Emotional Intelligence Abilities in Oncology and Palliative Care

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Abstract and Introduction

Abstract

Nursing research on emotional intelligence suggests a vast potential for this new concept to improve nursing performance, retention, and burnout prevention. The purpose of this article was to (1) summarize the findings of nursing research in emotional intelligence to date, (2) provide a case study exemplar of the use of emotional intelligence abilities in the oncology/palliative care setting, and (3) illustrate the importance of emotional intelligence abilities to patient care, team relationships, and nurse self-care in the oncology/palliative care setting.

Introduction

It was a typical day on the busy oncology unit of The Queen's Medical Center, a large tertiary-care hospital in urban Honolulu, Hawaii. At the beginning of her shift, Ann, an experienced senior nurse, anticipated everything from administration of chemotherapy for patients receiving cancer treatment, to complex symptom management for people in the final hours of life. Advanced medical and surgical skills were routine for Ann, but she brought to her patients that day another set of abilities, the skills of emotional intelligence.

What is Emotional Intelligence?

The measures of intelligence most widely used in nursing are based on a traditional understanding of intelligence that emphasizes linear reasoning and analytical problem solving. Yet, much of nursing effectiveness depends on interpersonal skill, team problem solving, and the realm of nursing often referred to as "art" or "intuition." Nursing abilities that depend on these "nontraditional intelligences" are not typically taught, required, or rewarded, yet much of nursing effectiveness depends on them. Emotional intelligence, a new concept in intelligence theory, offers a conceptual structure for nurses to comprehensively articulate a kind of intelligence that is crucial for effective patient care, team relationships, organizational effectiveness, and self-care.

The 2000 publication of Daniel Goleman's blockbuster book, *Emotional Intelligence*,[1] reflected a dramatic change in intelligence theory that had been taking place in psychology, education, and organizational development for several decades. This change focused on the traditional definition of intelligence and its surprisingly limited ability to predict outcomes such as work performance, job and life satisfaction, wellness, and academic success.

The science behind Goleman's book was based largely on research by John Mayer and Peter Salovey,[1,2] cognitive psychologists interested in the role of emotions in reasoning. In the course of their research, Mayer and Salovey identified a subset of people who did not separate reasoning and emotion. Instead, those individuals "used emotions to facilitate their reasoning processes." When compared with other people, these individuals functioned very differently, in fact more effectively, in the work place, in relationships, and in managing their own health and wellness. Mayer and Salovey had a name for this difference. They called it emotional intelligence. Defined as the ability to correctly identify emotions, use emotions in reasoning, and understand emotions and manage them, emotional intelligence became the focus of workforce, academic, organizational, and clinical research that began to demonstrate outcomes that traditional measures of intelligence did not.[1,2]

Ann's patient, a middle-aged man in the final stages of cancer, had recently requested to be allowed a natural death and an "AND" order. Ann had cared for him throughout his hospital stay. During the last shift Ann worked, the care team had begun the transition from cure-focused medical treatment to comfort care, per the patient's request. Ann had worked hard to facilitate the transition and get a clear comfort care plan in place. Entering her patient's room after shift report, Ann's experienced eyes saw immediately that her patient had not only deteriorated dramatically since she had last seen him, but that his condition had also declined over the previous hour. He was clearly uncomfortable, gasping for breath, and fearful. Death was suddenly near. There were obvious physiological, psychological, interpersonal, and probably religious and cultural issues that needed to be addressed, but there was little time. What was most important? Where should she begin? Ann's response to her patient, her immediate assessment, problem solving, and interventions arose from a rich menu of experience and skills.

Ann immediately was in contact with her patient's family, and her intervention with the patient began. Ann's rapid assessment of her patient's physical condition included such findings as his obvious pain and air hunger. As important as the physiological issues was her patient's very human experience of dying—his anxieties, desires, and fears. Ann's ability to be effective with her patient was dependent on her ability to both think and feel, to integrate her critical-thinking abilities with her emotional abilities. She was effective because she integrated "her head and her heart." She did this by identifying emotions, understanding them, managing them, and using her emotions to facilitate her reasoning—these are the skills that make up emotional intelligence.

