Research Paper

The Support Role in Clinical Supervision of Nursing Students: Determinant in the Development of Emotional Skills

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ABSTRACT

The problematic situation faced by clients, associated to the processes of health and disease, is expressed through emotions that nursing students have to deal with in the course of care and their formative experiences in clinical teaching. Students have learning needs not only to manage emotions in the context of customer care, but also in terms of their own internal world, emotional conflicts, emotional stress and burn-out. With the present literature review, we intend to explore existing evidence regarding the ways in which the nurse supervisor's support towards nursing students potentiates the development of their competences for the performance of emotional labour. These skills prove to be the key in the ability to manage the emotionally intense situations of care practice and the support function of the nursing supervisor contributes to the development of such competences.

Key words: Clinical supervision, emotional skills, emotional labour, clinical teaching in nursing.

INTRODUCTION

Clinical supervision in nursing is decisive in the academic career of nursing students, regarding the specific clinical education. For this reason, the visibility of this in the curricula is privileged in a carefully planned process studied over the years. The possibility of contact with the reality of care in its different dimensions and the complex richness of the problems associated with the actions / interactions inevitably experienced in different clinical settings is part of the core of desired goals for growth and learning of nursing students. But as these experiences are essential and rich, they are also connoted by a strong affective and emotional dimension, whose intensity may lead to a disturbing and negative impact for the student. Nurse supervisor is in a privileged position to provide adequate support, through different interventions, aimed to positively transform the intense and disturbing experiences of customers and students / nurses, with the intention to promote a global well-being for all the people involved.

MATERIALS AND METHODS

In this literature review we resort to various scientific data bases – Scielo, CINAHL, Medline and EBSCO – and define them as research keywords: "Clinical Supervision", "Emotional Skills", "Emotional Labour", Clinical Teaching", "Nursing" and "Emotion". In addition, studies from Portuguese and English clinical supervision reference authors such as Wilson Abreu and Brigid Proctor as well as, works regarding the emotional dimension in nursing such as Pam Smith's were consulted. The comparative, descriptive and comprehensive analysis methodology was also used.

RESULTS AND DISCUSSION

Nursing student's supervision

Supervision in nursing incorporates an essential theme for discipline, as an essentially practical science. It is characterized as a key tool to develop the quality of nursing care (Walsh et al., 2003; Hancox et al., 2004; Edwards et al., 2005) that involves a focused process of reflection on, for and about the practice, aiming its improvement and achieving greater health gains (Cruz, 2008). Although in the literature, there are multiple definitions of this concept, the acquisition and development of professional skills and improving the quality of care provided to clients emerged as the primary objectives during its approach (Clough, 2003; Garrido, 2004).

Although, the clinical supervision in nursing is focused primarily on the supervision of the professional practice in nursing, this concept is extended to the period of scholastic formation (Abreu, 2003; Silva et al., 2011) and how it should "move towards an individualization of the teaching / learning process in order to contribute to "the full development of the person - mind and body, intelligence, sensitivity, aesthetic sense, personal responsibility and spirituality" (Delors et al., 2010: 99). Similarly, the health metaparadigm associated with Jean Watson's theory (2002) stresses the importance of "totality of the individual nature in its physical, social, aesthetic and moral domain" (Watson, 2002: 86), framing the nurse and the client in a dynamic where "both are in the process of being and becoming" (Watson, 2002: 104) determined by the current transformation paradigm in the philosophy of nursing care. This attention to the uniqueness of the individual means developing personal, relational, social and affective competences open the door to the cognitive and technical skills (Rabiais, 2010: 45). The same author points out that a complementarity between emotional and cognitive aspects is sought at the heart of supervision, which cannot be seen in an isolated manner, despite having a narrow degree of interdependence. At the same time, recent studies show that every rational system has an emotional foundation" (Silva et al., 2006: 617).

