Cathrine Bang Hellum

Tacit competencies in the Emergency Department

A Q-methodological study into how nurses in the Emergency Department experience the use of reflection in relation to empathy and emotional awareness in their practice

Master of Science in Counselling
Trondheim
Spring 2016

Advisor
Camilla Fikse

Department of Education and Lifelong Learning
Faculty of Social Sciences and Technology Management
NTNU, Norwegian University of Science and Technology

Front page illustration by Jannike Dohrn Dyrhaug

Abstract

Nursing is an education than can be put in to use in a myriad of different jobs and work arenas. This diversity also means that there are many different conditions, perspectives, preferences, cultures and dispositions for nurses' practice. The purpose of this study is to better understand nurses in the emergency department and their relationship to some of the tacit competencies in their work. The research question is: *How do nurses experience the use of reflection in relation to empathy and emotional awareness in their practice in the emergency department?*

The study is based on Q-methodology and has 20 participants sorting 36 statements in relation to the three effects; reflection, empathy and emotional awareness. The participants are all nurses in an emergency department at a university hospital. The statements are sorted in an inverted pyramid pattern from agreeing (+5) to disagreeing (-5).

The participants' sorting go through a factor analysis program resulting in three factors, which through interpretation are named; (F1) All about the patient, (F2) Independent, automated and with emotional distance, (F3) Reflecting in action and keeping on top of the affective. The factors are discussed in light of different learning theories, skills acquisition, empathy and self-awareness.

The study reveals that the nurses differ in the way they use reflection in their practice. Factor 1 seems to be novice nurses and use different reflective modes, while Factor 3 nurses fit the concept of expert nurses, using reflection during action and are highly intuitive in their approach. Factor 2 nurses stand out compared to Factor 1 and 3, as they are more focused on procedures and the automated actions, and have no distinct mode of reflection. Factor 2 nurses are more emotionally distanced and do not recognize colleagues as reflective partners, contrary to Factor 1 that emphasize relational closeness and Factor 3 that recognize the importance of emotional labour and adapting to the patient's needs.

In conclusion, given the large differences in modes of reflection and strategies concerning emotional awareness and empathy, training and further education for the nurses in the ED would benefit from being more individualized and adapted to their particular needs.

Sammendrag

Sykepleie er en utdannelse som kan benyttes på i mange ulike jobber og på ulike jobbarenaer. Dette mangfoldet betyr også at det finnes ulike forhold, perspektiver, preferanser, kulturer og karakterer som påvirker en sykepleiers praksis. Hensikten med studien er å få en bedre forståelse av sykepleiere I akuttmottaket og deres forhold til noen av arbeidets tause kompetanser. Forskningsspørsmålet er: *Hvordan opplever sykepleierne refleksjon i relasjon til empati og emosjonell tilstedeværelse i deres yrkespraksis i akuttmottaket?*

Studien er basert på Q-metodologi og har 20 deltakere som sorterer 36 utsagn som omfatter de tre effektene; refleksjon, empati og emosjonell tilstedeværelse. Deltakerne jobber alle som sykepleiere i et akuttmottak på et universitetssykehus. Påstandene er sortert i et opp-ned pyramidemønster fra enig (+5) til uenig (-5).

Deltakernes sorteringer blir så faktoranalysert i et dataprogram som gav tre faktorer som gjennom videre tolkning ble gitt navnene; (F1) Pasienten i fokus, (F2) Uavhengig, automatisert og med emosjonell distanse, (F3) Refleksjon-i-handling og å ha kontroll med det affektive. Faktorsynene blir diskutert med bakgrunn i ulike læringsteorier, empati og selv-bevissthet.

Studien viser at sykepleierne bruker refleksjon på distinkt ulike måter i jobben sin. Faktor 1 ser ut til å være ferske sykepleiere og bruker flere ulike refleksjonsmetoder, mens Faktor 3 sykepleiere passer inn i konseptet ekspertsykepleiere. De bruker refleksjon-i-handling og er meget intuitive i deres tilnærming til faget. Faktor 2 sykepleiere skiller seg ut i forhold til Faktor 1 og Faktor 3, da de er mer fokusert på prosedyrer og automatiske handlinger. De har heller ingen spesifikke metoder for refleksjon. Faktor 2 sykepleiere er mer emosjonelt distansert og anerkjenner ikke kollegaene sine som refleksjonspartnere, i motsetning til Faktor 1, som vektlegger relasjonell nærhet og Faktor 3 som fremhever viktigheten av emosjonelt arbeid og å tilpasse seg pasientens ønsker og behov.

For å konkludere, gitt de store ulikhetene i refleksjonsmodus og strategier i relasjon til emosjonell tilstedeværelse og empati, så ser det ut til at trening og videreutdanning for sykepleiere i akuttmottaket burde være mer individualisert og tilpasset deres ulike behov.

Acknowledgements

I consider this master thesis not to be an ending point of my years within the educational system, but rather another starting point for my continuing education and development, both professionally and personally. My thesis work has been a side project in my very full and active life, taking time to mature as I myself has grown as a professional. My biggest challenge has been to limit my scope and focus on answering my research question, rather than to dive into the world of counselling as I have found it unfolding before me.

Doing this research, I have challenged my own prejudices and preconceived notions, both as a nurse and as a colleague. I have challenged myself in using my second language, English, in writing the thesis. Due to a maternity leave, I postponed my thesis work, and ended up working without the support of fellow students and on the outskirts of the faculty. I have also been fully employed as a nurse and lately as a humanist hospital chaplain during the whole period of the master. I can honestly say I have not made this project easy for myself.

Albeit the work of course have been done on my own, it is particularly important for me to show gratitude and honor to those who have lifted me up, supported, sacrificed, challenged, picked on, read and corrected, and served as pure inspirational sources in my work. Many thanks to my advisor, Camilla Fikse, who has kept her door open to me, for years. I am grateful to my colleagues in the Mottaksavdelingen in St. Olav's Hospital, for supplying my data, for nighttime reflections and for showing me the diversities in good nursing. My amazing colleagues in the Hospital Chaplaincy also ought to be praised, for stimulating, motivating and expecting the very best of me.

To my five children, for putting up with all the nights mummy was at her desk, and of course my fantastic, one of a kind husband, Bent Hellum. He matches me in all areas of life except for in area of science, yet is still able to challenge me, counsel me when I am stuck, kick start me when I am down and to give me the time and strength needed to finish the job.

I am grateful for every one of you, and for all the different parts you play in my life!

Cathrine, May 2016

Table of Content

Abstract iii

Sammendrag v

Acknowledgements vii

Table of Content ix

List of tables and figures xii

1 Introduction 1

1.1. My background and history 1

1.2. Motivation and choice of thesis 1

1.3. Relevance to the field of nursing as well as counseling 2

1.4. Limitations and definitions 3

1.5. The thesis structure 4

2 Theory 5

2.1 Empathy 5

2.1.1 The word and concept 5

2.1.2 The mystical approach 6

2.1.3 The structural approach 6

2.1.4 Distinction between the affective and cognitive 7

2.1.5 The clinician and health worker 8

2.1.6 Teaching and strengthening 8

2.2 Emotional awareness 9

2.2.1 Self-awareness, meta-awareness and developing a witness-self 9

2.2.2 Distance and closeness 10

2.3 Reflection 10

2.3.1 Definitions of reflection and the temporal axis 11

2.3.2 Reflection on action in retrospect - Experiential Learning Model 11

2.3.3 Reflection in action, in preparation to the act and the reflective practitioner 12
2.3.4 Reflecting to learn a skill, “from novice to expert” 13
2.3.5 Intuition 14
3 Method 17
3.1 Q-methodology background and suitability 17
3.2 Concourse – the communication universe 17
3.3 Fisher plot - block design 18
3.4 Testing the quality of the design 19
3.5 Participants - The P-set 20
3.6 Recruiting 20
3.7 Collecting 20
3.8 Material 21
3.9 A possible sorting of demographic groups 21
3.10 The computer analysis program 22
3.11 The interpretation and principle of abduction 23
3.12 Quality of the study 23
3.13 Ethical considerations 24
3.14 Prejudices and biases 24
4 Results and findings 27
4.1 Factor 1 – All about the patient 27
4.1.1 Taking patient perspective and having raised cognitive empathy 28
4.1.2 Not emotionally switched off and recognizing relational closeness 28
4.1.3 Reflection after the action, out of focus 29
4.1.4 Openness to change and adapting behavior 30
4.1.5 Distinguishing statements 31
4.1.6 Summary of Factor 1 32
4.2 Factor 2 – Independent, automated and with emotional distance 32

4.2.1 Reflecting out of focus and not a practice 32
4.2.2 Automated and mechanical actions 33
4.2.3 Emotional distancing 33
4.2.4 Minute openness for change and the seeking of another perspective 34
4.2.5 Distinguishing statements 35
4.2.6 Summary of Factor 2 35
4.3 Factor 3 – reflecting in action and keeping on top of the affective 36
4.3.1 Reflection in action 36
4.3.2 Not distanced, but in control. 37
4.3.3 Objectifying and questioning perspectives 38
4.3.4 Distinguishing statements 39
4.3.5 Summary of Factor 3 39
4.4 Consensus statements 39
5 Discussion 42
5.1 Reflection – as a learning strategy 42
5.2 Distancing as a strategy for dealing with emotional work 45
5.3 Searching for alternate perspectives 47
5.4 The tacit sciences in the hospital - The two-legged model… 49
6 Conclusion 53
6.1 Methodological weaknesses and study limitations 54
6.2 Practical implications 54
6.3 Possibilities for further research 55
Litteraturliste 57
Appendices 61

List of tables and figures

Table 1 Fisher plot.....19

Table 2 Factor array for Factor 1.....28

Table 3 Factor array for Factor 2.....32

Table 4 Factor array for Factor 3.....36

Table 5 The Dichotomy of Hospital work.....50

1 Introduction

1.1. My background and history

I am a registered nurse with three years in nursing school. Throughout my studies, I excelled with good academic reviews and grades, but in the field of practice I was continuously challenged in relational competencies, empathic communication and having a nurse's "soft hands"(Olin, 2004). These, at least for me, more subtle and elusive parts of nursing, left me fumbling and I struggled to "learn", and master them, just as my practice counselors struggled to find ways to teach them to me. After a decade of clinical practice and experience, I still find it challenging and exciting to identify, define and explain these abstract and theoretical constructs in my own, as well as others, nursing practice.

As a part of my continuous questioning and query in this field of human psychology, and in a strong belief in adult learning and development, I have finished this master in counseling. It has been a long journey and taken far too much time. Nevertheless, as I now have completed this research project, I start the rest of my professional life with a suitcase full of new knowledge, some limited understandings, and even more curiousness towards the human mind.

1.2. Motivation and choice of thesis

Emotional labour is a theoretical construct of Hochschild that describe how some occupations focus on other people's feelings and emotions, and thereby use the workers own expressions of emotions as a tool. Hochschild's focus is in the different service jobs, where the worker is constantly in empathic alert to the customer/client/patient/etc. This includes teachers, phone support, nurses, cleaners, drivers, bartenders, and so on. Although society assumes it, not all nurses are naturally empathic to this extent. Neither do all teachers master their emotional self-awareness and nor do all bartenders excel in relational work (Hochschild, 2003).

During nursing school, all students get education, practice periods and counselling to develop such skills (Kunnskapsdepartementet, 2008). As a fully trained nurse with several years of experience, I can still find myself struggling with these rather vague areas of nursing, and I find myself looking and longing for ways to further grow and expand my skills in the busy every day environment at work. Within the specialized somatic health service, and especially in the Emergency Department (ED), my experience is that the focus of research and

development is constantly tuned towards the “hard sciences”. The objective and quantifiable data of technology, evidence based research and standard operating procedures seems to be more acceptable. In a system that cultivates standardized course of treatment for all patients, streamlined organization and quantify quality of care, this is perhaps expected.

Nevertheless, although I work in a university hospital with the best of scholars and researchers, I still ponder: How do I give this particular patient good care, my presence and empathy, in the average 2:34 hours (average time in the ED, per patient, unpublished internal statistical report, Mottaksavdelingen 2012) he or she spends in my care? When all the technological and procedural issues are taken care of, what else can I do to calm and ease the patient in acute distress? In this weave of experience, thoughts, feelings and cogitations, I have wanted to take a closer look at reflection as a source for human development. This led me to develop the following research question:

How do nurses experience the use of reflection in relation to empathy and emotional awareness in their practice in the emergency department?

1.3. Relevance to the field of nursing as well as counseling

Nursing: The field of nursing tends to be extroverted in the sense that it focuses on the patient, the health system, the institution/organization and the community of professionals working together, for the patient. Focus on the nurses themselves, building their character, professional mind and ability, may be more out of focus after you finish your training in nursing school. Believing that making a good nurse only takes the three years of school is probably an illusion at best, as so many of the intrapersonal skills needed in relational work is intertwined with personal adult development at large (Chinn & Kramer, 2015). Some of these skills are the ones I have used in my research question.

Reflection is a central term used inn building knowledge and in learning both skills and theory. This is also true to nursing education, and can be seen in the way nursing schools in Norway today base much of their teaching methods on reflection in groups with a nurse counsellor, in practice with an expert nurse mentor, and in written notes and texts reflecting on their experience from practice. Empathy and emotional awareness are theoretical constructs not easy to grasp in measurement, and most certainly not in teaching to

others(Hojat, 2007). Nevertheless, they represent some of the tacit aspects of the expert nurse and her skills, and in a developmental perspective, it is important to be able to identify, define, discuss, experience, and evolve them.

Counselling: An almost limitless field of inquiry into the human mind and personality, interacting with each other, the system and society around us (Gjerde, 2010). Counselling, in Norway, is a new science on its own, but in my view an integrated field of focus in many occupations, such as nursing, teaching, mental health, chaplaincy, social work, leadership, organizational work and so on. Within counselling, using reflection in all of its different modalities is fundamental. Reflection done in relation with a counsellor, might be the first concept that comes to mind, but by using counselling techniques one also build the persons abilities to do introspective work and to run reflective processes on your own.

I have experienced it as useful to ground the theories to real life experience and structures, and hope that this thesis will help visualize points of interaction and possibilities between the two academic disciplines of nursing and counselling. Some areas are already overlapping, but more could be done to draw experience and scientific benefits from one another.

1.4. Limitations and definitions

In later chapters, I will clarify different theoretical terms and concepts relevant for my project. However, writing this text in English, and thereby making it available for other readers than Norwegians, I would first like to point out some of the particulars in the Norwegian healthcare system, different from that of other countries.

Norwegian healthcare system is divided into a first line, the community health care, and a secondary line, the specialized health care. There is a system of publicly funded family doctors or general practitioners available for all, with long term follow-up and primary care. All citizens has a designated family doctor to provide this care. A person with e.g. a long-term health issue like diabetes, pregnancy, need of documentation of good health, or a sick leave will need to see the family doctor about these issues. These general practitioners only work on weekdays, so on nights and weekends, these problems have to be addressed in the first line, the community health system, “Legevakten”. This department handle acute illnesses or injuries that cannot wait until normal work hours but at the same time do not require seeking a

specialist or a hospital admittance. If the health issue is so severe that hospital admittance or at least a consultation with a specialist is necessary, you will be referred to the closest hospital's ED. Smaller injuries, like uncomplicated broken bones and cuts needing stiches, are dealt with in a separate outpatient clinic called "Skadepoliklinikk". The ED handles all admittances to the hospital, both planned and acute. Patients come directly through the ambulance service or by a phone-referral from their general practitioner or the "Legevakt". All these medical services are free of charge or highly subsidized. The ED in my research project sees approximately 20.000 patients a year (unpublished internal statistical report, Mottaksavdelingen 2012). They have three trauma bays, seven triage beds, ten consultation rooms, and several buffer areas. The ED covers a wide patient population including severely injured children, suspected serious somatic illness, acute psychiatry, diffuse ailments in the elderly or life threatening diseases like heart attacks or septic shock, as well as surgical consultations, complicated orthopedic trauma, and so on.

Although differently organized than the healthcare system in other countries, I have used the term ED throughout this thesis, referring to the term Emergency Department commonly used in countries like USA and Canada to describe the hospitals department of emergency medicine.

1.5. The thesis structure

This thesis is organized in the manner suited for a master thesis in counselling. First of all, this introduction to the work, secondly theoretical clarifications of the research area. Then comes a walk-through of the method used to gather the empirical data, followed by a presentation of my findings. Finally I will be discussing some of the issues discovered in my findings and develop a concluding answer to my research question.

2 Theory

In this chapter, I will present theoretical concepts relevant to the research question. This includes the concepts of empathy, reflection and emotional awareness, which are the three effects in the study's design. In the section about empathy, I will present the work and perspectives of Stein and Davis, Rogers, Hojat and Kinge. In presenting awareness of emotions, I have focused on the works of Goleman, complemented by the perspectives of Jordan. Lastly, presenting the concept of reflection, I have chosen Kolb's experiential learning theory, Schön's Reflection in Action and Dreyfus and Dreyfus' work on Skill Acquisition, accompanied by Benner and Wrubel's adaption to the field of nursing. These theories all complement each other with different aspects of reflection as a tool for learning and development.

2.1 Empathy

Early theorist Robert Vischer wrote in his dissertation within the field of art history and philosophy, about the problem later known as "emotional projection". He employed expressions, like Mitfühlung (feeling with), to describe different aspects of feeling and sensing others (Jahoda, 2005). His term "Einfülungvermögen" was originally introduced to describe the minds ability to experience artistically expressed emotions in paintings.

2.1.1 The word and concept

Directly translated, the term empathy draws on the Greek "em" and "patheia", meaning "in feeling/suffering/passion". Titchener is often credited to have coined the English word "empathy" in his translation of the German psychologist Wilhelm Wundt and Sigmund Freud. Until the introduction of empathy, "sympathy" had been the term used to describe positive relations between people or objects. Indeed, argue has been made that Titchener's translation of "Einfühlung" might have been a mistaken identity for "sympathy" in the first place (Jahoda, 2005).

Originally, empathy was described as value neutral and almost a factual and technical component of human consciousness (Holm & Nilsen, 2005). However, the concept of empathy has evolved to describe a positive and necessary element in all human relations and especially in helping relations. The ambiguities and conceptual inconsistencies relating to empathy as a concept have been a challenge to further research and to the validity of the term.

It has been difficult to find a consensus on a clear definition and distinction to bordering theoretical constructs, thus making empathy a multi-focal field of research depending on how each researcher defines their views of empathy (Gladstein, 1983). Still, there are two fundamentally different understandings of empathy in academia, the mystical and the structural approach.

2.1.2 The mystical approach

Judith Stein, a Jewish psychologist and phenomenologist, explained empathy as something mystical. As an insight, unexplainable and unpredictable, except for in retrospect after the fact (Holm & Nilsen, 2005). This "nonprimordial" and post event realization is also the reason for the claim that empathy cannot be planned or caused, but need to be experienced and registered in retrospect (Davis, 1990).

Stein presented a three-stage model of empathy, the first stage being the action of self-transposal and positioning yourself for actively and cognitively tuning into the other persons' perspectives and feelings (Stein, 1964). The second stage is the sudden experience of being connected to, or in a close identification with, another person. This sudden merging of your own self with the other is similar to Martin Buber and his descriptions of "crossing-over" in the dialogue between two people. This shared moment of meaning is instant and often unaware to us. It only becomes aware to us after it has passed, as we in the moment is far too busy feeling the connectedness. The third stage is described as getting back control of our "self" and differentiate the "I – thou" relationship. Although separated, we are still connected in sympathy to the other through our shared experience of connection and identification. Stein also describe how the most challenging step of empathizing with another person, is the actual spontaneous empathy (Davis, 1990). People not comfortable with empathy, will most likely regress back to stage one and cognitive processes where one's self is more secure and emotional risks are lower.

2.1.3 The structural approach

Carl Rogers was the first theorist to really embellish empathy as the significant part of a therapeutic relationship and his definition seems to be a common basis for later research (Kinge, 2014). "To sense the client's private world as if it were your own, but without ever losing the "as if" quality - this is empathy, and this seems essential to therapy" (Rogers,

1957). He discussed the concept to include both cognitive, emotional and communicative dimensions (Holm & Nilsen, 2005). These areas have since been elaborated and researched by numerous theorists and scientists (Gladstein, 1983; Hojat, 2007; Neukrug, Bayne, Dean-Nganga, & Pusateri, 2013). As this thesis goes into the nurses experiences with their own use of reflection, I have chosen not to focus on the communicative parts of Rogers's definition.

Most theorists building on Rogers, view empathy as a combined effort between the cognitive and emotional. Linking the two makes us able to get a balance in how we understand and relate to other people. Emotional empathy place emphasis on sharing emotions and the experience of identical affects between individuals. Hoffman (1981) defined it as "a vicarious affective response to someone else's situation rather than one's own" (Hojat, 2007, p. 8). MacKay, Hughes and Carver (1990) highlights that empathy place more emphasis on taking the clients perspective and "the ability to understand someone's situation without making it one's own" (Hojat, 2007, p. 7). Cognitive empathy has to do with putting oneself in, trying to understand and to practice social insight to the client's situation.

2.1.4 Distinction between the affective and cognitive

Hojat and Kinge distinguish between sympathy, as only containing an affective component, and empathy, being a more clear-cut cognitive process. Further on, sympathy today is often associated with "feeling with" someone in a negative or difficult situation, fostering feelings as sorrow, grief, anger and so on (Kinge, 2014). The dangers are that the sympathy takes too much of your awareness and can mix up what is yours and what is your clients emotions. Empathy, on the other hand, represent more than just emotions. To understand another human you need a deeper understanding and a rational mind, balancing your affective responses, so you do not over-identify or become blind-sighted by your own emotions.