The field of intelligence theory has evolved over the last hundred years. The notion that intelligence is a unified concept, one "thing" that is fixed at birth, unchangeable, largely inherited, and measured by traditional measures of intelligence such as IQ and standardized test scores is no longer universally accepted. Many intelligence theorists now describe intelligence as a multifaceted concept that is developed throughout life. There is also an increasing acknowledgement of the limitations of traditional measures of intelligence such as IQ, GPA, and standardized test scores in predicting academic and professional outcomes.

One intelligence theorist, Howard Gardner,[3] developed the idea of multiple intelligences. This theory describes nine types of intelligence that range from mathematical, linguistic, kinesthetic, and spatial intelligence, to musical, interpersonal, and intrapersonal intelligences (Figure 1). Emotional intelligence theory grew out of the interpersonal and intrapersonal intelligences that Gardner[3] described.

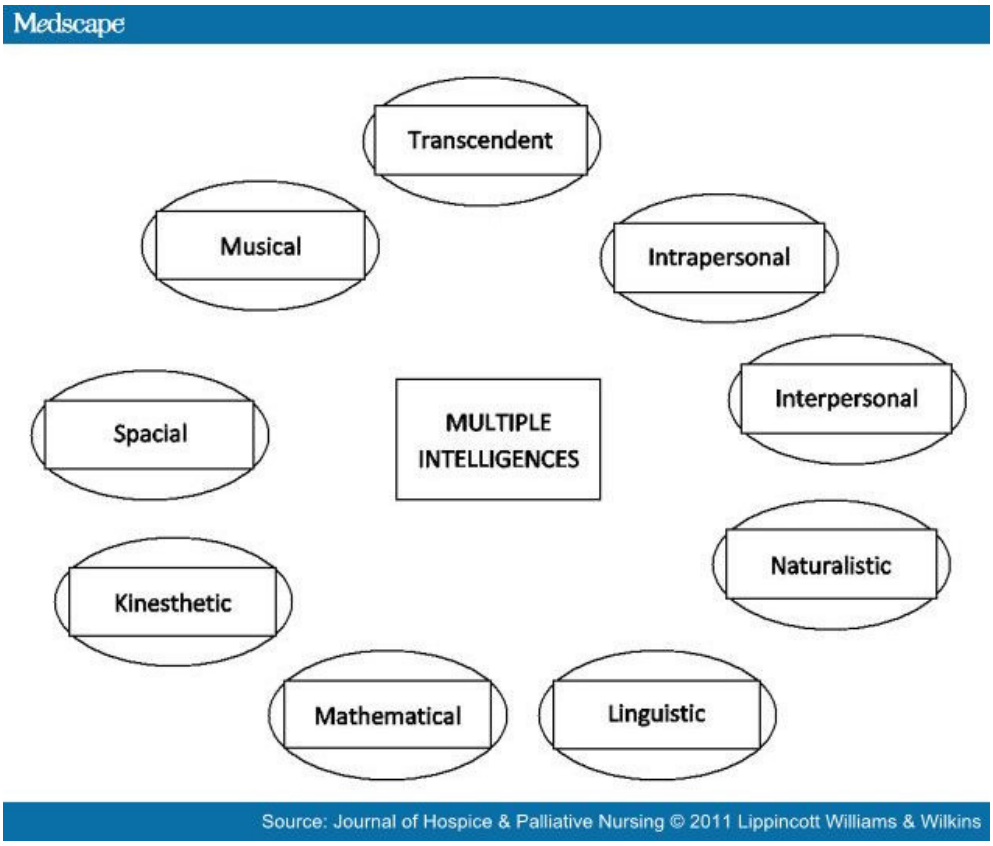

Figure 1.

Multiple intelligences (Howard Gardner's theory).

As Ann rapidly assessed her patient, the strong relationship she had developed with him enabled a deep and subtle assessment of his emotions, the complex constellation of his family and social system, and his integrated body-mind-spirit. Her own assessment was integrated with that of the other team members, the chaplain, pharmacist, social worker, and physician team members. She knew his dyspnea limited his ability to speak and that questions could worsen both his objective hypoxia and his subjective air hunger and fear. Still, she needed information to assess his condition accurately and intervene appropriately. Her knowledge of his life gave her a shorthand way to do this. "You are a scuba diver…do you feel like you are breathing underwater?" He nodded…his breaths were labored, wet, and short.

