n = 707)

TMMS subscales	TAS-20 DIF	TAS-20 DDF	TAS-20 EOT	DAI-R	RSES
Attention	0·22**	−0·10	−0·06	0·15**	−0·15**
Clarity	−0·41**	−0·59**	−0·31**	−0·10**	0·41**
Repair	−0·42**	−0·48**	−0·27*	−0·17**	0·42**

DAI-R, Death Anxiety Inventory-Revised; DDF, Difficulties Describing Feelings; DIF, Difficulties Identifying Feelings; EOT, Externally Oriented Thinking; RSES, Rosenberg Self-Esteem Scale; TMMS, Trait Meta-Mood Scale.
*$p < 0·05$; **$p < 0·01$.

the original three-factor structure proposed by the scale's authors (Salovey *et al.* 1995, p. 134), that is, Attention to Feelings, Clarity in Discrimination of Feelings and Mood Repair.

As regards item functioning, the analysis showed that item 23 made a considerably smaller contribution to the construct than did the other items, and when the model was respecified without this item, the fit was significantly better than that of the original 24-item model. It therefore seems appropriate to eliminate item 23 from the scale. Similar results were obtained by other authors (Martín-Albo *et al.* 2010, p. 482; Salguero *et al.* 2010, p. 1205), who also opted to eliminate item 23. In fact, Martín-Albo *et al.* (2010) also eliminated item 5, which in the present analysis was not necessary as its factor loading was acceptable. The values obtained for internal consistency and temporal stability likewise support the three-factor structure.

A further aim of the study was to assess the differences between Spanish nursing students and hospital nurses in perceived emotional intelligence, and to evaluate gender differences. The results reveal no significant differences between the two groups (nurses and students). In relation to gender differences, Thayer *et al.* (2003, p. 355) found that women scored higher than men on more items that were indicative of greater attention to their mood and feelings. Therefore, men had a harder time distinguishing one emotion from another (Thayer & Johnsen 2000, p. 245). Similarly, van Dusseldorp *et al.* (2010, p. 560) found that female nurses scored significantly higher on emotional self-awareness than did their male counterparts. The results of the present study are consistent with these findings, because women scored significantly higher than men on Attention, although the effect size (Cohen 1988, p. 83) was low. While acknowledging that the small proportion of men in the sample could affect these results, it is also common for women to predominate when study samples are drawn from the nursing context (Augusto Landa *et al.* 2009, p. 803; Chan *et al.* 2011, p. 3556).

A final objective of this study was to analyse the relationships between perceived emotional intelligence and alexithymia, self-esteem and death anxiety. The correlation analyses show that emotional intelligence was negatively associated with alexithymia, except for the relationship between Attention and the DIF factor of the TAS-20. This positive relationship between Attention and DIF suggests that even if people attend to their emotions and perceive emotional signals, they may nonetheless have difficulties identifying them and giving them a name, this being an aspect that is closely related to emotional Clarity. Indeed, other authors have suggested that there is an overlap between these two dimensions, Clarity and the DIF aspect of alexithymia, and this may mean that these dimensions measure related but distinct aspects of the ability to identify and distinguish specific emotions (Extremera & Fernández-Berrocal 2005, p. 944). This view is consistent

with that of Parker *et al.* (2001, p. 112), who state that although emotional intelligence and alexithymia are independent concepts, there is a considerable overlap between the two and they show strong negative correlations. In the present study, the correlations between the three emotional intelligence factors and the DDF and EOT factors of alexithymia are all negative and significant. Alexithymia is thus shown to be closely related to emotional intelligence, and some authors even consider that it can be a useful measure for identifying individuals with low emotional intelligence (Taylor *et al.* 2000, p. 305). Similarly, it has been suggested that individuals who score high on alexithymia show a limited capacity to empathise with the emotional states of others (Krystal 1979, p. 17). This latter idea is of particular relevance to the nursing profession, where empathy is a fundamental skill that enables nurses to identify with the person who is suffering and to understand better his or her situation and the emotions that arise from it.

As regards self-esteem, previous research indicates that individuals reporting greater emotional Clarity and a greater ability to Repair their own emotional states also report higher levels of self-esteem (Ghorbani *et al.* 2002, p. 302; Salovey *et al.* 2002, p. 615). The present results are consistent with this, in that nurses who scored higher on self-esteem were also more aware of their emotional skills related to understanding and managing emotions. Numerous studies have demonstrated the influence of self-esteem on psychosocial well-being, noting its importance as a personal resource that enables people to reduce the potentially negative effects of stressful life events (Taylor & Stanton 2007, p. 392; Lee-Flynn *et al.* 2011, p. 263; Schraml *et al.* 2011, p. 991). Specifically, Harmon-Jones *et al.* (1997, p. 33) state that self-esteem acts as a protector against anxiety and especially against death anxiety. This could be of vital importance in the nursing context, because caring for people in the final stages of life and having to face the death of others constitutes one of the most difficult aspects of the nurse's job.

Death anxiety is defined by Abdel-Khalek (2005, p. 256) as the set of negative human emotions characterised by worry, anxiety and insecurity, accompanied by apprehension, tension or distress generated by the awareness of one's own death, by seeing symbols related to death or by feelings of imminent danger. In the present study, the correlational data revealed that emotional Attention was positively associated with death anxiety, whereas Clarity and Repair showed negative correlations. Fernández-Berrocal and Extremera (2008, p. 37) analysed the implications of achieving high scores on Attention and concluded that paying excessive attention to one's emotions could generate personal distress. In line with this view, the present results suggest that nurses who pay too much attention to their emotions also experience higher levels of death anxiety. However, there is, as yet, little evidence in the literature about the relationship between emotional intelligence and variables related to death. A recent study of nursing students by Aradilla-Herrero *et al.* (2012–2013, p. 49), nonetheless, found similar results to those obtained here. The authors state that students with higher scores on emotional Clarity and Repair experience less global anxiety and death anxiety and report lower levels of fear of death and fear of others dying. In this context, Letho and Stein (2009, p. 36) argue that research is needed to develop targeted nursing interventions that would reduce the maladaptive consequences associated with death anxiety. Common clinical stressors in nursing students include watching a patient suffer, death of a patient and listening to or talking with a patient about his or her imminent death (Burnard *et al.* 2008, p. 143). Indeed, care of the dying is one of the most stressful aspects of nursing work (Hopkinson *et al.* 2005, p. 125; Peterson *et al.* 2010, p. 181), and in the study by Bailey *et al.* (2011, p. 3367), several nurses revealed the emotional impact of caring not only for patients near the end of life but also for their relatives. In their study, which was carried out with emergency department nurses, Bailey *et al.* (2011) suggest three distinct stages that nurses go through to develop expertise in end-of-life care. First, they must invest their therapeutic self into the nurse–patient relationship in order to develop the intuitive skills associated with recognising deterioration and the individual needs of the patient as death nears. Second, they have to manage the emotional labour, because if they feel too anxious when faced with these death situations, this anxiety could be manifested as avoidance behaviours (Mok *et al.* 2002, p. 319). And third, nurses have to develop the skills of emotional intelligence that will enable them to build effective interpersonal relationships with patients and their relatives. These findings are especially important for nursing practice and nurse education, because as Caton and Klemm (2006, p. 607) point out, providing quality end-of-life care can help nurses and nurse students to overcome their fear and denial of death, improving their attitudes and giving them greater control over their emotions. Several authors have recommended that emotional intelligence be included as a core skill within the training offered to healthcare professionals (Bellack 1999, p. 4; Akerjordet & Severinsson 2007, p. 1411). However, there is a need for further research into the best

ways of developing it effectively and of evaluating its subsequent influence on the relationship with patients and relatives.

Conclusions

The findings of this study add further evidence about the validity and reliability of the TMMS as a measure of perceived emotional intelligence, in this case in the Spanish nursing context. Furthermore, its three dimensions (Attention, Clarity and Repair) are shown to be stand-alone factors. This is an aspect that should be taken into account when analysing the data and interpreting results, and confirms the original idea behind the TMMS, which was not designed to provide a global score.

The results of the study also suggest that high levels of perceived emotional Clarity and Repair seem to act as protective factors against death anxiety. In summary, our correlational results show that nurses with high emotional Attention experience greater death anxiety and find it more difficult to identify feelings, whereas nurses who score higher on emotional Clarity and Repair report greater self-esteem.

The study has a number of limitations. First, the present findings are only applicable to the nursing context. Second, the subsample of hospital nurses was very small in comparison with the group of nursing students, and there was a similar imbalance as regards the proportion of men and women, the latter being a typical feature of the nursing profession. A further limitation is that the use of a cross-sectional and observational design does not enable any causal relationships to be established between the study variables. Follow-up studies are therefore required to analyse the causality aspect in greater detail.

Relevance to clinical practice

Use of the TMMS in the nursing context would provide information about nurses' perceived abilities to interpret and manage emotions when interacting with patients. In this regard, the assessment of perceived emotional intelligence could be an important factor to include in training programmes that aim to develop emotional skills among nurses. Studies using the TMMS can add to the scientific evidence regarding the relationship between perceived emotional intelligence and other variables in nursing.

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Contributions

Study design: AA-H, JT-S, JG-B; data collection and analysis: AA-H, JT-S, JG-B and manuscript preparation: AA-H, JT-S, JG-B.

Conflict of interest

The authors declare that they have no conflicts of interests.

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3.5. ESTUDIO EMPÍRICO II:
Death Attitudes and Emotional Intelligence in Nursing Students

Aradilla-Herrero A., Tomás-Sábado J. y Gómez-Benito J. (2012-2013). Death attitudes and emotional intelligence in nursing students. *OMEGA, 66 (1), 39-55. doi. 10.2190/OM.66.1.c*

En este segundo trabajo empírico se analiza la relación entre la IEP y las actitudes ante la muerte en una muestra de estudiantes de Enfermería, y si existen diferencias entre los diferentes cursos académicos.

El cuidado de los enfermos al final de la vida, es uno de los aspectos más difíciles a los que se enfrentan los estudiantes de enfermería, en sus prácticas clínicas. En este contexto, muchos autores afirman que la inteligencia emocional es una habilidad esencial para ofrecer cuidados de calidad a pacientes y familiares (Bulmer, Profetto-McGrath, & Cummings, 2009; Epstein & Hundert, 2002; Freshwater & Stickley, 2004; Hurley, 2008; Rochester, Kilstoff, & Scott, 2005). No obstante, la muerte sigue siendo un tabú en nuestra sociedad y, como tal, también produce un impacto emocional en los profesionales de la salud, sobretodo en los primeros años de la profesión (de Araújo, da Silva, & Francisco, 2004; Rooda, Clements, & Jordan, 1999).

En el caso de que las enfermeras presenten ansiedad y dificultad en el afrontamiento de las situaciones de acompañamiento a los enfermos que se aproximan a la muerte, pueden tener dificultades en el cuidado de los enfermos y desarrollar comportamientos de evitación (Mok, Lee, & Wong, 2002). Como resultado de ello, se pueden comprometer la calidad de los cuidados y la salud física y mental de los propios profesionales (Boroujeni, Mohammadi, Oskouie, & Sandberg, 2009; Zomorodi & Lynn, 2010).

En este estudio, se analiza la relación entre la inteligencia Emocional y las actitudes ante la muerte en estudiantes de Enfermería y las diferencias en relación al año de la titulación cursado. Participaron en el estudio 243 estudiantes de enfermería que respondieron a un cuestionario autoadministrado que evaluaba la IEP, el Miedo a la Muerte, la Ansiedad ante la Muerte, la Depresión ante la Muerte y la Obsesión ante

la Muerte. Se utilizaron las formas españolas de los siguientes instrumentos: Trait Meta_Mood Scale-24 (TMMS-24); Death Anxiety Scale (DAS); Death Anxiety Inventory-Revised (DAI-R); Death depression Scale (DDS); Death Obsesssion Scale (DOS), Collet-Lester Fear of Death Scale (CLFDS).

Los datos fueron tabulados con el SPSS 17.0 para Windows. Se calcularon los índices de correlación de Pearson y el análisis de la varianza (ANOVA). Asimismo, para determinar la capacidad estadística predictiva de la IEP en relación a las actitudes antes la muerte, se llevó a cabo un análisis de regresión múltiple, utilizando cada escala de actitudes ante la muerte como variable independiente.

