Emotional intelligence in nursing work

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Background. Emotional labour has been widely accepted in the literature as part of nursing work, however the contribution of emotional intelligence in the nursing context requires further study.

Aim. This paper aims to present an analysis of the literature on emotional intelligence and emotional labour, and consider the value of emotional intelligence to nursing.

Method. A literature search was undertaken using the CINAHL and MEDLINE databases. Search terms used were ‘emotions’, ‘intelligence’, ‘emotions and intelligence’ and ‘emotional labour’. A hand-search of relevant journals and significant references added to the data.

Results. Emotional intelligence plays an important part in forming successful human relationships. Emotional labour is important in establishing therapeutic nurse–patient relationships but carries the risk of ‘burnout’ if prolonged or intense. To prevent this, nurses need to adopt strategies to protect their health. The potential value of emotional intelligence in this emotional work is an issue that still needs to be explored.

Conclusions. Analysis of the literature suggests that the modern demands of nursing draw on the skills of emotional intelligence to meet the needs of direct patient care and co-operative negotiations with the multidisciplinary team. The significance of this needs to be recognized in nurse education. The link between emotional intelligence and emotional labour is a fruitful area for further research. The potential benefits of gaining a better understanding of how these concepts interact is largely conjecture until we have more evidence. The prospect that there may be advantages to both nurses and patients is a motivating factor for future researchers.

Keywords: emotional intelligence, emotional labour, emotions, caring, nursing

Introduction

Emotional intelligence (EI) is a concept increasingly recognized in the social psychology literature (Cherniss 2002) and is making an appearance in nursing journals (Cadman & Brewer 2001, Evans & Allen 2002, Freshman & Rubino 2002). It is considered to be an asset in contexts where it is important to understand other people and be an effective manager (Vitello-Cicciu 2002). Emotional intelligence, therefore, seems a relevant concept in health care, when it is considered important for practitioners to understand patients’ perspectives and for nursing leaders to engage in relationships that will facilitate successful management.

In this paper I suggest that EI is a skill that deserves to be given credence in nursing for its potential benefits to patient care and staff welfare. While I acknowledge that it also has a place in nursing management, this is not addressed in this article.

Search method

In order to focus the search strategy on nursing the databases employed in the literature search were CINAHL and Medline. Key words used were ‘emotions’, ‘intelligence’, ‘emotions and intelligence’ and ‘emotional labour’. In addition to articles retrieved from the databases, other sources were
acquired by hand-searching current journals and following up references listed in the papers reviewed. Inclusion of papers for the review was based on those judged to provide a theoretical perspective relating to EI and emotional labour, and those considered relevant to aspects of nursing care and relationships in health care.

Theoretical understandings

Emotional intelligence

Traditionally, intelligence has been associated with performance in IQ tests. Over recent decades, however, it has come to be realized that IQ is only one of several types of intelligences. Gardner (1993) identified seven key types of intelligences, although he indicated that the seven major types can be further categorized to specify multiple, varied abilities. Goleman (1996) claimed that this wide perspective, incorporating a multiplicity of talents, provided a richer picture of abilities relating to potential success in life than performance in standard IQ tests. The multiple intelligences can be usefully brought together in three groups: abstract intelligence; concerned with verbal and mathematical skills; concrete intelligence; concerned with manipulation of objects; and social intelligence; concerned with understanding and relating to people.

Emotional intelligence has its roots in the social intelligences first proposed by Thorndyke (1920), who noted that it was of value in human interactions and relationships. He concluded that social intelligence was discrete from academic abilities and was a key to success in the practicalities of life. Within the group of social intelligences, Gardner (1993) distinguished between two types of personal intelligences: interpersonal and intrapersonal. Interpersonal intelligence was concerned with the ability to understand other people and to work well in co-operation with them. Intrapersonal intelligence involved being able to form an accurate picture of one’s self and to use this to operate successfully in life. The latter included the ability to be self-aware, to recognize one’s own feelings and to take account of them in social behaviour.