Research on Emotional Intelligence

Since Mayer and Salovey's first research on emotional intelligence, hundreds of research studies have explored its application to education, psychology, and a range of related fields. There is extensive evidence that emotional intelligence abilities correlate with performance at work.[4,5] There is also evidence that emotional intelligence abilities correlate with a wide variety of important workplace outcomes such as increased job satisfaction and retention, positive conflict styles, team performance, and psychological and physiological health.[4–6] Over the past decade, emotional intelligence has also become the focus of a new but growing body of nursing research.

What is Emotional Intelligence?

Mayer and Salovey describe emotional intelligence as a set of abilities. It is operationally defined by the following four skills: (1) correctly identifying emotions in self and others, (2) using emotions to facilitate reasoning, (3) understanding emotions, and (4) managing emotions.[4] In her care of a dying patient, Ann demonstrated excellence in each of these four skills, and her care illustrated their importance.

Correctly Identifying Emotions in Self and Others

Emotions are elemental to nursing practice. To understand and manage emotions in self and in others, emotions must first be identified correctly. This sounds simple but often is not. Anger is a good example. When a nurse is caring for a patient who is exhibiting angry behaviors, it is crucial that the nurse correctly identify this emotion. Is the patient really angry? Or is he experiencing some other emotion such as relief, fear, frustration, or grief that is easy to mistake for anger? Numerous emotions may on the surface appear to be anger, and if the emotion is not correctly identified, the intervention chosen by the nurse may be inappropriate.

Ann rapidly and accurately assessed her patient's emotions. He was fearful, but his fear focused not on dying, but rather on struggling to breathe, "drowning," having pain, and being alone. He feared being put on a ventilator and being kept alive with aggressive treatment. Because Ann identified her patient's emotions accurately, she was able to address his feelings effectively. She would administer Lasix, decrease his IV fluids, and stay with him until his friends could arrive. His fear and anxiety decreased as he realized that his nurse was addressing both his physical symptoms and his fears.

As important as it is for a nurse to be skilled in correctly identifying a patient's emotions, it is as important that she be able to identify her own. For example, nurses frequently have difficulty accepting their own anger at patients. If the nurse does not identify this feeling and manage it appropriately, the anger may compromise patient care, resulting in unintended negative behaviors such as less frequent rounding, delayed pain medication, or even callous emotional or physical interactions. The same holds true for other challenging emotions, such as fear, anxiety, and sadness.

Ann's effectiveness with her patient depended in part on her ability to assess herself as well as her patient. This began the moment she became aware of the change in his condition. A quick "pulse check" of her own feelings…"Oh no, this is so sad!" enabled her to move ahead with his care without being held back by her own feelings. Ann was aware that she was sad, but she was also angry. As soon as she had seen her patient, she knew the comfort care regimen she had tried to put into place during her last shift had not been implemented by the team. Upon cessation of the curative treatment plan, the team had not made an effective plan for the patient's symptom management. Her patient had been unnecessarily uncomfortable for hours. Ann was furious. Her anger at the team could easily have undermined her ability to focus clearly on what needed to be done. Identifying her anger was the first step in managing it effectively. Ann was able to work with the team to identify what changes in the care plan needed to be made, but her emotional insight also laid the groundwork for returning to the team with her concerns later on, with a goal of improving future team care.

Correctly identifying emotions is a skill just like other nursing skills that take practice and ongoing development. Ann's patient care illustrated the importance of the first emotional intelligence ability: correctly identifying emotions in self and others for effective patient care, self-management, and good teamwork.

Using Emotions to Facilitate Reasoning

The second ability that defines emotional intelligence, using emotions to facilitate reasoning, is the one that first caught Mayer and Salovey's attention. This ability in many ways runs counter to traditional views of intelligence. Traditionally, emotions and reasoning are assumed to be in opposition, to work against each other. With this view, to be "objective" is to be unemotional. Many people believe that effective reasoning must be free of emotions and that emotions are intrinsically irrational. Mayer and Salovey's work provides evidence that runs counter to this traditional understanding of emotions and reasoning. Many nurses intuitively understand this. Nursing care demands that nurses "think/feel" using

their emotional awareness and their analytical awareness simultaneously. When nurses use emotions to facilitate their reasoning, they integrate their thinking and feeling. The nurse asks, "How does this feeling change the way I am thinking about this situation?" and "How does my thinking about this situation change the way I am feeling about it?"