Los principales resultados de este estudio confirman, en el análisis de correlación, que todas las variables de actitudes ante la muerte muestran una relación positiva con la Atención emocional y negativa con la Claridad y la Reparación. Asimismo, se realizó un análisis de regresión lineal múltiple, utilizando las tres subescalas de la IEP (atención, claridad y reparación) como variables predictoras y las medidas relacionadas con la muerte (ansiedad, depresión, obsesión y miedo) como variables dependientes. Los principales resultados de este análisis muestran que los tres factores de la TMMS emergen en el modelo como variables predictoras del Miedo a la Muerte explicando el 12% de la varianza.

En relación al curso académico, los estudiantes de tercer curso de la titulación obtienen puntuaciones mayores que los de primero en las tres dimensiones de la TMMS (atención, claridad y reparación), aunque la diferencia es tan solo significativa en el caso de la claridad emocional. En las medidas relacionadas con la muerte, en general, las puntuaciones de varias medidas disminuyen progresivamente desde el primer al último año académico. Sin embargo, los resultados del ANOVA indican que la diferencia solo es significativa en la subescala de Miedo a la Muerte de otros de la CLFDS.

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DEATH ATTITUDES AND EMOTIONAL INTELLIGENCE IN NURSING STUDENTS

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ABSTRACT

The aims of this study were to analyze the relationships between death attitudes and perceived emotional intelligence in a sample of nursing students, and to determine whether there are differences between different academic years with regard to both emotional intelligence and death attitudes. The participants were 243 nursing students. They all responded voluntarily and anonymously to a questionnaire that assessed the following constructs: Fear of death, Death anxiety, Death depression, Death obsession, and Emotional intelligence (Attention, Clarity, and Mood Repair). Students' scores on Fear of Death of Others subscale ($p < .05$) decreased significantly across the 3 years of the nursing degree program and increased significantly on emotional Clarity ($p < .05$), a dimension of emotional intelligence. The multiple linear regression analyses confirmed the predictive value of Attention, Clarity, and Mood Repair regarding levels of Fear of Death of Others. The importance of including emotional skills training and death-education programs as part of professional nursing curricula are discussed.

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Death is an inevitable phenomenon. Indeed, despite our attempts to control it, death, disease, and suffering are reminders of how little power we have over the circumstances of our lives. In Spanish society, death undoubtedly remains a taboo subject. However, attitudes toward death, and the level of anxiety experienced when faced with death and dying, vary from one individual to another, due above all to the intrinsic relationship death attitudes have with individual beliefs, customs, and social environment (Abdel-Khalek, Lester, Maltby, & Tomás-Sábado, 2009). On this topic, Neimeyer, Moser, and Wittkowski (2003) underscored the importance of understanding cultural perspectives on death attitudes.

There is a large body of research to support the effects of culture of death anxiety levels (Abdel-Khalek et al., 2009). Abdel-Khalek and Tomás-Sábado (2005), in two samples of female nursing undergraduates, found that Egyptian students attained significantly higher mean total scores on death anxiety and general anxiety scales than their Spanish peers. Roff, Simon, Klemmarck, and Butkeviciene (2006) found that Lithuanian health and social service personnel reported greater fear than their American counterparts on the subscales measuring fear of the dying process and fear of the unknown, but Americans reported greater fear of the dead. Neimeyer, Currier, Coleman, Tomer, and Samuel (2011), in a study with hospice patients, established that African-American participants displayed higher death avoidance and escape acceptance than Caucasian patients. Therefore, these results identifying cultural differences could be important for developing educational programs aimed to improve attitudes toward death.

Despite great technological and therapeutic advances, there are many diseases that cannot be cured and which leave the affected individual in a terminal and irreversible situation. Such circumstances have increased not only the demand for care in general, but specifically the societal need for palliative care. In this professional context of end-of-life care, nurses play an essential role regardless of cultural differences (Dunn, Otten, & Stephens, 2005; Miyashita, Nakai, Sasahara, Koyana, Shimizu, Tsukamoto, et al., 2007).

The professional duties of nurses in this setting relate both to patients and their relatives, the main tasks being to offer a close and empathic presence, to provide comfort, to listen, and to provide specific care as regards symptom control (Bach, Ploeg, & Black, 2009). Nowadays, a great many of the people in Western countries spend the last days of their lives in residential health centers, and this means that nursing professionals are increasingly working in close and continuous contact with death. Although this may be regarded as a normal part of their professional duties, research has indicated that nurses often find death and working with dying individuals to be some of the most difficult aspects they face in their work (Allchin, 2006; Fitch, Bakker, & Conlon, 1999). Moreover, their personal, cultural, and professional experiences of death and dying influence their attitudes toward death, which is particularly important insofar as it may affect their professional performance (Dunn et al., 2005;

Zomorodi & Lynn, 2010). In this regard, Braun, Gordon, and Uziely (2010), in a study with Israeli oncology nurses, designed to assess attitudes toward death and caring for dying patients, found that nurses who show high levels of fear of death and death avoidance present more negative attitudes toward the care of dying patients.

Given the social taboo surrounding death, it seems reasonable to assume that the avoidance of death and the feelings of fear and anxiety which its presence arouses may have an impact on the way in which health professionals cope with the death of their patients (de Araújo, da Silva, & Francisco, 2004; Rooda, Clements, & Jordan, 1999). Indeed, if nurses feel anxious when faced with these situations, then they may well find it difficult to talk about death with patients and their families, and any unease they feel in the presence of the terminally ill could lead them to develop avoidance behaviors (Mok, Lee, & Wong, 2002). Obviously, the care of dying patients can be a very painful experience for nurses (Mok et al., 2002), and it may lead them to suffer from irritability, anxiety, low self-esteem, depression, moral distress, and burnout (Plante & Bouchard, 1995-96; Vachon, 2011). Such repercussions can compromise the quality of care offered to patients and their families, as well as undermining the physical and mental health of nurses themselves (Boroujeni, Mohammadi, Oskouie, & Sandberg, 2009; Zomorodi & Lynn, 2010). As a result, educational programs that include aspects related to end-of-life care and strategies for coping with dying are essential in the nursing context (Aradilla-Herrero & Tomás-Sábado, 2011; Heaston, Beckstrand, Bond, & Palmer, 2006).

The study of death attitudes in the general population has led to numerous publications and the development of various assessment instruments. These include the widely-used Death Anxiety Scale (DAS; Templer, 1970) and the Collett-Lester Fear of Death Scale (CLFDS; Lester & Abdel-Khalek, 2003), developed in the United States and later translated and adapted to different languages. In Spain, the only instrument developed and validated in the Spanish population for assessing death anxiety is the Death Anxiety Inventory (DAI; Tomás-Sábado & Gomez-Benito, 2005; DAI-R; Tomás-Sábado, Gómez-Benito, & Limonero, 2005). In recent years, interest in the study of death anxiety has led to the appearance of other related constructs, with their corresponding measurement instruments, for example, death depression (Abdel-Khalek, 1997) and death obsession (Abdel-Khalek, 1998). Although these constructs may seem similar to death anxiety, a study carried out by Tomás-Sábado and Gómez Benito (2004) on Spanish nursing students, using Abdel-Khalek's Death Obsession Scale (DOS; Abdel-Khalek, 1998) and Templer's Death Anxiety Scale (DAS; Templer, 1970), found that the constructs of death obsession and death anxiety refer to different aspects of attitudes toward death, thereby supporting the discriminant validity between the two constructs. Empirical research has also found that death depression and death obsession are different constructs (Tomás-Sábado & Limonero, 2007).

Death anxiety is defined by Abdel-Khalek (2005) as the set of negative human emotions characterized by worry, anxiety, and insecurity, accompanied by apprehension, tension, or distress generated by the awareness of one's own death, by seeing symbols related to death, or by feelings of imminent danger. The concept of death anxiety is becoming increasingly important for nursing practice, and given that it may depend on emotional, cognitive, experiential, and motivational aspects, as well as on those related to personal and professional development, its assessment is critical in order to ensure continuity of care (Letho & Stein, 2009). This is not least because, as Neimeyer (1994) states, health professionals with high levels of death anxiety use avoidance as a means of coping. Conversely, Servaty, Krejci, and Hayslip (1996) suggest that people with lower levels of death anxiety are better able to communicate with people who are dying. In addition, these authors found that senior nursing students who were older and who had had more personal experiences showed less death anxiety and were less apprehensive than freshmen nursing students about communicating with a dying person.

These results are consistent with the findings of Deffner and Bell (2005), from a sample of American nurses, who reported that older registered nurses with more work experience, and who had also received communication skills training, showed lower levels of death anxiety and were more willing and at ease when talking about death with patients and relatives. Similar results have been obtained in other studies done in different cultural contexts such as Dunn et al. (2005) in the United States, Payne, Dean, and Kalus (1998) in England, and Román, Sorribes, and Ezquerro (2001) in Spain. The findings of these studies indicate that those nurses who had had more contact with terminally ill or dying patients were found to hold more positive attitudes and exhibit less anxiety toward patients who were dying. Rooda et al. (1999), in a sample of American nurses, found that positive attitudes toward the care of terminally ill patients were negatively associated with the fear and avoidance of death.

The emotional labor that accompanies nursing care of the dying and the bereaved can be intense and exhausting and can be seen to require a great deal of support and personal awareness and coping strategies (Bailey, Murphy, & Porock, 2011). Providing care for people in the final stages of their lives and coping with the death of others constitutes one of the key aspects of nursing practice in palliative care. These situations require professionals to have high levels of emotional intelligence in order to manage the effect of continuous contact with death and having to cope with loss (Aradilla-Herrero & Tomás-Sábado, 2011). Indeed, many authors argue that emotional intelligence is an essential skill for nursing professionals who care for patients and their families in this context (Bulmer, Profetto-McGrath, & Cummings, 2009; Epstein & Hundert, 2002; Freshwater & Stickley, 2004; Hurley, 2008; Rochester, Kilstoff, & Scott, 2005).

The concept of emotional intelligence was defined by Salovey and Mayer (1990) as the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action. In this regard, several authors stress the need for nurses to be taught specific strategies for managing their emotions, and for them to receive social and communication skills training, the aim being to help nursing students and professionals to cope with emotionally stressful situations (Dickinson, 2007; Hainsworth, 1996; Mallory, 2003). Salovey et al. (1995) developed the Trait Meta Mood Scale (TMMS) to assess people's beliefs about their mood states and emotions. The TMMS contains three dimensions: Attention to feelings, emotional Clarity, and Mood Repair. The evidence suggest that emotional Clarity and Mood Repair were associated with better psychological adjustment, while high levels of emotional Attention have been associated with anxiety and depressive symptomatology (Extremera & Fernández-Berrocal, 2006; Fernández-Berrocal, & Extremera, 2008; Salovey, Stroud, Woolery, & Epel, 2002).

de Araújo et al. (2004) argue that nurses require a high degree of emotional equilibrium as otherwise feelings and emotional conflicts can interfere with the quality of care provided. Without an adequate degree of emotional control, nurses may find it difficult to carry out their professional duties effectively, due not only to the emotional suffering they experience but also to the presence of distancing and avoidance behaviors (Hopkinson, Hallett, & Luker, 2003; Reidun, Athlin, & Hedelin, 2009). Nonetheless, Dunn et al. (2005) state that the majority of nurses working in this field regard their work as being highly worthwhile and report feeling both satisfied and appreciated by patients and their families.

In light of the above, the aim of the present study was to analyze the relationships between death attitudes and perceived emotional intelligence in a sample of nursing students. A further objective was to determine whether there are differences between different academic years with regard to both emotional intelligence and death attitudes.

METHOD

Participants

Participants were 243 Spanish nursing undergraduate students recruited in the Autonomous University of Barcelona, Spain, from across 3 years of a nursing degree program, during the 2008-2009 academic course (110 students from year one, 66 from year two, and 67 from year three). There were 214 women and 29 men, with a mean age of 21.45 years (SD = 4.6). The program combines theory, lab work, and clinical practice. All the first-year students undergo clinical training in hospitals. The more specific training sessions in palliative care units and acute geriatric units are done during the last year of the degree.

