Exploring the relationship between perceived emotional intelligence, coping, social support and mental health in nursing students

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Studies conducted with nurses or nursing students have shown that emotional intelligence is a skill that minimizes the negative stress consequences. The present work examines the role of perceived emotional intelligence (PEI) measured by the Trait Meta-Mood Scale, in the use of stress-coping strategies, in the quantity and quality of social support and in the mental health of nursing students. The results indicated positive correlations between clarity and social support, social support and repair, and social support and mental health. Hierarchy regression analysis pointed out that clarity and emotional repair are predictors of social support, and emotional repair is the main predictor of mental health. These results show the importance of PEI in stress coping within the nursing framework.

Keywords: coping, emotional intelligence, health, nurses, TMMS

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Introduction

There has been a growing concern about stress in nursing during the last years (Owen 1995, O'Donnell 1996, Dinsdale 1998). Nursing is a complex profession which requires an continuous interaction with a variety of individuals (colleagues, clients or patients and families) in a high-stress environment (Reeves 2005). Therefore, nurses are easily affected by stress. Stress has different economic consequences as financial costs for employing organizations, and consequences in physical and psychological health (Kipping 2000). In nursing professionals, the effects that stress causes are various, including absenteeism (Wheeler & Riding 1994), somatic illnesses (Lindop 1999), coronary artery illnesses, alcoholism (McGrath *et al.* 1989), exhaustion in their professional skills and suicide attempts (Jones *et al.* 1987). The literature about occupational stress has

shown that all kinds of nurses are affected by the stress phenomenon: nursing students and nurses working in renal cares, in psychiatry (Hipwell *et al.* 1989, Foxall *et al.* 1990, Wheeler & Riding 1994, Ryan & Quayle 1999, Tully 2004) and in mental health cares (Munro *et al.* 1998, Dallender *et al.* 1999). A literature review (Magnussen & Amundson 2003) has highlighted nursing students' stressor factors: (1) difficulty in balancing home and college demands; (2) time pressure; (3) financial concerns; (4) feelings of distance from the faculty and staff in the clinical setting; (5) stress associated with feeling unprepared for clinical practice; and (6) feeling incompetent in clinical skills (Beck 1995, Hammil 1995, Jones & Johnston 1997, Lauder & Cuthbertson 1998, Brown & Edelmann 2000, Poorman *et al.* 2002). As stress affects a large number of nursing professionals and gives rise to different negative consequences, it is necessary to pay attention to the

resources or devices that nurses could use to diminish these effects.

Devices to diminish stress consequences

One of these devices are coping strategies which refer to how these professionals manage with the stressing event's demand. Coping is a process that is frequently present in the most important theories about organizational stress. Folkman & Lazarus (1984) defined coping as the cognitive and behavioural efforts in order to manage, reduce or tolerate the internal or external demands that have been created by a stressing transaction. The kind of conflict would determine the use of ones or other strategies. There are different factors that have influence on the selection and effectiveness of coping strategies. Therefore, it is important to establish a distinction between moderator and mediator variables. The former are those which are previous to the situation and that interact in the situation assessment process such as sex, socio-economic status or personality traits. The latter are generated by the own coping process (Folkman & Lazarus 1988). The family also has an important role as social support: familiar balance and the family's skill to cope with a difficult situation as a social group can affect the individual's stress-coping skill (Ali & Khalil 1991). In this sense, social support can be a stress-diminishing device (Laschinger & Havens 1997, Laschinger et al. 2001). One reason for social support mediation in stress could be that social support would increase the feeling control (Krause 1987).

Concerning stressing situation characteristics, we can say that literature has recognized the role played by the person himself or herself or close people's previous similar experiences. Hence, the person is more prepared to cope with stress when he or she has had similar experiences, as long as these experiences have not happened in an intense or fast succession. A traditional classification distinguishes between the strategies focused on the problem and the strategies focused on emotions, although the same person can use both of them in most stressing situations. Problem-based strategies are likely to predominate when the person feels that he or she can do something constructive, whereas emotion-based strategies are more prone to be used when the person feels that the stressing situation must be tolerated (Folkman & Lazarus 1980). Finally, we have to point out that people select the different strategies depending on the kind of conflict, and specifically, depending on a number of factors that also have influence on the coping strategy effectiveness. In short, the different factors that affect the coping strategy choice show that these strategies can be efficient in some conditions and inefficient in others, as they are very differently deter-

mined by stable and situational aspects (Augusto & Martínez de Antoñana 1998).