As Ann interacted with her patient, she became aware of her own emotional distress watching him near death. Although she knew his goal was a dignified, comfortable death, part of her wanted to return to an aggressive mode of therapy. She didn't want to "lose" this patient. Awareness that his symptoms had not been well controlled over the past few hours also left her feeling guilty. She was aware that all these feelings could easily undermine the patient's wishes about the end of his life. Recognizing and naming her own resistance to her patient's death and using this knowledge to ensure that her chosen interventions were congruent with his wishes, not hers, are an example of the importance of using emotions to facilitate a reasoning process. After her patient's death, further "thinking/feeling" transformed her sadness to a sense of accomplishment that she had supported his wishes and that his death had been comfortable and according to his desires.

As a nurse "thinks/feels" or "uses emotions to facilitate reasoning" with the same deliberation and intention that other skill sets demand, interactions with patients, families, and colleagues change. This can result in an improvement in relationships with patients and their families, as well as team members. A nurse may witness a new physician being defensive and dismissive of the nurse's input about a patient. If the nurse can correctly identify the physician's emotions and use emotions to facilitate reasoning, the response to the situation may be quite different. How will this change the interaction with this physician? Perhaps this physician is feeling insecure, or feeling a need to assert authority in a new environment. As this nurse thinks/feels through this interaction, chosen responses may be more effective.

Understanding Emotions

Identification of emotions and use of emotions to reason are crucial, but there is much to understand about each emotion. Understanding an emotion involves appreciating its depth, diversity, and complexity. Emotions also evolve, change, and blend with other emotions, and these evolutions must be appreciated. This enables nurses to assess and intervene creatively and constructively.

The grieving process is a good example. Oncology nurses in particular know that shock, anger, and denial are characteristic stages of the early grieving process. They also know that patients move between these emotions in a nonlinear manner. Early-stage emotions can reappear in even the latest stages of grieving. Understanding the patterns and dynamics of emotions in the grieving process enables nurses to intervene effectively.

Ann's care of her patient illustrated the importance of understanding emotions. Throughout her management of her patient's labile emotions as he neared death, she was guided by her understanding of grief. There were moments close to death when he cycled back to anger and even denial. Ann's understanding of the way emotions change in the grieving process enabled her to stay focused on his goals and desires for comfort and dignity at the end of his life. Her understanding of her own grief also enabled her to work effectively with her patient and his family without suppressing her own emotions or being controlled by them.

Understanding emotions enables a nurse to intervene in emotional situations more effectively. A nurse who knows that a young physician's defensiveness may be related to insecurity or fear in a new role will be able to adapt communication with the physician in a way that enhances both care of the patient and long-term development of a positive collegial and team relationship. When a nurse understands a patient's emotions with depth and sophistication, the interventions selected are more effective. Nurses who have a comprehensive understanding of their own emotions are able to engage challenging emotional situations in a way that enhances their self-care and well-being. This is particularly crucial in oncology and palliative care settings, where emotional labor is such a predominant feature of the nursing work

Managing Emotions

Once a nurse correctly identifies, understands, and uses an emotion to facilitate reasoning, there is a greater ability to manage emotions or emotional situations effectively. With the same careful assessment, intervention, and reassessment that nurses apply to wound care, fluid/electrolyte balance, and pain management, nurses can identify emotions, think with them, understand them, intervene, and then reassess the intervention. This process is applied not only to patients and their families, but also to the nurse's emotional self-management and management of charged emotions in nursing and multidisciplinary teams.

As Ann's patient neared and then reached his death, there were moments when Ann needed to care for her own feelings to manage his care effectively. Throughout the day, there were small "timeouts" when she took a moment to pause and reflect on what was happening and how she felt. She emotionally "checked in" with team members and colleagues, sharing her own feelings and receiving suggestions, support, and additional multidisciplinary input. During this phase of her patient's care, it was particularly important that the multidisciplinary care be both coordinated and focused on the patient's care goals. Ann's effective management of her own emotions made it possible for her to be more effective in managing those of her patient and his family.

At the end of the day, the nursing excellence that Ann demonstrated in the care of her dying patient was dependent on her outstanding emotional intelligence skills. Working with the patient, his family, and the care team, Ann was able to identify emotions in herself, her patient and his family, and team members. She used emotions to facilitate her reasoning, and this led to a good understanding of the emotional component of her patient's care. Lastly, she used all these abilities to effectively manage her own emotions and the emotional component of her patient's experience and that of the care team.