The clinical context fits the students in the nursing care reality confronting them "with diverse experience, giving them the chance to understand that there is no overlap between reason and emotion, to find out different aspects of their own self, their relationship with each other and with the world, and have the ability to plan intervention methodologies in order to encourage the psychological, social and cultural development" (Rabiais, 2010: 50-51). The learning context facilitates (Alarcão and Rua, 2005):
- Contact with the practice (in its predictability and unpredictability);
- The mobilization, integrated and contextualized in different knowledge selected according to their relevance;
- The way towards professional identity.

The formative dimensions of clinical teaching which must be present in the formative contexts are divided into 14 dimensions, "Realistic, Technical, Interactive, Analytics, Reflective, Interdisciplinary, Integrative, Projective, Holistic, Metapraxeological, Metacognitive, Constructivist, Prospective and Selective" (Alarcão and Rua, 2005: 377). The integration and socialization of students to the context leads to learning "practical nursing, so as to facilitate future market integration through the organization's operating rules" (Silva and Silva, 2004: 103). Associated with this social integration are competences derived from this experience, such as "teamwork, individual work organization, interpersonal relationships, sharing responsibilities, learn to learn from new situations, communication and the individual or group decision towards new situations "(Silva and Silva, 2004: 103). The clinical education contributes to the socialization of nursing student a complex process that allows the development of knowledge, habits and professional identity (he/she learns and thinks as a nurse) and is also a way to develop values" (Simões et al., 2008: 93).

The atmosphere that surrounds the training context contributes to the promotion of "trust and responsibility in the students inherent to the adequacy of training situations, their learning styles and training needs" (Mestrinho, 2004: 10). The context where care and learning moments occur is another aspect stressed by Mestrinho (2004: 9); this constrains or promotes the development of competences for the nursing care assisted by a work team in close proximity between nurses and teachers which naturally makes it easier in the dynamics of the training process in partnership." The importance of context for the development of skills in the nurse is widely reinforced by Serrano et al. (2011).

Each context implies the mobilization of different skills, including cognitive, affective, aesthetic and reflective. Having regard to the development of these skills, Benner (2001) recognizes the importance for nurses to fit in a context in order to participate in a number of experiences that allow them to "take ownership of such an amount of knowledge, becoming capable of understanding, interpreting and responding to the needs of patients with flexibility and intelligence "(Benner, 2001: 204, 207). This domain and deep knowledge of the context and its specific issues is recognized as essential for the nurse, to be a vehicle of knowledge and clinical experience to transmit to students (Benner, 2001).

The reflective practice in clinical supervision of students

Highlighting the reflective practice aims at structuring thinking, while guiding and justifying the action. Schon (1983:16), cited by Cruz (2008: 201), underlines this practice as primordial, which includes "situations in which the student can practice under the supervision of a

competent professional that is simultaneously the supervisor, advisor (coach) and companion, integrating and helping to understand reality which, given its unknown nature is presented to him/her initially in the form of chaos (*mess*)". Thus, not only the intrinsic values of the practice are defined, but the student is also introduced to an orientation paradigm based "on the reflection on and about practice" (Mestrinho, 2004: 10). Thus, not only the intrinsic values of the profession are defined, but an orientation philosophy based in the same reflection on and about the practice is also instilled in the student (Mestrinho, 2004: 10). Specifically regarding the "reflection in action", Ferreira (2004: 129) stresses once more the importance of the care context, which occurs during practice and influences the decisions taken and the care provided. Zeichner (1993) supports the importance of practice based on reflection as a process of critical analysis in the formation process, combined with professional experience and emphasizes concurrently the "reflection, process of reflection and the action of reflection" (Mestrinho, 2004: 10). The reflective practice is thus revealed as an important tool through which students express personal and professional projects as a contact with new social realities through lived experiences (Mestrinho, 2004: 10).

