Exploring physiotherapists' emotion work in private practice

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ABSTRACT

Emotion aspects of physiotherapy work were explored with in-depth interviewing of ten experienced physiotherapists in private practice in New Zealand to meet the following three research objectives: (1) to identify the range of emotions felt, (2) to identify emotional themes in context, and (3) to identify self-management techniques. Emotions were mapped onto Larson and Diener's (1992) circumplex model of affect and scenarios reviewed for evidence of Bolton and Boyd's (2005) schemata of emotion work. Presentational and philanthropic forms of emotion work were identified. Caring (philanthropy) motivated the physiotherapists to build their patient relationships. No pecuniary emotion work was found. Findings showed that social and technical scenarios produced highly activated emotions, which sustained the physiotherapists in their role. A wide range of negative emotions were found; this may be indicative of increased risk of workplace stress. Surprisingly, there was no evidence of pleasant unactivated emotions; emotions that were expected given the experience and skill mastery of the participants.

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INTRODUCTION

The work of physiotherapists, like all health professionals, has physical, intellectual and emotional aspects. Within physiotherapy research and practice, the emphasis has been almost completely on the intellectual and physical aspects of the job; that is, on the knowledge needed to understand how the body works and responds to treatment, and to the physical skills required to manipulate the body of the patient. The other aspect of their job, the emotional component, is rarely, if ever, acknowledged. The research presented here aims to open up this area for further exploration and debate by the physiotherapy profession.

In this study, we use two concepts: 'emotion' and 'emotion work'. Emotions are complex psychophysiological experiences associated with a wide variety of factors including environment, behaviour and personality. There is no definitive taxonomy of emotions, but in this study, we used the understanding of emotions developed by Finemann (2003). Emotion work is the effort a person exerts to change their own emotions into an appropriate situational response (Miller 2007), called an emotional display. For instance, an exhausted nurse may be feeling angry following patient demand but will nevertheless smile and act serenely towards the patient thereby displaying an appropriate emotion for her or his role. This emotional display can be mobilised through the nurse's proficiency with surface or deep acting (Hochschild 2003). Acting describes the process by which the nurse acts out her role appropriately in a social situation. Four reasons have been proposed as to why people engage in emotion work: money (pecuniary), social acceptance (presentational), caring (philanthropic) and organisational rules (prescriptive) (Bolton and Boyd 2005). Emotion work may be loosely or tightly regulated by employers, or self-regulated through professional judgment in conjunction with organisational and customer expectations (Ekman 1973, Hochschild 2003).

Research confirms that health professionals manage their emotions in order to be effective in their roles. Exploration into emotion work has been conducted in nursing and mental health (Lewis 2005, Lopez 2006, Miller 2007, Theodosius 2008), massage therapy (Blau et al 2010), osteopathy (Harter and Krohn 2001), counselling (Kahn 1990, Lent 2010), and paramedic work (Boyle 2005). Professions and professionals differ in how they manage their emotions, but they all engage in emotion work, and manage emotions as part of everyday practice. For instance, nurses have been found to 'gift' emotions above their role requirement (philanthropic work) but they also often simply display appropriate emotions to satisfy rules and guidelines (prescriptive work), as in the above example (Lewis 2005).

The purpose of this research was to explore the emotional dimensions of physiotherapists' work. In order to achieve this, three research objectives (RO) were identified:

RO 1) To identify the range of emotions physiotherapists feel as they conduct their work with patients.

RO 2) To identify contexts within which characteristic emotions (identified in RO1 above) are performed.

RO 3) To identify self-management techniques physiotherapists use to manage their emotions.

METHODS

Emotions and emotion work have not previously been researched in the physiotherapy profession, although the topic is well studied in other disciplines. This exploratory study used existing conceptual categories of emotions and emotion work to recognise patterns in physiotherapists' experiences.