Nursing Research on Emotional Intelligence

Approximately three-dozen research reports that represent over seven countries were identified in a literature search that extended from the first nursing research study on emotional intelligence in 1999 to August 2010. As with emotional intelligence research in professions outside nursing, the earliest nursing research on emotional intelligence was focused on nursing leadership.[7–9] Some research focused on specialty nurses or nursing students.[10–16] Other research has focused on job stress, job satisfaction, physical health, and burnout.[17–22] A few researchers began to examine patients' emotional intelligence and how it related to care outcomes.[23,24] Other studies explored the presence of emotional intelligence in nursing practice and its relationship with concepts such as intuition, professionalism, and caring. In one study, emotional intelligence in nurses correlated with patients' perception of caring behaviors on the part of the nurse.[25,26]

Nursing research on emotional intelligence has also examined its role in nursing technology and in conflict management among nurses.[16,27] Nursing workforce research has demonstrated both pilot and supporting evidence of correlations between measured emotional intelligence and job performance. Emotional intelligence scores have also correlated with retention in nursing and self-reported organizational commitment.[27,28] Correlation between emotional intelligence scores and nurses' ethical behavior has also been explored.[29]

Results of these studies validate similar research done in other professions. It is clear that leader performance across a wide range of criteria correlates with emotional intelligence abilities.[4,28,30] Fiscal outcomes, effective organizational change, and organizational performance have been demonstrated to correlate with emotional intelligence scores in nurse leaders.[7] Improved retention, psychological and physiological wellness, stress resilience, and prosocial organizational behaviors and attitudes have been correlated with emotional intelligence.[27,29,31,32] There is little research on emotional intelligence and patient outcomes, but there has been tantalizing pilot data. One pilot study on diabetics demonstrated a correlation between patient emotional intelligence scores and glycemic control.[23]

Research on emotional intelligence in nursing is in its infancy. Further research is needed to explore the concept as nurses apply it to patient care, team care, and self-care. Research on emotional intelligence abilities and their relationship with patient care outcomes is needed. Educational methodologies for the development of emotional intelligence abilities in nursing practice need to be developed and tested. However, despite these limitations, the potential importance of emotional intelligence to nursing lays in its ability to articulate a form of intelligence that is an integral part of nursing practice. With this articulation may come nurses' ability to better name, measure, and develop the skills related to emotional intelligence and to integrate them into nursing education and practice.

References

1. Mayer J, Salovey P, Caruso D. Emotional intelligence: theory, findings, and implications. *Psychol Inq*. 2004;15(3):197–215.
2. Mayer JD, Salovey P, Caruso D. Emotional intelligence new ability or eclectic traits? *Am Psychol*. 2008;63(6):503–517.
3. Gardner H. *Frames of Mind: The Theory of Multiple Intelligences*. New York: Basic Books; 1983.
4. Van Rooy DL, Viswesvaran, C. Emotional intelligence: a meta-analytic investigation of predictive validity and nomological net. *J Vocation Behav*. 2004;61:1:71–95.
5. Rosette D, Ciarrochi CV. Emotional intelligence and its relationship toworkplace performance outcomes of leadership effectiveness. *Leadersh Organ Dev J*. 2005;26(5):388–399.
6. SchutteN,Malouf J, Thornsteinsson E, Bhullar N, Rooke S. A meta-analytic investigation of the relationship between emotional intelligence and health. *Pers Individ Diff*. 2007;42(6):921–933.
7. Molter NC. *Emotion and Emotional Intelligence in Nursing Leadership* [doctoral dissertation]. Santa Barbara, CA: Fielding Graduate Institute; 2001.
8. Vitello-Cicciu JM. Emotional intelligence. *Nurs Manage*. 2003; 34(10):28–33.
9. Vitello-Cicciu JM. Exploring emotional intelligence: implications for nursing leaders. *JONA*. 2002;32(4):203–210.
10. Akerjordet K, Severinsson E. Emotional intelligence in mental health nurses talking about practice. *Int J Ment Health Nurs*. 2004;13(3):164–170.
11. dos Santos L, de Almeida F, da Costa Lemos, S. Emotional intelligence: testing the future nursing. *Rev Bras Enferm*. 1999; 52(3):401–412. MEDLINE database. Accessed September 12, 2008.
12. Humpel N, Caputi P, Martin C. The relationship between emotions and stress among mental health nurses. *Aust N Z J Ment Health Nurs*. 2001;10(1):55.
13. Montes-Berges B, Augusto J. Exploring the relationship between perceived EI, coping, social support and mental health in nursing students. *J Psychiatr Ment Health Nurs*. 2007;14(2):163–