Kinge draws lines back to the origins of empathy, as a way to feel yourself into a piece of art. This "in-feeling" with a client is not a talent or an ability one can master, or not. According to Kinge, it is better described as a process where the key prerequisites are an interest in the client's perspectives and a will to step into it. This means that you cannot be consumed by your own feelings, stress or chaos, but you need to be able to listen more to the clients emotions than your own thoughts (Kinge, 2014). The process then requires that you register and reflect on what you have observed in the client. That means your focus has to be, not only

on what is in focus for the client, but also what is out of focus. The subtle awareness of something being off and incongruent is not necessarily accessible to the client (Neukrug et al., 2013).

2.1.5 The clinician and health worker

Hojat present empathy as a predominantly "cognitive" (rather than an affective) attribute, that involves an "understanding" (rather than feeling) of experiences, concerns and perspectives of the patient, combined with a capacity to "communicate" this understanding (2007, p. 5-15). Hojat points out in his works the many studies into medical students evolving towards cynicism through their educational years. He addresses the ideal of detached concern as having its origin in the relationship between the emotionally driven sympathy and the cognitive empathy. Where sympathy can lead to emotional over-identification and cloud ones judgement, cognitive overindulgence through empathy will lead to better diagnosing and healthcare judgements. Hojat use "understanding" as a keyword in his definition of empathy. This is explained by the fact that you have to put yourself in what you think is the patients perspective, but never in such a way that you lose sight of your one role as a healthcare professional. Finally, we have the keyword "communication", and the importance to use communication as a means to check your empathizing behavior and to gain a good report with the patient's own experience (Hojat, 2007).

2.1.6 Teaching and strengthening

Stein (1964) and Davis (1990) work on teaching empathy evolves around the postulate that empathy cannot be caused actively and therefore it is not possible to teach either. Their understanding of empathy as a concept opposes the structural concept of Rogers and his partition into affective, cognitive and communicative. Stein and Davis contest that by removing the obstacles and instead teach e.g. self-awareness, self-confidence, non-judgmental positive regard for others, attentiveness, listening skills and cognitive identification, you can lay way for empathizing to spontaneously occur (Davis, 1990; Stein, 1964). There are many different studies for training students in medicine, nursing and other helping professions, but they also differ in success. Especially the long-term effect of such educational efforts needs further studying and documentation. Training programs may include interpersonal skills courses, perspective taking, different types of roleplay and training with patient-like situations, narrative skills and other relevant arts and literature studies. Most of these

programs aim to strengthen the cognitive attributes of empathy more than the affective attributes (Hojat, 2007).

2.2 Emotional awareness

For my thesis, one of the theoretical terms used is awareness, the emotional aspect to be specific. The reason for focusing on this particular micro skill lies in Hochschild's theory of emotional labour. His research has focused on occupations that have a strong emphasis on person-to-person relationships, such as flight attendants, nurses, sales personnel and teachers. These occupations demand that you, through your behavior and expressed emotions, generate a positive experience and notion in the customer/client, making your own emotions irrelevant and unwanted in the workplace. Tis may lead to making yourself distanced and disconnected to your own emotions and affects. Hochschild calls this commercialization of your emotional life (Hochschild, 2003).

The theorizing of Daniel Goleman describes how the ability to recognize and reflect on emotions and affects, in yourself and others, is necessary elements in his construct "Emotional intelligence". Emotional intelligence consists of several micro skills such as emotional self-awareness, self-regulation, social skills, empathy and motivation (Goleman, 1995).

2.2.1 Self-awareness, meta-awareness and developing a witness-self

Thomas Jordan has developed a theory of evolving self-awareness, and ultimately forming a concept he calls the witness self (2001). This framework of understanding includes several distinct ego-processes, including emotions, moods and feelings, in which people develop from being subject to their experience, through three phases of objectifying the ego-process, until they manage to make the experience subject to their own consciousness and acquire a level of witness self. Jordan describes different types of ego-processes; perceiving and organizing experiences, thought patterns, opinions and preferences, motivation and desires and behavior and habitual reactions. Most relevant to this thesis though, is the ego-process of emotions, moods and feelings which is the focus of the next paragraph (Jordan, 2001).

The three phases consist of the ability to notice, interpret/evaluate and actively engage in and transform the specific element of awareness. In the case of emotions, feelings and moods,

Jordan describes how people subject to their emotions find themselves always stuck in their ever-changing affective states and leading predominantly reactive lives. Whereas people making their emotions object to their awareness, and building their meta-awareness, start by noticing what feelings they are experiencing and thus develop a language and narrative to describe them. Second to that, they can start evaluating their emotional reactions. They can ask the questions of whether the reactions are good or bad, wanted and warranted, or rash and unsubstantiated? Ultimately, people making their emotions object can initiate intentional actions to transform their emotions, for example through acting-out, seeking alternatives and compensating experiences or simply to reinterpret the causalities and identify other perspectives (Jordan, 2001).

2.2.2 Distance and closeness

Relational competencies are fundamental to all personnel working with people, especially when the purpose for the relation is process based, rather than problem based (Røkenes, Hanssen, & Tolstad, 2012, p.21-22). Relational competencies can be a premise for doing your job, or if poorly mastered, a large hinder to good work. Part of relational work is also the more specific skills of emotional distance and the corresponding emotional closeness. Baily et al. (2011) have identified three stages in the development of emotional intelligence in nurses working in an ED and their way of dealing with death and bereavement in their work. The three stages starts with the nurses realizing the benefits and having the courage to engage in a therapeutic relationship with the patient. The second stage is acknowledging the emotional labour in their work, and to actively manage their own emotions. Finally they develop the emotional intelligence of an expert nurse and intuitive professional (Bailey et al., 2011). That means they are aware of and managing their own emotions, as well as those of the other person and any emotional sides of the relationship (Goleman, 1995).

2.3 Reflection

My research question to look at nurses' experience of empathy and emotional awareness in their work also meant looking in to how one can facilitate and contain such skills in everyday practice. Reflection is widely promoted as a key component in teaching, learning and developing good healthcare professionals and their skills as practitioners (Benner & Wrubel, 2001; Bie, 2007; Brinchmann, 2012; Kristoffersen, 1996; Skau, 2011).

2.3.1 Definitions of reflection and the temporal axis

Reflection is a varied concept and its wide use gives us a myriad of definitions, nuances and specifications. Defining it is complex as different researchers each have their own views and perspectives. In 1985, Boud developed the definition "a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to a new understanding and appreciation"(Mann, Gordon, & MacLeod, 2009, p.597). Thus incorporating both feeling and thinking as essential parts of the process (Mann et al., 2009). Wahlgren (2002) defines reflection as "more or less conscious, and more or less a comprehensive consideration of the connections between our actions and their consequences" (p. 17). Bie describe reflection as something more than self-criticism. Through reflection you should also be able to find a balanced and kind view of yourself, your resources and actions (Bie, 2007).

For the purpose of this thesis, I have decided to focus on the temporal perspective in the relationship between the reflection and the action it focuses on, meaning reflection in advance, reflection during and reflection after the action itself. Different theories have different emphasis on this temporal line. Kolb theorize about reflection on an action from a primarily retrospective view (Kolb, 1984). Schön focus his work on reflection in action, but also address how reflection is used to prepare in advance of any new and similar actions (1995). Dreyfus and Dreyfus, with their Model of Skill Acquisition, describes the development from a novice to an expert, and how we use different ways of reflection depending on which level we are at (Dreyfus & Dreyfus, 1980). These three temporal perspectives have been one of the basis for the methodological design in this thesis (see chapter 3).

2.3.2 Reflection on action in retrospect - Experiential Learning Model

Kolb's work on experiential learning builds on the works of cognitivists such as Piaget, Lewin and Dewey. The Experiential Learning Model (ELM) of Kolb, describe a cyclic process, in which we find meaning in our direct experiences through our reflective observations, abstract conceptualizations and subsequently active experimentation to find new problem solving or decision-making skills. This can also be portrayed as a journey through a cycle of feeling, watching, thinking and doing. Thereby joining the different concepts of emotions, perceptions, cogitating and acting (Kolb, 1984).

Kolb focus on how the Experiential Learning is an independent and individualistic process. He describes it as a process between each individual learner and the concrete experience they are having. Thus, his model stands in contrast to academic and theoretical learning and old-school classroom education (Wahlgren, 2010). Dewey writes about how reflective thought repeats itself, grow out of one another, and support one another (Dewey, 1933). That iterative dimension and spiraling notion is also described in what Kolb calls The Learning Cycle. As you go through the cycle, you gain new perspectives, new knowledge and new skills to deal with the outcomes of your new experiences.

As a continuation of the ELM, Kolb also developed the Learning Style Inventory, in which he depicts different strategies and preferences of learning. The two continuums of "active experimentation" –"reflective observation" and "abstract conceptualization" – "concrete experience", cross and form four different styles of learning in which people's preferences can be scored. This can be a helpful perspective to bring into reflective work as this conceptualization may make you want to challenge yourself to go beyond your preferences in the cycle of experiential and reflective learning (Kolb, 1984).

2.3.3 Reflection in action, in preparation to the act and the reflective practitioner

The lifelong focus of Donald Schön's research was on learning, its cognitive tools, and the role of reflection (or lack of it) in the learning processes in general (Jarvis, 2006). Schön's work together with Chris Argyris brought forth theories around learning, both in organizations, as professionals, and sub sequentially, as practitioners.

In their early work, they described how mental maps rather than theory govern our actions. "Espoused theory" is theories and words we chose to describe and explain our actions to others. "Theory in action" on the other hand is theories that are implicit in how we act in a given situation. They contain three elements: governing variables; the goals, terms, rules and preset conditions of the situation, action strategies; the action one choses, and consequences; the measurement of success of the chosen action strategy (Argyris & Schön, 1974). Single loop learning is a term for what happens when you, because of the consequence, look for a better solution in your chosen action strategy, but you still fulfill the governing variables. This is their version of Kolb's learning cycle. Double loop learning happens when you instead

learn to question the governing variables themselves and thereby change the frame of the action strategy and the consequences (Schön, 1995).

The expression "reflection-in-action" is sometimes referred to as "thinking on your feet". It describes the merging of experience, emotions and theories in use, into new understanding and better-suited actions, while they are happening (Schön, 2001p. 51-56). Through reflection we develop questions and ideas as to what is happening, and why. This process is thereby part in building up a repertoire of action strategies one can later draw on in new similar or un-similar situations, thus "Theory in action" (Argyris & Schön, 1974). Reflection in retrospect to the action is not in focus with Schön and Argyris.

2.3.4 Reflecting to learn a skill, "from novice to expert"

The Dreyfus brothers proposed in 1980 a model of skill acquisition. This theory describe how students learning a new skill through instruction and experience will pass through stages of development. They describe a development from the rational and rigid adherence to rules, to a stage of tacit knowledge and intuitive reasoning (Dreyfus & Dreyfus, 1980). Dreyfus and Dreyfus describe five distinct stages, linked within four different dimensions or qualities. These four are recollection, recognition, decision-making and awareness. Recollection describes the transition from non-situational to situational recollection and effortlessly making connections to our earlier memories and experiences. Recognition refers to practitioner's ability to see "the large picture" and go from a decomposed to a holistic recognition of the situation at hand. Decision-making refers to the transfer from analytical strategies towards less conscious and more intuitive processes. Awareness is the dimension describing your development from a monitoring, registering, evaluating and revising performer, to a more aware, absorbed and fully embedded person in the activity or tasks at hand (Dreyfus & Dreyfus, 1980).

According to Benner's earlier work it will take a novice nurse a minimum of five years reflective practice to reach a level of expert nursing (Benner, 1982). The nurses development from novice to expert is described in more detail by Benner and Wrubel in their collaborative work (Benner & Wrubel, 1989). The different levels of development each have their distinctions, but to simplify this presentation of their theoretical work, I will focus on the first and last level of development; the novice and the expert. The novice nurse is recognizable as

doing rational reflection in preparation to challenging situations. To the more experienced nurse, these details are obvious and implicit, and do not require attentive reflection.

Some of the development in this reflective practice is the repetitive acts and their manifestation into what they call embodied intelligence. Daley's research show how the novice nurse use reflection to establish concept formation and to consolidate their practical skills into embodied intelligence (Daley, 1999). Benner and Wrubel explain how the body can "take control" and then acting is done without conscious reflection or consideration. This type of automated actions can be seen in procedural settings familiar and well known to the nurse.

Benner use the term phronesis, or practical wisdom, to describe the expert nurse's way of integrating all sensed and recognized information, with all the available actions and their immediate possible outcomes (2004). These nurses easily become situational leaders, because of their comprehensive understanding of the situation in at hand. The expert nurse do more of calculative reflection during actions, by relying on intuition and gut feeling, they adapt their approach to the feedback they constantly register from the surroundings. Where the novice reflects on observations as a direct source of information for action, the expert will be able to reflect on the internal processes, governing circumstances, and to question and analyze the premises for their own intuition and the ever-changing circumstances for their field of practice (Benner, 2004; Daley, 1999).

2.3.5 Intuition

Intuition is loosely understood as "the process of thought that gives you an answer, a solution or an idea, without strain or effort, and without really being aware of the process behind it all" (Kirkebøen, 2012, p.132, my translation). Intuition can be traced back to Plato and "The Republic», through eastern mysticism, Buddhism and New Age philosophy. Still, intuition is viewed by many as something mystical, as higher processes that represent a direct link to your inner thoughts and your true self. In nursing, intuition is also idealized as a higher form of practice and skills, only mastered by the experienced nurse (Benner & Wrubel, 1989). One perspective on the field of intuition is the two-system model (Kahneman, 2011).

When you encounter a problem that needs tackling, you use one of two systems of thinking. Often referred to as System1 and System 2, these are not to be understood as either-or, but

both are involved in some degree in all types of thinking. System 1 represents quick unconscious, automated and often affective thought. System, 2 on the other hand, represents slow, conscious, controlled, methodical and rational thought processes. (Kirkebøen, 2012, p. 53-71). Reducing intuition to one of two modalities is an oversimplifying, though. Kahneman states himself, that today we can recognize that the good intuitive decisions of professionals and experts have more basis in their long experience in the field, rather than the heuristics used as explanation, and that the heuristic of affect plays a larger part than stipulated in his earlier work together with Tversky (Kahneman, 2011, p. 11-13).

In this chapter, I have presented the theoretical background for answering my research question. Focusing on the three terms, empathy, emotional awareness and reflection, I have included and presented some of the theories enlightening this field. I will now address the methodology used in my thesis project. This means presenting the method and to describe in more detail how I have gathered the data for the thesis.

3 Method

3.1 Q-methodology background and suitability

William Stephenson developed Q-methodology in 1935, as an adaption of the earlier developed factor analysis (Thorsen, Allgood, Brown, & Berner, 2010). Factor analysis was in itself a quite new method in psychological research, when introduced by Charles Spearman in the early 1900's. Stephenson's critique to factor analysis was based upon the complicated statistical methods underlying the approach. In short, the use of standardized scores means that all collected variables are converted into z-scores; variables in relation to the population rather than in relation to the rest of the variables of that specific individual. As a consequence, you lose the individual to a focus on the individual's relation to the whole population (Watts & Stenner, 2012). This methodology, named R-methodology by Stephenson, concerns itself with the use of complex correlation analysis to identify underlying factors not directly measured in the variables. (E.g., you test verbal skills, mathematics and abstract thinking. The factor analysis ends up with a factor correlating with the three variables, which could be called "intelligence".)

Q-methodology is a phenomenological approach and a scientific method as well as a philosophy. It was controversial when introduced in the 1930s, but has since grown into acceptance and is now acknowledged as a well-suited method for studying human subjective through quantification and statistics. It contains both quantitative and qualitative aspects and is considered to be a phenomenological approach. Abduction is the central principal for meaning-making and the creation of an explanatory hypothesis or theory for the phenomenon studied (Thorsen et al., 2010; Watts & Stenner, 2012).

As my research question is focused on the nurses own experiences, Q-methodology is a well-suited methodological approach. It captures the nurses' experiences, and thereby their values, perspectives, opinions, preferences, prejudices and other nuances (Thorsen et al., 2010; Van Exel & Graaf, 2005).

3.2 Concourse – the communication universe

The concourse is the term used to describe all knowledge in which everyone involved in the context easily can recognize. The concourse includes all written, spoken, visual or other contents that can be made available for a study participant. This material is then adapted into

elements upon which the participants can prioritize and express their preferences towards. Opening the concourse as wide as this reduces the possibility for the researcher transferring his or hers own thoughts and conceptions on the matter into the final empirical data, and also ensures a higher degree of reliability (Van Exel & Graaf, 2005).

In this research project, I have collected and read large amounts of research, articles, notes, reviews and other writings concerning one or more of the three focus areas: empathy, emotional awareness or reflection. I have also made a point in attending and participating in different arenas of reflection for the nurses in the ED, either in social or professional settings. Making small notes of spoken language relating to work was also an inspiring and rich part of the concourse. All these texts then constitute the communication universe and it was gathered with the purpose of creating a large amount of statements and sentences, both based on the concourse, and the research question. This is what is called the Q-set. The nurses are what constitutes my P-set. How they experience is picked up in the Q-methodology itself.

3.3 Fisher plot - block design

To ensure a systematical approach, a Fisher plot was applied during the development of the Q-set. This technique is based on isolating and defining different theoretical themes and sorting them into a plot in which you can find the most central theoretical aspects of your research question. By using Fishers block design you are able to get nuances and to balance your inclusion of theoretical perspectives in the Q-set (Thorsen et al., 2010).

My research question could be broken down into many different components, but the theoretical abstracts I chose to put in my plot was "reflection, empathy and emotional awareness". The three effects were then divided into different levels, based on the available communication in the concourse. This made it possible to choose and put together elements with less risk of a skew or too narrow material. (McKeown & Thomas, 2013). This is an important methodological tool in fighting ones biases and predispositions.

Table 1: Fisher plot

Effects	Levels		
Reflection	a) Pre-action	b) Per-action	c) Post-action
Empathy	d) Cognitive	e) Affective	
Emotional awareness	f) Subject	g) Object	

Based on the plot, you can construct sentences and statements that contains all effects and in time, all levels of them. The combinations in my study then became ADF, ADG, AEF, AEG, BDF, BDG, BEF, BEG, CDE, CDG, CEF, and CEG. To be sure that the statements gives a good representation of the concourse and captures the nuances in the nurses experience and subjectivity, all twelve combinations are repeated three times, and I have tried to capture the effects in both a positive and a negative perspective. Examples of this can be seen in statement 13 and 31, where the former present a cognitive approach to empathy and emotional awareness on a subjective level. The latter statement presents no real engaging in any cognitive empathy and furthermore a lack of time to engage in the subjectivity of their emotional awareness. The last statement then represents a switched representation of the effects measured.

C	D	F	13: Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv.

C	D-	F-	31: Med bedre tid til faglig etterarbeide så kunne jeg kanskje klart å isolere både pasientens og mine egne reaksjonsmønstre og årsaksforhold. Det synes jeg er lettere å få frem etterpå når situasjonen har roet seg.

3.4 Testing the quality of the design

Before starting the collection of data from the E.D. nurses, three different nursing colleagues within other areas of the healthcare system and a friend with no healthcare experience, but strong linguistic skills, did a trial sorting with the complete package of study material. This helped to isolate bad language and some design flaws in the instructions they were given. Based on the feedback from the trial sorting, several statements were altered and refined so they became more focused on the research question and the concourse. Still some of the participants expressed their frustration after doing their sorting, that some of the language was

too complicated to separate and that it had been a challenge to range them in relation to each other because of the similarities in meaning and wordings.

3.5 Participants - The P-set

My research question is directed onto, and specific to, nurses working in a Norwegian ED. These nurses work in an environment with great differences in workload and demands. Working with patients in acute distress holds high demands to the nurses' abilities in effectiveness, high production and versatility when it comes to technical and procedural knowledge. The patients pass through a system of reception, triage, waiting time to be admitted, consultation with nurse and doctor, and finally waiting for examinations or admittance to a ward. Most patients will meet a minimum of five individuals during their time in the E.R, all in charge of their own separate part of the system. Thus, the nurses have a limited time to spend with each patient before they leave the department. This makes relational competencies and the ability to communicate and connect, with the patient as well as colleagues, crucial to working in the ED.

Albeit this, the focus of research and development in these types of departments is all too often focused on the technical issues, medical procedures or clinical approaches. These are quantitative areas and quantifiable qualifications. Whilst emotional work, communication, awareness, empathy and other more social work competencies are abandoned for each nurse to ponder upon in solitude.

3.6 Recruiting

I recruited informants through posters in the staffrooms and an e-mail sent to all employees of the department. I also talked about the project at a weekly staff meeting. The administration encouraged all employees to volunteer, but responding/sorting had to be done in between workloads or on their off time. Some nurses volunteered even before the data collection was ready, and some nurses volunteered after some additional dialogue and information about content and amount of work.

3.7 Collecting

Collecting the data was done by the informant's choice, either by posting the envelope, or by handing it in via my letterbox at work. During an eight-week data-collecting period the

summer of 2014, I handed out 25 envelopes with data collection material. Twenty nurses returned the consent form. Twenty responses/sorts was handed in via postal mail or my letterbox at work. All were without flaws or errors, leaving me with 20 responses to plot into the computer analysis program.