Other determinants factors of students' clinical supervision

The pace of learning both deep and superficial when managed through the critical reflection process promotes a learning situation that is transformative for the student (Freshwater and Stickley, 2004: 95). Time management is considered by students an element that affects the quality of learning. Students recognize that the major constraint affecting the quality of support given by the nurse supervisor is the limited time available to devote to this function (Terry and Carroll, 2008; Gidman et al., 2011). Corroborating this aspect, Simões et al. (2008: 106) show in their study the lack of teachers and time. This concluded that "the service overload leads to a deficient supervision making it easier to do than to help and guide students' actions. The lack of support and inability to ask immediate questions are referred as a result of the lack of time that nurses face in their shifts "(Simões et al., 2008: 106). The environment in which learning takes place also needs to be enhanced in order to provide a reliable configuration and support in which students feel safe to explore their feelings and express their views (Rogers, 1969 cited by McQueen, 2004: 106).

Emotional skills of nursing students in clinical education

The nursing education according to Rabiais (2010: 36)

should not be confined to technical and scientific process, but also highlight the personal development of the student by the generator role it has in all skills, particularly, in relational skills". So, one cannot separate the cognitive, social, affective and emotional dimensions when trying to clarify the factors that underlie the development of learning in nursing care.

In addition, the emotions are an essential dimension not only for the nursing care provider, but also for the student who seeks success in a turbulent tangle of experiences, thoughts and emotions that he/she needs to learn how to manage. Analyzing the process of care as an impregnated relational process of emotions and feelings like other relational processes (Goleman, 2011) is an attractive horizon because the emotional experience is omnipresent in every act of caring.

Working with emotions is inherent to professional performance, which justifies the awareness to use them in the relationship with the customer, making it important to understand how nurses should approach and develop the human experience of 'feel' as an instrument of care (Diogo, 2006). Emotions are felt and help guiding the action of the nurse, expressing the intentionality in care. From the theoretical perspective of Jean Watson (2002), emotions are a key element in the nurse's connection with self (body and soul) of caregivers. This relationship appears to be a rich experience for both parties in which all grow and learn with each other. Thus, nursing care falls into a "process of taking care of human-to-human" (Watson, 2002: 69).

Damásio (2012) argued that emotional development is an integral part of the decision-making process and works as a vector for actions and ideas, consolidating the reflection and discernment. In fact, without an emotional involvement, any action, idea or decision would be based solely on a rational basis. Therefore, the emotional involvement is a concept closely linked to nursing care characterized by sensitivity of the nurse to the client's emotional needs (Morse et al., 2006). The same authors pointed out that the nurse, as an entity who cares for and is close to the customer shares experience of suffering with their clients. Although not being absent from this fact, the nurse plays an important role in relieving suffering through interventions dependent on how he/she stands emotionally (focused on themselves or on the client).

It is in the daily care of the various clinical settings that the nursing student is in touch with clients and their families, establishing a relationship that determines the mobilization of emotions which may be a source of discomfort. Specifically, at the customer care end of life, students revealed an increased need for emotional support (Terry and Carroll, 2008). These experiences generate feelings of powerlessness in the student regarding their performance leading to difficulties in managing their emotions often mirrored in feelings of abandonment and guilt (Terry and Carroll, 2008). The disclosure of these feelings underlines the importance of the nurse

supervisors and emotional support elements in situations that are emotionally intense for the student (Terry and Carroll, 2008).

In clinical supervision, monitoring the student's emotional needs is the key, in which the nurse supervisor becomes the closest element to the student and sensitive to such needs (Por et al., 2011), also being aware that emotional challenges cannot be restricted to customer relationships, but can also arise with colleagues and the immediate families of clients (McQueen, 2004: 106).

Clinical supervision has a range that extends to the development of emotional competences. Goleman (1999: 38) defines emotional competence as an "acquired capability based on emotional intelligence." Mayer and Salovey (1997) present a model referring to the four dimensions of emotional intelligence [EI]: the perception of emotion, integration and assimilation of emotion, knowledge about emotions and managing emotions.