A semi-structured interview format was chosen to allow structured exploration of a previously unresearched population (Morse 2011). We wished physiotherapists to speak freely and

frankly about their work, but within a format designed to elicit relevant information to answer the research aims and objectives. Thus, the interview schedule was designed to allow participants to freely describe how they went about their working days, focusing specifically on their emotions and how they managed them. Participants were invited to describe their work; firstly they were asked about a typical working day; then to specifically talk about how they go about developing a relationship with patients and how this makes them feel; then to discuss what they like and do not like about their work. Because we were interested in the emotion work of physiotherapists, our focus was on their therapeutic relationship with patients. The interview schedule we used is attached (Appendix 1).

Ten private practice physiotherapists working in the Auckland area were purposefully sampled. All participants had a minimum of five years physiotherapy experience to allow sufficient reflection on the non-technical aspects of their role. The sample number of ten is slightly larger than many studies in this field, further enhancing the generation of rich data.

The study was conducted with full approval from the Massey University Human Ethics Committee. The primary researcher was an experienced physiotherapist having worked for 18 years in private practice. All interviews were recorded and transcribed with each research objective analysed according to the criteria set out below.

ANALYSIS OF RESEARCH OBJECTIVES

Research Objective One (RO1)

RO1 was achieved by analysing transcripts using content analysis to identify words signifying emotion and then mapping them onto Larsen and Diener's (1992) circumplex model, which provides graphical representation of ranges of emotions. The model enables contrasts to be seen between emotions in two-dimensional space. Dimensions of activation and pleasantness form the axis of the circle. Emotions are mapped along the circumference of a circle relative to their pleasant/activation degree.

This study used the definition of emotion proposed by Finemann as the outward display of subjective inner feeling (Finemann 2003). Emotion words were identified and then assigned into an emotional category based on Larson and Diener's (1992) model. For example, "I feel disappointed when…" was categorised as 'disappointed'. All emotional words used by participants were easily categorised as they corresponded directly with the words used by Larsen and Diener (1992) in their original model. Using Finemann's (2003) broad definition of emotions, all mentions of emotions were noted and allocated into 33 emotional categories. Emotion words arose directly from the respondents themselves and were directly mapped onto Larsen and Diener's (1992) circumplex model. The circumplex model only represents the range of emotions experienced, it does not represent intensity or frequency of emotions. Nevertheless, this process clearly showed that unactivated pleasant feelings such as calmness and serenity were never felt by physiotherapists in our sample. Emotion words are shown in Table 1.

Research Objectives Two and Three (RO2 and RO3)

RO2 was to identify contexts within which characteristic emotions (identified in RO1) are performed. Further analysis

Table 1: Participant Emotions and Larsen, Diener and Lucas' (2002) Affect Categories

Emotions felt by Physiotherapists (strongest emotion at top of each category)	Larsen, Diener and Lucas' (2002) Affect Categories
Stimulated Excited Inspired Interested Hopeful Good Happy Satisfied Proud Worthy Confident Belonging	Activated pleasant
None	Unactivated Pleasant
Drained Tired Exhausted Unappreciated Inadequate Disheartened Disappointed Resigned Rejected Unconfident	Unactivated Unpleasant
Frightened Angry Intimidated Resentful Annoyed Pressured	Activated Unpleasant

contextualised emotions so that they could be more fully understood in relation to the patient relationship and other scenarios. We placed the therapeutic relationship at the centre of our study because we already know that quality therapeutic alliances facilitate patient compliance, and patient participation can predict treatment success (Safran and Muran 2000). The importance of relationships to health outcomes is fundamental to patient-centred medicine, which places patients' emotional and physical needs and life issues at the centre of treatment plans (Stewart 2001, Miller 2007, Øien et al 2011).