Measures

All participants responded anonymously to a self-administered questionnaire containing the Spanish forms of the following scales:

The Collet-Lester Fear of Death Scale (CLFDS; Lester & Abdel-Khalek, 2003; Abdel-Khalek & Lester, 2004), translated and adapted to Spanish by Tomás-Sábado, Limonero, and Abdel-Khalek (2007). The CLFDS is one of the multidimensional classic instruments used in assessing attitudes toward death, and which is unique in that it distinguishes between death and the process of dying for oneself and others. It is thus organized into four separate subscales: Fear of Death of Self (e.g., "How it will feel to be dead"), Fear of Dying of Self (e.g.. "Your lack of control over the process of dying"), Fear of Death of Others (e.g., "Losing someone close to you"), and Fear of Dying of Others (e.g., "Watching the person suffer pain"). In Lester and Abdel-Khalek's (2003) revised version, the CLFDS contains 28 items, with seven items for each subscale. They reported indexes of internal consistency (alpha) of .83 for Fear of Death of Self, .89 for Fear of Dying of Self, .79 for Fear of Death of Others, and .86 for Fear of Dying of Others. In the present study, we obtained Cronbach alpha values for each subscale of .83, .80, .79, and .83 for Fear of Death of Self, Fear of Dying of Self, Fear of Death of Others, and Fear of Dying of Others, respectively.

The Death Anxiety Inventory-Revised (DAI-R; Tomás-Sábado et al., 2005; Tomás-Sábado & Gómez-Benito, 2005). The DAI-R is a psychometric inventory for assessing death anxiety, originally constructed in Spanish, but there are also English and Arabic versions. The DAI-R contains 17 items (e.g., "I think I am more afraid of death than most people") rated by respondents using a 5-point Likert format, anchored by 1 (totally agree) and 5 (totally disagree). Possible total scores range from 17, indicating the minimum level of death anxiety, to 85, for the maximum level. The Cronbach Alpha Coefficient was .89. The same one as in the current sample.

The Death Anxiety Scale (DAS; Templer, 1970). The DAS was translated and adapted to Spanish by Tomás-Sábado and Gómez-Benito (2002). This scale is the most widely used and cited instrument for assessing death anxiety. It contains 15 dichotomous (true/false) items (e.g., "I am not afraid to die") and possible scores range from 0 to 15, with the highest scores corresponding to the highest levels of death anxiety. The scale's internal consistency, estimated by the Cronbach Alpha Coefficient, was .73. In the present study it was .69.

The Death Depression Scale-Revised (DDS-R; Templer, Harville, Hutton, Underwood, Tomeo, Russell, et al., 2001), translated and adapted to Spanish by Tomás-Sábado, Limonero, Templer, and Gómez-Benito (2004-2005). The DDS-R was developed to quantify the depressive reactions that people have in relation to the idea of death. The scale is a 21-item instrument (e.g., "Death makes me feel discouraged about the future") that uses a 5-point Likert format. In the original adapted scale the Cronbach Alpha Coefficient was .90. In this study it was .91.

The Death Obsession Scale (DOS) was devised by Abdel-Khalek and adapted to Spanish by Tomás-Sábado and Gómez-Benito (2002-2003). The concept of death obsession was introduced by Abdel-Khalek, arguing that death constituted an element or idea of obsession in some individuals who could come to be dominated by an obsessive notion of death. The construct is justified on the basis of clinical observations that show the idea of death to be a common theme among obsessive disorders (Abdel-Khalek, 1998). The DOS is a 15-item scale (e.g. "I think about death continuously") based on a 5-point Likert format, and has been shown to have adequate psychometric properties for use in a Spanish population. In the present study the Cronbach Alpha Coefficient was .94. In the original adapted scale the Cronbach Alpha Coefficient was .89.

The Trait Meta-Mood Scale (TMMS-24), devised by Salovey et al. (1995) and modified and adapted to Spanish by Fernández-Berrocal, Extremera, and Ramos (2004). The TMMS-24 is a 24-item scale that uses a 5-point Likert format (anchored by 1 = strongly disagree and 5 = strongly agree). The scale assesses people's beliefs or perceptions about their emotional skills, and its subscales (eight items each) address three dimensions of emotional intelligence: Attention to Feelings (e.g., "I pay a lot of attention to how I feel"), Clarity of Feelings (e.g., "I am usually very clear about my feelings"), and Mood Repair (e.g.. "I try to think good thoughts no matter how badly I feel"). Responses are analyzed by taking into account the scores obtained on each of the three subscales or dimensions, not the overall score. The internal consistency of the subscales was .90 for Attention, .90 for Clarity, and .86 for Repair. Using the present sample, we obtained Cronbach alpha values for each of the TMMS dimensions of .85, .89, and .85 for Attention, Clarity, and Repair, respectively.

Procedure and Data Analysis

The study design was cross-sectional and correlational. Participants responded voluntarily to the questionnaire, and the anonymity and confidentiality of the data were ensured at all times. The questionnaire was administered to students during their regular class timetable. Data were tabulated and analyzed using SPPS 17.0 for Windows. In addition to a descriptive analysis, Pearson *r* correlation coefficients were calculated and an analysis of variance (ANOVA) was performed. In order to determine the statistical predictive capacity of perceived emotional intelligence with regard to death attitudes, a series of multiple regression analyses were performed using each death attitude variable as the dependent variable.

RESULTS

Table 1 shows the Pearson *r* correlation coefficients for the three dimensions of emotional intelligence and the various measures of death attitudes. It can be

Table 1. Pearson's Correlations (*r*) between the Trait Meta Mood Scale and Death Attitudes Measures

	1	2	3	4	5	6	7	8	9	10
1. Attention (TMMS)										
2. Clarity (TMMS)	.20**									
3. Repair (TMMS)	−.00	.38**								
4. Fear of Death of Self (CLFDS)	.07	−.12	−.12							
5. Fear of Dying of Self (CLFDS)	.10	−.11	−.22**	.62						
6. Fear of Death of Others (CLFDS)	.18**	−.24**	−.23**	.48**	.57**					
7. Fear of Dying of Others (CLFDS)	.13*	−.16**	−.15*	.42**	.57**	.64**				
8. Death Anxiety Scale (DAS)	.11	−.16*	−.18**	.55**	.40**	.40**	.40**			
9. Death Anxiety Inventory–Revised (DAI-R)	.10	−.15*	−.15*	.63**	.37**	.44**	.50**	.66**		
10. Death Depression Scale–Revised (DDS-R)	.09	−.12	−.25**	.55**	.40**	.46**	.54**	.59**	.75**	
11. Death Obsession Scale (DOS)	.06	−.10	−.12	.62**	.37**	.28**	.36**	.58**	.68**	.67**

*$p < .05$; **$p < .01$.

seen that there are positive correlations between Attention and all the other death-related variables. By contrast, Clarity and Repair are negatively correlated with all these variables.

A series of multiple linear regression analyses were performed using the three subscales of perceived emotional intelligence (attention, clarity, and mood repair) as predictor variables and all the death-related measures as dependent variables (see Table 2). All three TMMS factors emerged in the model as predictor variables that accounted for 12% of the variance of Fear of Death of Others (CLFDS); whereas, Attention and Clarity accounted for 5% of the variance of Fear of Dying of Others (CLFDS), 5% of Death Anxiety (DAS), and 4% of Death Anxiety (DAI-R). Finally, mood repair accounted for 5% and 7% the variance of Fear of Death of Self (CLFDS) and Death Depression (DDS-R), respectively.

Table 3 shows the mean TMMS scores (with standard deviations) obtained by students across the 3 years of the nursing degree program, as well as the results of the ANOVA and their significance. It can be seen that third-year students obtained higher scores than first-year students on all three subscales (Attention, Clarity, and Repair), although the difference between the 3 academic years was only significant for Clarity ($p < .05$).

Table 4 shows the mean scores and standard deviations obtained by students across the 3 years of the nursing degree program on the different measures of death attitudes. It can be seen that, in general, the scores on the various measures of death attitudes decrease progressively from years one to three. However, the results of the ANOVA indicate that the difference is only significant for one subscale of the CLFDS, Fear of Death of Others.

DISCUSSION

The aim of this study was to analyze the relationships between death attitudes and perceived emotional intelligence in nursing students, and to determine whether there are differences between different academic years with regard to both emotional intelligence and death attitudes. In relation to this last aim, regarding death attitudes, it should also be noted that as the students progress through their studies they show less fear of death of others. These results contrast with those obtained by Chen, Del Ben, Fortson, and Lewis (2006), in a sample of American nursing students, who reported that students in the final years of their studies exhibited a greater fear of death than did new students, a finding that led the authors to suggest that the fear of dying develops during professional training. In relation to the changes that take place in the emotional intelligence as they increase the academic years, in the present study scores on Clarity increased from the earlier to later academic years. It would be interesting, in a future study, to examine the causal relationships underlying these changes, thereby determining whether it is due to processes of academic learning, to the students' own personal development, or to other causes of a different nature.

Table 2. Results of the Multiple Regression Analysis of the Three Components of Perceived Emotional Intelligence and Death-Related Measures

Variable/predictor variable	R^2	F	β	P	ΔR^2
Death of Self (CLFDS)	.03	2.60			.02
Attention			.10	.13	
Clarity			−.12	.11	
Repair			−.08	.25	
Dying of Self (CLFDS)	.07	5.53			.05
Attention			.12	.06	
Clarity			−.07	.33	
Repair			−.20	.04*	
Death of Others (CLFDS)	.14	12.47			.12
Attention			.24	.00**	
Clarity			−.24	.00**	
Repair			−.14	.03*	
Dying of Others (CLFDS)	.06	5.43			.05
Attention			.17	.01**	
Clarity			−.17	.02*	
Repair			−.09	.20	
Death Anxiety Scale (DAS)	.06	5.40			.05
Attention			.15	.02*	
Clarity			−.15	.04*	
Repair			−.12	.07	
Death Anxiety Inventory–Revised (DAI-R)	.05	4.14			.04
Attention			.13	.05*	
Clarity			−.14	.05*	
Repair			−.10	.15	
Death Depression Scale–Revised (DDS-R)	.08	6.61			.07
Attention			.10	.10	
Clarity			−.05	.47	
Repair			−.24	.00**	
Death Obsession Scale (DOS)	.03	2.00			.01
Attention			.08	.24	
Clarity			−.08	.24	
Repair			−.09	.19	

*$p < .05$; **$p < .01$.

Table 3. Mean Scores, Standard Deviations, Results of ANOVA and Significance of the Differences in Trait Meta Mood Scores across the 3 Years of the Nursing Degree Program

	Year 1 (N = 110)		Year 2 (N = 66)		Year 3 (N = 67)			
	$\bar{x}$	(SD)	$\bar{x}$	(SD)	$\bar{x}$	(SD)	F	p
Attention	27.94	(4.95)	29.30	(4.81)	28.79	(4.96)	1.68	.18
Clarity	26.23	(5.71)	27.63	4.41)	28.17	(5.45)	3.15	.04*
Repair	27.59	(5.42)	28.39	(4.86)	28.07	(5.99)	.47	.62

*$p < .05$.

Table 4. Mean Scores, Standard Deviations, Results of ANOVA and Significance of the Differences in Death Attitudes across the 3 Years of the Nursing Degree Program

	Year 1 (N = 110)		Year 2 (N = 66)		Year 3 (N = 67)			
	$\bar{x}$	(SD)	$\bar{x}$	(SD)	$\bar{x}$	(SD)	F	p
Death of Self (CLFDS)	22.82	(6.27)	22.35	(5.93)	22.61	(7.15)	.11	.89
Dying of Self (CLFDS)	26.18	(4.95)	24.98	(5.08)	25.63	(5.74)	1.09	.33
Death of Others (CLFDS)	29.03	(4.35)	27.59	(5.39)	27.22	(4.81)	3.56	.03*
Dying of Others (CLFDS)	24.71	5.36)	24.83	(5.22)	23.12	(5.78)	2.20	.11
Death Anxiety Scale (DAS)	7.62	(2.77)	7.47	(2.94)	7.31	(2.69)	.90	.40
Death Anxiety Inventory–Revised (DAI-R)	41.28	(12.82)	40.62	(11.57)	39.64	(12.71)	.25	.77
Death Depression Scale–Revised (DDS-R)	47.61	(11.92)	47.52	(12.30)	45.69	(16.08)	.35	.70
Death Obsession Scale (DOS)	31.54	(12.12)	30.38	(11.18)	33.24	(13.81)	.48	.61

*$p < .05$.

These relations could be important in terms of the design of academic programs for future nursing professionals.