3.8 Material

Material was handed out in pre-stamped and pre-addressed large envelopes. The Q-set was precut and numerated to ease the workload on the participants and the material also included instructions and a "map" guiding them through the process. See appendixes 1 and 7.

Q-methodology is vulnerable to changes in subjectivity. It is difficult to get a uniform context for all the Q-sorts, but identical information about how to do the sorting is one way of securing as similar mental frames of reference as possible for the respondents. The instructions for the nurses was to put themselves into a mental state of "being at work".

The framework for sorting is in the shape of an inverted pyramid, with the continuum stretching from agreeing or "like me" on the right side, to disagreeing or "unlike me" on the left side. The center is for statements in which you are indifferent or which are meaningless to you. The pyramid like shape of the frame is used to mathematically enhance both ends of the scale, and to put less meaning into the ones in the middle (Van Exel & Graaf, 2005).

After sorting all statements into the framework, the informant had to write down the statements numbers in their assigned squares and fill in their own gender, age and seniority in the ED. Then all the material was to be put into the envelope.

3.9 A possible sorting of demographic groups

The collection of the three demographical variables was motivated by their relevance in the theoretical material of the research area. In regards to both reflection, empathy, and emotional awareness, there is a developmental aspect. To some extent, both personal and professional development could have been addressed through collecting data on age and seniority. The data could also have been used to rotate the factor analysis by these data.

I early discovered that there was only one male respondent and it would be a breach his anonymity to use these data. Based on my knowledge of the volunteers it would also be possible to make some assumptions of the other Q-sorts. To protect my respondents' anonymity and to compensate for my own possible biases towards the data, I physically cut the demographic part of sheet off and destroyed them. This was particularly important to me as I, at the time, also carried a role as a colleague.

3.10 The computer analysis program

There are several computer programs available for q-methodological analysis. I used PQMethod (Schmolck, 2014), based on availability and user interface. The program does statistical calculation of variances, significances and correlations in the material. The normal approach is to start out by identifying as much as seven or eight factors in the first analysis; based on whether you do a Centroid analysis or a Principal Component analysis. Looking at the calculations of variance, number of sorts loading for each factor and Eigenvalue you can then reduce the number of factors in a second analysis.

My initial analysis of the q-sorts revealed four factors, with the fourth having an Eigenvalue as high as 1.6587, making all four significant and desirable to include in the analysis (Watts & Stenner, 2012). Albeit the high Eigenvalue, we did not have more than two representatives for the fourth factor. Furthermore, the lack of demographic data or a possibility for a follow-up interview led me to the decision to concentrate on the first three factors in my second run of analysis. Thereby getting respectively eleven, five and four defining q-sorts. Between the twenty respondents in my study, all of them loaded to one of the three factors and none was a mixed sort.

To clarify the different factors even more, you can do a rotation of the axes. If you have a known variable you would like to correct for or enhance in the data, you can do a theoretical approach also known as a Judgmental rotation. I did not have this, so I used an objective approach also known as Verimax rotation (McKeown & Thomas, 2013; Watts & Stenner, 2012).

The program makes a report of the data also calculating each factor's "z-score" and returning a factor array. This is a constructed sorting of the Q-set for each of the identified factors from

the analysis. The program also calculates each q-sort's loading for each of the factors and isolate those of the statements that are most discriminating or in correspondence with each factor (Thorsen et al., 2010; Van Exel & Graaf, 2005; Watts & Stenner, 2012). (See the appendices for more details.)

3.11 The interpretation and principle of abduction

The factor arrays and statistical report produced by the computer program forms the basis for the following analysis. Going through one factor at a time, I have tried to form an impression of the factor nurses and their perspective. Going through the array, I focused on any themes or similarities in the outer rims of the matrix. I also looked at the distinguishing statements, giving them emphasis in my analysis. After getting a hold of the particulars for a factor, I addressed the next, and the next. Then finally, I went back to the consensus statements to look for any possible information from them. Based on the interpretations of the factors, you can find themes and topics not necessarily covered in the initial theory or in the Fisher's block design. This openness to new discovery, and to look for even another level of meaning in the data is the Q-methodological principle called abduction. In this thesis, particularly factor two made it necessary to look for new theory and research in order to discuss the data (Thorsen et al., 2010; Watts & Stenner, 2012).

3.12 Quality of the study

Reliability is the term used to define whether a person, given the same criteria, would replicate the data. Reliability in a Q-methodological study relates to the Q-sets loadings for the respective factors, the factor scores and the number of defining sorts in each factor (Kvalsund, 1998). The number of statements in the P-set can raise the reliability as it makes the study material more nuanced and thereby giving a higher reliability. Given the same P-set, Q-set and instructions, one can usually get a reliability coefficient of 0.800 or higher, indicating a high reliability for same results if the participants were given a chance to do a second sorting (Brown, 1991-1992). The reliability coefficient is also one of the criteria used in selecting how many factors to keep in the analysis. See appendix 8 for further details.

The validity is a measurement of whether the data collected actually describe what you wanted them to describe. In a Q-methodological study it is hard to conclude on validity, as the focus is on operant subjectivity (Brown, 1991-1992; Watts & Stenner, 2012). Subjectivity can

by nature not be measured by external validation and is therefore of less importance in Q-methodological studies. Still, through focused and clear instructions, and by using post-interviews to discuss any hypotheses and assumptions, one can increase and clarify the validity of the data to some extent. Another important area of weakness for validity is the concourse and the construction of the Q-set. Using Fisher's balanced design and test sorts to check for ambiguities is important to the study's overall validity (Watts & Stenner, 2012).

3.13 Ethical considerations

I have tried to ensure all informants full anonymity, from myself included. Studying someone's subjectivity is an intimate issue, which is not to be taken lightly (Brinchmann, 2012). In Q-methodological research, one often do focused post interviews. This is an interview done with the person with highest correlation to the factors revealed in the analysis, and is intended to further investigate and confirm the factors revealed (McKeown & Thomas, 2013). In this study, all research material was separated from any identifying marks and thereby eliminating the possibility to do post interviews. This was done to ensure anonymity for my colleagues supplying the material and for my own distance to the data (Floyd & Arthur, 2012).

This study has treated personal information and is approved by Norsk Samfunnsvitenskapelig Datatjeneste (NSD). See appendix 2 and 3. The study has been conducted in accordance to the ethical principles of informed consent and the open opportunity to withdraw from the study at any given time. The participants were all informed that after turning in the Q-sort, their identity would no longer be traceable, and it would not be possible to withdraw from the study.

3.14 Prejudices and biases

No external organization or company has funded this project. The research has been done independently, but under guidance of my thesis advisor, associate professor Camilla Fikse. I was granted a two-week study leave from work to do the analysis of my Q-sorts. I worked in the ED during most of this thesis work and this made it possible to develop the research question close to the clinical field of nursing. Being surrounded by partners in reflection during long nightshifts was helpful, but my colleagues were not involved in the analysis, nor the interpretations of the empirical data. For the latter part of this project, I have worked in the

hospital chaplaincy as a humanist chaplain, adding a more refined perspective into the tacit sides of nursing and professional development in the hospital arena.

My role as the researcher has been challenged by the fact that I, myself, am a nurse in an ED. Distancing oneself from ones prejudices and biases is always important, but especially in Q-methodology (Floyd & Arthur, 2012; Watts & Stenner, 2012). This methodology opens up for the opportunity to find hidden meanings, connections and experiences not familiar to oneself. Always taking one step back and looking at my own analysis in a meta perspective have been an important step in guarding my own objectivity to the field of analysis. Spending so much time on the analysis and discussion has also offered me with the opportunity to go back and forth in the material and each time finding new nuances.

4 Results and findings

This chapter will present the three-factor solution derived from the statistical analysis. As I present the different factors and their corresponding factor arrays, I will give interpretations of different themes and connections that have come into figure for me during the interpretation of them (Thorsen et al., 2010). In order to achieve this, it is necessary to look at each factor's array of statements as a whole. Each factor will be summarized separately. Lastly, I will present the consensus statements, the similarities between the factors.

In the text in this chapter, I have chosen to start each factor presentation with an overview of the factor array. Distinguishing statements significant to a P .01 is marked with a * by the statement number. Some statements appear several times during one factor interpretation, as they are relevant to more than one theme in the understanding of the factor. Not all statements are relevant to my interpretation, thus not all statements are cited in the text. To find full statements not cited in the text, look in Appendix 1, which lists the statements by number. In appendix 10, you can find the English translation of the same statements. Furthermore, all statements cited in the text are followed by a parenthesis giving the score for Factor 1, 2 and 3, in that order. For example: (1, -5, 5).

In Appendix 9, you can find the factor arrays, which is the theoretical sorting of an ideal member of each of the three factors. In each of the factor arrays, the distinguishing statements, being statistically significant for the factor, is marked with a gray background, the dark one to a .01 level and the lighter one to a .05. The consensus statements between all three factors are in a light gray text. This is not to say they are unimportant to the whole, but less important in describing each factors uniqueness to the others.

4.1 Factor 1 – All about the patient

Defined by eleven q-sorts, this factor has an explaining variance of 25%. It has a relative low correlation with both factor 2 and 3 at -0.2185 and 0.2770.

Table 2: Factor array for Factor 1.

-5	-4	-3	-2	-1	0	1	2	3	4	5
10	24	8	5	1	19	4	3	12	18	2
	34	17	15	11	20	6	7	13	30	
		21	23	25	28	9	14	16		
			32	26	31	22	29			
				33	35	27				
					36					

4.1.1 Taking patient perspective and having raised cognitive empathy.

Taking the patients perspective is weighted positive in this factor. The statements on the right side of the matrix, the positive side, describe the nurse looking for the patient's perspective (Statements 2, 30, 18, 12, 13, 16, and 29). In fact, all of the statements rated 3+ or above have the patient perspective in focus. Furthermore, statement 2 and 30 represent a cognitive approach to their empathy as they not only describe a search for the patient's perspective, but it is also an active, intentional and willed process.

> *2*: Skal jeg få til en god pasientkontakt må jeg forsøke å sette meg inn i pasientens situasjon og perspektiv, og å lytte til de signalene jeg får underveis fra pasienten. (5, 0, -1)*
>
> *30*: Jeg synes det er enklere å håndtere vanskelige pasientsituasjoner hvis jeg har fått tid til å forberede meg. Det handler om teknisk utstyr og prosedyrer så vel som situasjoner der pasientens emosjonelle behov er i fokus. (4, 1, 0)*

Statement 18 on the other hand, describe awareness of the patient's emotions as appearing without an active process in the nurse. The subsequent empathic feeling and action occur without reflection or thought, but instantaneously. Still, all three statements show that the patient is in focus.

> *18*: Jeg kan se at pasienten er engstelig og redd. Da føler jeg virkelig med ham eller henne, og prøver å nå inn til vedkommende og å hjelpe. (4, -1, -2)*

4.1.2 Not emotionally switched off and recognizing relational closeness

Being emotionally "switched off" from the patients is rated in the left side of the matrix, showing a negative recognition to this theme, meaning this is traits they do not recognize as

descriptive of their own practice (Statements 10, 8 and 17). These three statements all depict an approach to the patients based on automation and procedures, an approach these Factor 1 nurses then have rated as unfamiliar to themselves.

> *10*: Enkelte pasienter blir bare en del av den grå massen. Jeg er forberedt og trygg på alle aktuelle prosedyrer og rutiner, og det er lite ved pasientmottaket som utmerker seg eller engasjerer meg. (-5, 4, -2)*
>
> *8*: Enkelte kontaktårsaker er så vanlig at de bare blir rutine. Da kan jeg lene meg tilbake og la klinisk blikk og mageføelse få styre måten jeg gir pleie og omsorg. (-3, 2, 0)*
>
> *17*: Noen ganger er faktisk jobben bare en jobb, og det er som om jeg er følelsesmessig "skrudd av" fra alle inntrykk og reaksjoner. Da får det heller bli prosedyrer og rutiner som styrer hva jeg gjør. (-3, 5, 1)*

On the far right side of the matrix there are three statements concerning closeness in the relationship with the patient and seeking to strengthen it.

> *2*: Skal jeg få til en god pasientkontakt må jeg forsøke å sette meg inn i pasientens situasjon og perspektiv, og å lytte til de signalene jeg får underveis fra pasienten. (5, 0, -1)*
>
> *18*: Jeg kan se at pasienten er engstelig og redd. Da føler jeg virkelig med ham eller henne, og prøver å nå inn til vedkommende og å hjelpe. (4, -1, -2)*
>
> *12: Det blir lettere å se bakgrunnen for pasientens atferd og reaksjoner om jeg forsøker å se situasjonen fra pasientens ståsted. Da kan jeg også planlegge mine handlinger utfra hva jeg antar at pasienten vil foretrekke. (3, -1, 1)*

In the left side of the matrix, in position -3, statement 21 is a negative over the same theme thus emphasizing the positive sortings of statement 2, 18 and 12.

> *21*: Når jeg identifiserer meg selv eller noen som står meg nær, kan pasientmøtet bli så nært og utfordrende at jeg blir følelsesmessig satt ut. (-3, 0, -1)*

4.1.3 Reflection after the action, out of focus

This factor have no clear preference in temporal mode of reflection. Only thing noticeable is that in the area around zero, there is a higher concentration of statements concerning

reflections after an action has taken place. Three of them are distinguishing statements (Statements 31, 25, 1, 35, 20, 19, 6, 9, and 26).

> *31*: Med bedre tid til faglig etterarbeid så kunne jeg kanskje klart å isolere både pasientens og mine egne reaksjonsmønstre og årsaksforhold. Det synes jeg er lettere å få frem etterpå når situasjonen har roet seg. (0, -2, -3)*
>
> *25*: Noen ganger gjør man seg jo noen tanker etterpå om hvorvidt jeg kunne gjort mer? Men det er ikke alle pasientene som vekker følelser og engasjement hos meg. Noen pasienter er bare navn og diagnoser som skal prosesseres gjennom standardiserte forløp. (-1, 1, 2)*
>
> *1*: Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang? (-1, -5, -5)*

This puts the concept of reflection posteriorly out of focus and not very relevant to comment on for these nurses. This can have many explanations, for example, that it is not something they practice and thereby neither can enjoy nor disapprove. On the other hand, it might be that they feel content with their work, and therefor need not evaluate and reflect on it in hindsight.

4.1.4 Openness to change and adapting behavior

The theoretical construct of emotional labour can be found primarily in statements 11, 22 and 33. For Factor 1, these statements are sorted in the area around zero, which indicates that this way of acting towards the patients is not in their foremost consciousness.

> *11*: Når pasienter* opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedenfor har jeg lært meg til å smile og avvæpne *pasienten. (-1, -3, 4)*
>
> *22: Når pasienten er sint og avvisende, er det lett å reagerer med sinne og avvisning selv.* Jeg har lært meg å se det og klarer derfor å endre mine egne handlingsmønstre slik at jeg kan dempe konflikt og uro hos pasienten. (*1, -1, 3)*
>
> *33: Det er vanskelig når en pasient mener at jeg ikke bryr meg og at jeg gjør en dårlig jobb. Da prøver jeg å sette meg i pasientens sted og forstå hvordan han/hun opplever situasjonen for så å endre min egen atferd. (-1, -2, 0)*

4.1.5 Distinguishing statements

For a full overview of the distinguishing statements for Factor 1, see appendix 1 and 8. Some of them are commented on already in the identified themes, but I will draw attention to two more statements not mentioned earlier.

> *34*: I sykepleierdokumentasjonen kan jeg legge mine egne oppfatninger på bordet og diskutere pasientbildet. Slik kan jeg noen ganger utvikle nye tanker om pasienten og hans/hennes situasjon og opplevelse. (-4, -2, -2)*

This is a negative rated distinguishing statement, which means the Factor 1 nurses do not recognize themselves here. This statement is rated negatively in all three factors, but particularly low in Factor 1, and thus addressed now.

The nurses' documentation in the ED is not built for presentation of personal impressions or elaborate descriptions of the patient's situation. The nurses' documentations is for the most part about filling in forms and writing down objective vital parameters, signs and symptoms. The negative rating of this statement can be explained in that the nurses are unattentive to the possibilities and thereby do not use the few, but never the less available tools for written reflection and discussion. It can also be that the nurses define it as unlike, or unimportant, to them, all due to the way the forms and documentations are designed and how they do not allow for elaborate reflection.

Statement 30 is also particularly relevant for Factor 1. It addresses the topic of preparing in advance of difficult situations and nurses recognize themselves in this to a much higher degree than the other two factors.

> *30*: Jeg synes det er enklere å håndtere vanskelige pasientsituasjoner hvis jeg har fått tid til å forberede meg. Det handler om teknisk utstyr og prosedyrer så vel som situasjoner der pasientens emosjonelle behov er i fokus. (4, 1, 0)*

Statements 13, 14, 7, 36, 32 and 23 are distinguishing for Factor 1 nurses, but they do not fit any of the themes that have come into figure for me during the abductory analysis of the data. All other distinguishing statements with significance $P \leq .01$ can be found in the paragraphs above and are marked with a star by their statement number.

4.1.6 Summary of Factor 1

Factor 1 consists of eleven nurses that recognize themselves in seeking the patient's perspective and relating to the cognitive sides of empathy. The nurses are not emotionally switched off or distanced, and they acknowledge closeness as part of their relationship to the patients. They have no clear preferences in reflective modes, but one statement highlights in a clear way the importance of getting to prepare before entering a difficult situation. Emotional labour and willingness to change and adapt your ways is not something in focus for these nurses. This can be explained by it being second nature for them to address and adapt to other people's needs. It might also be seen as a behavior they are still not aware of and therefore do not consider relevant for their practice.

4.2 Factor 2 – Independent, automated and with emotional distance

This factor has five defining q-sorts to it and an explaining variance of 24%. It has a correlation to Factor 1 of -0.2185 and factor 3 is -0.0967.

Table 3: Factor array for Factor 2

-5	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**
1	13	11	14	12	2	4	8	3	7	17
	35	15	31	18	5	6	23	32	10	
		29	33	20	9	24	27	36		
			34	22	16	25	28			
				26	19	30				
					21					

4.2.1 Reflecting out of focus and not a practice

Factor 2 nurses have put statements that clearly depict reflection to the left side of the matrix and around the zero line. The statements they have rated positive are all either unclear or lack a reflective element at all. Statement 7, a statement the nurses recognize in their own practice, accentuates this further by arguing that you simply cannot prepare for a good relational meeting, it just have to occur on its own premises.

> *7*: De fleste pasientene blir etter hvert et nummer i rekken, men det er alltid noen som utmerker seg og som "kommer under huden din". Sånne møter kan man ikke planlegge eller forberede, de bare skjer. (2, 4, -2)*

The statements 17, 32 and 36, which are all sorted positive, depict some degree of preparing or having thought through how you are going to act in advance, and at the same time, these are also relevant for creating an emotional distance, as discussed below.

4.2.2 Automated and mechanical actions

Factor 2 nurses positively recognize themselves in statements that describe the use of automated, and to some extent mechanical, approaches to nursing and decision-making (Statements 17, 10, 32, 23 and 8). This can also be interpreted as expressions of an expert-like and intuitive approach to nursing, which I will come back to in the discussion in chapter 5.

> *17*: Noen ganger er faktisk jobben bare en jobb, og det er som om jeg er følelsesmessig "skrudd av" fra alle inntrykk og reaksjoner. Da får det heller bli prosedyrer og rutiner som styrer hva jeg gjør. (-3, 5, 1)*
>
> *10*: Enkelte pasienter blir bare en del av den grå massen. Jeg er forberedt og trygg på alle aktuelle prosedyrer og rutiner, og det er lite ved pasientmottaket som utmerker seg eller engasjerer meg. (-5, 4, -2)*
>
> *32*: Noen pasientmøter er så standard at jeg på forhånd har et godt bilde av hva pasienten står oppe i. Da slipper jeg å bruke lang tid på relasjonsarbeidet men kan handle utfra erfaring og mageføelse. Ting går gjerne med automatisk. (-2, 3, -3)*

4.2.3 Emotional distancing

The matrix show positive ratings of statements that describe a lack of emotional presence in the nursing situations through actively or passively to practice distancing in relation to the patients (Statements 17, 10, 32, 36, 8, and 23).

> *36*: Jeg kan noen ganger ha valgt å aktivt distansere meg fra pasienten og situasjonen så ikke jeg blir revet med i de følelsesmessige opp eller nedturer de står i. (0, 3, -4)*
>
> *23*: Sykepleiedokumentasjonen og prosedyrene er nyttige å ha. Spesielt når pasientsituasjonen er så sterk eller vanskelig at jeg er i ferd med å miste rasjonaliteten og sakligheten til fordel for empati og omsorg for pasienten.(-2, 2, -4)*
>
> *8: Enkelte kontaktårsaker er så vanlig at de bare blir rutine. Da kan jeg lene meg tilbake og la klinisk blikk og mageføelse få styre måten jeg gir pleie og omsorg. (-3, 2, 0)*

Factor two nurses negatively rate the two statements 13 and 35, relating to colleagues as support and partners in reflection. These are also distinguishing statements for this group of nurses, and can be interpreted as a sign of individuality and working autonomously.

> *13*: Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv. (3, -4, 5)*
>
> *35*: Å diskutere pasienten med kolleger gir et nytt perspektiv som kan utfordre meg på hvem jeg tror at pasienten er og på hvordan jeg forholder meg til han/henne. (0, -4, 1)*

Nurses in the ED are for the most part engaged in individual and independent tasks and assignments. This goes for all the nurses, of course, but nurses within factor 2 has a distinct resistance to reflective practice with colleagues.