Emotional intelligence refers then to the ability to manage feelings and emotions on a personal level and in social relations. These involve five dimensions regarding the personal development; the dimensions would be self perception, motivation, and self-regulation at the interpersonal level, empathy and social skills. The emotionally intelligent nurse is one who can act in harmony with thoughts and feelings (Freshwater and Stickley, 2004). Emotional intelligence still plays an important role in building human relationships of success (McQueen, 2004: 101). Students who have higher EI levels (scale for assessing emotional intelligence) have lower levels of stress and anxiety, since they can manage their emotions and find ways to actively canalize these emotions to sources of emotional support, as coping mechanisms or seeking social support when faced with problems (Por et al., 2011). The same authors stress the importance of monitoring the emotional needs of students in carrying out their tasks, among these training directed to the recognition and management of emotions of self and others, but also the existence of adequate supervision during clinical teachings recommended in their training where many of the events triggered at this stage are of great emotional intensity (Por et al., 2011).

With regard to self-perception in the context of clinical practice, the nursing student absorbs and experiences the problems of people who care in a particular way through emotional empathy leaving them sometimes to take care of himself/ herself. However, it is essential to acquire a perception of himself/ herself as a bio-psycho-social and spiritual person, as it will help him/her to identify and develop the capacity to understand the needs and suffering of others and simultaneously differentiate their experiences (Rabiais, 2010: 38).

Learning the emotional labour in clinical education

In this process, emotional labour assumes outstanding

value. The first studies regarding the concept of emotional labor in nursing was published in the 90s. This concept integrates different focus and a variety of similar concepts (Smith and Hunter, 2007; Huynh et al., 2008). The sociologist, Hochschild (1983: 36), applying the concept of emotional labour to various professions, described it as the "induction or suppression of feelings to maintain an outward appearance that results in the care of the feelings of others and providing a safe environment". According to the researcher, the professional attitude imposed to deal with many negative tones of emotions arises as a source of internal conflict and emotional exhaustion. Pam (1992), a pioneer in the study of the emotional labour in nursing, argued that this is directed to both professionals and customer care. Students / nurses must learn to manage their emotions and customers' emotions; a double centrality of emotional labor.

On the other hand, the author identifies the components of emotional labour in nursing as: support and tranquility, gentleness and kindness, sympathy, cheer, use humor, being nice and patient, alleviate suffering, compassion, knowing the customer and help solve their problems.

Pam (1992) also found that emotional labour has the following characteristics: the contact face-to-face or voice to people; producing an emotional state on the other person; the presence of a degree of control over the emotional labour activities through training and clinical supervision. Smith (1992), who studied about how nursing students learn emotional labour suggested that these competences are mostly learned informally in the workplace and less in the training context, as such students learn to manage emotions adopting an adequate approach to the task in nursing care. The author also defends that emotional labour has a specialized nature that has to be learned in the same way as competences related to "physical care". Thus, Smith emphasizes not only the learning of emotions management, but also the emotional labour components in nursing care.

The performance of emotional labour in nursing is based on the conceptual complexity of human care, particularly, in its specificities and emotional components (Smith, 1992; Smith and Gray, 2001: 231). Emotional labour incorporates actions / interactions included in the process of care, affective and emotional dimension, positively transforming the intense and disturbing experiences of customers and students / nurses themselves with the intention to promote the global well being of the people involved (Diogo, 2015). Examples of the importance of this transformation in the affective and emotional dimensions are: the recognition of clients' emotions and acting in accordance with them individualizing care. Caeiro and Diogo (2014) proposed an algorithm that reflects the adequacy of interventions with hospitalized adolescent; the emotionally upsetting experience for the teenager and the actions / interactions that help in the management of such emotional experiences.

Despite the recognized importance of emotional labour

in therapeutic intervention in nursing, it is necessary to take into account that prolonged and intense, and if there is no room for the management of experienced emotionality may cause burn-out (McQueen, 2004). To prevent this, nurses must adopt strategies to protect their health and promote their emotional balance, including the introduction of EI in nursing curricula, as well as, in recruitment in order to improve the understanding of each other and others, as well as, the development of skills, particularly with regard to self-knowledge, self-regulation and social skills (McQueen, 2004: 106).