These results suggest that those students with high scores on emotional attention find it harder to cope with the idea of death. By contrast, the students who present a better understanding and management of the emotional process obtain, in general, lower levels in the measures related to death distress. Although there are no previous studies in nursing that specifically examine the relationship between these constructs, these results are consistent with other research relating emotional intelligence, as assessed by the TMMS, with variables related to health, personal well-being, and psychological functioning. For example, Salovey et al. (2002) found that people with high scores on Clarity and Repair showed lower levels of depression and displayed fewer physical symptoms. Similarly, Fernández-Berrocal and Extremera (2008) state that people with better levels of psychological adaptation obtain moderate-low scores on Attention and high scores on Clarity and Repair. These results suggest that people who pay a great deal of attention to their emotions and who do not have an adequate capacity for emotional understanding and management may develop ruminative thoughts that enhance their negative emotional states (Extremera & Fernández-Berrocal, 2006). Attention to feelings is a dimension that is characterized by continuous monitoring of one's own moods, something which may not be productive, especially if the individual is unable to discriminate between the causes and consequences of the observed changes (Augusto & Lopez-Zafra, 2010). In the context of the present study, this might mean that nurses who pay constant attention to their emotions when faced with the experience of death could actually enhance their own anxiety, depression, and fear of death. This could have negative consequences both for themselves and their patients, insofar as it may affect the care they are able to provide.

The results of the present study should be interpreted with caution, not least because the correlational and cross-sectional design prevents any strict causal relationships from being established on the basis of the correlations observed. In this regard, it is necessary to design longitudinal studies that allow us to determine the potential causal effect which emotional intelligence may have on the death attitudes of nursing students. Moreover, the participants' previous death-related experiences have not been specifically evaluated; nevertheless, third-year students have had some experience of this kind since they have all had part of their training program in hospital units with terminally ill patients, such as palliative care units or acute geriatric units. A further limitation is that the use of a sample based exclusively on students from a single school of nursing makes it difficult to extrapolate the results to all such students.

Despite these limitations, the present results should be of interest in the field of nurse education and suggests the convenience of including emotional skills training (Freshwater & Stickley, 2004) and death-education programs (Khader, Jarrah, & Alasad, 2010; Reidun et al., 2009) as part of professional

development, especially in relation to the care of the terminally ill and their families.

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3.6. ESTUDIO EMPÍRICO III: Emotional Intelligence, Depression and Suicide Risk in Nursing Students

Aradilla-Herrero A., Tomás-Sábado J. y Gómez-Benito J. (en revisión). Emotional Intelligence, Depression and Suicide Risk in nursing students. *Nurse Education Today.*

Finalmente, en este trabajo empírico se pretende profundizar en las relaciones existentes entre la IEP, la depresión y el riesgo suicida, específicamente esta investigación pretende contrastar la hipótesis que la IEP y la autoestima actúan como factores moduladores del riesgo suicida, mientras que la depresión y la ansiedad ejercen como factores predisponentes del mismo.

Este fenómeno, el suicidio y particularmente el riesgo suicida, emerge posteriormente de la revisión de las actitudes ante la muerte en Enfermería. El suicidio constituye un problema muy importante de salud pública, en la actualidad, cada año casi un millón de personas pone fin a su vida por suicidio (OMS, 2011). En los últimos 45 años, las tasas de suicidio a nivel mundial se han incrementado en un 60%, situándose entre los 10 a los 24 años en la segunda causa principal de muerte.

En el caso concreto de los estudiantes de enfermería, los factores estresantes que pueden afectar a su comportamiento incluyen el fracaso académico, la falta de tiempo libre, la dificultad de los estudios y la compaginación de los estudios con un programa exigente de prácticas clínicas (Pryjmachuk & Richards, 2007; Pulido-Martos, Augusto-Landa, & López-Zafra, 2012). Asimismo, la revisión de la literatura pone de manifiesto una elevada tasa de suicidio en los profesionales de enfermería (Hawton et al., 2002; Agerbo, Gunnell, Bonde, Mortensen, & Nordentoft, 2007).

En este estudio participaron 93 estudiantes de enfermería del primer curso de la titulación que respondieron un cuestionario anónimo autoadministrado que evaluaba: IEP *(Trait Meta_Mood Scale - TMMS-24*), Riesgo Suicida *(Plutchik*

Suicide Risk Scale – SRS), Autoestima *(Rosenberg Self-esteem scale – RSES),* Depresión *(Zung Self-Rating Depression Scale – SDS*) y Ansiedad *(Trait Subscale of the State- trait Anxiety Inventory – STAI).*

Los datos fueron tabulados y analizados mediante el paquete estadístico SPSS 18.0 para Windows, calculándose índices descriptivos, coeficientes de correlación de Pearson, y análisis de regresión lineal múltiple.

En los principales resultados se observan correlaciones positivas y significativas entre el riesgo suicida y la depresión (p<0,01), ansiedad (p<0,01) y la Atención emocional (una de las tres subescalas de la TMMS) (p<0,01). Sin embargo, las correlaciones son significativas y negativas entre el riesgo suicida y la autoestima (p<0,01), la Claridad y la Reparación emocional (p<0,05). Posteriormente, se realizó un análisis de regresión lineal múltiple, método stepwise, introduciendo como variable dependiente el riesgo suicida y como variables independientes aquellas que habían mostrado una correlación significativa. La depresión y la Atención emocional (TMMS) fueron, por este orden, las únicas variables identificadas por el modelo como predictoras del riesgo suicida, explicando conjuntamente un 38,8% (R^2aj) de la varianza.

EMOTIONAL INTELLIGENCE, DEPRESSION AND SUICIDE RISK AMONG NURSING STUDENTS

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ABSTRACT

Background: Suicide is the second most frequent cause of death between the ages of 10 and 24. The most important factor which predisposes young people to suicide is depression, although protective factors such as self-esteem, emotional adaptation and social support may reduce the probability of suicidal ideation and suicide attempts. Little is known, however, about the relationship between perceived emotional intelligence and suicide risk. It is important to identify the factors associated with suicide behaviour in nursing students in order to initiate early interventions.

Objectives: The main goals of this study were to determine the prevalence of suicide risk among nursing students, and to examine the relationship between suicide risk and perceived emotional intelligence, depression, trait anxiety and self-esteem.

Method: Cross-sectional study of nursing students (n = 93) who completed self-report measures of perceived emotional intelligence (Trait Meta-Mood Scale), suicide risk (Plutchik Suicide Risk Scale), self-esteem (Rosenberg Self-esteem Scale), depression (Zung Self-Rating Depression Scale) and anxiety (Trait scale of the State-Trait Anxiety Inventory).

Results: The results indicated that 14% of nursing students had at some point thought about suicide, and 6.5% had a lifetime suicide attempt. Overall, 14% of the students were considered to present a substantial suicide risk. Linear regression analysis confirmed that depression and emotional attention are significant predictors of suicidal ideation. Suicide risk showed a significant negative association with self-esteem and with emotional clarity and repair.

Conclusions: The findings suggest that interventions to prevent suicidal ideation among nursing students should include strategies to improve their self-esteem and emotional coping skills, and that special attention should be paid to the early detection of mood disorders in this population.

Key Words: emotional intelligence, suicide risk, nurse education, depression, self-esteem, anxiety, mental health.

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INTRODUCTION

Suicide is a public health problem of considerable importance, and over the last 45 years suicide rates have increased worldwide (World Health Organization, 2012). Notably, young people constitute the highest-risk group in one third of the world's countries, and between the ages of 10 and 24, suicide is the second most frequent cause of death.

Despite this, recent research concerning young people has shown encouraging results. One study that examined suicide rates among US college students over the period 1920 to 2004 found that suicide rates have decreased since 1960 (Schwartz, 2006). A similar trend was reported by a recent study conducted at Oxford University (UK), where it was found that suicide rates among students aged 18-25 decreased over the period between 1976 and 2006 (Hawton et al., 2012). Unfortunately, in Spain there is limited epidemiological data on the rate of suicide among university students, and official data on suicidal behaviour (including suicide attempts and suicidal ideation) are generally not available.

It appears that the most important factor which predisposes both adolescents and adults to suicide is mood disorders, especially depression (Chiou et al., 2006; Nrugham et al., 2008; Wang et al., 2011). However, protective factors such as self-esteem, emotional adaptation, positive social support and experiential well-being may reduce the probability of suicide risk (Hirsh and Barton, 2011; Wang et al., 2011; Willburn and Smith, 2005). These findings suggest that social and emotional competences could be a modulator of both suicidal ideation and behaviour.

Although there is limited evidence about the relationship between emotional intelligence and suicidal behaviour, research conducted with young students has concluded that emotional intelligence is a protective factor against suicidal behaviour and ideation (Cha and Nock, 2009; Ciarrochi et al., 2002). Cha and Nock (2009) examined whether the relationship between childhood sexual abuse and suicidal ideation and suicide attempts was moderated by adolescents' emotional intelligence. The results revealed that childhood sexual abuse was strongly associated with both suicidal ideation and suicide attempts among participants with low emotional intelligence, whereas this relationship was weaker for those with medium scores on this competence and completely absent for those with high emotional intelligence. For their part, Ciarrochi et al. (2002) evaluated whether emotion perception increases people's sensitivity to stress, leading them to report higher levels of depression, hopelessness and suicidal ideation. The results of this study showed that emotionally perceptive people appeared to be more strongly impacted by stress than were their less perceptive counterparts, and they experienced higher levels of depression, hopelessness and suicidal ideation.

The concept of emotional intelligence has become a focus of considerable research interest

over the past two decades, and it has been approached from a number of different perspectives. Since the concept of emotional intelligence became popular various theoretical models and numerous measurement instruments have emerged. One of the most widely used classifications, that proposed by Petrides and Furnham (2001), differentiates between ability and trait models. In the trait model, emotional intelligence refers to a constellation of behavioural dispositions and self-perceptions concerning a person's ability to recognize, process and utilize emotion-laden information (Petrides et al., 2004), and it is measured by self-report instruments. In the ability model, by contrast, emotional intelligence is defined as the ability to perceive and express emotion, to assimilate emotion in thought, to understand and reason with emotion, and to regulate emotion in oneself and in others (Mayer and Salovey, 1997), and here it is assessed by maximum-performance tests. Recent research on emotional intelligence and health has suggested that of these two theoretical approaches (ability vs. trait), emotional intelligence measured as a trait offers a better health predictor (Davis and Humphrey, 2012; Martins et al., 2010; Shutte et al., 2007).

In the nursing context several authors have ascribed a key role to emotional intelligence, and it has been suggested that the nursing curriculum should include the teaching of specific strategies for managing emotions, as well as social and communication skills training. The aim here would be to help nursing students and professionals cope with emotionally stressful situations (Bulmer et al., 2009; Görgens-Ekermans and Brand, 2012; Fernández et al., 2012). This is supported by research showing that emotional intelligence is associated with physical and psychological health, and also that greater emotional competence helps nursing students to adopt active coping strategies when dealing with stress, thereby enhancing their subjective well-being and perceived social support (Por et al., 2011; Montes-Berges and Augusto, 2007).

The main stressors that have been identified among nursing students are related to 1) the academic aspect (frequent assessments and workload, difficulty with their studies), 2) their clinical placements (fear of unknown situations, mistakes with patients, negative responses to the death or suffering of patients, relationships with other staff), and 3) personal issues such as financial problems or difficulty adapting to university life (Pryjmachuk & Richards, 2007; Pulido-Martos et al., 2012; Timmins & Kaliszar, 2002). Furthermore, university students in general are exposed to circumstances and expectations that may place them at risk for mental health or substance use disorders, or exacerbate pre-existing problems (Cleary et al., 2011). In this regard, Ross et al. (2005) found that 50% of the nursing students they tested obtained scores indicative of depression.

The main goals of the present study were to determine the prevalence of suicide risk in a sample of nursing students, and to examine the relationship between suicide risk and other variables (perceived emotional intelligence, depression, trait anxiety and self-esteem). The specific hypothesis tested was that perceived emotional intelligence and self-esteem protect against the risk of suicide, whereas depression and anxiety are predisposing factors.

METHOD

Participants

First-year nursing undergraduates from a university nursing school in Catalonia (Spain) were invited to participate in the study. Of the 140 students enrolled, a total of 105 were present in class on the day of test administration, and of these, 93 completed the questionnaire and 12 returned it blank. Therefore, the study sample corresponded to 66.43% of the total number of first-year nursing students enrolled at that time.

Ethical considerations and data collection

A descriptive, cross-sectional study was carried out. Ethical approval was obtained from the research ethics committee of the School of Nursing. All the participants received oral and written information about the aims of the study. It was made clear to them that their participation was voluntary and that all data would remain confidential. Research participants could not be personally identified and they were assured that participation would in no way affect their academic results.