It was decided that the use of mini-scenarios was appropriate to contextualise emotional patterns. Developing mini-scenarios is a type of thematic analysis (Braun and Clarke 2006). Thematic analysis is widely used in psychological and other research, mainly because of its flexibility, but as with quantitative and other forms of text-based research, credibility, transparency and reasonableness are the criteria for perceived research quality. How mini-scenarios are arrived at can be a difficult step to understand conceptually because researchers do rely to an extent on intuition to perceive patterns between trigger events. Analysis involves identifying groups of emotions that seem to occur in similar situations. The primary interviewer's physiotherapy experience was vitally important in this case because she made initial 'sense' of feelings in contexts; that is, she could empathise with physiotherapists, which helped her make 'sense' of their experiences. Empathy is always tempered by self-refection in qualitative processes, and so any assumptions that are made are always scrutinised to minimise the risk of overly-identifying with the feelings of other physiotherapists, or allowing personal feelings to structure others' feelings. Also, the two researchers discussed the themes with one another in order to minimise bias. After numerous readings and discussions of the transcripts, meaning started to emerge. From initial patterns a list of possible scenarios was developed. These initial themes were then grouped into four basic mini-scenarios, or themes. These scenarios were not independent of each other, but they did have characteristics that enabled meaning to be made of the emotions felt in the contexts described. A full description of this type of analytic process is provided by Braun and Clarke (2006).

RO3 was to identify self-management techniques physiotherapists use to manage their emotions. RO3 was achieved by noting during the RO2 analysis phase the emotional self-management techniques physiotherapists used.

RESULTS

General Description of Participants and Work Practices

The youngest participant was 37 years, the oldest 59 years, with the average age being 44 years. The clinical experience of the practitioners ranged from 6 to 33 years, with an average of 17.1 years; six owned the clinic they worked in and four were contractors. Six participants worked more than 40 hours per week.

The four final scenarios (or themes) identified were: social relationships, technical skills, professional development, and health structure limitations.

Findings - RO1

Participants' emotion words were charted onto Larsen and Diener's (1992) circumplex model. Emotion words were positioned onto the circumference in the positions defined by Larson and Diener (1992) and refined by Larson et al (2002). The level of activation can be seen as the level of arousal the emotional state presents and the level of pleasantness or unpleasantness is simply how agreeable the emotion was to the respondent. The three main findings from analyses of RO1 were: (1) physiotherapy participants felt a wide range of emotions while they conducted their work; (2) pleasant/inactive emotions (such as calm and contentment) were absent; and (3) the negative emotions were mentioned twice as often as the positive emotions.

Findings - RO2 and R03

Illustrating emotions on a circumplex model enabled an overview of the physiotherapists' emotions. Thematic analysis suggested specific scenarios consistently related to certain emotions. Scenarios did overlap, for example, the social and technical scenarios, so we have discussed them below in relation to their primary themes. The following section summarises each scenario with illustrative quotes from interviewees, and indicates some of the self-management strategies used.

Technical

The technical aspect of the physiotherapists' roles provided the most activated emotions across the board. Helping patients achieve life-changing outcomes through the therapists' application of knowledge and skills activated interest, stimulation and excitement for all ten therapists. On the model formulated by Larsen et al (2002), emotions associated with successful patient outcomes were pleasant emotions with variance into activation.

However, somewhat paradoxically, the physiotherapists also said that their technical skills were automatic, and they perceived this aspect of their work as undemanding in comparison to therapeutic communication.

> *"The technical skills are automatic, they come without much effort. It is more about the relationship…Gaining trust is vital or what you do technically will be a total waste of time."* (Therapist 4)
>
> *"That is where the energy goes, in the client relationship."* (Therapist 3)
>
> *"I do like to know about people or it would be dry, like a technician. Once you understand people's personalities you can see who you have to soft-talk to, or hard-talk to, and see how you can work better with them."* (Therapist 9)

Therapists consistently said that the relationship aspect of their role was central to the technical success of their physical interventions; that is, the relationship skill of 'reading' the client was crucial to successful patient outcomes. In these instances, presentational emotion work was evident.

Receiving patient affirmation validated the physiotherapists' sense of pride.