There were four separate abilities within interpersonal intelligence. They included the ability to organize groups, negotiate solutions, make personal connections and engage in social analysis. According to Goleman (1996, p. 118) these skills demonstrate ‘interpersonal polish’ and facilitate social success. People who possess such skills can form connecting relationships with others easily, read other people’s feelings and responses accurately, lead and organize other people and handle disputes successfully. It seems appropriate, therefore, to foster interpersonal intelligence in nursing, where it is advantageous to form good rapport, and indeed form connected relationships with patients (Morse 1991). The skills of social analysis are undoubtedly part of nursing work, whereby nurses interpret and understand how patients feel, ascertain their motives and concerns, and demonstrate empathy in their care. Furthermore, organizational and negotiating skills are required in teamwork, both within nursing and in co-operative working with other health care professionals.

Intrapersonal intelligence is also demanded in nursing when nurses empathize with patients, try to understand their perspectives and engage in counselling skills. In these circumstances, it is recommended that nurses have engaged in a self-reflective process to become aware of their own values and prejudices. Any personal prejudices that conflict with those of patients or clients can then be set aside in helping patients come to their own decision, appropriate to their circumstances (Burnard 1994).

The social adeptness referred to above is demonstrated in the definition of EI proposed by Freshman and Rubino (2002, p. 1) as:

Proficiency in intrapersonal and interpersonal skills in the areas of self-awareness, self-regulation, self-motivation, social awareness and social skills.

Mayer and Salovey (1993) are more explicit when they describe EI, indicating that it involves verbal and non-verbal assessment and expression of emotions, control of emotions and the use of emotion in solving problems. This can be demonstrated in nursing when, for example, in the course of assessing patients and identifying their needs, nurses are sensitive to patients’ emotions. The interpretation of emotional expression and intelligent response in the application of appropriate professional skills, such as emotional work, empathy and counselling skills, can result in patients’ emotional states being modified and anxiety being ameliorated. Furthermore, it is claimed that EI adds significantly to performance attributed to the cognitive abilities associated with general intelligence (Strickland 2000, Lam & Kirby 2002).

Lam and Kirby (2002), using the Multifactorial Emotional Intelligence Scale (MEIS), investigated the claim that EI increases performance in excess of that attributed to general intelligence. This tool incorporates three EI abilities: perceiving, understanding and regulating emotions. The authors concluded that the abilities of EI improved the cognitive-based performance in their sample, supporting the claim that EI gives added advantage to cognitive abilities. Others have also investigated the additive value of EI, agreeing that people with this form of intelligence show better interactive skills,
are more co-operative and form closer relationships (Schutte et al. 2001). Indeed, Strickland (2000) asserts that EI is twice as important as IQ and technical skills combined.

Goleman (1996, p. 160) suggests that when people come together to collaborate they work together with a group IQ, i.e. ‘the sum total of the talents and skills of all those involved’. He claims, however, that ‘The single most important element in group intelligence...is not the group IQ in the academic sense, but rather in terms of emotional intelligence’. Evans (2001) also believes that intelligent action results from a helpful mix of both reason and emotion.

Emotions in nursing

In traditional training programmes nurses were encouraged to conceal their emotions and to maintain a professional barrier. This conferred some protection from the emotional concerns of patients (Menzies 1960). The way in which work was organized, with nurses approaching patients to carry out particular tasks of a physical nature, helped to maintain this. In recent decades, however, there has been a move away from maintaining distance and detachment towards an appreciation of involvement and commitment (Williams 2000). Furthermore, the introduction of the named nurse concept and primary nursing has resulted in less formal nurse–patient relationships than those traditionally encouraged.

Many concepts now valued in health care, such as partnership, open communication and ‘new nursing’ (Savage 1990), emphasize the importance of nurse–patient relationships. The value of each nurse adopting a holistic approach to patient care and addressing psychological, social and spiritual needs has been acknowledged, and necessitates closer relationships, as well as continuity in the delivery of nursing care (Benner 1984). The move to encourage partnership in health care requires open communication and mutual understanding that can be facilitated when there is good rapport between patient and professional (McQueen 2000). Getting to know patients helps nurses to interpret concerns, anticipate patients’ needs and adds to job satisfaction (Luker et al. 2000). In adopting values of holistic care, partnership and intimacy, nurses get to know their patients as individuals and experience emotional responses to their suffering. They are, therefore, now more exposed to both physical and emotional distress of the patients and have to deal with this as part of their work.