Several other authors add that a curriculum which addresses the emotional intelligence learning aspects incorporates reflection on the lessons learned and supervision, based on the support function; availability features for creative work in conjunction with other sciences, including art and humanities, focused on self-knowledge, in relations based on dialogue, fostering empathy and investment in emotional competence. Supervisors and teachers as elements that already dominate the context of care and its singular experience play a central role in nursing students' learning, in particular the involvement of emotional labour and their development as nurses (Smith and Gray 2001: 231).

Interestingly, students resort to emotional labour so that the relationship with the nurse supervisor arises in harmony, because they rely on this relationship for the success of their clinical training. They try to trigger a particular emotional state in the nurse supervisor, using features that seek to convey enthusiasm and confidence (Webb and Shakespeare, 2008).

The response from the nurse supervisor to the needs / emotional instability of students, seeks to prevent emotional stress, which if not timely detected can result in inadequate coping mechanisms that may question emotional stability and development of competence (Terry and Carroll, 2008). The concept of emotional empathy (Morse et al., 2006) is based on vigilant sensitivity (Diogo, 2015), which is characterized by the nurse's ability to understand the emotional experiences of others and also intentionally feel that understanding.

In a nutshell, the development of emotional competences proves to be crucial in the ability to manage emotionally intense situations from the nursing practice and the nurse supervisor's support function may influence the development of these competences.

Nurse supervisor support function

As there are endless clinical supervision definitions, there are also numerous models of clinical supervision in nursing which may fall into at least four theoretical perspectives, particularly those that emphasize: the development, the functions of clinical supervision in practice; the relationship of clinical supervision; the relationship with customers (Hyrkäs, 2002). Let us focus

on the roles of clinical supervision in practice. Proctor (1986) suggested an interactive model of three functions:

1) *Formative***:** Related to the development of knowledge and competences through reflection, labour exploitation and experience of supervised;
2) *Normative***:** Regarding responsibility and job satisfaction, which includes actions for the development of safety, quality and management (Winstanley and White, 2003);
3) *Support***:** Focused on emotional responses and the need to support functions and responsibilities inherent to context demands, that is, focused on supporting actions and supervised responses with the view not only to the reduction of stress, but also to support appropriate emotions in particular situations (Winstanley and White, 2003; Abreu, 2007; Cruz, 2008).

Note that in addition to the Proctor model, other models fit the support as a function of the operations which play an essential role in the perception of students as successful (Sloan and Watson, 2001). As for the relationship features built in the clinical supervision process, it highlights two major styles of approach:

- *Authoritative:* This is related to the supervisor's assertiveness regarding supervised actions. In turn, this style is divided into three: prescriptive (the supervisor gives advice directly to the supervised and explicitly directs their behavior); informative (the supervisor gives information and instruction to the supervised); confrontational (the supervisor is face to face with the supervised in order to clarify and challenge their attitudes and simultaneously to give immediate feedback).
- *Facilitator***:** This is less directive and authoritative and is related to gradual information being provided to the supervised. This style is also divided into three: cathartic (the supervisor appreciates the necessity of students to express their emotions (Abreu, 2007: 163), thereby reducing the tension of supervised); Catalytic (the supervisor encourages the student to reflect on certain areas or significant experiences (Abreu, 2007: 163), by stimulating to be self directed and reflective); support (the supervisor tends to emphasize the personal dimensions and to promote security of the supervised (Abreu, 2007: 163), so in this way confirms and validates their value and merit).

Severinsson's model (2001) revealed a perspective that focuses on the relationship of those involved in supervision directed to the "support for the development of the supervised in their professional identity, competence, skills and ethics" (Cruz, 2008: 203). To this end, as the same author highlights "this model is based on three basic premises: confirmation, giving meaning and self-awareness, emphasis is given on responsibility and the competence of the supervisor to establish the key concepts in the clinical supervision process. Knowledge and values related to care are transformed and seized during the

development of this process" (Cruz, 2008: 203).