> *"You think, wow, I did make a difference to that person's life. I do attribute to it to myself because they say I turned their life around."* (Therapist 4)

Not all emotions associated with technical issues were positive. Non-compliance and poor outcomes affected professional confidence. Tiredness when outcomes were not achieved was also evident, especially with rehabilitation work. Frequently these emotions were strongly worded.

> *"It's draining on me when they disappoint me."* (Therapist 3)
>
> *"You really get to know what life is like for them and their barriers…the rehab time is much more patient centred."* (Therapist 4)
>
> *"… hugely emotional."* (Therapist 4)

"The bad ones tend to live with you. I think I could be more hard-hearted and efficient but I am too conscientious for that." (Therapist 2)

In these instances, philanthropic emotion work was strongly evident. Feelings of disappointment however, were discarded quickly.

"There are far more positives in my day so the next person who walks in is more than likely going to be someone who is lovely, who appreciates what I do." (Therapist 5)

Social

The second inter-related theme, the social, profoundly influenced the physiotherapists' emotions, both positively and negatively. Social factors relating to the patient relationship were central to all ten physiotherapists who reported satisfaction, self-worth and belonging because of their work with people. Pleasant feelings were also mentioned about other types of social configurations such as collaborations with colleagues.

"It is a great satisfaction in my work that we can sit around a table with a shared vision... about physiotherapy in that people have understood what I was trying to communicate and have wanted to share it." (Therapist 7)

Being part of a local community provided a strong sense of self worth and satisfaction.

Belonging to the community, supporting the local school; that is what I like to do." (Therapist 5)

"I love the sense of community… not only in the clinic but in the supermarkets. I love that belonging." (Therapist 9)

Meeting new people was stimulating for all participants, with euphoria reported:

"I try not to come down off the high of seeing patients; the paperwork interrupts that." (Therapist 6)

Interviewees also felt negative emotions about their relationships with wider communities. Several interviewees expressed frustration and disappointment for an apparent professional devaluation:

"I think as a profession we have really undervalued ourselves." (Therapist 7)

Others mentioned, to avoid being judged they preferred not to introduce themselves as physiotherapists. Difficult emotions such as these were managed by something within their control; returning their focus to treating the patient. In other words, presentational emotion work was performed.

Other negative emotions arose when patients were non-adherent or doubting of the therapist's ability. Pressure to meet high expectations was the primary source of tiredness, fatigue, feeling drained and exhaustion:

"Sometimes I go to work and think I don't know if I can give. I just say I am a little bit slow today." (Therapist 6)

Patients who appear distant also precipitated feelings of inadequacy or tiredness.

"The more I was trying to help her the more I got knocked back a bit. I felt like I was trying to dig a hole and the dirt was falling back in." (Therapist 1)

Fatigue and inadequacy lie close to the unactivated unpleasant dimension in Larsen and Dieners' model (1992).

Ways of coping included identifying communication barriers and trying to overcome them, and by 'gifting' time and service, or 'digging deep' to access a well of philanthropy and regain a sense of meaning. Others simply respected the patient distance; employing presentational emotion work:

"I don't feel we have to be warm and fuzzy. If they don't want to engage that's fine." (Therapist 7)

"If I am treating someone who is not so open emotionally and try to get that connection, then it will be a big mismatch." (Therapist 6)

"You get people that are terribly private that do not appreciate enquiry. You have to have the sense to tell whether they want to tell you things." (Therapist 10)

Patients who some therapists found 'challenging' were a source of satisfaction for others. For instance, Therapist 4, in contrast to her partner (another physiotherapist), enjoyed working with more complex patients:

"My partner would hate to do this sort of work (chronic rehabilitation), as he likes to treat someone quickly and get them back to their sport. He doesn't really enjoy the emotional side of a relationship so it suits him not to do this sort of work."