4.2.4 Minute openness for change and the seeking of another perspective

Statements regarding willingness to change and adapt are scored negatively in Factor 2, showing how these nurses do not recognize such openness in themselves. It can also be interpreted as a resistance to change and adaption (Statements 1, 35, 11, 14, 33, 34, 12, 22, and 26).

> *1: Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang? (-1, -5, -5)*
>
> *11*: Når pasienter opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedenfor har jeg lært meg til å smile og avvæpne pasienten. (-1, -3, 4)*
>
> *33: Det er vanskelig når en pasient mener at jeg ikke bryr meg og at jeg gjør en dårlig jobb. Da prøver jeg å sette meg i pasientens sted og forstå hvordan han/hun opplever situasjonen for så å endre min egen atferd. (-1, -2, 0)*

In the two statements regarding collegial reflection (13 and 35) questioning your own experience of the situation is captured. This theme is also repeated in several other statements

describing more individualized reflection (14, 15, 29 and 34). A positive sorting of them would mean the nurse consider alternate experiences and perspectives on the situations at hand. Nurses within Factor 2, however, have sorted most of these in the left side of the matrix, viewing them as unlike or unfamiliar to the way they work.

> *15*: Jeg prøver å gå igjennom mine egne holdninger og reaksjoner etter et pasientmottak. Spesielt de gangene jeg merker at jeg har redusert pasienten til å kun være et romnummer og en diagnose. (-2, -3, 0)*
>
> *29*: Det hadde vært interessant å visst hva pasientene opplevde som nødvendig for at relasjonen og pasientmøtet skulle bli så godt som mulig. (2, -3, 1)*
>
> *14: Det er nyttig med tanke på læring og utvikling at jeg etterpå forsøker å gå igjennom mine egne handlinger og følelser som en selvstendig del av pasientsituasjonen. (2, -2, -1)*
>
> *34: I sykepleierdokumentasjonen kan jeg legge mine egne oppfatninger på bordet og diskutere pasientbildet. Slik kan jeg noen ganger utvikle nye tanker om pasienten og hans/hennes situasjon og opplevelse. (-4, -2, -2)*

4.2.5 Distinguishing statements

Statement 24 describe the patient relatives crying and letting yourself cry too. This is something the nurses in factor 1 and factor 3 do not agree with. Factor 2 on the other hand is neutral to this, giving it a +1 rating. I interpret this as yet another example of these nurses' distance to, and failure to recognize the emotional aspects of the patient situations.

For a full overview of the distinguishing statements for Factor 2, see appendix 1 and 8. All distinguishing statements significance of P .01 can be found in the paragraphs above and are marked with a star by their statement number. Statements 22 and 24 do not fit any of the themes that have come into figure for me during the abductory analysis of the data.

4.2.6 Summary of Factor 2

Factor 2 is made up of five nurses who show independence in their work, and do not spend much time reflecting on their own or others thoughts, practice or perspectives. They are experienced with procedures and routines, which makes it possible for them to go about their business effortless. They seem to practice emotional and relational distance, both towards patients and colleagues, routinely. Their lack of interest in pursuing other perspectives and

alternative views might be, from their point of view, a comfortable and secure strategy. However, it will also limit their ability to relate and facilitate the patients need to feel heard and met.

4.3 Factor 3 – reflecting in action and keeping on top of the affective

This factor has four defining q-sorts to it and an explaining variance of 24%. It has a correlation to factor 1 of 0.2770 and factor 2 is -0.0967.

Table 4: Factor array for Factor 3

-5	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	**5**
1	23	24	7	2	8	6	3	9	4	13
	36	31	10	14	15	12	5	22	11	
		32	18	16	19	17	20	27		
			34	21	28	29	25			
				26	30	35				
					33					

4.3.1 Reflection in action

This factor has a primary focus on reflection during action (Statements 13, 11, 4, 22, 27, 3, and 5), meaning your analytical skill is used to adapt and adjust your actions, either as they play out, or in really close temporal proximity.

> *13*: Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv. (3, -4, 5)*
>
> *11*: Når pasienter opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedenfor har jeg lært meg til å smile og avvæpne pasienten. (-1, -3, 4)*
>
> *4*: Jeg planlegger og har noen antakelser for hvordan pasienten har det før jeg går inn. De er mine antakelser og stemmer ikke nødvendigvis med pasientens opplevelse av situasjonen. (1, 1, 4)*
>
> *27: Du møter alle pasienter med antakelser om hvem han eller hun er. Det er viktig som sykepleier å gjenkjenne disse fordommene som "falske" og å kunne smidig tilpasse seg den "virkelige" pasienten uten at dette går utover pasientens opplevelse. (1, 2, 3)*

The pre- and post-reflection statements are spread out over left and mid-section of the matrix, showing no clear preferences or tendencies. Still worth noticing, is that statements showing automated actions and mechanical adhering to procedures and routines are rated negatively (23, 24 and 32).

4.3.2 Not distanced, but in control.

Some of the statements sorted left and negatively for Factor 3 nurses describe distancing yourself as a technique (23, 36, 32 and 10), indicating that they reject distancing as a strategy for their type of nursing.

> *23*: Sykepleiedokumentasjonen og prosedyrene er nyttige å ha. Spesielt når pasientsituasjonen er så sterk eller vanskelig at jeg er i ferd med å miste rasjonaliteten og sakligheten til fordel for empati og omsorg for pasienten. (-2, 2, -4)*
>
> *36*: Jeg kan noen ganger ha valgt å aktivt distansere meg fra pasienten og situasjonen så ikke jeg blir revet med i de følelsesmessige opp eller nedturer de står i. (0, 3, -4)*
>
> *32*: Noen pasientmøter er så standard at jeg på forhånd har et godt bilde av hva pasienten står oppe i. Da slipper jeg å bruke lang tid på relasjonsarbeidet men kan handle utfra erfaring og magefølelse. Ting går gjerne med automatisk. (-2, 3, -3)*
>
> *10*: Enkelte pasienter blir bare en del av den grå massen. Jeg er forberedt og trygg på alle aktuelle prosedyrer og rutiner, og det er lite ved pasientmottaket som utmerker seg eller engasjerer meg. (-5, 4, -2)*

Statements describing emotions becoming dominant (1 and 24) are also rated negative in this group, indicating that losing control to the affective sides of nursing is not common nor attractive to them.

> *1: Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang? (-1, -5, -5)*
>
> *24: Jeg har bestemt med på forhånd for at dersom de pårørende begynner å gråte er det helt i orden om tårene triller hos meg også. (-4, 1, -3)*

Furthermore, these nurses have sorted statements regarding controlling ones emotions in relating to patients positively (Statements 11, 9, 22 and 3).

> *11*: Når pasienter opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedenfor har jeg lært meg til å smile og avvæpne pasienten. (-1, -3, 4)*
>
> *9*: Noen pasienter provoserer og pusher grensene mine. Med faglig diskusjon og refleksjon rundt pasienttypen klarer jeg etterhvert å kjenne dem igjen, og å kjenne igjen hvordan jeg selv reagerer på dem. (1, 0, 3)*
>
> *22: Når pasienten er sint og avvisende, er det lett å reagerer med sinne og avvisning selv. Jeg har lært meg å se det og klarer derfor å endre mine egne handlingsmønstre slik at jeg kan dempe konflikt og uro hos pasienten. (1, -1, 3)*

This adds to the impression that the nurses favor emotional control, but not necessarily emotional detachment.

4.3.3 Objectifying and questioning perspectives

Statements regarding taking others perspectives are scattered across the array for this factor. Nevertheless, the statements most clearly describing objectifying, questioning and nuancing elements as emotions, relations and behavior is positively rated to the far right of the matrix (Statement 13, 4 and 9).

> *13*: Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv. (3, -4, 5)*
>
> *4*: Jeg planlegger og har noen antakelser for hvordan pasienten har det før jeg går inn. De er mine antakelser og stemmer ikke nødvendigvis med pasientens opplevelse av situasjonen. (1, 1, 4)*
>
> *9*: Noen pasienter provoserer og pusher grensene mine. Med faglig diskusjon og refleksjon rundt pasienttypen klarer jeg etterhvert å kjenne dem igjen, og å kjenne igjen hvordan jeg selv reagerer på dem. (1, 0, 3)*

Statement 1 also describe contemplating and questioning your perspectives, but also bringing it home with you.

> *1: Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva*

tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang? (-1, -5, -5)

The positioning of statement 1 at -5, deviates from the other three statements positions. This difference can be explained by the fact that statement 1 describes a mix of the home-life and work-life (bringing it home). This mixing is in nursing literature often seen as a warnings signal for bad "emotional hygiene" and lack of professional distance.

4.3.4 Distinguishing statements

Statement 17 is a distinguishing statement for factor 3. It highlights some of the differences between the three factors. This statement describe how you sometimes can get emotionally detached from your work and simply go with the procedures. This is something the factor 1 nurses do not recognize, but the factor 2 nurses highly recognize in themselves. The nurses in factor 3 on the other hand, are neutral to this statement, which to me means they acknowledge that this sometimes happen but it is not something they fear nor favor.

For a full overview of the distinguishing statements for factor 3, see appendix 1 and 8. Statements 7 do not fit any of the themes that have come into figure for me during the abductory analysis of the data. All other distinguishing statements to significance of P .01 can be found in the paragraphs above and are marked with a star by their statement number.

4.3.5 Summary of Factor 3

The four nurses in Factor 3 are aware and present in their actions, reflecting as they go along. They are not relying on automated actions or procedures, but are actively reflecting on the patient's perspectives and experiences. These nurses are emotionally present in their work, but not to the extent that it takes over and invades their professional presence. They are in control of the affective, but not necessarily through detachment.

4.4 Consensus statements

There are five statements flagged as non-significant to the 0.01 level. These statements are what the three factors share as common views and positions. In this study, the consensus statements are also dispersed mainly to the area around zero, meaning they are statements that the nurses are neither negative nor positive towards. There are several reasons for the

consensus statements to be in the mid-section of the matrix, amongst others they can of course be irrelevant or simply badly formulated, and thereby not accessible to their reference of experiences. Ambiguities in the sentence structure, one part being agreeable and the other not, would also make the statement difficult to place, and therefore more likely to be placed in the middle.

I have discussed the consensus statements with three of my former colleagues, reflecting on why these statements have ended up as out of focus to the nurses. Statement 19 is an example of a statement that seem to have little relevance to the ED nurses. Writing reports and giving over the patient is usually subject to the same formal, scheme-like checklist. The statement describes a situation that rarely will appear, as the nurses are seldom given time to reflect on the events of one admission, before they have to move on to the next patient.

> *19: Pasientkontakten i akuttavdelingen er effektiv, behovsstyrt og med fokus på å få pasienten raskt videre til et riktig behandlingsnivå. Men når jeg skal skrive eller gi rapport, kan jeg bli oppmerksom på hvor lite jeg egentlig vet om pasienten og pasientens situasjon. (0, 0, 0)*

Statements 6, 26, 28 and 33 all describe the nurses spending time actively searching for the meaning and reason for the situation and the emotional responses of the patient. This is a theme covered in other statements too, but these four statements stand out as they are consensus statements and in the center of the matrix. Thus, trying to grasp the patients' reactions is something the nurses in my study do not oppose nor favor, or they are simply not aware of it or hold in focus.

> *6: Hvis jeg etterpå tenker tilbake på en hendelse er det lettere å både se og å forstå hva som forårsaket pasientens opplevelse eller atferd. (1, 1, 1)*

> *26: Det er enklere å akseptere andres oppfatninger av hva som skjedde hvis jeg har fått litt avstand til det hele. Både i tid og rom. Da har jeg kanskje fått egne følelser mer på avstand og kan lettere diskutere det som skjedde på en nøytral måte. (-1, -1, -1)*

28: Jeg opplever av og til at pasienten har negative følelser overfor meg. Da er det viktig å ikke la det gå inn over seg personlig, men prøve å se bakgrunnen for pasientens opplevelse og å vurdere behov for og eventuelle mulige endringer i pasientbehandlingen. (0, 2, 0)

33: Det er vanskelig når en pasient mener at jeg ikke bryr meg og at jeg gjør en dårlig jobb. Da prøver jeg å sette meg i pasientens sted og forstå hvordan han/hun opplever situasjonen for så å endre min egen atferd. (-1, -2, 0)

5 Discussion

This study has focused on nurses in the ED, specifically. Their work situation deviates from that of other wards in that it focus more on efficiency, hard science, procedural and routine based nursing skills. At the same time, the nurses work with patients for the most part in an acute crisis in their health, and they have a short time window to establish a good relationship report with a very diverse group of patients. The purpose of the study has been to identify different perspectives in the nurse's experiences with different theoretical constructs. The research question has been:

> *How do nurses experience the use of reflection in relation to empathy and emotional awareness in their practice in the emergency department?*

Based on the Q-sort I have found three significantly different factors and presented an interpretation of these in the previous chapter. I will now take a closer look at three different themes coming to my focus and attention, based on theories from chapter two (Theory) and the data presented in chapter four (Results and findings). I will also add some new theory in this discussion, based on some of the findings, in accordance with the Q-methodological approach and its principle of abduction. First, I will look at reflection as a strategy for learning and fostering development. Secondly, I will discuss searching and looking for alternative perspectives. Distancing, as a strategy for coping and dealing with emotional demands is my third focus and finally I will take an organizational overview of hospital work in general and ED nursing specifically.

5.1 Reflection – as a learning strategy

In this study, I have chosen to let a temporal perspective on reflection give structure to my methodology, meaning reflection in advance of an action, reflection during an action and reflection in hindsight and after the action has occurred. I would like to reiterate shortly some of my results regarding reflection. Factor 1 have no clear mode of reflection and when it comes to reflection after the act, they are either unaware of this as concept or of it even being a possible learning technique in their work. They do however seem to favor one particular statement regarding preparing for entering a difficult situation. Factor 2 has some statements towards preparedness sorted positively, but is mostly out of focus or negative for the other

two modes of reflection. Factor 3 is a "go with the flow" type focusing on reflection during action and with no clear preference for the other two modalities I have focused on.

We all have different preferences in life and what makes us choose one method over the other has to do with whatever skills and talents we bring with us into the situation at hand. If you are professionally confident, experienced and skilled, like described by Benner and Wrubel (1989), an expert nurse, reflecting and preparing in advance of an action is unnatural, since most practical details and procedural issues are already an intuitive and integrated part of you. You do not need to reflect on how to draw blood from a patient, it is instinctive and requires little or no attention. The expert nurse do more reflecting during her actions, and she does it in an automated and effortless way. The expert nurse is attentive to more streams on information, since their automated actions mean they have more attention to give to other aspects of the experience than just the practical and procedural sides of it. I assume this is what we see in Factor 3.

Retrospective reflection for an expert nurse has little relevance when focusing on the concrete sides of nursing, the "who-did-what", or technical issues. These nurses are more focused on the situational aspects, the embedded experience and the governing variables. Retrospective reflection on actions done by these nurses will be focused on what Schön call double loop learning. It will be about evaluating the premises for their actions, more than the actions themselves. Based on these premises, one can imagine a division in the way a formal debriefing, like Critical Incident Stress Debriefing, would play out for nurses in different levels of proficiency (Mitchell & Everly, 2001). The technical part of such a debriefing focus on the factual sides of the incident, and an expert nurse would be able to get confirmation of choices made and reaffirming the actions taken. However, the learning cannot start until these expert nurses are allowed to address the aspects of their attention, which most likely will be different from those of a novice nurse, dealing with more concrete and fragmented parts of the event (Daley, 1999). The factor array for Factor 3 matches the findings of Daley, in regard of their focus on reflection in action, and on gathering information and adapting to changing circumstances as soon as you discover them; like described in statement 4:

> *4: Jeg planlegger og har noen antakelser for hvordan pasienten har det før jeg går inn. De er mine antakelser og stemmer ikke nødvendigvis med pasientens opplevelse av situasjonen. (1, 1, 4)*

An unskilled, newly employed and novice nurse, unsure of procedures and routines and with less experience will need more time preparing and she needs to be more focused during an action too. Benner and Wrubel (1989) describe how the novice nurses have less automated actions, and the concrete actions therefore take up more of their attention and mental capacity during an action. This means that the novice nurse will focus on details and hence retrograde recollection and recognition will also contain the same level of detail. They miss the bigger picture and it might be helpful for them, reflection-wise, to get help in putting their details in context. Their decision-making is also analytical rather than intuitive, taking more time and effort to reach a conclusion.

Factor 1 has a raised focus on being prepared before entering a difficult situation. Other modes of reflection are scattered across the matrix, not giving me any clear possible interpretations. Based on the overall factor array for Factor 1, I am inclined to view them as quite inexperienced nurses. I believe these nurses to have the best of intentions and to be focusing on the concrete sides of the patient's needs through cognitive approaches, rather than the experts more intuitively driven behavior. Attention is payed to the cognitive and tangible sides of empathy, seeking the patients' perspectives and relational closeness.

As described by Daley, these novice nurses are open and attentive to most sides of their concrete practice, with the subsequent possibility to form new concepts, accumulate information and build new understanding of nursing (Daley, 1999). They might not be sufficiently aware of their own emotions, but at the same time, they do focus on not being emotionally switched off. This shows their cognitive knowledge that there is a realm of emotional labour they eventually will learn to master, but that they for now will have to approach through more analytical and objective skills and methods. They have to actively engage, rather than to go with the flow.

Describing the nurses in Factor 2 is less clear-cut. They prefer being prepared and appreciate the time to reflect before going into a situation. They do not acknowledge retrograde reflection as relevant for their way of practice, and reflection in action is centered on zero in the matrix, indicating that this way of reflecting is out of focus as a strategy for these nurses.

Jarvis writes about un-reflective practice, a practice you repeatedly engage in, but do not reflect upon (Jarvis, 2006). He also uses the term ritualization to describe the way some people do not progress, but get stuck in actions based on presumptions and do not develop themselves along such lines of development as described by Benner and Wrubel (1989) or the Dreyfus brothers (1980). Jarvis continuous to describe how this can further lead to alienation of the patient, something I find similar or closely related to distancing behavior, favored by the nurses in this factor.

I find the concept of un-reflective actions close to the concept of "impediments to development of clinical knowledge and ethical judgement" (Rubin, 2009). Rubin, through an interview based study, isolated a practice that do not seem to fit the levels of development, as described by Benner and Wrubel (1989), nor does it have any developmental trajectory of its own. She found a group of nurses, which after years of experience in their field, should have been professional experts, but had never developed to that level. They were considered by their supervisors to be safe in their occupational practice, however not experts in the sense described by Benner and Wrubel.

The concept of Rubin's nurses fits my impression of Factor 2. They lack developing and learning skills considered to define professional expertise, they lack reflective processing, and as I will go more into in the next chapter, they lack a will for identifying, defining and understanding other people's perspectives and point of view. In summary; where Factor 1 nurses represent the eager learner, trying to prepare to new and unfamiliar situations, Factor 3 nurses do reflection on the go, during their activities, adapting to the patients behavior and needs. Factor 2 nurses go about their business, attending to the patients and the organization's demands, but with less focus on critical reflection than the others do.

5.2 Distancing as a strategy for dealing with emotional work

In the Q-set, several statements describe distancing as a technique, and particularly Factor 2 have agreed to them. As described above, interpreting these findings as proof of apathy, antipathy or as a negative trait of these nurses would be too obvious, so I have tried to look for an explanation hidden behind the obvious and feel I have found it in the theme of relational distance versus closeness.

The theoretical work of Jordan (2001), and the research of Bailey (2011) was introduced in the section on emotional awareness (chapter 2.2). The similarities between Jordan's and Bailey's work is mainly found in the common field of awareness. Both describe increasing awareness, in both inner emotions and the observations, and those of others. Jordan focuses more on the concept of awareness itself, while Bailey has a more operationalized approach through research and collected data from the field of nursing. More importantly for this thesis, both approaches describe distancing as a behavior. A poor strategy, hindering development and potentially to cause danger to the nurses' health through raised levels of stress, according to Bailey et al. (2011). Jordan, on the other hand describe emotional distancing as a coping strategy to dampen negative emotions running too high. He claims that this not necessarily is a bad strategy, but a behavior that keeps emotions from taking over all the attention and consciousness of the person experiencing them (Jordan, 2001).

Factor 3 nurses show in their sorting to prioritizing emotional control. They favor adapting their emotional expression to get the best out of a situation, but they also sort negatively statements describing distancing and being emotionally detached. This makes me think of these nurses as unafraid to engage in emotional situations, and at the same time never to turn off their emotions or to be unaware of this side of their work. They seem to have found some balance in a practice of professional distance, but not emotional and relational detachment.

Factor 1 nurses have some of the same sorting of statements describing distancing as unlike themselves, but focus on being unacquainted with the generalization of others more than the emotional sides of distancing. Particular statement 36, talk about actively distancing yourself so that emotions cannot run off with the whole situation. While Factor 3 nurses rate this as very unlike them, nurses in Factor 1 has this as a neutral. Thus leading me to assume that the latter group of nurses are less emotional conscious. Furthermore, they know that generalization is problematic and to some extent, they might seem to confuse the emotional detachment of generalizing behavior, with the emotionally aware, but reserved, distancing techniques of Factor 3.