Instruments

The students responded anonymously to a self-report questionnaire, which in addition to gathering information about age and sex contained the Spanish versions of the following scales:

Trait Meta-Mood Scale (TMMS-24) (Fernández-Berrocal et al., 2004; Salovey et al., 1995). This instrument evaluates perceived emotional intelligence, i.e. people's knowledge about their own emotional abilities. The Spanish version of the TMMS contains 24 items that are responded to on a five-point Likert scale (anchored by 1 = strongly disagree and 5 = strongly agree) and which assess levels of perceived emotional intelligence (PEI) across three dimensions: Attention, Clarity and Repair. There are eight scale items for each of these dimensions. Responses are analysed by taking into account the scores obtained on each of the three subscales or dimensions, not the overall score. The internal consistency of the subscales in the original validation study was 0.90 for Attention, 0.90 for Clarity and 0.86 for Repair. In the present sample we obtained Cronbach's alpha values of 0.87, 0.85, and 0.86 for Attention, Clarity and Repair, respectively.

Rosenberg Self-esteem Scale (RSES) (Rosenberg, 1965; Martín-Albo et al., 2007). The RSES

comprises 10 questions presented in a four-point Likert format. The reported internal consistency, test-retest reliability, and convergent and discriminant validity are all adequate. In this study Cronbach's alpha was 0.81.

Plutchik Suicide Risk Scale (SRS) (Plutchik et al., 1989). This is a self-report instrument containing 15 dichotomous (yes/no) items. Scores range from 0 to 15, with higher scores indicating a higher risk of suicide. In the validated Spanish version (Rubio et al., 1998) the cut-off point indicating substantial suicide risk is set at 6. This scale has shown good reliability and validity, and it can be used with attempters and non-attempters. In the present study Cronbach's alpha was 0.70.

Zung Self-Rating Depression Scale (SDS) (Zung, 1965). The SDS is a self-report scale comprising 20 statements related to depression, with half being formulated in positive terms and half in negative terms. The scores obtained are interpreted according to the following categories: normal (not depressed, raw score < 40), mild (raw score 40–47), moderate (raw score 48–55) and severe (raw score > 55) (Passik et al., 2001). In this study Cronbach's alpha was 0.78.

Trait scale of the State-Trait Anxiety Inventory (STAI-T) (Spielberger et al., 1983). This instrument is designed to assess trait anxiety and comprises 20 items, each with a 4-point item response scale. Possible total scores therefore range between 20 and 80, with higher scores indicating greater levels of anxiety. Cronbach's alpha in the present study was 0.85.

Data analysis

The data were tabulated and analysed by means of SPSS 18.0 for Windows (SPSS Inc., Chicago, IL, USA), which was used to calculate descriptive indices and Pearson correlation coefficients, as well as to conduct a multiple linear regression analysis.

RESULTS

The 93 participants had a mean age of 20.49 years (*SD*=3.75; range 18-42), with 75 (80.6%) being female and 18 (19.4%) male. Total scores on the 15-item Plutchik Suicide Risk Scale (SRS) ranged from 0 to 10, with a mean of 3.03 (*SD*=2.29). The analysis showed that 86% of the 93 nursing students obtained a total score of 5 or less (Figure 1). Thus, applying the cut-off score of 6 that has been established for the Spanish version of the SRS (Rubio et al., 1998) would mean that 14% of these students presented a substantial suicide risk. In terms of the students' responses to individual items on the SRS, 19 students (20.4%) had a relative who had attempted suicide, 13 (14%) had at some point thought about committing suicide, and 6 (6.5%) had made a previous attempt to take their own life.

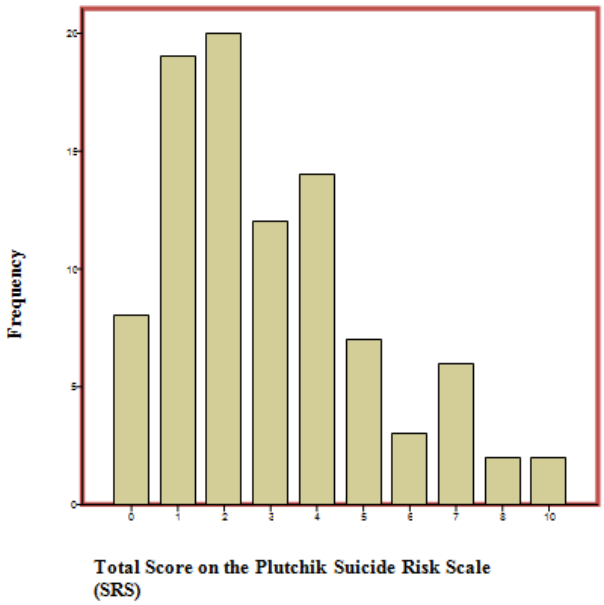

Figure 1. Frequency distribution of total scores on the Plutchik Suicide Risk Scale (SRS) in the total sample of nursing students.

Table 1 shows the means and standard deviations for the scores obtained by the total sample and by male and female students separately on the three subscales of the TMMS (Attention, Clarity and Repair) and on the measures of suicide risk (SRS), self-esteem (RSES), depression (SDS) and anxiety (STAI-T). It can be seen that women scored higher on suicide risk, depression, anxiety and emotional attention, whereas men scored higher on self-esteem and emotional clarity and repair. However, these differences were only significant in relation to depression (t = 2.25, p<0.05) and the effect size was small (Cohen's d = 0.33). It can also be seen in Table 1 that the mean scores on the Zung Self-rating Depression Scale were all < 40. A more precise analysis revealed that 55.9% of the students scored < 40, 31.2% scored between 40 and 47, 9.7 % between 48 and 55, and 3.2% > 55.

Table 2 shows the Pearson correlation coefficients between suicide risk and the three components of emotional intelligence (Attention, Clarity and Repair), self-esteem, depression and anxiety. Note particularly that the first column shows significant and positive correlations between suicide risk and depression (p<0.01), anxiety (p<0.01) and emotional attention (one of the three subscales of the TMMS) (p<0.01). Conversely, there are significant and negative correlations between suicide risk and both self-esteem (p<0.01) and emotional clarity and repair (p<0.05).

Table 1. Means, standard deviations, *t* values and significance (*p*) for the scores obtained by the total sample and by male and female students separately on the three dimensions of perceived emotional intelligence (Attention, Clarity and Repair) and on the measures of suicide risk (SRS), self-esteem (RSES), depression (SDS) and anxiety (STAI-T).

Scale	Mean (*SD*) Total Sample N = 93	Mean (*SD*) Women N = 75	Mean (*SD*) Men N = 18	*t*	*p*
Attention	30.01 (5.17)	30.44 (5.10)	28.22 (5.20)	0.73	ns
Clarity	28.52 (4.73)	28.39 (4.70)	29.06 (4.97)	- 0.53	ns
Repair	29.32 (5.46)	29.31 (5.48)	29.39 (5.57)	- 0.05	ns
RSES	29.55 (4.34)	29.44 (4.40)	30.00 (4.14)	- 0.48	ns
SRS	3.03 (2.28)	3.07 (2.28)	2.89 (2.34)	0.29	ns
SDS	39.03 (6.97)	39.81 (6.93)	35.78 (6.30)	2.25	**< 0.05***
STAI-T	43.56 (8.34)	44.18 (8.45)	41.05 (7.55)	1.43	ns

*Cohen's *d* = 0.33

Table 2. Pearson correlation coefficients (*r*) between suicide risk (SRS) and the three dimensions of perceived emotional intelligence (Attention, Clarity and Repair), self-esteem (RSES), depression (SDS) and anxiety (STAI-T).

		SRS	Attention	Clarity	Repair	RSES	SDS
1.	**SRS**						
2.	**Attention**	0.32**					
3.	**Clarity**	- 0.20*	0.14				
4.	**Repair**	- 0.21*	0.02	0.23*			
5.	**RSES**	- 0.43**	- 0.09	0.24*	0.40**		
6.	**SDS**	0.61**	0.17	- 0.17	- 0.41**	- 0.53**	
7.	**STAI-T**	0.55**	0.34**	- 0.29**	- 0.48**	- 0.64**	0.66**

*$p<0.05$; **$p<0.01$

The final step in the analysis was to apply multiple linear regression (stepwise method), entering suicide risk as the dependent variable and taking as independent variables all those factors which had shown a significant correlation in the bivariate analysis. It can be seen in Table 3 that depression and emotional attention (TMMS) were, in this order, the only variables identified by the model as predictors of suicide risk, and together they explained 38.8% (R^2_{adj}) of the total variance.

Table 3. Multiple linear regression analysis.

Suicide risk (DV)	B	Beta	*t*	*p*	Confidence Interval (95%)	
Constant	- 7.05		-5.05	<0.01	- 9.83	- 4.28
Depression (SDS)	0.18	0.55	6.62	<0.01	0.13	0.24
Attention (TMMS)	0.10	0.22	2.67	<0.01	0.02	0.17

$R=0.63$; $R^2_{adj}=0.39$; $F_{2,88}=29.50$; $p<0.01$

DISCUSSION

The death by suicide of a young person has an enormous impact on the family and society, and hence the identification and prevention of factors associated with suicidal behaviour in young people should be regarded as a priority. The results of the present study reveal depression and emotional attention to be significant predictors of suicide risk. This is consistent with the findings of a study of Greek nursing students by Melissa-Halikiopoulou et al. (2011), who reported a significant relationship between depression and suicidal ideation. Similarly, a recent study of Taiwanese medical students carried out by Fan et al. (2012) found that those who scored as depressed were significantly ($p<0.01$) more likely to experience suicidal ideation. In the present study 11.9% of nursing students presented moderate or severe levels of depression, a figure that is similar to the 10% of Iranian nursing students who, in the study by Ahmadi et al. (2004), were reported to show moderate to severe depression. As regards gender, although female students scored significantly higher on depression than did their male counterparts, the effect size was very low. Future studies need to examine these differences in greater depth.

According to the present analysis, 14% of students could be classified as high suicide risk, 14% had at some point thought about suicide, and 6.5% had made a previous suicide attempt. These results are in line with those of other studies carried out with students of nursing and other disciplines (Ahmadi et al., 2004; Garlow et al., 2008; Toprak et al., 2011). Garlow et al. (2008) reported that 11.1% of college undergraduates endorsed current suicidal ideation and 16.5% had a lifetime suicide attempt or self-injurious episode. This underlines the idea that university students are an at-risk population in which the identification of early signs and appropriate treatment is important in order to achieve better outcomes (Cleary et al., 2011).

Although no previous research has focused on the association between emotional intelligence and suicidal ideation in nursing students, generic research in the field of emotional intelligence has suggested that people who score high on emotional attention report more physical, depressive and

anxiety symptoms (Extremera and Fernández-Berrocal, 2006; Salovey et al., 2002; Thompson et al., 2007). Augusto et al. (2009), in a sample of nursing students, reported that attention to emotions was negatively associated with self-esteem and self-concept. More recently, Aradilla-Herrero et al. (2012-2013) suggested that those nursing students who are high on emotional attention find it harder to cope with the idea of death.

In terms of other aspects of emotional intelligence, people with high levels of emotional clarity and repair generally report greater life satisfaction and less stress (Extremera et al., 2009; Extremera and Fernández-Berrocal, 2005). In this context, a study of nursing students by Montes-Berger and Augusto (2007) showed that emotional repair was the main predictor of mental health. Similarly, a recent study of South African nurses by Görgens-Ekermans and Brand (2012) suggested that improving emotional intelligence may help to reduce the likelihood of burnout in the face of chronic stress.

High self-esteem has been shown to act as a protective factor against mental health problems among young adults and adolescents (Hur et al 2011; Sharaf et al. 2009; Wilburn and Smith, 2005), and Karatzias et al. (2006) suggested that self-esteem and affectivity are important predictors of well-being. Our results would seem to support the idea that self-esteem has a positive influence in terms of preventing suicidal behaviour.

It should be noted that in the only study, to our knowledge, to have examined the relationship between emotional intelligence (assessed by an ability performance-based test) and suicidal behaviour among adolescents, Cha and Nock (2009) found that emotional intelligence was a protective factor against suicidal ideation and suicide attempts. In the present study, although clarity and repair showed negative and significant correlations with suicide risk, they were not identified as predictive factors of this risk. Further research is clearly needed to analyse this relationship in greater depth.