Emotional intelligence (EI) is another mechanism that could moderate stress influence (Slaski & Cartwright 2002, Limonero et al. 2004, Edward & Warelow 2005). EI is a construct about an individual skill that would help to understand better why some people are more prone to have negative consequences of the stress and however, others manage better the stress effects using more adaptive coping strategies. This construct got popularity with Daniel Goleman's book, titled *Emotional Intelligence* (Goleman 1995), and since then, it has increasingly appeared in popular literature (Cooper & Sawaf 1997, Wessinger 1998), making interest grow among the scientific community (Mayer & Salovey 1997, Bar-On & Parker 2000, Ciarrochi et al. 2001). Although research about this concept has been carried out from different theoretical conceptions, we will focus on Mayer & Salovey's (1997) perspective. These authors define the construct of EI as the people's skill to perceive, understand and express emotions. In accordance with this, EI refers to: (1) abilities to identify our own and others' emotions; (2) abilities to regulate and modify our mood in an adequate manner; and (3) abilities to improve our own thought. One of the most frequently used self-reports in EI measure, from our perspective, is the Trait Meta-Mood Scale (TMMS), created by Salovey et al. (1995). This questionnaire measures the perceived emotional intelligence (PEI) that refers to people's knowledge about their own emotional abilities and not about their own real abilities (Mayer et al. 2000, Salovey et al. 2001, 2002). The TMMS gives an estimation about our emotional experience subjective aspects. It contains three intrapersonal EI key dimensions (subscales): (1) attention to feelings ('I think about my mood state continuously'); (2) emotional clarity ('I usually fail to understand my feelings'); and (3) own emotion repair ('Although sometimes I feel sad, I usually have an optimist vision'). The studies conducted with this instrument have found an interesting relationship between this construct and different factors. Therefore, Gohm & Clore (2002) examined the coping styles and EI measured by the TMMS. The results showed that assessing emotional experience and being confident with our skills to pay attention, to understand and to regulate our emotions are associated with a more adaptive coping style. The authors found in two different samples that high total scores in the TMMS were significant in relation to positive reinterpretation and growth strategies, to more active coping, action planning and social and emotional support search. So, people with higher PEI scores were more prone to be concentrated on their emotions and ease them, but were not likely to avoid the stressing situation by means of behav-

iours or mental suppression. In general, the results have indicated that coping strategies are congruent with the person's affective state.

As far as nursing is concerned, an emotionally intelligent nurse is the one who can work in harmony with his or her thoughts and feelings (Freshwater & Stickley 2004). The importance of empathy development (as an aspect of emotional competence) appears as a central factor to play her or his role in many nursing theories (Peplau 1992, Newman 1994, Parker 2002). Some studies showed that EI allows nurses to develop therapeutic relationships, care for patients and their families and manage stress (Cadman & Brewer 2001, Simpson & Keegan 2002). The Limonero et al.'s (2004) study has shown that nursing professionals' expressed stress were negatively correlated with the clarity and repair components. In this way, nursing professionals, who knew their emotions, the situations that produced them and were able to regulate these emotions, had lower stress level in their jobs.

Extremera et al. (2003) pointed out that TMMS subscales (clarity, attention and repair) had important different effects on health. Thus, as far as attention is concerned, when people paid excessive attention to their emotions, an increase of ruminative thoughts and anxious-depressive mood states could be shown (Salovey et al. 1999). Other studies (Extremera & Fernández-Berrocal 2002, Salovey et al. 2002) have indicated that people with high attention on emotion level reported that they were more prone to have physical, depressive and anxious symptoms. Fernández-Berrocal et al. (2001) have also demonstrated that a high clarity and regulation of our emotions seemed to help reduce the subjective discomfort and negative emotions, as these people were less likely to present less anxious and depressive symptoms and more likely to present a higher life satisfaction.

The present work

This research is based on two essential evidences mentioned in previous works. The first one makes reference to the importance of coping strategies and EI as stress-diminishing devices, whereas the second lies on the fact that nursing professionals and students suffer from high stress levels which have important economic, psychological and physical consequences both for themselves and for patients. In this work, we suggest studying these variables in nursing students with the aim of studying the relationship between them in order to offer some hints that could provide stress-diminishing devices.