Describing nurses in Factor 2 and their inclination towards the procedural and automated, one could look to the concept of expert nurses' intuitive decision-making and embodied intelligence as described by Benner and Wrubel or Daley (1989; 1999). The embodied

intelligence would make it possible for the nurses to focus their attention on less tangible elements of the situation. Except other parts of their sortings show emotional distance and unreflective practice not corresponding with that level of development.

Another way of understanding this preference for the routine based nursing would be that these nurses are emotionally switched-off, cold and mechanical in practice and showing relational rejection towards patients, as well as colleagues. However, I feel that is not the case with these nurses, and understanding this factor view has meant taking a second look at the array and at the theory. Rubin's findings have given me a less judgmental framework to describe these nurses.

One of the particulars of Rubin's nurses is their inability to differentiate patients and to individualize their cases, but rather generalize and mix them together. Factor 2 nurses have sorted several statements, including elements of such generalizations, quite high. Terms like "a grey mass" and "just another number in the line" show a objectifying and desensitizing to each individuals unique situation. Rubin also describe how the nurses find it difficult to distinguish their own meaning making from that of their patients, and this in turn also makes it difficult to acknowledge their own importance and role as stakeholders in decisions made concerning the patient. Common for Rubin's nurses was also a feeling of not having made any difference in the situations at hand. I see a clear link to how the nurses in the ED might end up feeling they have no real significance in the patient's situation, except for filling in admission papers and documentation, before calling for an orderly to bring the patient to the next, and more correct, level of care.

5.3 Searching for alternate perspectives

The three factors have different approaches to searching for, and grasping alternate perspectives. Factor 2 nurses sort statements depicting openness to change and adapting your behavior negatively. These statements are, in part, representative to searching for and being open to other people's perspectives. By sorting the statements negatively, the Factor 2 nurses lets us know that this is unlike their practice, meaning they avoid taking patient perspective into consideration or changing their ways because of patient feedback.
Rubin's (2009) findings have been misinterpreted by many as being judgmental towards the nurses' skills and competencies. Benner, as editor of the book where she publicized her

research, stresses that this is not the case (Rubin, 2009). Rubin's particular research is imperative to understand and complement the theories of the skillful and virtuous expert nurse when compared with a group of nurses and a practice that is emotionally disengaged from their work and who do not fit the existing theories of professional development. To compare Factor 2 nurses with Rubin's nurses is not meant to be harsh or judging, but to illustrate and explain my interpretation of this factor through already existing research and academic writings. Indeed, finding this factor and Rubin's description, I have reflected on whether or not these nurses are more suitable than any for work in the ED. They do not spend any unnecessary time reflecting on the tacit sciences, but instead follows protocol and gets the job done, with a minimal of time needed to reflect, analyze, communicate, document and "see" the whole of the patient situation.

Factor 1 and Factor 3 both are open to taking the patient perspective. However, taking a patient perspective is not only about addressing other points of views, but to sincerely accept the fact that you, yourself, might be wrong in your opinions. Compared to Factor 1, the Factor 3 nurses sort statements regarding taking the patient perspective in a more inconsistent way. Nevertheless, statements regarding questioning your own opinions and perspectives are sorted positively and found to be recognizable to how they practice their nursing.

Factor 1 nurses are unaware of openness to change and adapting their actions based on the patients' responses. This is an important element in emotional labour and in emotional intelligence, for that matter (Goleman, 1995; Hochschild, 2003). Sorting statements regarding perspective-taking to the mid-section of the matrix, do not mean that the Factor 1 nurses frown upon this behavior or distance themselves from it, but rather that they are not aware of this as concepts in their way of practicing nursing. In my view, this accentuates the impression of their inexperience, as their attentiveness not yet fully can hold the other's perspective in addition to their own. Given mentoring and guidance, they may be able to build a capacity for this.

Adult development, in the workplace or through further education, might facilitate such development. Reflective practice is one way of achieving development. Not only for the novices, but also for the expert nurse to stay reflective and not be stuck in old patterns. The developmental potential of Factor 2 nurses would be interesting to explore further. Identifying

such nurses would be difficult except for as part of a voluntary developmental program exploring the areas of nursing as identified in this thesis. Making unreflective practice conscious and aware to the nurses would perhaps be challenging, but also potentially propel them into a developmental trajectory for proficiency (Jarvis, 2006; Rubin, 2009).

5.4 The tacit sciences in the hospital - The two-legged model…

In the data from the three factors, supplemented by elements from theory, there are several perspectives and approaches to nursing that come into focus. I have begun to view these more as lines or axis. An axis like relational closeness versus distance does not have a distinct right or wrong side. The expert nurse needs to find a balanced approach, adapted to the specifics of each case, by considering the situation, relation, resources, timeline and many other variables. Nothing is black or white, but rather different tones of grey, complementing the uniqueness of the context in which you are to act.

I have spent a long time cultivating and finishing this thesis work. The time spent has also offered me time to reflect on the research question from different perspectives, both in my academic development but also as a professional. I have moved from the position as a nurse in the ED, to doing humanist counselling within the frames of the hospital chaplaincy. Through this transition, I have been introduced to new perspectives and thoughts on nursing and healthcare professionals in general. Discussing with colleague chaplains, especially at Utrecht Medical Center (UMC), a University Hospital in the Netherlands, a new structured view of hospital life has emerged to me in the form of a dichotomy of the hospital work, as shown in table 5. This is a coarse, incomplete and crude description of some of the outlines of work and everyday life in the hospital. It covers themes as communication, knowledge, science, affects, role and relations. Nevertheless, it also represents a simplified framework from which to discuss different facets and extremes of hospital work. The list below is inspired by the UMC Chaplaincy's Strategy document for 2014-2020 (unpublished).

Table 5: The Dichotomy of Hospital work

“Hard”	“Soft”
Patient	Person
Diagnosis	Ailment
Symptom	Feeling
Fact	Experiences
Distance	Closeness
Rational	Emotional
Treatment	Care
Dependence	Mutuality
Body	Human
Profession	Interdisciplinary
Individual	Group
Argumentation	Reflection
Objective	Subjective
Procedure	Individualized care
Read	Interpret
Avoid	Uncover

These two pillars of contradictions, or axis of opposites is not to be understood as constants for how people work, but rather a series of continuums on which we all move from one side to the other, depending on the situation. Some tendencies to cling to one side or the other can be attributed to sex, age, experience, occupation, and so on. Much like the tendencies to cling to one particularly comfortable mode of reflection as described by Kolb and his Learning Style Inventory, but nevertheless being able to use other styles and modes too. Furthermore Kahneman’s work on intuition describe similar polarities between system 1 and system 2, and he also stress that these should not be understood as mutually exclusive (2011).

Some research suggest that taking a more emotional approach to the care for the patients will increase effectivity (Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001). At the very least, this dichotomy gives you a structure from which you can discuss and reflect on you sciences. The crucial element though, according to the chaplains of UMC, is the acknowledging that you need both extremes. Like in walking, you need both legs to get anywhere, and you need to keep your balance as you shift from one leg to the other. This is also similar to Røkenes et

al.'s (2012) work on relational competencies and communication skills for professionals, where they point out that relational understanding, skills and reflections are crucial for occupational competence in all professionals working with people (Røkenes et al., 2012, p. 9).

The expert nursing, then, lies not in mastering closeness, nor distance, like in Factors 1 and 2 respectably. It lies in mastering both extremes, and to gently sway between techniques, modes and systems, as the patient or the situation demands it. This balancing act is more present in Factor 3 than the other factor views. When analyzing the array of Factor 3, I found dispersion across the whole scale rather than distinct clusters of statements concerning certain topics. A good example is the finding that the nurses favored emotional and affective control, but at the same time dissociated themselves from distancing as a concept.

Mastering these different outer rims of nursing and health-care means having action strategies and tools to meet all the different demands present in the health-care system. I find this particularly relevant to a department like the Norwegian Emergency Department. Including both trauma and acute medical life-threatening cases, the nurses are also expected to deal with deteriorating patients with chronic illnesses, psychiatric and psychosomatic patients, pediatric and orthopedic cases, addicts, the bereaved, the protective, the aggressive, the unconscious and also the palliative and dying patient.

Mastery of every possible nursing scenario is not possible, especially in the ED. However, it is possible to work towards mastering the shifts between different situations and different approaches to nursing. To accomplish this we would have to try to chart how each and every one in in the collegium reflect, learn and develop. We would need to build awareness of preferred action strategies relating to the way we empathize. We would have to build emotional awareness so that we sense the patient's needs, as well as our own, at an early stage in any situation.

In this chapter, I have discussed some themes that have come into focus for me working with this thesis. Taking patient perspectives and distancing as a technique are concepts closely connected and intertwined, but at the same time distinctly different in the three factors. I have also shown how the nurses have different preferences regarding reflection, and how this can be linked to different developmental levels. Particularly exciting to me is the way the nurses

differ in their practice, and how these all can be viewed as relevant for nursing in the ED. As presented in table 5 and chapter 5.4, we need both sides of the dichotomies to make the system work!

6 Conclusion

Answering my research question in a short sentence is close to impossible. Nevertheless, in short, the nurses in my study experience using reflection, in relation to empathy and emotional awareness, in very different ways, with different emphasis and different preferred modes of action. Seeing since the research question try to fathom tacit and illusive sides of nursing, it is interesting to have been able to get such clear and unlike factors in my dataset.

Factor 1 is the largest group, with 11 nurses, and corresponds well with the lower levels of developmental like the novice nurses. In the same way, Factor 3, with 4 nurses, fit the corresponding group of higher levels of development, like the expert nurses. Factor 2, with 5 nurses, I have not been able to fit into the developmental theory of Benner and Wrubel (1989), but show a more procedural focused nurse that do not spend much time reflecting, but focus on acting efficiently and in accordance to procedures and protocols alone.

The ED nurses apparently adhere to different strategies to deal with the emotional challenges in their work. These are relational and professional distancing as well as emotional detachment and being switched off. The nurses' ability to relate to a patient's perspective and the nurses ways of adapting and changing their actions, like in emotional labour, also varied from ignorance to full focus. Particularly defining and interpreting Factor 2, with their otherness from the other two factors and their deviation to common theoretical constructs have been interesting. These nurses and Rubin's research have shed a different light on a type of nursing easily judged as cold hearted and cynical, instead addressing their difference in taking perspectives, and emotional awareness.

I can see several areas where this knowledge can come to use. Both in working with professional development of nurses in the ED, for nursing educators in general and for raising awareness of their own skills among the nurses themselves. Working as a humanist chaplain, I also see the potential for using this theoretical material, and my findings, in lectures and presentations I give. In my work, I also serve as a partner in reflection with the staff, and it is useful to have some knowledge of different perspectives and developmental issues in nursing. Especially when it is related to the tacit and illusive sides of the soft science-leg of the healthcare system. In the somatic everyday life in a hospital, this type of knowledge is my opinion a bit out of focus, in general.

6.1 Methodological weaknesses and study limitations

Generalization is always a challenge using qualitative research methods, and being partly qualitative in its analysis, Q-method does not escape this weakness. At the same time, this weakness is also its strength. Going into depth in how this population experience and view the research topic, and how they quantify it in a factor analysis, gives me a way to understand both the large differences within the group as well as the commonalities. Using the Q-method I have also had to make choices in what effects to measure, nuances to look for and academic perspectives on which to build my design. This has put my focus of research in certain directions and closing up for discoveries in other dimensions of the research area.

Although 20 participants is not a large number of respondents, it represents approximately 15% of the staff in the studied department. Still the participation was voluntary and there by opens up to a skew representation in gender, age, seniority and other parameters. It would have been preferable to reference my findings with demographic variables, and to do post-interviews with those respondent most equal to the factor-arrays. As explained earlier, these variables was collected as a precondition for participation, but had to be deleted to secure the respondent's anonymity.

6.2 Practical implications

All people learn and evolve, both personally and professionally, as a part of and consequence to living and being an experiencing person. However, as shown in my research, different people have different modes of reflecting and learning. To some it might be ideal with classroom education, while for others, the same classroom might be detrimental for their possibility to reflect, test and develop new skills for acting. Where one nurse might enjoy collaborating and group reflection, another needs individual reflection and tutoring. This is the diversity of human development, and thereby professional development, which has to be covered by the ED's Research and Development staff.

The tacit sides of nursing, in my thesis represented by emotional self-awareness and empathic skills, can be hard to define, hard to identify in everyday tasks and hard to operationalize. Even the linguistics are a challenge as the terms and expressions vary in different languages. "Å føle" in Norwegian is not the same as the English term "to feel". The difficulties lie in

defining and agreeing on the content of concepts like empathy, sympathy, compassion, caring and concern. This then add to the challenges of correctly measuring and documenting such skills, and most certainly to teach them to others.

6.3 Possibilities for further research

The type of relational work nurses in the ED do differs from that of a nurse in a normal ward. Most patient relations are short, procedural and routine and this will most certainly shape the way ED nurses develop as professionals. Their arenas developing relational and emotional skills may then be different from those of, for example, the nurses in a ward, or a nursing home. It would be interesting to give the same research design to a P-set of another background. Also opening up for the fact that different departments have different cultures relating to this thesis focus areas, one could also use the design on a P-set from another hospital's ED.

If one were to implement varied arenas for learning and make available different modes of reflection for the employees, this should give the nurses a possibility to enhance their abilities to empathize with both patients and colleagues. Such development would of course differ depending on the nurses varying personal dispositions and preferences for learning styles and initial level of emotional awareness. Such interventions in the ward would open up for longitudinal studies to identify changes over time. Doing interventions on a ward level would also mean one could include other professions working in the same type of environment.

Litteraturliste

Argyris, C., & Schön, D. A. (1974). *Theory in practice: increasing professional effectiveness*. San Francisco: Jossey-Bass.

Bailey, C., Murphy, R., & Porock, D. (2011). Professional tears: developing emotional intelligence around death and dying in emergency work. *Journal of Clinical Nursing, 20*(23-24), 3364-3372. doi:10.1111/j.1365-2702.2011.03860.x

Benner, P. (1982). From novice to expert. *Am J Nurs, 82*(3), 402-407. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/6917683

Benner, P. (2004). Using the Dreyfus Model of Skill Acquisition to Describe and Interpret Skill Acquisition and Clinical Judgment in Nursing Practice and Education. *Bulletin of Science, Technology & Society, 24*(3), 188-199. doi:10.1177/0270467604265061

Benner, P., & Wrubel, J. (1989). *The primacy of caring: stress and coping in health and illness*. Menlo Park, Calif.: Addison-Wesley.

Benner, P., & Wrubel, J. (2001). *Omsorgens betydning i sygepleje: stress og mestring ved sundhed og sygdom*. København: Munksgaard.

Bie, K. (2007). *Refleksjonshåndboken : for bedre læring*. Oslo: Universitetsforlaget.

Blasi, Z. D., Harkness, E., Ernst, E., Georgiou, A., & Kleijnen, J. (2001). Influence of context effects on health outcomes: a systematic review. *The Lancet, 357*(9258), 757-762. doi:10.1016/S0140-6736(00)04169-6

Brinchmann, B. S. (2012). *Etikk i sykepleien* (3. utg. ed.). Oslo: Gyldendal akademisk.

Brown, S. R. (1991-1992). A Q Methodological Tutorial.

Chinn, P. L., & Kramer, M. K. (2015). *Knowledge Development in Nursing, theory and process* (9th ed. ed.). St. Louis: Elsevier Mosby.

Daley, B. J. (1999). Novice to Expert: An Exploration of How Professionals Learn. *Adult Education Quarterly, 49*(4), 133-147. doi:10.1177/074171369904900401

Davis, C. M. (1990). What Is Empathy, and Can Empathy Be Taught? *Physical Therapy, 70*(11), 707-711. Retrieved from http://ptjournal.apta.org/content/70/11/707.abstract

Dewey, J. (1933). How We Think: a restatement of the relation of reflective thinking to the educative process.

Dreyfus, S. E., & Dreyfus, H. L. (1980). *A Five-stage Model of the Mental Activities Involved in Directed Skill Acquisition*. Retrieved from https://books.google.no/books?id=dt4OnQEACAAJ

Floyd, A., & Arthur, L. (2012). Researching from within: external and internal ethical engagement. *International Journal of Research & Method in Education, 35*(2), 171-180. doi:10.1080/1743727X.2012.670481

Gjerde, S. (2010). *Coaching : hva - hvorfor - hvordan* (2. utg. ed.). Bergen: Fagbokforl.

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental, and social psychology perspectives. *Journal of Counseling Psychology, 30*(4), 467-482. doi:10.1037/0022-0167.30.4.467

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam Books.

Hochschild, A. R. (2003). *The managed heart: commercialization of human feeling*. Berkeley, Calif.: University of California Press.

Hojat, M. (2007). *Empathy in patient care: antecedents, development, measurement, and outcomes*. New York, N.Y.: Springer.

Holm, U., & Nilsen, L. (2005). *Empati : å forstå menneskers følelser*. Oslo: Gyldendal akademisk.

Jahoda, G. (2005). Theodor Lipps and the shift from "sympathy" to "empathy". *Journal of the History of the Behavioral Sciences, 41*(2), 151-163. doi:10.1002/jhbs.20080

Jarvis, P. (2006). *Towards a comprehensive theory of human learning*. London: Routledge.

Jordan, T. (2001). Self-awareness, metaawareness and the witness self. *Unpublished paper. Retrieved from: http://www. perspectus. se/tjordan*.

Kahneman, D. (2011). *Thinking, fast and slow*. New York: Farrar, Straus and Giroux.

Kinge, E. (2014). *Empati - nærvær eller metode?* Oslo: Gyldendal akademisk.

Kirkebøen, G. (2012). *Hva er intuisjon*. Oslo: Universitetsforl.

Kolb, D. A. (1984). *Experiential learning: experience as the source of learning and development*. Englewood Cliffs, N.J.: Prentice-Hall.

Kristoffersen, N. J. (1996). *Generell sykepleie : 1 : Fag og yrke : utvikling, verdier og kunnskap* (Vol. 1). Oslo: Universitetsforl.

Kunnskapsdepartementet. (2008). Rammeplan for sykepleierutdanning. Retrieved from https://www.regjeringen.no/globalassets/upload/kd/vedlegg/uh/rammeplaner/helse/rammeplan_sykepleierutdanning_08.pdf

Kvalsund, R. (1998). *A theory of the person : a discourse on personal reality and explication of personal knowledge through Q-methodology - with implications for counseling and education.* Department of Education, Faculty of Social Science and Technology Management, The Norwegian University of Science and Technology, Trondheim.

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. *Advances in Health Sciences Education, 14*(4), 595-621. doi:10.1007/s10459-007-9090-2

McKeown, B., & Thomas, D. (2013). *Q methodology* (Vol. 07-66). Thousand Oaks, Calif.: Sage.

Mitchell, J. T., & Everly, G. S. (2001). *Critical incident stress debriefing: an operations manual for CISD, defusing and other group crisis intervention services*. Ellicott City, MD: Chevron Pub.

Neukrug, E., Bayne, H., Dean-Nganga, L., & Pusateri, C. (2013). Creative and Novel Approaches to Empathy: A Neo-Rogerian Perspective. *Journal of Mental Health Counseling, 35*(1), 29-42. doi:doi:10.17744/mehc.35.1.5q375220327000t2

Olin, M. (2004). Dei mjuke hendene. Nesbru: Scanbox Entertainment Norway.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103. doi:10.1037/h0045357

Rubin, J. (2009). Expertise in Nursing Practice, Second Edition. In P. Benner, Tanner, C. & Chesla, C. (Ed.), *Expertice in Nursing Practice*. New York, US: Springer Publishing Company.

Røkenes, O. H., Hanssen, P.-H., & Tolstad, O. (2012). *Bære eller briste: kommunikasjon og relasjon i arbeid med mennesker*. Bergen: Fagbokforl.

Schmolck, P. (2014). PQMethode 2.35 with PQROT. http://schmolck.userweb.mwn.de/qmethod/downpqwin.htm.

Schön, D. A. (1995). *The reflective practitioner: how professionals think in action*. Aldershot: Arena.

Schön, D. A. (2001). *Den reflekterende praktiker : hvordan professionelle tænker, når de arbejder*. Århus: Klim.

Skau, G. M. (2011). *Gode fagfolk vokser: personlig kompetanse i arbeid med mennesker*. [Oslo]: Cappelen Damm akademisk.

Stein, E. (1964). *On the Problem of Empathy*

Thorsen, A., Allgood, E., Brown, S. R., & Berner, K. (2010). *Q-metodologi: en velegnet måte å u[t]forske subjektivitet*. Trondheim: Tapir akademisk.

Van Exel, N., & Graaf, G. d. (2005). Q methodology: A sneak preview (version 05.05).

Wahlgren, B. (2002). *Refleksion og læring : kompetenceudvikling i arbejdslivet* (1. udgave. ed.). Frederiksberg: Samfundslitteratur.

Wahlgren, B. (2010). *Voksnes læreprocesser: kompetenceudvikling i uddannelse og arbejde*. København: Akademisk forl.

Watts, S., & Stenner, P. (2012). *Doing Q methodological research: theory, method and interpretation*. Los Angeles: Sage.