Some participants admitted they did not like some patients. Emotions in this regard varied from fear and aversion to ambivalence, emotions that the therapists masked and presented more appropriately:

"I don't like everyone I treat so I pretend to like them. I am good at acting, especially when pretending to like someone that I don't like or I won't get anywhere with them." (Therapist 4)

"I feel like a chameleon, morphing into whatever is needed." (Therapist 9)

Six therapists employed acting to manage their emotions.

The physiotherapists said, out of respect for patient's time, they kept conversation completely patient-focused when working with patients, although occasionally they shared some personal information.

"They have to feel like they are the only pebble on the beach." (Therapist 10)

"There is a boundary that I don't want to share. It comes from a necessity to preserve myself." (Therapist 7)

If the physiotherapists were uncomfortable with topics brought up by their patient they actively neutralised the conversation, for instance, feigned indifference. Two therapists, who felt that professional boundaries deterred them from sharing personal information, reported being less drained as a result. Other strategies used by the physiotherapists to mitigate negative emotions brought about by the social aspects of their jobs were to seek collegial and family support. There was no evidence to suggest employers exerted norms for emotional displays on the four participants that were employed in our sample.

Professional

Learning new skills inspired, stimulated and satisfied all ten therapists. Confidence and self-worth were derived from skill mastery, experience and professional recognition. All positive

emotions in the professional category were activated and pleasant. Additionally participants typically commentated:

> *"I am more realistic about what I can do and am trying to be happy doing a good enough job. Whereas 10 years ago I wanted to do the best all the time, now I am happy that what I am doing is my best and that is good enough."* (Therapist 2)

Arguably this comment signifies resignation; however, we believe it demonstrated a pacing of effort by the therapist to allow continuance in their role long term. Experience appeared to enable a sense of maturity and self-confidence in interviewees' skills and abilities.

Structural

Structural factors intrinsic to the job itself - autonomy, variety, and flexibility, precipitated emotions such as stimulation, excitement and interest. Emotions in this category were more highly activated, used to mobilise and sustain therapists through their negative periods. In this study, structural scenarios presented physiotherapists with the majority of negative emotions. Negative emotions such as frustration arose directly from tensions between serving the patient and funder requirements.

> *"We often see ourselves as an advocate for the patient and we are obligated to ensure that the process is successful but the process itself is seldom successful and it is limiting."* (Therapist 7)

> *"The relationship with ACC has changed and that has been frustrating. They are now suspicious and judgmental of physiotherapy. I am starting to feel threatened."* (Therapist 9).

Other therapists reported they felt fatigued due to funder demands, and felt policy changes had devalued their profession.

> *"I just think it is all turned upside down; it should be getting easier not harder… If the trend continues to deteriorate I am asking myself: Will I be able to continue?"* (Therapist 9)

Additional administrative tasks associated with these requirements were an additional source of frustration as it took time away from patients. A large degree of effort was apparent in the presentational emotion work required to manage the negative emotions evident in these scenarios.

DISCUSSION

Findings showed that emotions are integral to the work performed by private practice physiotherapists. These emotions are complex, sometimes contradictory, and there are individual differences. The preponderance of negative emotions mapped on the circumplex model does not mean that the physiotherapists are negative about their work; merely that there was a greater variety of negative emotion words used than positive ones. Mann and Cowburn (2005) argue an increased variety of emotions is positively correlated with increased daily stress levels, so the wide variety of emotions we found may be indicative of stress risk. Stress may also come from reported unactivated states like fatigue and depression, which lie close to the un-activated unpleasant axis of the circumplex model. If these emotions are found in workplaces, they are indicative of emotional exhaustion and work place stress (Maslach 1982, Blau et al 2010). Another concern was the lack of un-activated pleasant emotions, like calmness, found amongst participants. It would be hoped these emotions would be increasingly present with skill mastery and experience.