While it is now considered acceptable for nurses to show their emotions as they empathize with patients and show their humanity (Staden 1998), there is clearly also a need for them to manage their emotions if they are to offer help and support. In this respect, Omdahl and O’Donnell (1999) differentiate between empathetic concern and emotional contagion. They advise nurses to use strategies that promote empathetic concern and avoid emotional contagion. The work of Hochschild (1983) is key to understanding emotional management, and her analysis demonstrates that work is involved in managing emotions. Her study was based on airline stewards, who were paid to engage in emotional management with the airline passengers. Recognizing the mental work involved, and acknowledging that the airline stewards were paid to perform in this way as part of their work, Hochschild referred to the emotional work as emotional labour.

Emotional labour

Emotional labour is defined by Hochschild (1983) as the induction or suppression of feeling to sustain the outer appearance that results in others feeling cared for in a safe place. According to her:

This kind of labour calls for a co-ordination of mind and feeling, and it sometimes draws on a source of self that we honour as deep and integral to our individuality. (Hochschild 1983, p. 7)

It is immediately clear that there are similarities here to the mental processes involved in EI. I am not suggesting that EI and emotional labour are similar concepts, but rather that emotional labour calls upon and engages interpersonal and intrapersonal intelligences. This view will be developed further in a later part of the paper.

In order to help patients feel cared for, nurses welcome patients, they are polite, respectful and considerate. In the course of nursing, they engage in various activities that correspond with caring behaviour, e.g. providing helpful information and advice; physically helping patients when necessary; engaging in supportive behaviour and administering technical care. Associated with these behaviours can be emotions such as sadness, joy and compassion (McQueen 1997). In addition to these positively valued emotions, nurses can also experience negative emotions such as frustration, disgust, irritation and anger. If patients are to feel cared for these latter emotions will require to be controlled to present a front appropriate for the situation (Goffman 1959). Emotional labour, however, is more than presenting a front to patients or observers: it also involves work on the emotions to correspond with this front.

Emotional labour is guided by ‘feeling rules’ derived from social conventions, the reactions of others or from within the individual (Hochschild 1983). Hochschild therefore argues that emotional life is socially controlled. In a nursing context, when nurses do not feel as they think they ought to feel in
particular situations they engage in emotional labour to manage, control or alter their emotional status to correspond with what they believe is appropriate for the situation. The emotional work involved to achieve correspondence between the emotions experienced and behaviour demonstrated helps to give the behaviour authenticity.

Hochschild (1983) describes two processes involved in emotional labour: surface acting and deep acting. Surface acting requires altering the outer expression to achieve correspondence between feelings and the behaviour demonstrated. Deep acting requires a change of inner feelings to those considered appropriate for the situation, so that these feelings are mirrored in facial expressions and outer behaviour. The feeling rules used to monitor emotional feelings and emotional labour may be unconscious or semiconscious (Hochschild 1983).

While Hochschild’s work was carried out with airline stewards, and is not without its critics (Wouters 1989, Tolich 1993), it has been shown to have wider application and its relevance in nursing has been clearly demonstrated (James 1992, Smith 1992, Phillips 1996, McQueen 1997). The purpose of emotional labour is to promote in others a feeling of being cared for (Hochschild 1983). Thus, its relevance in nursing is reinforced since caring is a central element in nursing (Watson 1990, Swanson 1993).