Implications for nursing education

The results of this study highlight the importance of nurse educators being able to recognize mental health problems among their students so as to initiate referral and early interventions (Cleary et al., 2011). A further priority would be to develop training programmes that can help nursing students improve their personal skills, self-esteem and life satisfaction (Ratanasiripong et al., 2011; Ross et al., 2005). In this regard, the prolonged contact that nurse educators have with students during their clinical placements makes them ideally placed to implement prevention and early detection programmes.

These aims are supported by recent empirical evidence suggesting that emotional intelligence training programmes can improve emotional intelligence among university students (Dacre Pool

and Qualter, 2012; Fletcher et al., 2009). The premise here is that the skills associated with emotional intelligence not only help individuals to deal effectively with unpleasant emotions but can also promote positive emotions, thereby fostering both personal growth and well-being (Brackett et al., 2011).

Recommendations for further research

In general, further research is needed to understand how emotions interact with suicidal ideation and suicide attempts. As regards the present study, our findings need to be replicated and validated in a more diverse sample of nursing students. We would also recommend designing and assessing emotional intelligence programmes that can improve nurses' emotional skills and help to prevent suicide behaviour. In fact, there is already evidence that programmes providing specific mental health support for students in the healthcare setting may significantly decrease the reported rates of depressive symptoms and suicidal ideation (Thompson, 2010.) Given the present findings it would also be important to examine in greater depth any gender differences related to risk factors for suicide among nursing students. Finally, it would be interesting to conduct research with both trait and ability measures of emotional intelligence in order to establish how each of these two approaches to the construct might be related to health variables.

Limitations

Firstly, the correlational design does not allow any causal inferences to be made among the factors studied, and neither can the findings be generalized to nursing professionals as a whole. Furthermore, the fact that we used a self-report measure of emotional intelligence means that social desirability might have influenced the results. Lastly, participants were all from the same university and they represented a very limited sample of nursing students. Despite these limitations, the data obtained are relevant to the field of nursing education and confirm the need for further research.

CONCLUSIONS

The present study supports the hypothesis that depression and emotional attention impact upon the risk of suicide among nursing students. In addition, the results suggest that interventions to reduce suicidal ideation among these students should include, as part of the nursing curriculum, strategies to enhance self-esteem and improve emotional intelligence.

The findings should, however, be treated with caution, not least because suicidal behaviour is a highly complex phenomenon that is influenced by a multitude of variables, not only personal but also those of a social and cultural nature. Nonetheless, the study does highlight that in terms of nurse education there is a clear need to establish programmes that are able to improve the

psychological well-being of students and to offer early detection of mental health problems, especially those associated with mood disorders.

The study adds to existing knowledge about an issue that is regarded as a serious public health problem, namely the risk of suicide among young people.

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4.
DISCUSIÓN DE LOS RESULTADOS

Los resultados de cada estudio han sido discutidos en los diferentes artículos publicados. No obstante, en este apartado se realiza un resumen de los principales hallazgos empíricos y se analizan y discuten sus implicaciones. Aún a riesgo de resultar redundante con los resultados presentados en los artículos, parece conveniente aglutinar en este espacio los principales resultados, contrastación de hipótesis, limitaciones e implicaciones para la práctica, tanto en relación a los estudiantes como a los profesionales, de todos los estudios llevados a cabo para la presentación de esta tesis doctoral.

OBJETIVO 1

Determinar si la estructura factorial de la Trait Meta-Mood Scale, instrumento que evalúa la Inteligencia Emocional Percibida, es consistente con la propuesta por los autores originales de la escala en una muestra de estudiantes y profesionales de enfermería.

El grupo de investigación de Salovey y Mayer (1990) desarrolló una medida de auto-informe congruente con su modelo teórico preliminar, el Trait Meta-Mood Scale (TMMS), que evalúa el conocimiento personal sobre los propios estados emocionales y proporciona una estimación personal sobre los estados de ánimo (Salovey et al., 1995), por lo que los autores conciben el TMMS como un instumento que evalúa la Inteligencia Emocional Percibida (IEP) (Salovey, Stroud, Woolery, & Epel, 2002). La versión extensa consta de 48 ítems de respuesta tipo Likert de 5 puntos. Salovey et al. (1995) realizaron un análisis factorial con 148 sujetos que confirmó que la escala presentaba tres factores: atención (capacidad percibida para identificar los estados de ánimo y las emociones), claridad (capacidad percibida para discriminar claramente los sentimientos) y reparación (habilidad percibida para regular los estados de ánimo). Posteriormente, Fernández-Berrocal et al. (2004) desarrollaron una versión en castellano abreviada de 24 ítems (TMMS-24), con 8 ítems para cada subescala (atención, claridad y reparación). La versión española del instrumento se adaptó en una muestra de adolescentes de 12 a 17 años, estudiantes de secundaria. Esta

versión del instrumento mostró una alta consistencia interna y una fiabilidad test-retest satisfactoria.

Uno de los objetivos del presente trabajo fue corroborar la estructura factorial propuesta por los autores del TMMS en una muestra de estudiantes y profesionales de enfermería. Los resultados de nuestro estudio, realizado con una muestra de 1417 individuos (1208 enfermeras y 209 enfermeras), muestran índices de ajuste satisfactorios, saturaciones elevadas, índices de consistencia interna adecuados e índices aceptables de estabilidad temporal aceptables para las tres subsescalas del modelo original (atención, claridad y reparación). La consistencia interna de cada dimensión, en la muestra de estudiantes de enfermería, fue de 0,86 (atención), 0,86 (claridad) y 0,84 (reparación). En la muestra de enfermeras, los coeficientes alfa de Cronbach fueron 0,89, 0,88 y 0,84 para las subescalas de atención, claridad y reparación, respectivamente. En relación al análisis de la estabilidad temporal, en la submuestra de 57 participantes, los índices de correlación test-retest fueron 0,70, 0,80 y 0,67 para atención, claridad y reparación, respectivamente. En general, los resultados indican que la TMMS-24 es un instrumento válido y fiable para evaluar la IEP en el contexto de enfermería, tal y como proponíamos en la hipótesis previa número 1. Estos resultados son coherentes con los estudios de adaptación del instrumento a otros idiomas y contextos culturales (Aksöz, Bugay, & Erdur-Baker, 2010; Bayani, 2009; Gorostiaga, Balluerka, Aritzeta, Haranburu, & Alonso-Arbiol, 2011), así como en otros ámbitos profesionales (Martín-Albo, Núñez, Navarro, & León, 2010).

El análisis factorial confirmatorio evidenció que el ítem 23 (Tengo mucha energía cuando me siento feliz) que pertenece a la subescala reparación, presentaba una carga factorial, en su respectiva dimensión, bastante inferior a las demás (0,31); asimismo, el análisis del modelo sin el ítem 23 presentaba un ajuste más satisfactorio. En consecuencia, parece apropiado, en consonancia con lo propuesto con otros autores (Salguero, Fernández-Berrocal, Balluerka, Aritzeta, 2010; Martín-Albo et al., 2010), eliminar el ítem 23 de la escala. No obstante, esta decisión no está exenta de controversias ya que puede afectar posteriormente a la comparación de resultados con otras muestras en las que se haya utilizado la versión original adaptada de 24 ítems. De hecho, los autores anteriormente citados que recomendaron utilizar el TMMS-23 siguen utilizando, en estudios recientes, el TMMS en su versión de 24 ítems (Extremera, Salguero, & Fernández-Berrocal, 2011; Salguero, Palomera, & Fernández-Berrocal, 2012).

Otro aspecto que ofrece el cuestionario es que las subescalas que lo forman pueden evaluarse de forma independiente, es decir que tienen entidad propia y pueden utilizarse por separado. Esta propiedad del cuestionario puede ser muy interesante en futuras investigaciones en que se puede evaluar una de las dimensiones de forma independiente según los objetivos específicos de los estudios. También puede ser beneficioso cuando no se dispone de mucho tiempo para cumplimentar los cuestionarios, como es el caso de las muestras de enfermeras asistenciales. Sin embargo, no existe en la literatura, según nuestro conocimiento, estudios que disgreguen el cuestionario y evalúen tan solo una de las dimensiones de la TMMS. Los resultados también muestran que las correlaciones entre las dimensiones atención y claridad son muy pequeñas, 0.19, algo superiores entre la claridad y la reparación, aunque también se pueden considerar bajas, y no existe correlación entre la atención y la reparación. Estos resultados coinciden con otros estudios (Gorostiaga et al., 2011; Salguero et al., 2010) en los que se afirma que existe una secuencia funcional en el proceso de regulación de las emociones. Es decir que podría ser necesario cierto nivel de atención a los sentimientos para ser capaz de comprender los estados emocionales y un cierto nivel de claridad de los sentimientos par ser capaz de moderar o regular las emociones. Tal como Mayer y Salovey (1997) describen en su modelo de cuatro ramas, las competencias emocionales son secuenciales y es necesario ir adquiriendo las competencias iniciales para finalmente llegar a gestionar de forma efectiva las propias emociones.

OBJETIVO 2

Determinar si existen diferencias de género y diferencias entre estudiantes y profesionales, en relación con las diferentes dimensiones de la Inteligencia Emocional, en el ámbito de la enfermería.

En relación a las diferencias de género en las tres dimensiones de la TMMS-24, nuestros resultados, en consonancia con los obtenidos en otros estudios (Fernández-Berrocal & Extremera, 2008; Thayer, Rossy, Ruiz-Padial, & Johnsen, 2003) muestran que las mujeres presentan una tendencia a prestar más atención a las emociones que los hombres, tal y como apuntábamos en la hipótesis número 2. Esta tendencia

también se puede observar tanto en adolescentes (Gorostiaga et al., 2011; Pena, Extremera, & Rey, 2011; Salguero et al., 2010), como en estudiantes (Augusto-Landa, López-Zafra, Berrios-Martos, & Aguilar-Luzón, 2008) y profesionales de enfermería (Montes-Berges & Augusto, 2007).

Estos hallazgos ponen de manifiesto la necesidad de seguir estudiando las diferencias de género y si esta tendencia en prestar mayor atención a las emociones, que se presenta en las mujeres, está debida a la influencia de otras variables. Asimismo, queremos enfatizar la necesidad de que futuras investigaciones en el ámbito de enfermería deben intentar que las muestras entre hombres y mujeres sean más homogéneas, ya que en todos los estudios mencionados en enfermería la proporción de hombres era mucho menor, por tanto los resultados podrían aparecer sesgados. Somos conscientes que es una dificultad presente en la profesión porque la proporción de hombres que estudian enfermería en relación a las mujeres es significativamente menor.

Sin embargo, en este sentido, destacamos que en un estudio reciente de Davis y Humphrey (2012a) que estudió las diferencias de género en adolescentes comparando medidas de habilidad y de auto-informe de evaluación de la IE, en muestras homogéneas entre hombres y mujeres, las mujeres obtienen puntuaciones significativamente mayores que los hombres en las medidas de IE habilidad, sin embargo, no se han observado diferencias de género en la IE rasgo. Las diferencias en relación a las mujeres parecen ser atribuibles a la mayor habilidad femenina en manejar las emociones (Davis & Humphrey, 2012a). Resultados similares se han obtenido con otras muestras de adolescentes (Davis & Humphrey, 2012b; Williams, Daley, Burnside, & Hammond-Rowley, 2009).

Por otra parte, Nolen-Hoeksema y Aldao (2011) han confirmado recientemente que las mujeres utilizan un número mayor de estrategias de regulación emocional que los hombres como la reevaluación, el afrontamiento activo, la aceptación, la búsqueda de apoyo emocional, sobretodo en mujeres de mayor edad, aunque estas estrategias no se asociaron a una menor sintomatología depresiva. Una posible explicación la encontramos en el meta-análisis llevado a cabo por Aldao, Nolen-Hoeksema y Schweizer (2010) que muestra que las estrategias desadaptativas están más relacionadas con síntomas psicopatológicos que las estrategias adaptativas y que las mujeres utilizan más estrategias desadaptativas como la rumiación. Los pensamientos rumiativos obsesivos pueden ser positivos o negativos, pueden aparecer de formas

muy diferentes (imágenes, impulsos, pensamientos verbales o recuerdos recurrentes) y pueden llegar a ser muy perturbadores cuando el individuo está llevando a cabo otras actividades de la vida diaria cotidiana. En esta línea, Nolen-Hoeksema (2012) sugiere que los programas de tratamiento y prevención de la depresión en mujeres deben estar focalizados especialmente en disminuir la tendencia a la rumiación.