Appendices

Appendix 1 - Q-set
Appendix 2 - Approval from NSD
Appendix 3 - Continuation from NSD
Appendix 4 - Approval Department Manager of Mottaksavdelingen, St. Olav's Hospital
Appendix 5 - Information Letter
Appendix 6 - Consent form
Appendix 7 - Instructions to study participants
Appendix 8 - Excerpts from statistical report
Appendix 9 - Visual presentation of the factor arrays

Appendix 1 - Research design, Q-set

1: Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang? (-1, -5, -5)
2: Skal jeg få til en god pasientkontakt må jeg forsøke å sette meg inn i pasientens situasjon og perspektiv, og å lytte til de signalene jeg får underveis fra pasienten. (5, 0, -1)
3: Pasientens situasjon kan noen ganger være emosjonelle berg og dalbaner, men skal jeg være den som har kontroll og følger opp planer og prosedyrer kan jeg ikke la følelsene flomme helt over med meg også. Da må jeg være profesjonell. (2, 3, 2)
4: Jeg planlegger og har noen antakelser for hvordan pasienten har det før jeg går inn. De er mine antakelser og stemmer ikke nødvendigvis med pasientens opplevelse av situasjonen. (1, 1, 4)
5: Man leser pasientens papirer og danner seg raskt en oppfatning av hva man har i vente. Men underveis i arbeidet kan det komme reaksjoner både hos meg og hos pasienten. (-2, 0, 2)
6: Hvis jeg etterpå tenker tilbake på en hendelse er det lettere å både se og å forstå hva som forårsaket pasientens opplevelse eller atferd. (1, 1, 1)
7: De fleste pasientene blir etter hvert et nummer i rekken, men det er alltid noen som utmerker seg og som "kommer under huden din". Sånne møter kan man ikke planlegge eller forberede, de bare skjer. (2, 4, -2)
8: Enkelte kontaktårsaker er så vanlig at de bare blir rutine. Da kan jeg lene meg tilbake og la klinisk blikk og magefølelse få styre måten jeg gir pleie og omsorg. (-3, 2, 0)
9: Noen pasienter provoserer og pusher grensene mine. Med faglig diskusjon og refleksjon rundt pasienttypen klarer jeg etterhvert å kjenne dem igjen, og å kjenne igjen hvordan jeg selv reagerer på dem. (1, 0, 3)
10: Enkelte pasienter blir bare en del av den grå massen. Jeg er forberedt og trygg på alle aktuelle prosedyrer og rutiner, og det er lite ved pasientmottaket som utmerker seg eller engasjerer meg. (-5, 4, -2)
11: Når pasienter opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedenfor har jeg lært meg til å smile og avvæpne pasienten. (-1, -3, 4)
12: Det blir lettere å se bakgrunnen for pasientens atferd og reaksjoner om jeg forsøker å se situasjonen fra pasientens ståsted. Da kan jeg også planlegge mine handlinger utfra hva jeg antar at pasienten vil foretrekke. (3, -1, 1)

13: Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv. (3, -4, 5)
14: Det er nyttig med tanke på læring og utvikling at jeg etterpå forsøker å gå igjennom mine egne handlinger og følelser som en selvstendig del av pasientsituasjonen. (2, -2, -1)
15: Jeg prøver å gå igjennom mine egne holdninger og reaksjoner etter et pasientmottak. Spesielt de gangene jeg merker at jeg har redusert pasienten til å kun være et romnummer og en diagnose. (-2, -3, 0)
16: Når en pasient blir meldt så kan historien og kontaktårsaken være nok til å vekke oppriktig omsorg og medfølelse fra meg. Det er viktig for meg å være oppmerksom på dette så ikke det "forstyrrer" den rasjonelle vurderingen av pasientens situasjon i mottaket. (3, 0, -1)
17: Noen ganger er faktisk jobben bare en jobb, og det er som om jeg er følelsesmessig "skrudd av" fra alle inntrykk og reaksjoner. Da får det heller bli prosedyrer og rutiner som styrer hva jeg gjør. (-3, 5, 1)
18: Jeg kan se at pasienten er engstelig og redd. Da føler jeg virkelig med ham eller henne, og prøver å nå inn til vedkommende og å hjelpe. (4, -1, -2)
19: Pasientkontakten i akuttavdelingen er effektiv, behovsstyrt og med fokus på å få pasienten raskt videre til et riktig behandlingsnivå. Men når jeg skal skrive eller gi rapport, kan jeg bli oppmerksom på hvor lite jeg egentlig vet om pasienten og pasientens situasjon. (0, 0, 0)
20: Et pasientmøte preget av dårlig kontakt og personkjemi kan ha mange årsaksforhold. Da er det viktig å også vurdere meg selv og min opplevelse av pasientene som en av disse faktorene. (0, -1, 2)
21: Når jeg identifiserer meg selv eller noen som står meg nær, kan pasientmøtet bli så nært og utfordrende at jeg blir følelsesmessig satt ut. (-3, 0, -1)
22: Når pasienten er sint og avvisende, er det lett å reagerer med sinne og avvisning selv. Jeg har lært meg å se det og klarer derfor å endre mine egne handlingsmønstre slik at jeg kan dempe konflikt og uro hos pasienten. (1, -1, 3)
23: Sykepleiedokumentasjonen og prosedyrene er nyttige å ha. Spesielt når pasientsituasjonen er så sterk eller vanskelig at jeg er i ferd med å miste rasjonaliteten og sakligheten til fordel for empati og omsorg for pasienten. (-2, 2, -4)
24: Jeg har bestemt med på forhånd for at dersom de pårørende begynner å gråte er det helt i orden om tårene triller hos meg også. (-4, 1, -3)

25: Noen ganger gjør man seg jo noen tanker etterpå om hvorvidt jeg kunne gjort mer? Men det er ikke alle pasientene som vekker følelser og engasjement hos meg. Noen pasienter er bare navn og diagnoser som skal prosesseres gjennom standardiserte forløp. (-1, 1, 2)
26: Det er enklere å akseptere andres oppfatninger av hva som skjedde hvis jeg har fått litt avstand til det hele. Både i tid og rom. Da har jeg kanskje fått egne følelser mer på avstand og kan lettere diskutere det som skjedde på en nøytral måte. (-1, -1, -1)
27: Du møter alle pasienter med antakelser om hvem han eller hun er. Det er viktig som sykepleier å gjenkjenne disse fordommene som "falske" og å kunne smidig tilpasse seg den "virkelige" pasienten uten at dette går utover pasientens opplevelse. (1, 2, 3)
28: Jeg opplever av og til at pasienten har negative følelser overfor meg. Da er det viktig å ikke la det gå inn over seg personlig, men prøve å se bakgrunnen for pasientens opplevelse og å vurdere behov for og eventuelle mulige endringer i pasientbehandlingen. (0, 2, 0)
29: Det hadde vært interessant å visst hva pasientene opplevde som nødvendig for at relasjonen og pasientmøtet skulle bli så godt som mulig. (2, -3, 1)
30: Jeg synes det er enklere å håndtere vanskelige pasientsituasjoner hvis jeg har fått tid til å forberede meg. Det handler om teknisk utstyr og prosedyrer såvel som situasjoner der pasientens emosjonelle behov er i fokus. (4, 1, 0)
31: Med bedre tid til faglig etterarbeide så kunne jeg kanskje klart å isolere både pasientens og mine egne reaksjonsmønstre og årsaksforhold. Det synes jeg er lettere å få frem etterpå når situasjonen har roet seg. (0, -2, -3)
32: Noen pasientmøter er så standard at jeg på forhånd har et godt bilde av hva pasienten står oppe i. Da slipper jeg å bruke lang tid på relasjonsarbeidet men kan handle utfra erfaring og mageføelse. Ting går gjerne med automatisk. (-2, 3, -3)
33: Det er vanskelig når en pasient mener at jeg ikke bryr meg og at jeg gjør en dårlig jobb. Da prøver jeg å sette meg i pasientens sted og forstå hvordan han/hun opplever situasjonen for så å endre min egen atferd. (-1, -2, 0)
34: I sykepleierdokumentasjonen kan jeg legge mine egne oppfatninger på bordet og diskutere pasientbildet. Slik kan jeg noen ganger utvikle nye tanker om pasienten og hans/hennes situasjon og opplevelse. (-4, -2, -2)
35: Å diskutere pasienten med kolleger gir et nytt perspektiv som kan utfordre meg på hvem jeg tror at pasienten er og på hvordan jeg forholder meg til han/henne. (0, -4, 1)
36: Jeg kan noen ganger ha valgt å aktivt distansere meg fra pasienten og situasjonen så ikke jeg blir revet med i de følelsesmessige opp eller nedturer de står i. (0, 3, -4)

Appendix 2 - Approval from NSD

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Camilla Fikse
Institutt for voksnes læring og rådgivningsvitenskap NTNU

7491 TRONDHEIM

Vår dato: 16.10.2013 Vår ref: 35612 / 2 / HIT Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 24.09.2013. Meldingen gjelder prosjektet:

35612	*Refleksjon og empati*
Behandlingsansvarlig	*NTNU, ved institusjonens øverste leder*
Daglig ansvarlig	*Camilla Fikse*
Student	*Cathrine Bang Hellum*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 31.12.2013, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Hildur Thorarensen

Kontaktperson: Hildur Thorarensen tlf: 55 58 26 54
Vedlegg: Prosjektvurdering
Kopi: Cathrine Bang Hellum Stokkanhaugen 54 7048 TRONDHEIM

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / District Offices
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Appendix 3 - Continuation from NSD

BEKREFTELSE PÅ ENDRING

Vi viser til statusmelding mottatt 11.03.2014.
Personvernombudet har nå registrert ny dato for prosjektslutt 31.08.2014.
Det legges til grunn at prosjektopplegget for øvrig er uendret.
Ved ny prosjektslutt vil vi rette en ny statushenvendelse.

Hvis det blir aktuelt med ytterligere forlengelse, gjør vi oppmerksom på at utvalget vanligvis må informeres ved forlengelse på mer enn ett år utover det de tidligere har blitt informert om.

Ta gjerne kontakt dersom du har spørsmål.

Vennlig hilsen,
Lene Christine M. Brandt - Tlf: 55 58 89 26
Epost: lene.brandt@nsd.uib.no

Personvernombudet for forskning,
Norsk samfunnsvitenskapelig datatjeneste AS Tlf. direkte: (+47) 55 58 81 80

AFFIRMATION

Referring to status report received 11.03.2014.

The Data Protection Official has registered that the project period has been extended until 31.08.2014.

We presuppose that the project otherwise remains unchanged.

You will receive a new status inquiry at the end of the project.

Please note that in case of further extensions, the data subjects should usually receive new information if the total extension exceeds a year beyond what they previously have received information about.

Do not hesitate to contact us if you have any questions.

Best regards,
Lene Christine M. Brandt - Phone number: 55 58 89 26
Email: lene.brandt@nsd.uib.no

The Data Protection Official for Research, Norwegian Social Science Data Services Phone number (switchboard): (+47) 55 58 81 80

Appendix 4 - Letter to Department Manager Mottaksavdelingen St.Olavs Hospital

Til avdelingssykepleier

”Refleksjon som verktøy i emosjonelt arbeid.”

Som avslutning på min masterutdannelse i Rådgivningsvitenskap ved NTNU skal jeg gjennomføre et forskningsprosjekt innenfor temaet refleksjon og emosjonelt arbeid. Formålet med studien er å avdekke hvordan sykepleiere i akuttmottak opplever å benytte refleksjon i utvikling og styrking av egen emosjonell kompetanse, spesielt med tanke på empati og emosjonell bevissthet.

Deltagelse i prosjektet er basert på frivillighet og datainnsamlingen vil bli gjort gjennom Q-metodologisk sortering av setninger og påstander som omhandler problemstillingen. Dette tar ca. 1 time for den enkelte informanten. Forskningsdataene vil bli anonymisert. Faktoranalyse og bearbeiding av dataene vil danne grunnlaget for diskusjon og resultater av studien. Oppgaven vil etter godkjenning, bli gjort tilgjengelig for interesserte gjennom DIVA.

Jeg ber med dette om tillatelse til å invitere sykepleiere ved din avdeling. Jeg håper at prosjektet vekker interesse og at du som avdelingssykepleier har anledning til å videreformidle informasjon om prosjektet. Vedlagt finner du et infoskriv som kan henges opp i avdelingen og eventuelt sirkuleres til ansatte. Interesserte sykepleiere kan ta kontakt med meg for mer informasjon og nærmere avtale.

På forhånd takk!

Med vennlig hilsen
Cathrine Bang Hellum
cathrba@stud.ntnu.no
Mob: 905 34 963

Appendix 5 - Information letter

Forespørsel om deltakelse i forskningsprosjektet

"Refleksjon som verktøy i emosjonelt arbeid."

Bakgrunn og formål

Som avslutning på min masterutdannelse i Rådgivningsvitenskap ved NTNU skal jeg gjennomføre et forskningsprosjekt innenfor temaet refleksjon og emosjonelt arbeid. Formålet med studien er å avdekke hvordan sykepleiere i et akuttmottak opplever å benytte refleksjon i utvikling og styrking av egen emosjonell kompetanse, spesielt med tanke på empati og emosjonell bevissthet.

Innenfor akuttaksen er mye av fag og kompetanseutviklingen fokusert på målbare og konkrete ferdigheter. Emosjonell- og relasjonskompetanse er ikke like lett å måle, og står sjelden på agendaen under fagdager og liknende. Like fullt er dette kompetanseområder man som sykepleier arbeider med hver eneste vakt og som er grunnleggende for god sykepleie. Jeg har i studien valgt å fokusere på sykepleiere ansatt i akuttmottaket ved St.Olavs Hospital og ønsker derfor akkurat deg som informant!

Hva innebærer deltakelse i studien?

Studien skal utføres ved en forskningsmetode kalt Q-metodologi. Du vil få tildelt en rekke utsagn og påstander som omhandler ulike sider ved problemstillingen. Disse skal så prioriteres og settes inn i et rammeverk i forhold til hva du kjenner deg mest og minst igjen i. Dette arbeidet gjøres på papir og sendes inn i en ferdig frankert konvolutt du får utlevert sammen med det øvrige materialet. Dataene vil senere bli samlet og bearbeidet digitalt. Foruten sorteringen av påstandene er det ønskelig å registrere ansiennitet og kjønn i datamaterialet. Dette skyldes at enkelte teoretikere fokuserer på nettopp disse to variablene som relevante i hvordan både refleksjon, emosjonelt arbeid og empati arter seg hos den enkelte.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt og det er kun undertegnede og veileder ved NTNU som vil ha tilgang til hele datasettet. Dataene vil ikke inneholde noen direkte personidentifiserende opplysninger. Indirekte identifiserende opplysninger som kjønn og ansiennitet vil bli kategorisert slik at identifisering ikke vil være mulig verken i masteroppgaven eller i eventuelle publikasjoner.

Prosjektet skal etter planen avsluttes 31.08.2014. Muntlig forsvar av oppgaven kan ventes å skje i løpet av høsten og etter dette vil alle rådata slettes.

Frivillig deltakelse

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert. Ved innsending av dataene vil du som deltaker være anonymisert og det vil etter dette derfor ikke være mulig å spore den enkeltes bidrag lenger.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med student Cathrine Bang Hellum på 90534963 eller per mail: cathrine.b.hellum@gmail.com eller veileder Camilla Fikse på 73590470 eller per mail: camilla.fikse@svt.ntnu.no

Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Appendix 6 - Consent form (unsigned)

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien "Refleksjon som verktøy i emosjonelt arbeid", og er villig til å delta som informant.

Navn (blokkbokstaver)

_____

Kontakttelefon

_____

(Signert av prosjektdeltaker, dato)

Kan legges i posthylle nr. 46. Du vil deretter bli kontaktet for en nærmere avtale om praktisk gjennomføring av datainnsamlingen.

Appendix 7 - Instructions to study participants

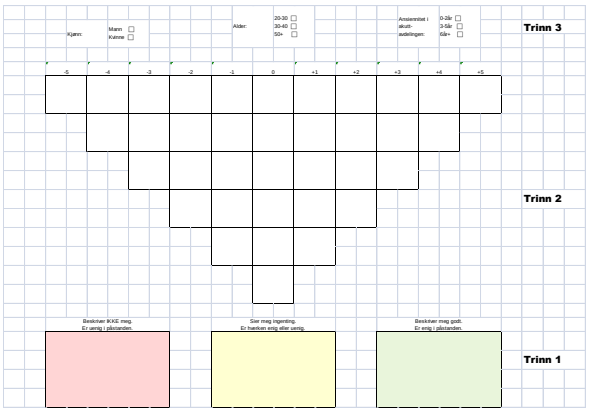
Instruks for sortering

Dette studiet baserer seg på en q-metodologisk tilnærming. Gjennom sortering av ulike utsagn som belyser problemstillingen på forskjellige måter og påfølgende faktoranalyse vil vi kunne avdekke likheter og nyanser mellom grupper av sykepleiere og deres opplevelse av problemstillingen. Det er derfor viktig at du underveis i sorteringsprosessen forsøker å holde deg mentalt "på jobb" slik at sorteringen representerer deg som sykepleier i akuttmottaket og ikke som privatperson eller med en annen rolle som utgangspunkt.

Arbeidet kan ta 30-60 minutter og gjøres best ved et stort bord eller på gulvet. Det kan være mange lapper å passe på til å begynne med, men følg instruksjonene så vil arbeidet bli enklere. Om du skulle ha spørsmål underveis i sorteringen må du gjerne kontakte meg for veiledning, enten via telefon: 90534963 eller mail: cathrine.b.hellum@gmail.com.

I sorteringsarbeidet vil vi at du følger følgende oppskrift:

- Åpne studiekonvolutten. Den skal inneholde:
  -et stort ark med opptegnede områder og rammer som skal hjelpe deg i sorteringen
  -36 ulike små kort som alle har påtrykket en setning/påstand og et nummer
  -en ferdig frankert og adressert svarkonvolutt
  Brett utover det store arket foran deg og ta frem kortene.



Noen pasienter er alltid utakknemlige. Jeg prøver å være imøtekommende, men får man noe hyggelig igjen...?		Jeg prøver alltid å være imøtekommende, men utakknemlige pasienter kan gjøre at jeg mister gnisten.
	Enkelte pasientgrupper er vanskelig å engasjere seg i. Da følger jeg kun prosedyrer.	
Når pasienter opptrer aggressivt, kan jeg selv ofte ha lyst til å bli kort og skarp tilbake. Istedetfor har jeg lært meg til å smile og avvæpne pasienten.		Vi lo så tårene trillet! Pasienten syntes det var veldig festlig, og jeg syntes det var godt å kunne slippe løs litt latter for engangs skyld. Det er nok noe jeg burde gjort oftere?

- Les igjennom alle kortene. Etterhvert som du leser på kortet skal du gjøre deg opp en mening om setningen passer godt for deg, om den ikke beskriver deg i det hele tatt, eller om du er likegyldig til påstanden som står på kortet. Legg kortet løst i bunker på de ulike rammene for dette på arket. Når du har sortert og fordelt alle kortene i de tre ulike bunkene er du klar for neste trinn.
- Legg til side bunkene for utsagn du er uenig og likegyldig til. Pass på at de ikke blandes eller kan forveksles. Ta kortene med utsagn du er enig i og spre dem utover bordet foran deg. Du skal nå rangere påstandene og plassere dem inn i matrisen/rammene ut fra hvor enig du er i påstanden. Den påstanden som best passer for deg som sykepleier i akuttmottaket skal plasseres lengst til høyre på +5. De to som passer nest best plasseres i rutene for +4, og så videre.
- Når du har plassert alle ifra "enig"-bunken er det på tide å sortere kortene fra "uenig"-bunken. Disse skal rangeres og plasseres i rammen på samme måte, men da speilvendt og mot venstre side av matrisen: Det kortet du er mest uenig i og som

beskriver deg minst skal plasseres lengst til venstre på plassen for -5, og så videre inn mot midten.

- Til sist tar du bunken over påstandene du er likegyldig til eller som ikke sier deg noe, og gjør en siste rangering og fordeling inn i rammene. De påstandene som er litt beskrivende for hvem du er som sykepleier plasseres på den positive siden, mens de påstandene du ikke kjenner deg igjen i plasseres mot den negative siden. Tilslutt vil du ha fylt hele matrisen med påstander.
- Se nå over sorteringene dine, og gjør eventuelle siste rokkeringer.
- På alle kortene står et nummer. Løft vekk kortet og skriv nummeret inn i rubrikken hvor det lå. Til slutt vil alle rubrikkene være fylt inn med et nummer og kortene kan legges vekk. Du er nå ferdig med trinn 2.
- Til sist ønsker vi at du krysser av for korrekte opplysninger om kjønn, alder og ansiennitet i akuttavdelingen. Disse opplysningene vil kunne gi en bredere forståelse for elementene erfaring, modning og kjønnsperspektiv til de endelige resultatene.
- Brett så sammen arket og putt alt materialet i den vedlagte ferdig adresserte konvolutten. Legg konvolutten i en postkasse eller i posthyllen min på jobb om du ønsker det.

Jeg vil få minne om at denne studien er frivillig og at du som respondent fritt kan trekke deg fra studien helt frem til du har sendt inn konvolutten. Etter dette er bidraget ditt ikke lenger sporbart tilbake til deg.

Om du skulle har spørsmål underveis eller i etterkant av sorteringen/deltakelsen må du gjerne kontakte meg på cathrine.b.hellum@gmail.com. Etter innlevering og eksamen vil oppgaven i sin helhet bli gjort tilgjengelig gjennom DIVA, en elektronisk database over ulike akademiske arbeider ved NTNU og hvis akseptert kunne publiseres i fagtidsskrift.

Tusen takk for at du har sagt deg villig til å delta og takk for bidraget ditt!

Med vennlig hilsen

Cathrine Bang Hellum

Appendix 8 - Excerpts from statistical report

Loadings

This table shows the three-factor solution chosen and the factor loadings for each statement, explanatory variance for each factor and the number of defining sorts found in the material.