Findings were presented according to the four themes of technical, social, professional and structural contexts. These themes demonstrate two of Bolton and Boyd's (2003) categories of emotion work: presentational and philanthropic. Technical scenarios show that skill mastery was a major source of activated pleasant emotions. When negative emotions were mentioned in technical scenarios they were attributed to patient non co-operation. Presentational and philanthropic emotion work were employed to overcome these emotions. This finding is consistent with Maslach's (1982) argument that patients who do not follow advice require more emotion work. Consequently, therapists' successes were tied to the quality of their therapeutic relationship, as well as their technical skills.

Social scenarios revealed the widest range of emotions and a large range of management techniques. All therapists reported satisfaction, self-worth and belonging because of their work with patients, colleagues and the community. Philanthropic examples of emotion work were evident. Complex clients were a source of tension and negative emotions like frustration but contradictorily, satisfaction also. This latter observation confirms Do Bonfim and Geudes Gondim's (2009) findings that positive effects can be felt even in a challenging and demanding environment. Although the physiotherapy participants enjoyed the autonomy and flexibility they had in their jobs, they also reported tensions between their desire to serve patients and funding regimes that enforced structures they felt detracted from their primary focus. Presentational emotion work was employed in these instances.

The professional scenarios highlight presentational emotion work was necessary, though emotions were largely pleasant and activated. Interviewees felt positively about learning opportunities and professional skill mastery. The structural theme showed highly activated emotions sustaining therapists through the more difficult presentational emotion work on negative emotions arising from conflicting funder and patient requirements.

No participants in this study suggested money was a motivation for their emotion work; pecuniary emotion work was not evident:

> *"If it was about the money I would be working in a different way. It is the satisfaction I get from helping people with my skills."* (Therapist 3)

> *"I don't look at the numbers; I am more about what we did for those people today."* (Therapist 9)

Philanthropy (caring) was clearly both a direct and indirect motivation across all themes. Therapists actively sought to understand their clients' motivations in order to break down psychological and physical barriers hindering them from healing.

> *"One of the skills we learnt is to deliver the information in such a way that the obstacles for taking the concept further are analysed"* (Therapist 7)

> *"I get involved with a patient and give them the time needed"* (Therapist 10)

Caring not only guides treatment choices (Greenfield 2006) but also motivates therapists to continue with complex patients in

difficult circumstances. Greenfield et al (2008) have shown that an emotional connection draws physiotherapists to continue to work with a patient even when rehabilitation goals have been met.

The therapists used presentational emotion techniques on a daily basis. They managed negative emotions mainly with surface acting, sometimes through deep acting or distancing techniques. The physiotherapists were aware of the limits of using acting techniques, being cognisant of the risks of faking emotion and destroying trust. Surface acting tended to occur in the regular clinic appointments, and deep acting when working with rehabilitation clients. Sampled physiotherapists reported that the emotion work done with these complex rehabilitation clients required more effort and could be more draining, hence the need to work (act) more consistently.

By using philanthropic and presentational methods, the therapists controlled their levels of engagement. There was minimal evidence of prescriptive emotion work and no pecuniary emotion work was reported. In some respects, there are similarities in these findings to nurses who also perform philanthropic emotion (Lewis 2005) but the physiotherapists we talked to carried out presentational rather than prescriptive emotion work. This result can be possibly explained by the smaller organisational size and level of autonomy that the physiotherapists had in comparison to nurses who tend to work in larger organisations.

The physiotherapists used acting and distancing techniques to manage their emotions. Additionally they sought collegial support and professional development opportunities. With distancing the therapists detached themselves from strong opinion during conversations, respected patients' privacy and restricted the sharing of personal information. Blau et al (2010) noted emotional displays were similarly managed with other types of demanding clients. The skill of distancing is a learnt one, also used by experienced nurses (Mazhindu 2003). Distance can be achieved through actively moving onto the next client, or envisaging the emotion exit with the patient. Experience enables therapists to develop their own methods of escaping negative feelings:

> *"Having worked for so long you do understand this game of not taking it seriously, not taking it home."* (Therapist 9)
>
> *"Walking the dog which is not demanding of my time or knowledge."* (Therapist 5)

Collegial support was sought and utilised to avoid exhaustion and to share negative emotions, particularly in the structural and technical categories. The physiotherapists in our sample worked in small organisations, and without access to collegial support, they may have been more vulnerable. Mancini and Lawson (2009) showed that mental health workers devoid of peer support tended towards emotional exhaustion, stress and burnout, causing an increasingly high turnover in their role.