Caring is a complex phenomenon and many definitions have been suggested. The two that follow indicate the physical and emotional nature of this concept for both carers and recipient of care:

Intentional actions that convey physical care and emotional concern and promote a sense of security in another. (Larson & Ferketich 1993, p. 690)

The mental emotional and physical effort involved in looking after, responding to and supporting others. (Baines et al. 1991 p. 11)

Caring for someone, in its fullest sense, includes an emotional element, i.e. to care for and about the person (Fealy 1995). Caring for someone is associated with the performance of physical tasks, whereas caring about someone implies care at a deeper level, where feelings are explicitly involved in the relationship and resulting care. If nurses are to form therapeutic relationships and engage with patients, to care for and about them, this involves their emotions. James (1992) suggests that emotional labour operates in the context of caring about, since it involves a ‘personal exchange’. She does, however, recognize that the feelings of the airline stewards in Hochschild’s study may not have been based on such a personal exchange, but could have appeared genuine because the stewards were trained to behave in this way. This lack of authenticity is, however, disputed by Wouters (1989).

To engage with patients at a level at which nurses can feel for and empathize with them may in some cases be reflexive or automatic, but in others will demand emotional work if their behaviour is to show genuine emotional responses. Such work on the emotions requires that nurses give of themselves, and this can have personal costs in terms of feeling emotionally drained or exhausted (Hochschild 1983). Clearly, not all patients require intense emotional engagement. However, in situations when they are emotionally upset, or when nurse–patient contact is maintained over a period of time (Morse 1991), the relationship is likely to develop as nurse and patient get to know each other and negotiate a relationship that satisfies both parties. Nurses in Henderson’s (2001) study experienced detachment or engagement on a continuum along which there was movement according to specific patient circumstances. Ability to move along such a continuum, according to individual circumstances, may confer an advantage and protect nurses from undue emotional stress.

Emotional work can involve nurses in managing instinctive emotions such as disgust, annoyance or frustration in patient interactions. By trying to view the situation from patients’ perspectives and empathizing with their emotions, nurses’ facial expressions and behaviour can be managed to display caring behaviour. Alternatively, when nurses reflexively identify with patients in suffering, a degree of emotional management may also be required to enable them to function in a manner that is beneficial for patients. While it is appreciated that showing emotion that reflects feelings for patients shows humanity on the part of the nurse (Staden 1998), the aim of emotional management is to facilitate the best possible outcome for patients or clients. If one is overcome with emotion, cognition and behaviour can be adversely affected (Ramos 1992).

Benefits of emotional labour in caring relationships

Emotional labour on the part of nurses may have benefits for both patients and nurses. The advantage to patients of feeling cared for can be demonstrated in physical behaviour, attentiveness, and the time that nurses give to meeting their needs (Smith 1992). The quality of care may be enhanced when nurses can engage with patients, detect and act on cues, anticipate needs and wishes, and respond accordingly to address physical, psychological and spiritual aspects of care. Muettzel (1988) describes this level of engagement as ‘being there’, nurses connecting with patients physically, psychologically and spiritually.
Von Dietze and Orb (2000) propose that it is important for nurses to experience compassion because it affects their decision-making and actions, contributing to excellence in the practice of nursing. Similarly, Henderson (2001) claims that emotional involvement by nurses may contribute to the quality of care because the majority perceive emotional engagement as a requirement of excellence in nursing practice. Thus, it seems that emotions are not to be dismissed, but rather have an important place in the quality of care one can provide.

Brechin (1998) identified other factors that may be associated with nurse–patient relationships and relevant to evaluating the quality of care. These include the importance of macro and micro communications, suggesting that these are fundamental to the way care is perceived. Brechin (1998) also acknowledged the value of ‘intrapersonal experience’ and the impact of caring relationships on the self-esteem of both carers and those being cared for, and the satisfaction experienced by both.

Nurses have also enjoyed benefit from emotional labour. Engaging with patients at a personal level has been reported to be satisfying, and job satisfaction is also achieved when feedback of appreciation is given by patients (McQueen 1995). However, emotional labour is skilled, demanding work (James 1992), and intense or continuous emotional work can be stressful and exhausting. Unrelenting work of this nature can adversely affect nurses’ physical and psychological health, potentially leading to burnout (Benner & Wrubel 1989). A balance is therefore required to provide intimate, personal attention to patients while recognizing personal limitations and engaging in coping mechanisms to protect oneself from burnout. Some such techniques are careful patient allocation so that the more demanding patients are shared amongst nurses, and provision of peer support and supervision (Staden 1998).