La habilidad para gestionar las emociones parece tener una importancia relevante en la disminución de la rumiación y pensamientos intrusivos. Según parece, las personas capaces de elaborar la información emocional tienen mayor habilidad de gestionar sus emociones, reponerse de las situaciones emocionales estresantes y disminuir los pensamientos intrusivos y, en general, mostrar un mayor ajuste psicológico (Gohm, Baumann, & Sniezek, 2001; Ramos, Fernández-Berrocal, & Extremera, 2007; Salovey et al, 1995). Específicamente, la IE rasgo está positivamente relacionada con el autoconcepto y la autoestima y negativamente relacionada con la ansiedad, la depresión, el enfado y el comportamiento disruptivo (Fernández-Berrocal, Ramos & Extremera 2001; Fernández-Berrocal, Ramos, & Orozco, 1999; Goldenberg, Matheson, & Mantler, 2006, Mavroveli, Petrides, Rieffe, & Bakker, 2007). No obstante, la rumiación y la supresión emocional se correlacionan con mayores síntomas depresivos, ansiedad, uso de substancias y desórdenes alimenticios (Aldao et al., 2010).

Según los hallazgos de los diferentes estudios parece claro que existen diferencias de género en la percepción y gestión de los sucesos emocionales y cómo estos afectan al ajuste psicológico de las personas. Es necesario seguir investigando por qué a pesar de que las mujeres tienen una mayor percepción emocional y utilizan un mayor número de estrategias de gestión emocional no muestran, por lo general, un mejor ajuste psicológico.

Otro aspecto del objetivo propuesto era analizar si existían diferencias entre estudiantes y enfermeras en relación a las tres dimensiones de la Inteligencia Emocional. Al contrario de lo que planteábamos en nuestra hipótesis número 3, en nuestro estudio no se perciben diferencias significativas entre los estudiantes y profesionales de enfermería en la percepción de sus habilidades emocionales. Tan solo se percibe que los profesionales de enfermería tienden a prestar menos atención a las emociones que los estudiantes y, por el contrario, presentan mayores puntuaciones en claridad y reparación. Según nuestro conocimiento, no existen

estudios que evalúen las diferencias en la percepción de la IE entre estudiantes y enfermeros.

Parece razonable pensar que los profesionales de enfermería perciban mejores habilidades emocionales que los estudiantes por su mayor formación y su experiencia laboral. De hecho, el estudio de Lange, Thom, y Kline (2008) muestra que las enfermeras con más experiencia tienden a tener actitudes más positivas para el cuidado de los pacientes moribundos.

Una posible explicación para que las enfermeras no muestren más IEP que los estudiantes podría deberse al déficit, manifestado por los propios profesionales, de formación específica en habilidades emocionales (Bellack, 1999; Henderson, 2001; Hurley, 2008). Por otro lado, existen numerosos estudios en enfermería que enfatizan la importancia de la implementación de habilidades de inteligencia emocional en muchas situaciones profesionales a las que se enfrentan las enfermeras en su práctica diaria, como sería la comunicación con los enfermos al final de la vida (Codier, Freitas, & Muneno, 2013; de Araújo et al., 2004), el manejo de situaciones estresantes (Augusto-Landa et al., 2008; Görgens-Ekermans & Brand, 2012), el liderazgo de equipos (Akerjordet & Severinsson, 2008; Freshman & Rubino, 2002; Vitello-Cicciu, 2002), así como el trabajo con enfermos con problemas mentales (Carmona-Navarro & Pichardo-Martínez, 2012; van Dusseldorp, van Meijel, & Derksen, 2011; Warelow & Edward, 2007).

En relación a la efectividad de la formación en habilidades emocionales, hay estudios recientes con resultados esperanzadores, en muestras de adolescentes, que corroboran que la formación en habilidades emocionales mejora las competencias de inteligencia emocional. Sin embargo, los estudios que actualmente disponemos en enfermería son evaluaciones de corte transversal, de cursos de corta duración, aunque también con resultados positivos (Bailey, Murphy, & Porock, 2011; Codier et al., 2013). Asimismo, son varios los estudios que evalúan el impacto de la formación de inteligencia emocional en los estudiantes de enfermería (Fernandez, Salamonson, & Griffiths, 2012; Harrison & Fopma-Loy, 2010; Por et al., 2011). Sería conveniente realizar estudios longitudinales, en el ámbito de enfermería, que permitieran establecer conclusiones más rigurosas respecto al impacto que produce la formación en las habilidades emocionales de estudiantes y profesionales.

OBJETIVO 3

Analizar la relación entre las tres dimensiones de la Inteligencia Emocional Percibida (atención, claridad y reparación) y las Actitudes ante la Muerte (ansiedad, miedo, depresión y obsesión ante la muerte) en enfermería.

El cuidado de las personas al final de la vida y el contacto con la muerte son situaciones usuales en la labor diaria de las enfermeras y de los estudiantes de enfermería en sus prácticas clínicas. Hay algunos estudios que apoyan la idea de que las actitudes ante la muerte son un factor muy importante que puede afectar al comportamiento de los profesionales en el cuidado de los paciente al final de la vida (Braun, Gordon, & Uziely, 2010; Rooda et al.,1999).

En el estudio llevado a cabo con una muestra de 243 estudiantes de enfermería se pretendía evaluar si la IE tenía relación con las actitudes ante la muerte. En nuestro estudio se confirmó que todas las variables relacionadas con las actitudes ante la muerte (ansiedad, depresión, obsesión y miedo) muestran una relación positiva con la Atención emocional y negativa con la comprensión y la regulación emocional. Por lo tanto, nuestra hipótesis previa número cuatro quedaría confirmada. Aunque no existen estudios de enfermería sobre la relación de estas variables, estos resultados son congruentes con estudios sobre la IEP evaluados con el TMMS (Extremera & Fernández-Berrocal, 2006; Fernández-Berrocal, Alcaide, Ramos, & Pizarro, 2006; Salovey et al., 2002). Específicamente, Fernádez-Berrocal et al. (2006) confirmaron en una muestra de adolescentes españoles que los adolescentes con mayor capacidad para discriminar entre los sentimientos y para regular los estados emocionales mostraban menos ansiedad y depresión; resultados muy similares a los obtenidos por estudiantes universitarios (Extremera & Fernández-Berrocal, 2006). Asimismo, otro estudio realizado por Ramos et al. (2007) con el TMMS-24 demostró que la IEP facilitaba el proceso cognitivo-emocional de adaptación a un evento estresante y que los individuos con mayor claridad emocional y reparación experimentan menos respuestas emocionales negativas y pensamientos intrusivos después de un evento estresante agudo. Asimismo, dos meta-análisis recientes (Martins et al., 2010; Shutte et al., 2007) han mostrado que niveles altos de IE, evaluada con medidas de auto-informe, estaban significativamente relacionados con un mejor ajuste mental. Parece ser, según estos resultados, que la IE nos hace menos vulnerables al efecto negativo de nuestros estados de ánimo.

Estudios previos con profesionales de enfermería corroboran que la claridad y la reparación emocional funcionan como protectores respecto al stress y al burnout profesional y están relacionadas con una mayor satisfacción laboral y una mayor percepción de salud general (Augusto-Landa, López-Zafra, Berrios-Martos, & Aguilar-Luzón, 2006, 2008; Limonero, Tomás-Sábado, Fernández-Castro, & Gómez-Benito, 2004). En esta línea, investigaciones con estudiantes de enfermería muestran que la reparación emocional es un predictor de un mayor soporte social y una mejor salud mental (Montes-Berger & Augusto, 2007), y que altas puntuaciones en claridad y reparación emocional mejoran el autoconcepto personal (Augusto-Landa, López-Zafra, Aguilar-Luzón, & Salguero de Ugarte, 2009). Asimismo, Augusto-Landa et al. (2009) confirmaron que los estudiantes de enfermería que poseen menos autoestima y un menor concepto de sí mismos tienen más dificultades de comprender y gestionar sus estado emocionales que las que presentan mayores puntuaciones en autoestima y un mayor autoconcepto personal. Estos resultados concuerdan con nuestros hallazgos en muestras de estudiantes de enfermería, la autoestima correlaciona negativamente con la atención emocional y positivamente con la claridad y la reparación, al contrario que las variables relacionadas con las actitudes ante la muerte.

En general, estos resultados adaptados al contexto de enfermería en el cuidado de enfermos al final de la vida, podrían hacernos pensar que las enfermeras que son capaces de discriminar sus sentimientos y que gestionan de forma adecuada las emociones que les suscita el contacto con la muerte y el cuidado de los enfermos al final de la vida, experimentarían menor ansiedad, depresión y miedo ante la muerte. Esta explicación de nuestros resultados puede relacionarse con los hallazgos obtenidos por otros estudios que muestran que las enfermeras con actitudes más favorables hacia el cuidado de los enfermos al final de la vida mostraban menos ansiedad y conductas de evitación (Rooda et al. 1999; Braun et al. 1999).

Aunque la capacidad de identificar y reconocer las emociones es un factor fundamental en la comunicación interpersonal y hay estudios que han demostrado que los trastornos de ansiedad y estados de depresión en adultos producen dificultades en reconocer las expresiones faciales y las emociones de los demás (Demenescu, Kortekaas, den Boer, & Aleman, 2010), los resultados anteriores muestran que no es positivo estar constantemente atento a los estados emocionales. Si la persona está en constante vigilancia de sus estados de ánimo, puede presentar dificultades en

comprender y gestionar sus emociones, no siendo capaz de discriminar entre ellas, evaluar sus causas y futuras consecuencias (Thayer et al., 2003).

También queremos resaltar que, según nuestros hallazgos, la comprensión y gestión emocional disminuiría el "miedo a la muerte de los otros" y por tanto, disminuiría el temor a la muerte de los pacientes al final de la vida. Estos resultados son alentadores ya que las enfermeras dedican mucho más tiempo al cuidado de los enfermos al final de la vida que los otros profesionales de la salud. Por esta razón tambiés es muy importante que estos profesionales no vivan estas situaciones como eventos estresantes y dispongan de estrategias de afrontamiento que les permitan acercarse a sus pacientes con empatía. También es imprescindible que no muestren conductas de evitación, ya que el cuidado de estos enfermos requiere de un contacto continuado para cubrir sus necesidades físicas, psicológicas, sociales y espirituales. Los estudiantes de enfermerían deben aprender contenidos y habilidades para ofrecer cuidados paliativos de calidad (Caton & Klemm, 2006), para ello deben aprender los aspectos derivados de la gestión de los síntomas y habilidades de comunicación, entre otras competencias como el trabajo interdisciplinar, la gestión del duelo y las pérdidas, estrategias para la gestión de la diversidad y conocimientos sobre los aspectos éticos y legales (Brajtman, Higuchi, & Murray, 2009; Ferrell et al., 2005; Wallace et al. 2009).

OBJETIVO 4

Explorar la relación entre la Inteligencia Emocional Percibida, la Depresión y el Riesgo Suicida.

El último objetivo propuesto fue analizar las posibles relaciones entre la IEP, la depresión y un aspecto tan impactante para la sociedad como la ideación suicida. Los resultados del estudio realizado con una muestra de estudiantes de enfermería muestran que la depresión y la atención emocional son variables predictoras del riesgo suicida. Una vez más, la atención emocional aparece como una variable asociada al desajuste psicológico, en este caso manifestado por la depresión y la ideación suicida. Los resultados de este estudio son congruentes con la hipótesis número cinco propuesta previamente. También queremos comentar que aunque la autoestima no ha resultado un factor predictor del riesgo suicida, los hallazgos parecen concluir que puntuaciones altas de autoestima mejoran la comprensión y gestión emocional y

minimizan los riesgos que tiene prestar demasiada a tención a los procesos emocionales. Este aspecto se debería tener en cuenta en el desarrollo de los programas formativos en el curriculum de enfermería.