Q-sort	Factor 1	Factor 2	Factor 3
1	-0.0200	**0.9439X**	-0.0554
2	0.1905	-0.0250	**0.9138X**
3	**0.7262X**	-0.1872	0.1696
4	0.2152	**-0.7988X**	0.0410
5	**0.7866X**	-0.0239	0.0168
6	**0.5898X**	-0.1506	0.2782
7	**0.4744X**	-0.4419	0.1260
8	-0.0346	-0.1063	**0.8717X**
9	**0.7186X**	0.2053	0.1795
10	0.2040	-0.1775	**0.9245X**
11	0.0270	**0.9018X**	-0.0591
12	**0.8082X**	-0.0946	-0.0341
13	**0.4798X**	-0.4757	0.0172
14	-0.0206	**0.8802X**	-0.0091
15	**0.6389X**	-0.2734	-0.2742
16	**0.7020X**	-0.3705	0.0556
17	0.2217	0.3955	**0.7304X**
18	**0.6084X**	0.3002	0.2577
19	-0.2379	**0.7808X**	0.1231
20	**0.5880X**	-0.1094	0.1971
% explanatory variance	25	24	17
Number of defining sorts	11	5	4

Reliability Coefficient

This table shows the average reliability coefficient for each factor. For more info, see the text.

	Factor 1	Factor 2	Factor 3
Number of Defining Variables	11	5	4
Average Reliability Coefficient	0.800	0.800	0.800
Composite Reliability	0.978	0.952	0.941

Correlations Between Factor Scores

	Factor 1	Factor 2	Factor 3
1	1.0000	-0.2185	0.2770
2	-0.2185	1.0000	-0.0967
3	0.2770	-0.0967	1.0000

Unrotated Factor Matrix

	Factors							
Sorts	1	2	3	4	5	6	7	8
1	-0.5947	0.6646	-0.3149	-0.1226	0.1538	0.1319	0.0273	0.0221
2	0.4103	0.5499	0.6333	-0.0096	0.0058	0.1332	-0.0179	-0.1203
3	0.7053	0.2377	-0.1930	-0.2715	0.0106	0.0407	-0.2032	-0.4034
4	0.6508	-0.4876	0.1571	0.1921	-0.2753	-0.1847	0.1647	0.0285
5	0.6110	0.3005	-0.3950	-0.1602	-0.0953	-0.1514	0.3022	-0.0501
6	0.6107	0.2700	-0.0454	0.6751	-0.0692	0.1368	-0.0624	0.0236
7	0.6560	-0.0742	-0.0187	-0.4721	-0.0997	-0.3203	0.1914	0.1040
8	0.2779	0.3783	0.7430	-0.1445	0.1297	-0.1895	0.0165	0.2296
9	0.4676	0.5322	-0.2981	-0.0869	0.4105	-0.2171	-0.2991	0.1159
10	0.5147	0.4476	0.6801	-0.0716	0.0489	0.0559	-0.0322	-0.0500
11	-0.5351	0.6497	-0.3302	0.0587	0.0378	-0.1170	0.2106	-0.0231
12	0.6555	0.2288	-0.4258	-0.0401	-0.2397	-0.1289	-0.1967	-0.1395
13	0.6503	-0.1561	-0.0979	0.1279	0.3778	0.3241	0.3973	0.0532
14	-0.5442	0.6419	-0.2588	0.0876	-0.1260	-0.1425	0.2288	-0.0117
15	0.5687	-0.1005	-0.4739	-0.1223	-0.2205	0.3052	-0.1937	0.4324
16	0.7652	0.0303	-0.2160	0.1650	0.2410	-0.2324	0.0041	0.1508
17	0.1318	0.7760	0.3456	0.0002	-0.3318	0.0869	0.0423	0.1238
18	0.3495	0.6017	-0.2060	-0.3719	-0.0778	0.3304	0.1023	0.0010
19	-0.6119	0.5540	-0.0093	0.3075	-0.0826	-0.1523	-0.1372	0.1530
20	0.5623	0.2562	-0.1213	0.7007	-0.0034	-0.0399	0.0516	-0.1104
Eigen-value	6.3544	4.0923	2.6391	1.6587	0.7583	0.7457	0.6566	0.5447
% explained variance	32	20	13	8	4	4	3	3

Factor Q-Sort Values for Each Statement

No.	Statement	Factor 1	Factor 2	Factor 3
1	Det finnes pasienter som kommer ordentlig under huden på d…	-1	-5	-5
2	Skal jeg få til en god pasientkontakt må jeg forsøke å set…	5	0	-1
3	Pasientens situasjon kan noen ganger være emosjonelle berg…	2	3	2
4	Jeg planlegger og har noen antakelser for hvordan pasiente…	1	1	4
5	Man leser pasientens papirer og danner seg raskt en oppfat…	-2	0	2
6	Hvis jeg etterpå tenker tilbake på en hendelse er det let…	1	1	1
7	De fleste pasientene blir etter hvert et nummer i rekken, …	2	4	-2
8	Enkelte kontaktårsaker er så vanlig at de bare blir rutine…	-3	2	0
9	Noen pasienter provoserer og pusher grensene mine. Med fag…	1	0	3
10	Enkelte pasienter blir bare en del av den grå massen. Jeg…	-5	4	-2
11	Når pasienter opptrer aggressivt, kan jeg lett få lyst ti…	-1	-3	4
12	Det blir lettere å se bakgrunnen for pasientens atferd og…	3	-1	1
13	Når jeg er i tvil om en pasientsituasjon kan jeg gå til e…	3	-4	5
14	Det er nyttig med tanke på læring og utvikling at jeg ett…	2	-2	-1
15	Jeg prøver å gå igjennom mine egne holdninger og reaksjon…	-2	-3	0
16	Når en pasient blir meldt så kan historien og kontaktårsa…	3	0	-1
17	Noen ganger er faktisk jobben bare en jobb, og det er som…	-3	5	1
18	Jeg kan se at pasienten er engstelig og redd. Da føler je…	4	-1	-2
19	Pasientkontakten i akuttavdelingen er effektiv, behovssty…	0	0	0
20	Et pasientmøte preget av dårlig kontakt og personkjemi ka…	0	-1	2
21	Når jeg identifiserer meg selv eller noen som står meg næ…	-3	0	-1
22	Når pasienten er sint og avvisende, er det lett å reagere…	1	-1	3

23	Sykepleiedokumentasjonen og prosedyrene er nyttige å ha. …	-2	2	-4
24	Jeg har bestemt med på forhånd for at dersom de pårørende…	-4	1	-3
25	Noen ganger gjør man seg jo noen tanker etterpå om hvorvi…	-1	1	2
26	Det er enklere å akseptere andres oppfatninger av hva som…	-1	-1	-1
27	Du møter alle pasienter med antakelser om hvem han eller …	1	2	3
28	Jeg opplever av og til at pasienten har negative følelser…	0	2	0
29	Det hadde vært interessant å visst hva pasientene opplevd…	2	-3	1
30	Jeg synes det er enklere å håndtere vanskelige pasientsit…	4	1	0
31	Med bedre tid til faglig etterarbeide så kunne jeg kanskj…	0	-2	-3
32	Noen pasientmøter er så standard at jeg på forhånd har et…	-2	3	-3
33	Det er vanskelig når en pasient mener at jeg ikke bryr me…	-1	-2	0
34	I sykepleierdokumentasjonen kan jeg legge mine egne oppfa…	-4	-2	-2
35	Å diskutere pasienten med kolleger gir et nytt perspektiv…	0	-4	1
36	Jeg kan noen ganger ha valgt å aktivt distansere meg fra …	0	3	-4

Variance = 5.833 St. Dev. = 2.415

Distinguishing Statements for Factor 1

(P < .05 ; Asterisk (*) Indicates Significance at P < .01)

No.	Statement	Factor 1	Factor 2	Factor 3
2	Skal jeg få til en god pasientkontakt må jeg forsøke å se…	5 *	0	-1
30	Jeg synes det er enklere å håndtere vanskelige pasientsit…	4 *	1	0
18	Jeg kan se at pasienten er engstelig og redd. Da føler je…	4 *	-1	-2
13	Når jeg er i tvil om en pasientsituasjon kan jeg gå til e…	3 *	-4	5
12	Det blir lettere å se bakgrunnen for pasientens atferd og…	3	-1	1
16	Når en pasient blir meldt så kan historien og kontaktårsa…	3	0	-1
14	Det er nyttig med tanke på læring og utvikling at jeg ett…	2 *	-2	-1
7	De fleste pasientene blir etter hvert et nummer i rekken,…	2 *	4	-2
22	Når pasienten er sint og avvisende, er det lett å reagere…	1	-1	3
36	Jeg kan noen ganger ha valgt å aktivt distansere meg fra …	0 *	3	-4
31	Med bedre tid til faglig etterarbeide så kunne jeg kanskj…	0 *	-2	-3
1	Det finnes pasienter som kommer ordentlig under huden på…	-1 *	-5	-5
11	Når pasienter opptrer aggressivt, kan jeg lett få lyst ti…	-1 *	-3	4
25	Noen ganger gjør man seg jo noen tanker etterpå om hvorvi…	-1 *	1	2
32	Noen pasientmøter er så standard at jeg på forhånd har et…	-2 *	3	-3
5	Man leser pasientens papirer og danner seg raskt en oppfa…	-2	0	2
23	Sykepleiedokumentasjonen og prosedyrene er nyttige å ha.…	-2 *	2	-4
8	Enkelte kontaktårsaker er så vanlig at de bare blir rutin…	-3 *	2	0
21	Når jeg identifiserer meg selv eller noen som står meg næ…	-3 *	0	-1
17	Noen ganger er faktisk jobben bare en jobb, og det er som…	-3 *	5	1
34	I sykepleierdokumentasjonen kan jeg legge mine egne oppfa…	-4 *	-2	-2
10	Enkelte pasienter blir bare en del av den grå massen. Jeg…	-5 *	4	-2

Distinguishing Statements for Factor 2

(P < .05 ; Asterisk (*) Indicates Significance at P < .01)

No.	Statement	Factor 1	Factor 2	Factor 3
17	Noen ganger er faktisk jobben bare en jobb, og det er som…	-3	5 *	1
7	De fleste pasientene blir etter hvert et nummer i rekken,…	2	4 *	-2
10	Enkelte pasienter blir bare en del av den grå massen. Jeg…	-5	4 *	-2
36	Jeg kan noen ganger ha valgt å aktivt distansere meg fra…	0	3 *	-4
32	Noen pasientmøter er så standard at jeg på forhånd har et…	-2	3 *	-3
23	Sykepleiedokumentasjonen og prosedyrene er nyttige å ha…	-2	2 *	-4
24	Jeg har bestemt med på forhånd for at dersom de pårørende…	-4	1 *	-3
16	Når en pasient blir meldt så kan historien og kontaktårsa…	3	0	-1
5	Man leser pasientens papirer og danner seg raskt en oppfa…	-2	0	2
12	Det blir lettere å se bakgrunnen for pasientens atferd og…	3	-1	1
20	Et pasientmøte preget av dårlig kontakt og personkjemi ka…	0	-1	2
22	Når pasienten er sint og avvisende, er det lett å reagere…	1	-1 *	3
11	Når pasienter opptrer aggressivt, kan jeg lett få lyst ti…	-1	-3 *	4
15	Jeg prøver å gå igjennom mine egne holdninger og reaksjon…	-2	-3 *	0
29	Det hadde vært interessant å visst hva pasientene opplevd…	2	-3 *	1
35	Å diskutere pasienten med kolleger gir et nytt perspektiv…	0	-4 *	1
13	Når jeg er i tvil om en pasientsituasjon kan jeg gå til e…	3	-4 *	5

Distinguishing Statements for Factor 3

(P < .05 ; Asterisk (*) Indicates Significance at P < .01)

No.	Statement	Factor 1	Factor 2	Factor 3
13	Når jeg er i tvil om en pasientsituasjon kan jeg gå til e…	3	-4	5 *
11	Når pasienter opptrer aggressivt, kan jeg lett få lyst ti…	-1	-3	4 *
4	Jeg planlegger og har noen antakelser for hvordan pasiente…	1	1	4 *
9	Noen pasienter provoserer og pusher grensene mine. Med fag…	1	0	3 *
22	Når pasienten er sint og avvisende, er det lett å reagere…	1	-1	3
5	Man leser pasientens papirer og danner seg raskt en oppfa…	-2	0	2
12	Det blir lettere å se bakgrunnen for pasientens atferd og…	3	-1	1
17	Noen ganger er faktisk jobben bare en jobb, og det er som…	-3	5	1 *
16	Når en pasient blir meldt så kan historien og kontaktårsa…	3	0	-1
10	Enkelte pasienter blir bare en del av den grå massen. Jeg…	-5	4	-2 *
7	De fleste pasientene blir etter hvert et nummer i rekken,…	2	4	-2 *
32	Noen pasientmøter er så standard at jeg på forhånd har et…	-2	3	-3 *
36	Jeg kan noen ganger ha valgt å aktivt distansere meg fra…	0	3	-4 *
23	Sykepleiedokumentasjonen og prosedyrene er nyttige å ha…	-2	2	-4 *

Consensus Statements

Those That Do Not Distinguish Between ANY Pair of Factors.

All Listed Statements are Non-Significant at P>.01, and Those Flagged With an * are also Non-Significant at P>.05.

No.	Statement	Factor 1	Factor 2	Factor 3
6*	Hvis jeg etterpå tenker tilbake på en hendelse er det le…	1	1	1
19*	Pasientkontakten i akuttavdelingen er effektiv, behovssty…	0	0	0
26*	Det er enklere å akseptere andres oppfatninger av hva som…	-1	-1	-1
28*	Jeg opplever av og til at pasienten har negative følelser…	0	2	0
33*	Det er vanskelig når en pasient mener at jeg ikke bryr me…	-1	-2	0

Appendix 9 - Visual presentations of the factor arrays

The distinguishing statements being statistically significant to the factor, is marked with a gray background, the dark one to a .01 level and the lighter one to a .05.

Faktor 1

-5	-4	-3	-2	-1	0
10 Enkelte pasienter blir bare en del av den grå massen. Jeg er forberedt og trygg på alle aktuelle prosedyrer og rutiner, og det er lite ved pasientmottaket som utmerker seg eller engasjerer meg.	24 Jeg har bestemt med på forhånd for at dersom de pårørende begynner å gråte er det helt i orden om tårene triller hos meg også.	8 Enkelte kontaktårsaker er så vanlig at de bare blir rutine. Da kan jeg lene meg tilbake og la klinisk blikk og magefølelse få styre måten jeg gir pleie og omsorg.	5 Man leser pasientens papirer og danner seg raskt en oppfatning av hva man har i vente. Men underveis i arbeidet kan det komme reaksjoner både hos meg og hos pasienten.	1 Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang?	19 Pasientkontakten i akuttavdelingen er effektiv, behovsstyrt og med fokkus på å få pasienten raskt videre til et riktig behandlingsnivå. Men når jeg skal skrive eller gi rapport, kan jeg bli oppmerksom på hvor lite jeg egentlig vet om pasienten og pasientens situasjon.
	34 I sykepleierdokumentasjonen kan jeg legge mine egne oppfatninger på bordet og diskutere pasientbildet. Slik kan jeg noen ganger utvikle nye tanker om pasienten og hans/hennes situasjon og opplevelse.	17 Noen ganger er faktisk jobben bare en jobb, og det er som om jeg er følelsesmessig "skrudd av" fra alle innstrykkk og reaksjoner. Da får det heller bli prosedyrer og rutiner som styrer hva jeg gjør.	12 Jeg prøver å gå igjennom mine egne holdninger og reaksjoner etter et pasientmottak. Spesielt de gangene jeg merker at jeg har redusert pasienten til å kun være et romnummer og en diagnose.	11 Når pasienter opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedetfor har jeg lært meg til å smile og avvæpne pasienten.	20 Et pasientmøte preget av dårlig kontakt og personkjemi kan ha mange årsaksforhold. Da er det viktig å også vurdere meg selv og min opplevelse av pasientene som en av disse faktorene.
		21 Når jeg identifiserer meg selv eller noen som står meg nær, kan pasientmøtet bli så nært og utfordrende at jeg blir følelsesmessig satt ut.	23 Sykepleiedokumentasjonen og prosedyrene er nyttige å ha. Spesielt når pasientsituasjonen er så sterk eller vanskelig at jeg er i ferd med å miste rasjonaliteten og sakligheten til fordel for empati og omsorg for pasienten.	25 Noen ganger gjør man seg jo noen tanker etterpå om hvorvidt jeg kunne gjort mer? Men det er ikke alle pasientene som vekker følelser og engasjement hos meg. Noen pasienter er bare navn og diagnoser som skal prosesseres gjennom standardiserte forløp.	28 Jeg opplever av og til at pasienten har negative følelser overfor meg. Da er det viktig å ikke la det gå inn over seg personlig, men prøve å se bakgrunnen for pasientens opplevelse og å vurdere behov for og eventuelle mulige endringer i pasientbehandlingen.
			32 Noen pasientmøter er så standard at jeg på forhånd har et godt bilde av hva pasienten står oppe i. Da slipper jeg å bruke lang tid på relasjonsarbeidet men kan handle utfra erfaring og magefølelse. Ting går gjerne med automatisk.	26 Det er enklere å akseptere andres oppfatninger av hva som skjedde hvis jeg har fått litt avstand til det hele. Både i tid og rom . Da har jeg kanskje fått egne følelser mer på avstand og kan lettere diskutere det som skjedde på en nøytral måte.	31 Med bedre tid til faglig etterarbeide så kunne jeg kanskje klart å isolere både pasientens og mine egne reaksjonsmønstre og årsaksforhold. Det synes jeg er lettere å få frem etterpå når situasjonen har roet seg.
				33 Det er vanskelig når en pasient mener at jeg ikke bryr meg og at jeg gjør en dårlig jobb. Da prøver jeg å sette meg i pasientens sted og forstå hvordan han/hun opplever situasjonen for så å endre min egen atferd.	35 Å diskutere pasienten med kolleger gir et nytt perspektiv som kan utfordre meg på hvem jeg tror at pasienten er og på hvordan jeg forholder meg til han/henne.
					36 Jeg kan noen ganger ha valgt å aktivt distansere meg fra pasienten og situasjonen så ikke jeg blir revet med i de følelsesmessige opp eller nedturer de står i.

+1	+2	+3	+4	+5
4 Jeg planlegger og har noen antakelser for hvordan pasienten har det før jeg går inn. De er mine antakelser og stemmer ikke nødvendigvis med pasientens opplevelse av situasjonen.	3 Pasientens situasjon kan noen ganger være emosjonelle berg og dalbaner, men skal jeg være den som har kontroll og følger opp planer og prosedyrer kan jeg ikke la følelsene flomme helt over med meg også. Da må jeg være profesjonell.	12 Det blir lettere å se bakgrunnen for pasientens atferd og reaksjoner om jeg forsøker å se situasjonen fra pasientens ståsted. Da kan jeg også planlegge mine handlinger utfra hva jeg antar at pasienten vil foretrekke.	18 Jeg kan se at pasienten er negstelig og redd. Da føler jeg virkelig med ham eller henne, og prøver å nå inn til vedkommende og å hjelpe.	2 Skal jeg få til en god pasientkontakt må jeg forsøke å sette meg inn i pasientens situasjon og perspektiv, og å lytte til de signalene jeg får underveis fra pasienten.
6 Hvis jeg etterpå tenkter tilbake på en hendelse er det lettere å både se og å forstå hva som forårsaket pasientens opplevelse eller atferd.	7 De fleste pasientene blir etter hvert et nummer i rekken, men det er alltid noen som utmerker seg og som "kommer under huden din". Sånne møter kan man ikke planlegge eller forberede, de bare skjer.	13 Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv.	30 Jeg synes det er enklere å håndtere vanskelige pasientsituasjoner hvis jeg har fått tid til å forberede meg. Det handler om teknisk utstyr og prosedyrer såvel som situasjoner der pasientens emosjonelle behov er i fokus.	
9 Noen pasienter provoserer og pusher grensene mine. Med faglig diskusjon og refleksjon rundt pasienttypen klarer jeg etterhvert å kjenne dem igjen, og å kjenne igjen hvordan jeg selv reagerer på dem.	14 Det er nyttig med tanke på læring og utvikling at jeg etterpå forsøker å gå igjennom mine egne handlinger og følelser som en selvstendig del av pasientsituasjonen.	16 Når en pasient blir meldt så kan historien og kontaktårsaken være nok til å vekke oppriktig omsorg og medfølelse fra meg. Det er viktig for meg å være oppmerksom på dette så ikke det "forstyrrer" den rasjonelle vurderingen av pasientens situasjon i mottaket.		
22 Når pasienten er sint og avvisende, er det lett å reagerer med sinne og avvisning selv. Jeg har lært meg å se det og klarer derfor å endre mine egne handlingsmønstre slik at jeg kan dempe konflikt og uro hos pasienten.	29 Det hadde vært interessant å visst hva pasientene opplevde som nødvendig for at relasjonen og pasientmøtet skulle bli så godt som mulig.			
27 Du møter alle pasienter med antakelser om hvem han eller hun er. Det er viktig som sykepleier å gjenkjenne disse fordommene som "falske" og å kunne smidig tilpasse seg den "virkelige" pasienten uten at dette går utover pasientens opplevelse.				