In a nutshell, regarding the clinical supervision models, the proposals are varied, but one of the central aspects in relation to this concept is that the various actors in the supervisory process should agree which the supervision model to give the best answer to their needs (Garrido, 2004). Abreu (2002: 55) emphasizes that in most models, there are two fundamental assumptions: "the recognition of the profession maturity, allowing having a critical view, as a signal of exigency and responsibility; the recognition that staff and students are victims and live potentially aggressive situations for their psychological integrity". The established relationship among different participants is an essential factor in learning where caring is learned through close relations established between the "Professor", the student and the client, in which all actively participate (Morcom and Hughes 1996; Rabiais, 2010). However, the authors stress that the main factors that facilitate learning are:

- The value of their feelings;
- The appreciation of stress;
- The valuation of anxiety;
- The opportunity to express their concerns and opinions;
- The support given by teachers.

However, to do so, the supervisor nurse must be aware of his/her own self-knowledge and expertise which will be appropriately mobilized to the training context under the form of clinical teaching. The adequate use of the self represents the essence of a supervisor, who ensures that the student not only achieves their training goals, but also promotes a rich and balanced path, presenting challenges to the student, but also allows them to find room for reflection and the construction of his/her own way supervised by nurses (Wilson, 2013).

Body language is highlighted in the study by Wilson (2013), having a great impact on the emotions experienced by students. The voice tone, facial expressions and body mechanics such as gestures convey a message or judgment that is understood and interpreted by the student. Supervision training programs should point out the importance of identifying and managing emotions, not only by nurses but also how they can be a key element to help students identify and manage their emotions framed in its support function and the emotional labour in nursing care (Wilson, 2013). This mobilization of self as a formative instrument conjures up the nurse's responsibility to be sensitive to his/her surroundings, adapting custom behaviors to give and receive answers between two people (nurses and others). These behaviors include the human transactions of care that nurses only make use of self through movements, senses, touch, sounds, words, colors that transmit and reflect the person's condition" (Watson, 2002: 103). This transaction helps to restore inner harmony, while also helping the client and the nurse to find a meaning in the experience (Watson, 2002).

The motivation of the nurse supervisor is crucial to the success of clinical teaching (Gidman et al., 2011; Wilson, 2013). This works as a vector for the nurse who cares and generates interest in the formation of the student, looking to integrate the supervised in the care team and reveal enthusiasm, availability and commitment to their support and training needs.

Students expect supervisor nurses to help them in their development as future professionals, as well as, a supporting element in their practice (Gidman et al., 2011). Expectations regarding the profile of nurses in this study are similar to the attributes founded by Smith and Gray (2001). As present supervisor, the ability to recognize and act on the student's emotional state is emphasized as a characteristic inherent to a "good mentor" (Smith and Gray, 2001; Webb and Shakespeare, 2008). The discussion about the experiences and reflection on practice is also referenced as a positive aspect for the management of emotions (Smith and Gray, 2001; Mestrinho, 2004; Terry and Carroll, 2008).

The importance of a supervisor is to watch over student's emotional needs in the care context (Webb and Shakespeare, 2008). The supervisor should have a training directed to the recognition and management of emotions of self and others, but also the appropriate supervision during clinical teaching is recommended in its formation, where many of the events that are triggered at this stage are full of great emotional intensity (Por et al., 2011).

One of the competencies identified by Mestrinho (2004: 10) refers to the "support and referral; how to listen and provide frameworks; express positive expectations; be defender; share and become special". According to Reid (1994), cited by Mestrinho (2004: 10), the need to ensure that the objectives are needed and framed for that clinical teaching context allows anticipating experiences and emphasizing skills that should be developed in the practice of nursing care. These are:

- Discuss and maximize resources and required strategies for learning;
- Planning the training experiences to promote the gradual development of skills by students;
- Encouraging self-evaluation and reviewing the formative objectives, ensuring which ones are suitable and can be achieved by each of the students;
- Identify and assure learning opportunities that enable the student to reflect about their experiences;
- Encourage students reminding them of their experiences through recorded critical incidents and resort to teachers / tutors to validate learning situations, whenever necessary".