14. Rochester S, Kilstoff K, Scott G. Learning from success: improving undergraduate education through understanding the capabilities of successful nurses. *Nurse Educ Today*. 2005;25:181–188.
15. Shanta LL. *A Quasi-experimental Study of the Impact of Nursing Education on the Development of EI Above the Level Acquired Through General Education* [doctoral dissertation]. Toronto, ON, Canada: Toronto University International; 2007.
16. Simpson R, Keegan A. Nursing informatics: how connected are you? Employing emotional intelligence in a high-tech world. *Nurs Adm Q*. 2002;26(2):80–86.
17. Augusto Landa JM, Lopez-Zafra E, Berrios Martos MP, Aguilar-Luzon. The relationship between emotional intelligence, occupational stress and health in nurses: a questionnaire survey. *Int J Nurs Stud*. 2008;45(6):888–901.
18. Budnik MF. *Emotional Intelligence and Burnout: Influence on the Intent of Staff Nurses to Leave Nursing* [dissertation]. Phoenix, AZ: University of Phoenix; 2003.
19. Farmer S. *The Relationship of Emotional Intelligence to Burnout and Job Satisfaction Among Nurses in Early Nursing Practice* [dissertation]. Salt Lake City, UT: University of Utah; 2004.
20. Gertis L, Derksen JJ, Verbruggen AB. Emotional intelligence and adaptive success of nurses caring for people with mental retardation and severe behavior problems. *Ment Retard*. 2004; 42 (2):106-121.
21. Neal J. *The Relationship Between Emotional Intelligence and Job Burnout Among Registered Nurses in Four Upstate North Carolina Hospitals* [dissertation]. Clemson, SC: Clemson University; 2002.
22. Tjiong L. The relationship between emotional intelligence, hardiness and job stress among registered nurses. *Leadersh Organ Dev*. 2005;26:5:388-399.
23. Samar A. *The Relationship Among Emotional Intelligence, Selfmanagement and Glycemic Control in Individuals With Type 1 Diabetes* [doctoral dissertation]. Amherst, MA: The University of Massachusetts at Amerst; 2001.
24. Willard S. Relationship of emotional intelligence and adherence to combination antiretroviral medications by individuals living with HIV disease. *J Assoc Nurses AIDS Care*. 2006;17(2); 16-26.
25. Rego A, Godinho L, McQueen A, Cuha M. Emotional intelligence and caring behaviour in nursing. *Serv Ind J*. 2010;30(9):1419-1437.
26. Codier E, Muneno L, Franey K, Matsura F. Is emotional intelligence an important concept for nursing practice? *J Psychiatr Ment Health Nurs*. In press.
27. Morrison JB. *The Relationship Between Emotional Intelligence and Preferred Conflict Styles; A Correlational Study of Nurses in Southern Mississippi* [PhD dissertation]. Minneapolis, MN: Capella University; 2005.
28. Codier E, Kamikawa C, Kooker BM, Shoultz J. Emotional intelligence of nurses: performance and retention. *Nurs Adm Q*. 2009;34(4):310-316.
29. Deshpande S, Joseph J. Impact of emotional intelligence, ethical climate, and behavior of peers on ethical behavior of nurses. *J Bus Ethics*. 2000;85(3):403-410.
30. Codier E, Kooker BM, Shoultz J. Measuring the emotional intelligence of clinical staff nurses: an approach for improving the clinical care environment. *Nurs Adm Q*. 2008;32(1):8-14.
31. Young-Ritchie C, Spence Laschinger HK, Wong C. The effects of emotionally intelligent leadership behavior on emergency staff nurses' workplace empowerment and organizational commitment. *Nurs Leadersh (Tor Ont)*. 2009;22(1):70Y85.
32. Cummings G, Hayduk L, Estabrooks C. Mitigating the impact of hospital restructuring on nurses: the responsibility of emotionally intelligent leadership. *Nurs Res*. 2005;54(1):2-12.