Emotional intelligence in the context of nursing

The UK Nursing and Midwifery Council (2002) supports the concept of partnership in nurse–patient relationships, and consumers are encouraged to be more involved in decisions about their care. The consultation required in partnership necessitates good interpersonal skills to convey information and provide support to patients and their families. However, the literature suggests that nurses often do not feel well-prepared for giving psychosocial support (Secker et al. 1999). In the current climate, when patients are hospitalized for shorter periods of time, there is a need for hospital nurses to be able to form good rapport rapidly with patients. This is necessary for the development of trusting relationships, so that patients feel able to discuss personal, sensitive issues associated with their recovery.

It is questionable whether education programmes prepare nurses adequately to be self-aware and to provide psychological support in the course of their work. There is evidence that the importance of self-awareness and understanding patients’ perspectives is recognized in nursing education (Mason et al. 1991; Wells-Federman 1996). However, some nurses feel inadequately prepared for the social, interpersonal and emotional demands of their roles (Henderson 2001).

In nursing literature, Evans and Allen (2002) acknowledge that nurses’ ability to manage their own emotions and to understand those of their patients is an asset in providing care, but that EI is generally overlooked in nursing curricula. Cadman and Brewer (2001) claim that EI is developed over time by interpersonal skills training, and propose that an assessment of EI should be made prior to recruitment of people into preregistration nursing programmes. Although EI evolves over time, this does not necessarily mean that it should not be addressed during nursing education. It is a quality that can be learned and taught throughout life (Segal 2002).

Carrothers et al. (2000) reported on the use of a 34 item semantic differential tool for measuring EI of medical school applicants. They identified five dimensions of EI (maturity, compassion, morality, sociability and a calm disposition) and validated their instrument for measuring desirable personal and interpersonal qualities. Data gathered using the tool was found to reinforce the belief of Raty and Snellman (1992) that women are more competent than men in interpersonal skills. Professional–patient relationships in both medical and nursing work are important and share many of the same features, including trust between patient and health care professional. Therefore this tool may be of value in assessing the EI of student nurses and qualified practitioners. There may be a relationship between gender and emotional skills, as suggested by Raty and Snellman (1992), but Caruso et al. (2002) have shown that EI is independent of personality traits.

In addition to the benefits of EI described in dyadic relationships, Druskat and Wolff (2001) emphasize its value in teamwork. Nurses are familiar with the concept of teamwork, not only in working with nursing personnel within a unit, but also in co-operating with other health care professionals. The United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) (1989) document on professional accountability recognizes that no single profession possessed all the knowledge and skills required to provide high quality, total patient care and the
UK Nursing and Midwifery Council (2002) refers to the importance of teamwork in its Code of Professional Conduct. The EI of a team is not merely the sum of individuals’ EI. Rather, EI is generated within the team as norms are created, mutual trust develops and a group identity is formed. Druskat and Wolff (2001) suggest that these qualities provide the basis for co-operation and collaboration. The system of health care professionals involved in hospitals, primary care, and the voluntary and independent sectors is complex and to be effective it requires trust, understanding and co-operation (Semple & Cable 2003). High group EI should therefore be beneficial in team approaches to patient care.

How is emotional intelligence relevant to emotional labour?

It is clear that the five components of EI identified by Goleman (1998), namely self-awareness, self-regulation, motivation, empathy, social skill, are relevant to nurses as they interact with others. Emotional intelligence requires that emotions are recognized and surfaced. The concept provides understanding of how the emotions experienced by individuals affect the work of the team (Druskat & Wolff 2001). Emotions, therefore, are not suppressed or ignored but are actually acknowledged and their value appreciated when there is awareness of the importance of EI.