Faktor 2

-5	-4	-3	-2	-1	0
1 Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang?	13 Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv.	11 Når pasienter opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedetfor har jeg lært meg til å smile og avvæpne pasienten.	14 Det er nyttig med tanke på læring og utvikling at jeg etterpå forsøker å gå igjennom mine egne handlinger og følelser som en selvstendig del av pasientsituasjonen.	12 Det blir lettere å se bakgrunnen for pasientens atferd og reaksjoner om jeg forsøker å se situasjonen fra pasientens ståsted. Da kan jeg også planlegge mine handlinger utfra hva jeg antar at pasienten vil foretrekke.	2 Skal jeg få til en god pasientkontakt må jeg forsøke å sette meg inn i pasientens situasjon og perspektiv, og å lytte til de signalene jeg får underveis fra pasienten.
	35 Å diskutere pasienten med kolleger gir et nytt perspektiv som kan utfordre meg på hvem jeg tror at pasienten er og på hvordan jeg forholder meg til han/henne.	15 Jeg prøver å gå igjennom mine egne holdninger og reaksjoner etter et pasientmottak. Spesielt de gangene jeg merker at jeg har redusert pasienten til å kun være et romnummer og en diagnose.	31 Med bedre tid til faglig etterarbeide så kunne jeg kanskje klart å isolere både pasientens og mine egne reaksjonsmønstre og årsaksforhold. Det synes jeg er lettere å få frem etterpå når situasjonen har roet seg.	18 Jeg kan se at pasienten er negstelig og redd. Da føler jeg virkelig med ham eller henne, og prøver å nå inn til vedkommende og å hjelpe.	5 Man leser pasientens papirer og danner seg raskt en oppfatning av hva man har i vente. Men underveis i arbeidet kan det komme reaksjoner både hos meg og hos pasienten.
		29 Det hadde vært interessant å visst hva pasientene opplevde som nødvendig for at relasjonen og pasientmøtet skulle bli så godt som mulig.	33 Det er vanskelig når en pasient mener at jeg ikke bryr meg og at jeg gjør en dårlig jobb. Da prøver jeg å sette meg i pasientens sted og forstå hvordan han/hun opplever situasjonen for så å endre min egen atferd.	20 Et pasientmøte preget av dårlig kontakt og personkjemi kan ha mange årsaksforhold. Da er det viktig å også vurdere meg selv og min opplevelse av pasientene som en av disse faktorene.	9 Noen pasienter provoserer og pusher grensene mine. Med faglig diskusjon og refleksjon rundt pasienttypen klarer jeg etterhvert å kjenne dem igjen, og å kjenne igjen hvordan jeg selv reagerer på dem.
			34 I sykepleierdokumentasjonen kan jeg legge mine egne oppfatninger på bordet og diskutere pasientbildet. Slik kan jeg noen ganger utvikle nye tanker om pasienten og hans/hennes situasjon og opplevelse.	22 Når pasienten er sint og avvisende, er det lett å reagerer med sinne og avvisning selv. Jeg har lært meg å se det og klarer derfor å endre mine egne handlingsmønstre slik at jeg kan dempe konflikt og uro hos pasienten.	16 Når en pasient blir meldt så kan historien og kontaktårsaken være nok til å vekke oppriktig omsorg og medfølelse fra meg. Det er viktig for meg å være oppmerksom på dette så ikke det "forstyrrer" den rasjonelle vurderingen av pasientens situasjon i mottaket.
				26 Det er enklere å akseptere andres oppfatninger av hva som skjedde hvis jeg har fått litt avstand til det hele. Både i tid og rom . Da har jeg kanskje fått egne følelser mer på avstand og kan lettere diskutere det som skjedde på en nøytral måte.	19 Pasientkontakten i akuttavdelingen er effektiv, behovsstyrt og med fokkus på å få pasienten raskt videre til et riktig behandlingsnivå. Men når jeg skal skrive eller gi rapport, kan jeg bli oppmerksom på hvor lite jeg egentlig vet om pasienten og pasientens situasjon.
					21 Når jeg identifiserer meg selv eller noen som står meg nær, kan pasientmøtet bli så nært og utfordrende at jeg blir følelsesmessig satt ut.

+1	+2	+3	+4	+5
4 Jeg planlegger og har noen antakelser for hvordan pasienten har det før jeg går inn. De er mine antakelser og stemmer ikke nødvendigvis med pasientens opplevelse av situasjonen.	8 Enkelte kontaktårsaker er så vanlig at de bare blir rutine. Da kan jeg lene meg tilbake og la klinisk blikk og magefølelse få styre måten jeg gir pleie og omsorg.	3 Pasientens situasjon kan noen ganger være emosjonelle berg og dalbaner, men skal jeg være den som har kontroll og følger opp planer og prosedyrer kan jeg ikke la følelsene flomme helt over med meg også. Da må jeg være profesjonell.	7 De fleste pasientene blir etter hvert et nummer i rekken, men det er alltid noen som utmerker seg og som "kommer under huden din". Sånne møter kan man ikke planlegge eller forberede, de bare skjer.	17 Noen ganger er faktisk jobben bare en jobb, og det er som om jeg er følelsesmessig "skrudd av" fra alle innstrykkk og reaksjoner. Da får det heller bli prosedyrer og rutiner som styrer hva jeg gjør.
6 Hvis jeg etterpå tenkter tilbake på en hendelse er det lettere å både se og å forstå hva som forårsaket pasientens opplevelse eller atferd.	23 Sykepleiedokumentasjonen og prosedyrene er nyttige å ha. Spesielt når pasientsituasjonen er så sterk eller vanskelig at jeg er i ferd med å miste rasjonaliteten og sakligheten til fordel for empati og omsorg for pasienten.	32 Noen pasientmøter er så standard at jeg på forhånd har et godt bilde av hva pasienten står oppe i. Da slipper jeg å bruke lang tid på relasjonsarbeidet men kan handle utfra erfaring og magefølelse. Ting går gjerne med automatisk.	10 Enkelte pasienter blir bare en del av den grå massen. Jeg er forberedt og trygg på alle aktuelle prosedyrer og rutiner, og det er lite ved pasientmottaket som utmerker seg eller engasjerer meg.	
24 Jeg har bestemt med på forhånd for at dersom de pårørende begynner å gråte er det helt i orden om tårene triller hos meg også.	27 Du møter alle pasienter med antakelser om hvem han eller hun er. Det er viktig som sykepleier å gjenkjenne disse fordommene som "falske" og å kunne smidig tilpasse seg den "virkelige" pasienten uten at dette går utover pasientens opplevelse.	36 Jeg kan noen ganger ha valgt å aktivt distansere meg fra pasienten og situasjonen så ikke jeg blir revet med i de følelsesmessige oppeller nedturer de står i.		
25 Noen ganger gjør man seg jo noen tanker etterpå om hvorvidt jeg kunne gjort mer? Men det er ikke alle pasientene som vekker følelser og engasjement hos meg. Noen pasienter er bare navn og diagnoser som skal prosesseres gjennom standardiserte forløp.	28 Jeg opplever av og til at pasienten har negative følelser overfor meg. Da er det viktig å ikke la det gå inn over seg personlig, men prøve å se bakgrunnen for pasientens opplevelse og å vurdere behov for og eventuelle mulige endringer i pasientbehandlingen.			
30 Jeg synes det er enklere å håndtere vanskelige pasientsituasjoner hvis jeg har fått tid til å forberede meg. Det handler om teknisk utstyr og prosedyrer såvel som situasjoner der pasientens emosjonelle behov er i fokus.				

Faktor 3

-5	-4	-3	-2	-1	0
1 Det finnes pasienter som kommer ordentlig under huden på deg og da kan jeg ofte sitte på fritiden og gruble over pasientmottaket. Hva oppfattet jeg av situasjons, hva tenkte jeg om det jeg så, hva følte jeg og hva var vurderingene mine? Hva kan jeg lære til neste gang?	23 Sykepleiedokumentasjonen og prosedyrene er nyttige å ha. Spesielt når pasientsituasjonen er så sterk eller vanskelig at jeg er i ferd med å miste rasjonaliteten og sakligheten til fordel for empati og omsorg for pasienten.	24 Jeg har bestemt med på forhånd for at dersom de pårørende begynner å gråte er det helt i orden om tårene triller hos meg også.	7 De fleste pasientene blir etter hvert et nummer i rekken, men det er alltid noen som utmerker seg og som "kommer under huden din". Sånne møter kan man ikke planlegge eller forberede, de bare skjer.	2 Skal jeg få til en god pasientkontakt må jeg forsøke å sette meg inn i pasientens situasjon og perspektiv, og å lytte til de signalene jeg får underveis fra pasienten.	8 Enkelte kontaktårsaker er så vanlig at de bare blir rutine. Da kan jeg lene meg tilbake og la klinisk blikk og magefølelse få styre måten jeg gir pleie og omsorg.
	36 Jeg kan noen ganger ha valgt å aktivt distansere meg fra pasienten og situasjonen så ikke jeg blir revet med i de følelsesmessige opp eller nedturer de står i.	31 Med bedre tid til faglig etterarbeide så kunne jeg kanskje klart å isolere både pasientens og mine egne reaksjonsmønstre og årsaksforhold. Det synes jeg er lettere å få frem etterpå når situasjonen har roet seg.	10 Enkelte pasienter blir bare en del av den grå massen. Jeg er forberedt og trygg på alle aktuelle prosedyrer og rutiner, og det er lite ved pasientmottaket som utmerker seg eller engasjerer meg.	14 Det er nyttig med tanke på læring og utvikling at jeg etterpå forsøker å gå igjennom mine egne handlinger og følelser som en selvstendig del av pasientsituasjonen.	15 Jeg prøver å gå igjennom mine egne holdninger og reaksjoner etter et pasientmottak. Spesielt de gangene jeg merker at jeg har redusert pasienten til å kun være et romnummer og en diagnose.
		32 Noen pasientmøter er så standard at jeg på forhånd har et godt bilde av hva pasienten står oppe i. Da slipper jeg å bruke lang tid på relasjonsarbeidet men kan handle utfra erfaring og magefølelse. Ting går gjerne med automatisk.	18 Jeg kan se at pasienten er negstelig og redd. Da føler jeg virkelig med ham eller henne, og prøver å nå inn til vedkommende og å hjelpe.	16 Når en pasient blir meldt så kan historien og kontaktårsaken være nok til å vekke oppriktig omsorg og medfølelse fra meg. Det er viktig for meg å være oppmerksom på dette så ikke det "forstyrrer" den rasjonelle vurderingen av pasientens situasjon i mottaket.	19 Pasientkontakten i akuttavdelingen er effektiv, behovsstyrt og med fokkus på å få pasienten raskt videre til et riktig behandlingsnivå. Men når jeg skal skrive eller gi rapport, kan jeg bli oppmerksom på hvor lite jeg egentlig vet om pasienten og pasientens situasjon.
			34 I sykepleierdokumentasjonen kan jeg legge mine egne oppfatninger på bordet og diskutere pasientbildet. Slik kan jeg noen ganger utvikle nye tanker om pasienten og hans/hennes situasjon og opplevelse.	21 Når jeg identifiserer meg selv eller noen som står meg nær, kan pasientmøtet bli så nært og utfordrende at jeg blir følelsesmessig satt ut.	28 Jeg opplever av og til at pasienten har negative følelser overfor meg. Da er det viktig å ikke la det gå inn over seg personlig, men prøve å se bakgrunnen for pasientens opplevelse og å vurdere behov for og eventuelle mulige endringer i pasientbehandlingen.
				26 Det er enklere å akseptere andres oppfatninger av hva som skjedde hvis jeg har fått litt avstand til det hele. Både i tid og rom . Da har jeg kanskje fått egne følelser mer på avstand og kan lettere diskutere det som skjedde på en nøytral måte.	30 Jeg synes det er enklere å håndtere vanskelige pasientsituasjoner hvis jeg har fått tid til å forberede meg. Det handler om teknisk utstyr og prosedyrer såvel som situasjoner der pasientens emosjonelle behov er i fokus.
					33 Det er vanskelig når en pasient mener at jeg ikke bryr meg og at jeg gjør en dårlig jobb. Da prøver jeg å sette meg i pasientens sted og forstå hvordan han/hun opplever situasjonen for så å endre min egen atferd.

+1	+2	+3	+4	+5
6 Hvis jeg etterpå tenkter tilbake på en hendelse er det lettere å både se og å forstå hva som forårsaket pasientens opplevelse eller atferd.	3 Pasientens situasjon kan noen ganger være emosjonelle berg og dalbaner, men skal jeg være den som har kontroll og følger opp planer og prosedyrer kan jeg ikke la følelsene flomme helt over med meg også. Da må jeg være profesjonell.	9 Noen pasienter provoserer og pusher grensene mine. Med faglig diskusjon og refleksjon rundt pasienttypen klarer jeg etterhvert å kjenne dem igjen, og å kjenne igjen hvordan jeg selv reagerer på dem.	4 Jeg planlegger og har noen antakelser for hvordan pasienten har det før jeg går inn. De er mine antakelser og stemmer ikke nødvendigvis med pasientens opplevelse av situasjonen.	13 Når jeg er i tvil om en pasientsituasjon kan jeg gå til en kollega og søke råd. Når jeg snakker om og forteller kan det bli lettere å se pasienten i et nytt perspektiv.
12 Det blir lettere å se bakgrunnen for pasientens atferd og reaksjoner om jeg forsøker å se situasjonen fra pasientens ståsted. Da kan jeg også planlegge mine handlinger utfra hva jeg antar at pasienten vil foretrekke.	5 Man leser pasientens papirer og danner seg raskt en oppfatning av hva man har i vente. Men underveis i arbeidet kan det komme reaksjoner både hos meg og hos pasienten.	22 Når pasienten er sint og avvisende, er det lett å reagerer med sinne og avvisning selv. Jeg har lært meg å se det og klarer derfor å endre mine egne handlingsmønstre slik at jeg kan dempe konflikt og uro hos pasienten.	11 Når pasienter opptrer aggressivt, kan jeg lett få lyst til å bli kort og skarp tilbake. Istedetfor har jeg lært meg til å smile og avvæpne pasienten.	
17 Noen ganger er faktisk jobben bare en jobb, og det er som om jeg er følelsesmessig "skrudd av" fra alle innstrykkk og reaksjoner. Da får det heller bli prosedyrer og rutiner som styrer hva jeg gjør.	20 Et pasientmøte preget av dårlig kontakt og personkjemi kan ha mange årsaksforhold. Da er det viktig å også vurdere meg selv og min opplevelse av pasientene som en av disse faktorene.	27 Du møter alle pasienter med antakelser om hvem han eller hun er. Det er viktig som sykepleier å gjenkjenne disse fordommene som "falske" og å kunne smidig tilpasse seg den "virkelige" pasienten uten at dette går utover pasientens opplevelse.		
29 Det hadde vært interessant å visst hva pasientene opplevde som nødvendig for at relasjonen og pasientmøtet skulle bli så godt som mulig.	25 Noen ganger gjør man seg jo noen tanker etterpå om hvorvidt jeg kunne gjort mer? Men det er ikke alle pasientene som vekker følelser og engasjement hos meg. Noen pasienter er bare navn og diagnoser som skal prosesseres gjennom standardiserte forløp.			
35 Å diskutere pasienten med kolleger gir et nytt perspektiv som kan utfordre meg på hvem jeg tror at pasienten er og på hvordan jeg forholder meg til han/henne.				

Appendix 10 - Research design, Q-set, in English

Translated by me.

1: There are patients that really get under your skin, and then I can often sit on my off-hours pondering about the patient admission. What did I perceive in the situation, what did I think about what I saw, what did I feel and what were my assessments? What can I learn from this until next time.? (-1, -5, -5)
2: If I am to get a good contact with the patient, I must try to put myself in the patient's situation and perspective, and to listen to the signals the patient gives me during our time together. (5, 0, -1)
3: The patient's situation can sometimes be on an emotional roller coaster, but if I am to be the one in control and the one to follow up on plans and procedures, I cannot let my own feelings get in the way. I have to stay professional. (2, 3, 2)
4: I plan and have some assumptions about how the patient is doing before I enter. They are my assumptions, and they do not necessarily correlate with the patient's experience and impression. (1, 1, 4)
5: Reading the patient's papers one quickly form a conception about what to expect. However, during the work, there might be reactions both with me and with the patient. (-2, 0, 2)
6: If I, in retrospect, reflect on an incident, it is easier both to percieve and understand what caused the patient's experience or behavior (1, 1, 1)
7: Most patients eventually become just a number in the line, but there are always some that stands out and "get under your skin". Such encounters cannot be planned or prepared, they just occur. (2, 4, -2)
8: Some reasons for admission are so common they end up being routines. Then I can lean back and let my clinical assessment and gut feeling control the way I nurse and give care (-3, 2, 0)
9: Some patients are provoking and push my boundaries. With professional discussion and reflection regarding the type of patient, I learn to recognize them, and also to recognize my own reactions towards these types. (1, 0, 3)
10: Some patients just become part of a grey mass. I am prepared and feel safe about all relevant procedures and routines, and there is little about the situation that stands out or excites me. (-5, 4, -2)

11: When patients act aggressively, I feel the urge to respond in the same way. Instead, I have learned to smile and defuse the patient. (-1, -3, 4)
12: It is easier to see the reasons for the patient's reactions and behaviors if I try to look at the situation from the patient's point of view. This also makes me able to plan my actions based on what I think the patient would prefer. (3, -1, 1)
13: When I'm in doubt regarding a patient situation, I can seek advice with a colleague. When I tell and talk about, it might be easier to see the patient in a new perspective. (3, -4, 5)
14: Regarding learning and development, it is useful to, in retrospect, to go through my own actions and emotions as an independent part of the patient whole situation. (2, -2, -1)
15: After a patient admission, I try to go through my own attitudes and reactions. Especially the times I have reduced the patient to only being a room number and a diagnose. (-2, -3, 0)
16: When a patient is announced to arrive, the patient history and reason for contact can be enough to illicit sincere care and compassion from my part. It is important for me to be aware of this, so it does not disturb the rational judgment of the patient during admission. (3, 0, -1)
17: Sometimes the job is just a job, and it seems that I am shut off from all impressions and reactions. I then rather will let routines and procedures take control of what I do. (-3, 5, 1)
18: I can see that the patient is afraid and anxious. Then I really feel sorry for him or her and I try to get a connection with them and to help (4, -1, -2)
19: In the ED, the patient contact is effective, controlled by demand and the focus is to quickly get the patient on to the correct level of treatment. But, when I am writing or giving off rapports, I can realize how little information I have about the patient and his/hers situation. (0, 0, 0)
20: A patient meeting that comes off with poor contact and bad chemistry can have many reasons. Then it is important to include me and my experience of the situation as one of the factors. (0, -1, 2)
21: When identifying with myself or someone close to me, the patient meeting can be so close and challenging that I am being emotionally put out of place. (-3, 0, -1)
22: When the patient is angry and dismissive, it is easy to react in the same way back. I have learned to see this, and can therefore change my own patterns of reaction, so I am able to calm the conflict and agitation in the patient. (1, -1, 3)

23: The nurse's documentation and the procedures are useful. Especially when the patient situation is so strong or difficult that I am about to lose my rationality and objectivity in favor of empathy and care for the patient. (-2, 2, -4)
24: I have decided in advance that if the patient's next of kin starts to cry, it is ok for me to cry as well. (-4, 1, -3)
25: Sometimes thoughts on whether I could have done something more emerges. But not all patients arouse feelings and dedication in me. Some patients are just names and diagnoses that are to be processed through standardized procedures. (-1, 1, 2)
26: It is easier to accept other people's views and takes on what happened after I have gotten some distance to it all, both in time and space. My own feelings are more manageable and it is easier to discuss the situation in a neutral way. (-1, -1, -1)
27: All patients are met with assumptions about who she or he is. As a nurse, it is important to recognize these biases as "false" and to adapt to the "real" patient without this affecting the patient's experience. (1, 2, 3)
28: I sometimes experience that the patient has negative feelings towards me. It is important to not take this personally, but instead try to see behind the patient's feelings and to consider the need and possibilities for potential changes in the patient treatment. (0, 2, 0)
29: It would have been interesting to know what the patients feel is neccessary for the relation between patient and nurse and their meeting to be as good as possible. (2, -3, 1)
30: If I have had time to prepare, I find it easier to manage difficult patient situations. It involves the use of technical equipment and procedures, as well as situations where the emotional needs of the patient are in focus. (4, 1, 0)
31: If given more time to do supplementary retrospective work, I might have been able to isolate both my own and the patient's reaction patterns and causalities. I find it easier to identify these afterwards, when the situation has calmed down (0, -2, -3)
32: Some patient meetings are so standard that I know beforehand what the patient is about. Then, I do not need to use a lot of time on the relational work, but can instead act upon experience and gut feeling. Things are progressing more automatically. (-2, 3, -3)
33: It is difficult when a patient thinks that I don't care and I am doing a lousy job. If so, I try to put myself in the patient's place and try to understand why he or she feels that way. I then change my way of behaving. (-1, -2, 0)

34: In the nurse's documentation, I can write down my own conceptions and discuss the patient situation. This way, I sometimes can develop new insights about the patient and his/hers situation and experiences. (-4, -2, -2)
35: Discussing the patient with colleagues gives me a new perspective that can challenge me in how I perceive the patient and how I relate to him/her. (0, -4, 1)
36: Sometimes I have actively decided to distance myself from the patient and the situation in order for me to not get involved in the emotional ups and downs. (0, 3, -4)