In 2010, 28% of physiotherapists considered leaving the profession (Physiotherapy New Zealand Workforce Survey 2010). Although the exact reasons for this finding are unknown, we argue that more research about how physiotherapists feel about their work is required to help mitigate this problem. Research is required to explore whether workplace stress is evident, whether emotion work differs with experience, gender or location, and whether those exiting the profession do so in relation to emotion work factors. The public sector may also present different findings. It would also be helpful to map the frequency of specific positive and negative emotions in order to determine their significance.

CONCLUSION

Nicholls et al (2009) reminded the physiotherapy profession that healthcare models must include psychological, social, economic and cultural dimensions. This research aimed to explore the emotion work dimension of the physiotherapy profession, both for the benefit of the patient relationship and the provider.

This study underlines the importance of emotions and emotion work to physiotherapists in private practice. Presentational and philanthropic emotion work is evident as physiotherapists manage negative emotions arising during their work whilst building the fundamental patient relationship. Alarmingly, the wide range of reported negative emotions may be indicative of workplace stress. Positive emotions were predominantly highly activated and these appeared to sustain the physiotherapists in their role. Philanthropic caring motivated the physiotherapists. Surprisingly unactivated pleasant emotions such as calmness were not found, despite the depth of experience and purported skill mastery of the participants.

KEY POINTS

- Private practice physiotherapists in this study performed presentational and philanthropic emotion work.
- Highly activated positive emotions arising from technical and social aspects of the role sustained the physiotherapists.
- The wide range of negative emotions experienced by participants highlighted the risk of workplace stress.
- Further research is recommended to examine emotions and the use of emotion work in physiotherapy practice.

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Appendix 1: Interview Schedule

General Introduction: I am interested in learning more about the emotion work that we do in our job. By emotion work I mean how we manage the emotions that we have at work, such as nervousness, pride, happiness and sadness. I would like your comments on some questions that I have. There is no right or wrong answer. This is more of a discussion so that I can learn about your thoughts.

1. Can you choose a day that was fairly typical for you and tell me about what you did? [Choose a day that was very recent such as yesterday].
   a. What did you like about the day?
   b. What things stirred up positive emotions for you, [such as pride or relief]?
   c. Can you tell me what it was that might have triggered that?
   d. How did you manage that emotion, did you share it with someone or forget about it and move on?
   e. What did you dislike about the day?
   f. What stirred up negative emotions, [such as fear or anger]?
   g. How did you cope with this? [For example, did you bottle it up, talk about it with someone or reflect on it privately?]
   h. Did the emotion change during the day or afterwards?
2. Let's talk about your clinical work, your time spent treating patients.
   a. What do you talk about with your patients?
   b. What things do you do to create a good relationship with your patients?
   c. What do you do to engage patients in their rehabilitation?
   d. When do you share your feelings with your patients and when do you not?
   e. What stops you sharing how you feel with patients?
3. Tell me about a time, or times, when you have disliked your job.
   a. What was it about that you found difficult?
   b. What emotion/s did that give you?
   c. What did you do to enable yourself to carry on with your day?
   d. What stopped you giving up on that task?
4. Tell me about a time, or times, where you enjoyed your job.
   a. What was it that you enjoyed about that?
   b. What emotion/s did you feel?
   c. What did you do with that, [did you share it with colleagues, ignore it for example]?
   d. Has the way you feel about the job changed since you first started? In what way?

Closing: Do you have anything else to add that would help me understand your experience of the emotion side of your work?