The significance of emotions in nursing work has come to be recognized in the literature. While nursing work involves cognitive and technical skills, there has been increasing recognition of the interpersonal and intrapersonal skills required to cope with the complex demands of modern health care systems (Bellack 1999), and emotional labour is a well-recognized concept in the literature. It is acknowledged that emotional work is involved in direct patient care (Smith 1992) and at management levels within the organization (Strickland 2000). I argue here that emotional work calls upon some of the skills that fall within EI.

The qualities in EI that are relevant to this discussion are the abilities to understand other people, work well in co-operation with them and be self-aware. These are relevant to direct patient care and multidisciplinary teamwork, and Graham (1999) indicates that nurses need ‘emotional competence’, the ability to question themselves and provide patient-centred care. My argument here is that management of emotions is required in successful interactions, so that professionals show understanding of others and in turn influence the feelings of others (who may be patients or colleagues).

Implications for nurse education

While the value of EI is becoming recognized in the nursing literature, there is now a need to address this in nursing curricula. Nurses feel that they lack essential social skills (Secker et al. 1999), and employers indicate that qualifying nurses are not equipped to adapt to the working world (Bellack 1999). The aims of incorporating EI training into nursing curricula should be to improve understanding of oneself and others and to develop improved skills when addressing psychosocial needs.

McMullen (2003, p. S19) states that ‘Cognitive intelligence on its own offers little preparation for the emotional challenges that you will meet in the course of your medical career’. While this quotation is taken from the British Medical Journal and was intended for doctors, it appears to be relevant to nurses because of the close nurse–patient contact and relationships that can develop during the course of nursing work. Furthermore, emotional challenges may not be restricted to relationships with patients, but also arise with colleagues and with patients’ relatives.

Recognition of the importance of EI in relationships and in work performance seems to be an important starting point. Its relevance in recruitment and nursing curricula has been acknowledged but has still to be included as a requirement in nursing education programmes. Approaches can be incorporated into educational programme to foster these skills, in particular self-awareness, self-regulation and social skills. Cook (1999) highlights the need for self-awareness in nursing and is concerned that a more structured, rigorous approach to teaching be taken to address this quality than that of experiential learning currently adopted. He draws attention to the financial drive that resulted in pressure on universities to teach students in large groups and the unsuitability of large group teaching to the realization of some teaching aims and learning outcomes.

Teaching methods and specific learning outcomes in the development of EI must be made explicit if this is to be included in the teaching programme. Based on the theory emerging in this area, approaches that incorporate reflective practice and self-evaluation may be ways to approach the issue. These may be important skills for life-long learning and professional development. The environment within which learning takes place also needs to be addressed to provide a trusting and supportive setting within which students feel safe to explore their feelings and voice their opinions (Rogers 1969). It has become clear that there is much scope for further research to ascertain the most advantageous ways of advancing EI and of teaching and supporting nurses in their emotional work.

What is already known about this topic

- Nurses require good rapport with patients and understanding of their needs in order to provide good quality care.
- Nurses engage in emotional work to foster caring relationships with patients.
- Emotional intelligence is valuable in interpersonal relationships.

What this paper adds

- Consideration of the role and value of emotional intelligence with respect to nurses’ emotional labour.
- Emotional intelligence, as well as general intelligence, is overtly developed in preparing nurses for their professional work.
- There is much scope for research in the area of emotional intelligence in nursing and preliminary questions are posed for investigation.

Conclusion

It is recognized that nurses engage in emotional labour as part of their professional work. Only relatively recently has the concept of EI appeared in the nursing literature, but its value is beginning to be acknowledged in health care work. This discussion has suggested that there may be a useful link between EI and emotional work. While some nurses show a tendency towards more emotional engagement with patients than others, the question remains as to whether these people have more EI. While there is an argument for inclusion of EI in nursing curricula, interesting questions still remain unanswered: Are people with higher levels of EI more adept at emotional labour? Is EI to some extent protective against burnout? What are the best curriculum strategies for enhancing EI?

Clearly this is an area for further research that may have personal, professional and economic benefits. If improving nurses’ EI can help them deal more ably with their emotional work and reduce the incidence of psychological stress, this will be of benefit to nurses, patients and employers.

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