Specifically, the purpose of the present work was to analyse the relationship between PEI and coping, social support and mental health variables. We examined the pre-dictive capacity that several emotional strategies had on the nursing students' coping styles and mental health. Our first hypothesis was that the different PEI factors measured by the TMMS would have a particular effect on assessed variables. Specifically, clarity and emotional repair would be positively related to adaptive coping strategies. Our second hypothesis claimed that PEI dimensions would predict a part of the coping and mental health variance.

Method

Participants

The sample consisted of 119 students of first grade of Nursing Studies at the University of Jaén. The reason to choose first grade students was that they were supposed to have stronger stress experiences because of their university studies in general, and their nursing studies specifically (Magnussen & Amundson 2003). The study was conducted during the second cuatrimester when the clinical practices had just started which supposed 6 h more each day adding to their studies. Ninety-three of them were women and 23 were men. The age oscillated between 18 and 42 years old and the average was 20.33 years old (Sx = 4.39). All the participants were volunteers and signed an informed consent.

Measures

TMMS (Salovey et al. 1995)
On a 5-point scale, participants completed 24 items that assessed PEI, that is, the meta-knowledge that people have about their own emotional abilities. This scale includes three interpersonal factors with eight items each: (1) emotional attention ('I think about my mood state continuously'); (2) emotional clarity ('I usually fail to understand my feelings'); and (3) emotional repair ('Although sometimes I feel sad, I usually have an optimist vision'). The Spanish version was carried out by Fernández-Berrocal et al. (2004). The Cronbach Alpha Coefficient for each component is 0.86 for attention, 0.90 for clarity and 0.86 for emotional repair.

Coping scale (Basabe et al. 1993)
This coping scale synthesizes the dimensions established by Folkman & Lazarus (1988), and Carver et al. (COPE) (1989). It consisted of 17 items with a Likert's answer format in which '1' means 'never' and '4' means 'many times'. The scale shows four coping dimensions: (1) active coping: this subscale includes active coping strategies such as fight against the problem, action planning, acceptance of the own responsibility and the self-control (contention wait-

ing for the adequate moment). The Cronbach Alpha Coefficient in this dimension was α= 0.73; (2) behavioural avoiding and denegation: this subscale contains avoiding/uncompromising strategies (by means of alcohol and drugs), behavioural avoidance (focusing on work or study and avoiding problems), behavioural lack of commitment (admitting not doing anything), the denegation (refusing to believe what has happened), and with lower importance, the lack of positive reinterpretation (learning nothing about the experience). The Cronbach Alpha Coefficient in this dimension was α= 0.47; (3) social support search, discharge and affective regulation: this dimension includes the confrontation and emotional regulation (discharging emotions), the instrumental support search (talking to somebody who has a similar problem), the affective support search (searching sympathy and understanding) and the positive reinterpretation (learning something about the experience). The Cronbach Alpha Coefficient in this dimension was α= 0.61; and (4) cognitive/passivity/repression avoiding: this factor contains acceptation (accepting what has happened without doing anything), escape-evitation (fantasying), behavioural lack of commitment (doing nothing), self-control (keeping feelings) and denegation (refusing to believe what has happened). The Cronbach Alpha Coefficient in this dimension is α= 0.66.

Vaux's subjective social support (Vaux et al. 1986)
This scale was translated into Spanish and adapted by Páez (1993). This scale measures the social support perceived aspect and the subjective family and friends' implication level (e.g. 'My friends respect me'). Response option ranges from 1 ('strongly agree') to 4 ('strongly disagree'). The Cronbach Alpha Coefficient was 0.70.

Objective social support (Conde & Franch 1986)
It measures the social network density (structural aspect) and is based on the objective social support scale of the Health Department in California. It was adapted by Conde & Franch (1986) and consisted of five items with a response option ranging from 1 ('none of them') to 4 ('4 or more'). The individual should answer items such as 'when you have a problem at school or job, how many people do you talk to about it?' The Cronbach Alpha Coefficient was 0.60.

Mental health 5 (Ware & Sherbourne 1992)
This is a reduced mental health scale with five items and derived from Health Questionnaire SF-36 (Health Survey SF-36; Ware & Sherbourne 1992), translated into Spanish and adapted by Alonso *et al.* (1995). This instrument provides a profile of the health state and can be applied to general population and also to patients. Items detect positive

and negative health states. Specifically, they assess the individual's depressive and anxious symptom level during the last month. The response option range goes from 1 ('always') to 6 ('never'). High scores are associated with a better mental health. The Cronbach Alpha Coefficient was 0.77.