Según los resultados de algunos estudios previos (Andersen, Hawgood, Klieve, Kõlves, & de Leo, 2010; Skegg, Firth, Gray, & Cox, 2010), la enfermería es una profesión que presenta un alto grado de riesgo suicida, aunque no están claras las razones que llevan a la conducta autolítica de estos profesionales, lo que dificulta la instauración de programas efectivos de prevención (Hawton et al., 2002). En un estudio prospectivo de mujeres enfermeras en Estados Unidos, se observó que las mujeres que manifestaban niveles de estrés en el trabajo y en el entorno laboral tenían más riesgo de suicidarse posteriormente (Feskanich et al., 2002). La profesión de enfermería es una profesión considerada altamente estresante por varios estudiós (Lim, Bogossian, & Ahern, 2010; Pulido-Martos, Augusto-Landa, & Lopez-Zafra, 2012; Riahi, 2011) y se ha observado que altos niveles de estrés están asociados a pensamientos suicidas. Ante estos resultados, parece que los métodos más eficaces de prevención serían la detección precoz de signos y síntomas de estrés y de depresión, así como iniciar lo antes posible programas de prevención y tratamiento.

Asimismo, estudios realizados con estudiantes universitarios corroboran que la depresión es un factor muy importante en la ideación y el riesgo suicida y que una amplia mayoría de estudiantes con depresión, conductas adictivas e ideas suicidas no estan bajo ningún tratamiento (Garlow et al., 2008). Estos hallazgos confirman, una vez más, la necesidad de implementar programas de detección precoz de conductas adictivas y transtornos mentales para esta población tan vulnerable.

5.
CONCLUSIONES, LIMITACIONES Y FUTURAS LÍNEAS DE INVESTIGACIÓN

5.1. CONCLUSIONES

a. Conclusiones derivadas de la revisión de la literatura

- Se evidencia una extensa literatura científica sobre los distintos modelos y conceptualizaciones de la IE.

- Se observa en las publicaciones sobre la IE una enardecida discusión y controversia sobre las distintas aproximaciones conceptuales al constructo.

- Se dispone de distintos instrumentos válidos y fiables para evaluar la IE de las personas acordes con cada conceptualización teórica del constructo.

- En enfermería existe un interés creciente por el estudio de la IE en el ámbito profesional y por su implicación en el desarrollo de la profesión que se caracteriza por la existencia de un número importante de publicaciones teóricas y empíricas sobre el tema.

b. Conclusiones derivadas de los estudios empíricos de la tesis

- La Trait Meta Mood Scale, en su versión adaptada al castellano (TMMS-24), es un instrumento válido y fiable para evaluar la IEP en el contexto de enfermería.

- Las subescalas de la TMMS-24 que evalúan atención, claridad y reparación emocional pueden utilizarse como instrumentos independientes para evaluar cada una de las dimensiones, aspecto muy interesante a tener en cuenta en el contexto laboral de enfermería en el que en ocasiones se dispone de tiempo limitado para poder responder a estos cuestionarios.

- En la IE evaluada con medidas de autoinforme, concretamente con la TMMS-24 no existen diferencias significativas en relación al género. Tan solo se percibe, en la mayor parte de estudios, una tendencia mayor en las mujeres a prestar mayor atención emocional que los hombres. Sin embargo, en la literatura se observa que en los estudios donde la IE es evaluada mediante medidas de habilidad las

mujeres puntúan significativamente más alto en el manejo de las emociones. Sería conveniente seguir investigando sobre estas relaciones.

- En general, los profesionales de enfermería no perciben más IEP que los estudiantes de enfermería. Se necesitarían diseñar estudios longitudinales para evaluar si la experiencia laboral y la formación en competencias emocionales puedan ser variables predictoras de la IEP.

- Las personas que prestan una atención constante a las emociones puede presentar dificultades para la comprensión y la gestión de las mismas, mientras que las personas que discriminan mejor entre sus sentimientos y regulan efectivamente sus emociones muestran menor ansiedad, depresión y miedo ante la muerte, aspectos relevantes en el caso de los estudiantes y profesionales de enfermería por su contacto continuado con la muerte y el sufrimiento durante su práctica clínica diaria. Por lo tanto, parece conveniente implementar programas de formación de habilidades emocionales en el currículo de la Titulación de Enfermería que permitan a los futuros profesionales desarrollar estrategias de afrontamiento ante las situaciones de muerte, sufrimiento y dolor que vivirán a lo largo de su trayectoria profesional. Asimismo, es imprescindible llevar a cabo la evaluación de dichos programas educativos para garantizar que se consiguen las competencias emocionales previamente definidas.

- Finalmente, según los hallazgos de los estudios con estudiantes de enfermería, es imprescindible inicar programas de detección de conductas adictivas y de enfermedades mentales, especialmente en el caso de la depresión, como medidas precoces de prevención del riesgo suicida en estudiantes de enfermería.

5.2. LIMITACIONES

Los estudios llevados a cabo para la presentación de esta tesis doctoral en formato compendio de artículos, presentan una serie de limitaciones que describimos a continuación:

- Los resultados obtenidos en los diferentes estudios tan solo son aplicables al contexto de la enfermería.

- Las muestras de los diferentes estudios son muestras de conveniencia, sería necesario ampliar las muestras y las instituciones de las cuales provienen los sujetos para comprobar si las diferencias no han sido tan solo debidas al azar.

- Sería conveniente que las muestras entre hombres y mujeres, y entre estudiantes y profesionales, fueran más homogéneas, aunque somos conscientes que en el contexto de enfermería lograr muestras homogéneas en relación al género es una propuesta difícil.

- Los diseños son transversales y, por tanto, no se pueden establecer relaciones causales entre las variables estudiadas. Sería conveniente diseñar estudios de seguimiento que permitiesen aumentar la evidencia causal.

- En todos los estudios se ha utilizado una medida de auto-informe de la IE (TMMS-24) y no se ha realizado una comparación de los resultados con medidas de habilidad. En un futuro, parece conveniente utilizar a su vez alguna medida de habilidad para analizar las diferencias entre las distintas variables estudiadas y las dos concepciones teóricas de la IE en el contexto de enfermería.

- El estudio que investiga las relaciones entre la IEP, la depresión y el riesgo suicida está realizado con una muestra pequeña de estudiantes de enfermería y aunque los resultados son interesantes para la profesión sería conveniente replicar el mismo con una muestra mayor y más representativa.

A pesar de estas limitaciones, pensamos que los estudios llevados a cabo presentan resultados interesantes para la práctica clínica en enfermería, su aplicación en la docencia de futuros enfermeros y para la comunidad científica interesada en el campo de la IE.

5.3. FUTURAS LÍNEAS DE INVESTIGACIÓN

Actualmente, seguimos trabajando en el estudio de las habilidades emocionales, las actitudes de los estudiantes y profesionales de la salud, ante los cuidados de las personas al final de la vida, y el impacto que causa en ellos el contacto con la muerte y el sufrimiento ajeno.

Algunas de estas investigaciones, a nivel general, son:

- Efectividad de la formación en habilidades socioemocionales en la asignatura de cuidados paliativos del Grado de enfermería: Evaluación de la IE, la ansiedad ante la muerte y las actitudes para cuidar a personas al final de la vida.

- Habilidades socioemocionales (inteligencia emocional, empatía y autoestima) y actitudes ante la muerte (ansiedad, depresión, miedo y obsesión ante la muerte) en estudiantes y profesionales de enfermería

- Evaluación del programa formativo en habilidades socioemocionales en el currículo de enfermería. Estudio longitudinal.

- Validación y adaptación de instrumentos de medida de las habilidades socioemocionales, actitudes ante el cuidado de personas al final de la vida y actitudes ante la muerte en el ámbito de enfermería.

- Propuestas de etiquetas diagnósticas de enfermería para el cuidado de las personas al final de la vida (ansiedad ante la muerte, temor al proceso de morir…)

- Análisis y evaluación de las estrategias pedagógicas más convenientes para desarrollar competencias emocionales, habilidades comunicativas, pensamiento crítico y resolución de problemas en el curriculum de enfermería.

- Extensión de la evaluación de las habilidades socioemocionales y comunicativas en otros profesionales de la salud como los psicólogos y los médicos.

6.
RELEVANCIA CIENTÍFICA DE LOS TRABAJOS REALIZADOS

El estudio de la inteligencia Emocional, especialmente en el contexto de la enfermería, y su relación con otras variables han dado lugar a otros trabajos publicados, conferencias y comunicaciones a congresos. Destacar que además de los estudios en Enfermería, también se han llevado a cabo estudios con otras muestras, principalmente de estudiantes en Psicología. Asimismo, se han realizado trabajos relacionados con la docencia y la divulgación de habilidades emocionales.

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8.
ABREVIATURAS

IE	Inteligencia Emocional
IEP	Inteligencia Emocional Percibida
DAI-R	Death Anxiety Inventory - Revised
TMMS-24	Trait Meta-Mood Scale - 24
DAS	Death Anxiety Scale
DDS-R	Death Depression Scale - Revised
CLFDS	Collet – Lester Fear of Death Scale
DOS	Death Obsession Scale
SDS	Zung Self – Rating Depression Scale
STAI-T	State-Trait Anxiety Inventory - Trait
TAS	Toronto Alexithymia Scale
RSES	Rosenberg Self-Esteem Scale
AFC	Análisis Factorial Confirmatorio

9.
ANEXOS

ANNEXO 1.

Documento aceptación del artículo del Journal Of Clinical Nursing

Manuscript Accepted - Updates Approved JCN-2012-0489.R1 [email ref: ENR-AW-1-e]

De : jcn@wiley.com vie, 04 de ene de 2013 17:31

Remitente : onbehalfof+jcn+wiley com <onbehalfof+jcn+wiley.com@manuscriptcentral.com>

Asunto : Manuscript Accepted - Updates Approved JCN-2012-0489.R1 [email ref: ENR-AW-1-e]

Para : amor aradilla <amor.aradilla@eug.es>, amor aradilla <amor.aradilla@gmail.com>

04-Jan-2013

Dear Mrs. Aradilla-Herrero:

Manuscript id: JCN-2012-0489.R1

The final files that you submitted for your manuscript have been checked and have been found to be suitable for publication and so will be forwarded to the publisher shortly.

Sincerely,
Journal of Clinical Nursing Editorial Office

ANNEXO 2.

Documento de revisión del artículo del Nurse Education Today

A manuscript number has been assigned: NET-D-13-00119

De : Nurse Education Today <jtyldsley@jtyldsley.karoo.co.uk> jue, 14 de feb de 2013 12:45

Remitente : ees net 0 1f3e48 1cce64ed <ees.net.0.1f3e48.1cce64ed@eesmail.elsevier.com>

Asunto : A manuscript number has been assigned: NET-D-13-00119

Para : amor aradilla <amor.aradilla@gmail.com>, amor aradilla <amor.aradilla@eug.es>

Ms. Ref. No.: NET-D-13-00119
Title: Emotional intelligence, depression and suicide risk among nursing students
Nurse Education Today

Dear Ms. Amor Aradilla-Herrero,

Your submission entitled "Emotional intelligence, depression and suicide risk among nursing students" has been assigned the following manuscript number: NET-D-13-00119.

You may check on the progress of your paper by logging on to the Elsevier Editorial System as an author. The URL is http://ees.elsevier.com/net/.

Your username is: amor.aradilla@gmail.com
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Thank you for submitting your work to this journal.

Kind regards,

Jill Tyldsley
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Your submission NET-D-13-00119

De : Nurse Education Today <jtyldsley@jtyldsley.karoo.co.uk> mié, 20 de mar de 2013 17:08

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Asunto : Your submission NET-D-13-00119

Para : amor aradilla <amor.aradilla@gmail.com>, amor aradilla <amor.aradilla@eug.es>

Ms. Ref. No.: NET-D-13-00119
Title: Emotional intelligence, depression and suicide risk among nursing students
Nurse Education Today

Dear Amor,

Thank you for submitting your article to Nurse Education Today for consideration. Reviewers have now commented on your paper and are advising revision. If you are prepared to undertake the work required, I would be pleased to reconsider the paper.

Reviewer comments are appended below for your information and guidance. Please submit a table/list of changes (or a rebuttal) against each point raised when you submit your revised article and upload this as your 'Response to Reviewers' file/doc. The table should contain the following column headings: (1) Reviewer Comment, (2) Author Response to Comment, (3) Changes made to article, (4) Page number. Also please highlight any revised text using coloured highlighting.

We prefer to receive resubmissions within 60 days if possible, if this is a problem can you please let us know. To submit a revision, please go to http://ees.elsevier.com/net/ and login as an Author.

Your username is: amor.aradilla@gmail.com
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On your Main Menu page is a folder entitled "Submissions Needing Revision". You will find your submission record there - any queries please contact the editorial office.

Regards,

Prof William Lauder
Editor in Chief

On behalf of the Editor:

Jill Tyldsley
Receiving Ed/Office
Nurse Education Today