The support supervision and the emotional labour in nursing

The emotional labour is an essential dimension in nursing aimed to the human care (Watson, 2002). It not only fits

the care provided by nurses in their daily lives, but also in the training aspect, increasing the quality of training when the supervisor support function is included. Edvardsson et al. (2008) pointed out that "when the emotional labour is supported by the working conditions and the nursing team is encouraged to work enhancing their strengths and areas of expertise, nurses feel better, morals of staff increases and the capacity to face the challenges of their role becomes higher (Maunder 2008: 49). Nurses constitute a model for the student and care should mirror a philosophy based on the report of McQueen (2004: 107) which states:

1) Good relationships with customers and understanding of their needs in order to be able to ensure quality care;
2) Working with emotional involvement and closeness to promote affective relationships with customers;
3) Emotional intelligence which is valuable in interpersonal relationships.

Smith and Gray (2001: 232-233) developed a study in which the emotional labour is regarded as a nursing intervention and a learning component in expert nurses and nursing students. From this study, a definition developed by students which distinguishes the characteristics of "good" and "bad" mentor arose. The good mentor is particularly useful in organizing reflection about the emotional labour (Williams, 1999, cited by Smith and Gray, 2001) and facilitates the transitions inherent to the emotional experiences. The "bad mentor" has limitations similar to the model of the toxic mentor identified by Darling (1985), cited by Smith and Grey (2001). In particular, toxic mentors tend not to facilitate learning; hence, students develop weak nursing competences.

Students also have some features that nurses identify as "ideal"; they highlight the enthusiasm that works as a vector of motivation to the nurse himself/herself. The attitude towards verbal and non-verbal posture as well as, confidence and assertiveness are aspects that are valued by nurses, however, it should be balanced, since overconfidence may also be harmful to their development (Webb and Shakespeare, 2008). The relationship between participants is analyzed from the perspective of positive or negative feedback that is given by the nurse, even by judgments that could be formed, impacting the student evaluation or performance. This relationship may also have negative contours when nurses inappropriately view the student as an extra team member or delegate to him/her tasks that belong to operational assistants (Webb and Shakespeare, 2008).

In a nutshell, according to Smith and Gray (2001), it is relevant to:

1) Provide a symbolic and operational link between practice and education; promote reflective learning which raises the discussion about emotional labour; share nursing experiences, communicate and listen to the nursing students; encourage students to learn from stories and personal experiences; promote informal relationships and support among health professionals, nurse supervisors, customers and students;
2) The emotional labour is often implicit in clinical and non-clinical settings; the relevance of maintaining this aspect by teachers and mentors needs to be recognized;
3) The importance of oral tradition is confirmed in promoting reflection and revelation of stories to describe the content and the emotional labour process;
4) The emotional labour is described as part of the nursing intervention in customer care, which ensures the proper functioning of the ward.

Conclusions

There are many contributions on scientific evidence that allows us to establish a connection between the support function, closely related to the emotional labour in nursing and how this influences the emotional experience of care experienced by the student. Consequently, as this determines the development of competences, particularly emotional competences, it influences the student growth as a future nurse. However, the support function specifically needs to be deepened, resulting in the need to outline a project to clarify and explain the effect of the nurse supervisor support function in the development of emotional competences in nursing students in clinical teaching.

This research project is under development, making this literature review an integral part, also aiming at responding and highlighting the importance of research as a crucial connecting factor between theory and practice in nursing education. It explores the hypothesis that the development of emotional competences in nursing students proves to be crucial in the ability to manage emotionally intense situations in clinical education and nurse supervisor support function may influence the development of these competences.

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