Results

In Table 1, means, standard deviations and reliability coefficients for all measured variables are presented.

The TMMS subscales presented an acceptable inner consistency (all α> 0.86). The coping subscales are the ones with lower inner consistency (α ranges from 0.35 to 0.57). It can be observed that the most used coping strategy by nursing students was an active coping, closely followed by a strategy based on social support search, and next by cognitive avoiding and behavioural avoiding strategies. Afterwards, we checked that these participants had high scores demonstrating that they had wide social networks. Finally, it is important to take into account that the mental health scale scores were similar to those in other studies.

The bivariated correlation analysis between the TMMS, coping, social support and mental health are shown in Table 2. As we can see, the attention subscale correlated positively with the other two TMMS scales (clarity and repair), and with social support search coping strategy. The emotional clarity correlated positively with emotional repair and subjective and objective social support scales. Clarity was negatively associated with behavioural and cognitive avoiding coping strategies. Finally, repair was positively associated with objective and subjective social support, and also with mental health.

Regression analysis

After that, we conducted different hierarchical regression analyses to check the relationships between the PEI com-

Table 1
Means, standard deviations and reliabilities for the different measures

Scale	Mean	SD	Cronbach Alpha
TMMS – attention	3.71	6.18	0.88
TMMS – clarity	3.34	6.92	0.91
TMMS – repair	3.34	6.40	0.86
Coping – active coping	16.50	3.00	0.54
Coping – support search	10.91	2.59	0.57
Coping – behavioural avoiding	6.51	1.88	0.39
Coping – cognitive avoiding	10.70	2.19	0.35
OSS	14.42	7.75	0.60
SSS	34.09	4.21	0.79
MH	4.00	4.29	0.85

MH, mental health; OSS, objective social support; SSS, subjective social support; TMMS, Trait Meta-Mood Scale.

Table 2
Correlations between TMMS subscales and coping strategies

	1	2	3	4	5	6	7	8	9	10
1. Attention										
2. Clarity	0.45**									
3. Repair	0.20*	0.34**								
4. Active coping	0.11	0.04	0.07							
5. Social support search	0.18*	0.09	0.13	0.24**						
6. Behavioural avoiding	0.08	−0.19*	−0.07	−0.03	0.11					
7. Cognitive avoiding	0.09	−0.22*	−0.13	0.14	−0.07	0.39**				
8. OSS	0.09	0.34**	0.25**	0.14	0.20*	−0.09	−0.40			
9. SSS	0.08	0.31**	0.29**	−0.04	0.09	−0.06	−0.16	0.42**		
10. MH	−0.10	0.07	0.28**	0.00	0.05	−0.09	−0.17	0.12	0.33**	

MH, mental health; OSS, objective social support; SSS, subjective social support; TMMS, Trait Meta-Mood Scale.
*$P < 0.05$, **$P < 0.01$.

Table 3
Regression analysis predicting scores on the coping, social support and metal health from perception of emotional intelligence ($n = 119$)

Variable	R^2	F	β	P	ΔR^2
Criterion: coping active	0.01	0.48			0.01
Atention			0.10	0.30	
Clarity			−0.02	0.83	
Repair			0.04	0.66	
Criterion: social support search	0.04	1.65			0.01
Atention			0.16	0.10	
Clarity			−0.01	0.88	
Repair			0.09	0.31	
Criterion: behavioural avoiding	0.07	3.03			0.05**
Atention			0.21	0.03*	
Clarity			−0.28	0.00**	
Repair			0.02	0.87	
Criterion: cognitive avoiding	0.09	3.94			0.07**
Atention			0.23	0.02*	
Clarity			−0.29	0.00**	
Repair			−0.09	0.35	
Criterion: objective social support	0.14	6.33			0.12**
Atention			−0.08	0.38	
Clarity			0.32	0.00**	
Repair			0.15	0.09	
Criterion: subjective social support	0.14	6.23			0.11**
Atention			−0.08	0.39	
Clarity			0.27	0.00**	
Repair			0.21	0.02*	
Criterion: mental health	0.11	4.87			0.09**
Atention			−0.18	0.07	
Clarity			0.05	0.63	
Repair			0.31	0.00**	

*$P < 0.05$, **$P < 0.01$.

ponents, the coping strategies, objective and subjective social support and mental health (see Table 3).

First, we analysed the relationships between the coping subscales with the rest of the variables. The dependent variables were active coping, social support search and behavioural and cognitive avoiding coping. Each variable was introduced individually in the model. In the first equation, the three dimensions of the TMMS (attention, clarity and repair) were introduced. In this case, none of them could explain the active coping variance. Similarly, the social support search was not predicted by any of the PEI variables.

In the case of behavioural avoiding coping, the 5% of variance was explained by emotion attention and clarity. And the 7% of the cognitive avoiding variance was also explained by emotion attention and clarity.

Second, we realized again a hierarchical regression analysis to examine the relationships between the social support (objective and subjective) with the dimensions of the TMMS. In a first place, the dependent variable was the objective social support. Results showed that the 12% of the variance was explained by the feeling clarity. In a second place, subjective social support was introduced as a

dependent variable, and in this case, the 11% of the variance was explained by the emotional clarity and repair.

Third, a new hierarchical regression analysis was carried out to observe the relationships between the mental health and the TMMS dimensions. The dependent variable considered was mental health. A 9% of the mental health variance was explained by the emotional repair factor. In this way, participants with a better emotional repair ability reported about a better mental health.

Gender differences

Finally, we conducted an ANOVA to examine gender differences in the studied variables. Analysis showed that there were gender differences in coping strategy concerning social support search ($F_{1,117} = 4.73$; $P < 0.032$). Women searched more social support than men (M = 11.16 vs. M = 9.87). There were no gender differences in the rest of variables including EI subscales (all the $F_{1,117} = 1.965$).

Discussion

In this work, we have checked the influence that PEI has on the nursing students' coping strategies, social support and mental health levels. Altogether, the correlation analyses have shown that the attention factor was positively associated with social support search coping strategy. If we bear in mind that this dimension is characterized by confrontation and emotional regulation, these results are in accordance with the ones found by Gohm (2003). He discovered that people who presented moderated emotional attention levels also used more frequently more adaptive regulation strategies as they used efficiently the information obtained by their emotions. The emotional clarity component of PEI was negatively associated with behavioural and cognitive avoiding coping strategies. Therefore, nursing students with higher emotional clarity scores clearly identify a specific emotion during stress situations, use less time to pay attention on their emotional reactions and invest correctly the cognitive resources which permit them to achieve more adaptive coping strategies. These data coincide with recent studies (Gohm et al. 2001, Gohm & Clore 2002). At the same time, emotional clarity was positively associated with objective and subjective social support. This is really important for stress situations, because if we realize that social support is considered by some authors (Lazarus & Folkman 1984) as another coping strategy, this would involve one or more of the following factors: (1) emotional compromise; (2) instrumental help; (3) communication; and (4) relevant information to assess. For this reason, the couple, family and friends' social support is not only beneficial when facing stressing situations but also necessary.

In this sense, it would be very positive for nursing professionals and students to use and develop certain skills to increase social support. Different studies have shown that social support is strongly related to mental health (Laschinger & Havens 1997) and stress in work environment (Laschinger & Havens 1997, Laschinger et al. 2001).

The third component of PEI, the emotional regulation, was positively associated with objective and subjective social support and mental health. The emotional regulation is defined as the ability that a person has to interrupt his or her negative emotional states and to prolong the positive ones. So, a high emotional regulation will endorse a social support search and this will influence the mental health because, as Catanzaro & Mearns (1990) found, the emotional regulation is a protector factor of our mental health and our well-being.

The hierarchical regression analyses have shown that PEI dimensions explained an important part of the nursing students' coping, social support and mental health variance. In this way, the 5% of the behavioural avoidance coping variance, which is characterized by avoidance/lack of commitment (people who focus on study to forget problems, who refuse to do anything, or who deny that something happens), was explained by the emotion attention and clarity PEI factors. A 7% of the cognitive avoidance variance, characterized by the acceptance, doing nothing, keeping own feelings and refusing what has happened, was similarly explained by emotion attention and clarity. Extremera & Fernández-Berrocal (2005) offered a plausible prediction explication of these coping strategies. They pointed out that a high or a low emotional attention is not productive for people, so the person who pays low attention to his or her emotions will not consider his or her affective states as relevant and will not use this information to regulate his or her mood states. In an opposite direction, too much attention makes the person pay attention to his or her emotional states constantly but he or she does not act in consequence. A low emotional clarity makes that person be confused about his or her emotions and he or she will use coping strategies labelled as no positive.

In respect to social support dimensions, on the one hand, the 12% of the objective social support that measures the social network density was explained by feeling clarity. Therefore, nursing students with high emotional understanding levels will also have more abilities in the emotional problems treatment and they will experience a higher emotional well-being which rebound on a higher social network development. Salovey et al.'s (2002) research has indicated that people with high feeling clarity show a better self-esteem and interpersonal satisfaction, and a lower stress vulnerability. On the other hand, the 11% of the subjective social support variance was

predicted by the clarity and repair factors. Recent studies have revealed that a well emotional repair plus a good clarity has an important predictive value on various studied criterion variables (Martínez-Pons 1997).

As for the mental health scale, we found that the 9% of this construct was predicted by emotional repair. These results are in accordance with those by Fernández-Berrocal & Extremera (2003) who found that the repair factor was associated with a mental health increase.

Finally, in contrast to previous studies (Gerits *et al.* 2004), we found no gender differences in EI. This result is not really odd because these authors used a different model (Bar-On & Parker 2000) and instrument (Bar-On 1997).

Implications for the nurses and nursing students

This study has different practical applications concerning nurses and nursing students training in stress-diminishing devices such as EI, coping and social support strategies; thus, it would allow them to enjoy life again (Fernández-Berrocal & Ramos 2004). Nurses need to be aware of their stress and its causing emotional reactions (Humpel *et al.* 2001) as a first step to fight against stress with their EI and other skills involved. As nurses do not always have enough interpersonal and empathy skills (Baille 1996), it would be interesting to develop EI (among others important variables) by means of a training programme in the working place (Goleman 1998).

In account on the nurse professional training, EI and other interpersonal and intrapersonal factors are recognized as crucial to develop a therapeutic alliance and good working relationships (Freshwater 2004). Therefore, it would be interesting to underline that it is better prevent stress than suffer from it, not only psychologically and physically for professionals, but also financially for health organizations because of absenteeism. In relation to nursing students training, following Freswater and Stickley's idea, we suggest that the nursing curriculum should also include some aspects as reflective learning experiences, supportive supervision and mentorship, modelling, developing empathy, and emotional competency. This EI training could be developed through a *tutorial action programme.* The tutorial action programme is an optional cross-curriculum programme, for students and lecturers, which is presented as an opportunity to develop students' skills and to have a mentor to lead and support decisions (Montes-Berges *et al.* 2006a,b). Lecturers are previously trained in the planned activities, which have been carefully prepared during the previous year. Some of these activities involve the stress and EI self-knowledge, a training of self-control and self-relaxation in anxious situations (such as exams), an exploration about their own intellectual capacities and a programme to improve them, or a training to speak in public (http://www.ujaen.es/centros/euccs/PAT). The first author of this paper is the coordinator of this programme at Nursing Studies at University of Jaén, and we can say that we are obtaining excellent results both for improving skills and for the students evaluation of the programme.

Limitations of this study

First, the findings can only be generalized to nursing students and not to nursing professionals. Second, participants were all from the same nursing school, and hence, they represented a very limited sample of nursing students. And third, this study is a correlational one and results cannot be taken as casual. However, the outcomes are relevant enough to make this a valuable area for further research.

Future research

For future research, it would be interesting to take into account several ideas. On the one hand, it would be recommendable to use samples of nurses who work in different services (urgencies, neonatal cares, renal cares, etc.). These studies could offer a more complete information about the relationship between the different services and physical and mental health, stress and somatic illness level. On the other hand, future research should control other important aspects such as occupational stressors (McGrath *et al.* 2003), and attitudinal variables such as job satisfaction (Cottrell 2001) and the organizational compromise (Lock & Crawford 2001). Finally, as we mentioned above, it would be a good idea to train the nurses and nursing students in stress-diminishing devices such as EI, coping and social support strategies. The tutorial action programme developed at Nursing Studies at University of Jaén is already training these skills. Comparing variable initial levels with later ones, we can analyse the benefits of training and how they manage their stress. Although the first results indicate the skill improvement and the students' high satisfaction with the tutorial action programme, we are looking forward to collecting and analysing the results of the whole academic year, and introduce the pertinent changes to improve the programme.

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