

**Emotional intelligence in health and social care; a guide for improving human relationships (2012)**

Section:

**Extracts pp. 6--14, 77--83**

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Name of Publisher:

**Radcliffe Publishing**

traits (Conte 2005). However, there remains a clear distinction between personality and EI in terms of its current theoretical modelling (Mayer *et al.* 2008).

Before moving on to explore EI models in more detail, first spend some time to explore the construct of personality. By looking at personality tests you can gain an understanding of what personality is.

**Box 1.4** Web-based activity

Look at some online personality tests to gain a sense of what items are considered to be part of 'personality'. This website is one example: [www.bbc.co.uk/labuk/experiments/personality](http://www.bbc.co.uk/labuk/experiments/personality)

**EMOTIONAL INTELLIGENCE**

Emotional intelligence has been defined as: 'the ability to monitor one's own and other's feelings, to discriminate among them and to use this information to guide one's thinking and actions' (Grewal and Salovey 2005, p. 333). As a result, we make decisions based not only after assessing their outcome, but also on the emotional qualities associated with the decisions or judgements (Grewal and Salovey 2005). This definition of EI explains, in part, the interest and use of EI capabilities across a range of health and social care contexts such as leadership (Akerjordet and Severinsson 2008, Burdett Trust 2009), organisational behaviour (Guleryuz *et al.* 2008), therapeutic relationships (O'Connell 2008), and education (Chabeli 2008, Wilson and Carryer 2008).

However, amongst this blossoming interest in EI there remain genuine tensions as to what precisely is included and excluded from its parameters. We are going to critically explore three major views of EI, the first being EI as an ability model separate from personality by Mayer *et al.* (2008), and then the models of Bar-On (2000) and Goleman (1995), who both offer EI as a fusion of ability and personality trait.

**Box 1.5** Reflection activity

There is some worth as you read on in considering and then critically reflecting on how the abilities explained below will help you in your clinical and academic work experiences.

**The emotional intelligence model of Mayer *et al.***

Locke (2005) forwards that such is the misuse of the term 'EI' and the palpable over-inclusiveness of abilities attributed to EI that there is no longer validity in its name.

Such views are strongly echoed by Mayer *et al.* (2008), who forward their own 'four-branch model' of EI as being the superior, empirically scientific and conceptually organised approach to EI. In doing so, Mayer *et al.* (2008) continue a longstanding discussion to anchor EI to its original concepts, derived and established through a researched evidence base that show personal and social advantages for people with high emotional clarity (Salovey and Mayer 1990).

Their four-branch model of EI basically consists of a hierarchy of abilities ascending from:

- 1 the ability to perceive emotions in oneself and others, accurately
- 2 the ability to use emotions to facilitate thinking
- 3 the ability to understand emotions, emotional language, and the signals conveyed by emotions
- 4 the ability to manage emotions so as to attain specific goals (Mayer and Salovey 1997).

Within each of these four branches there are subsets of hierarchical abilities that move from the fundamental to the more sophisticated. Central to this model is that EI is an ability that enhances the relationship between emotion and cognition.

Each of the four branches to the model are explained and detailed below:

**Stage one** of the model focuses upon emotional perception or the picking up on emotions that in turn influence how and what we think. Without this foundational ability to perceive emotions, none of the subsequent steps would be possible.

- 1 Stage one involves the ability to perceive emotions in one's self and others accurately as:
  - the ability to identify emotion in physical states
  - the ability to identify emotions in other people or items (such as artwork) through mediums of language, sound, and/or behaviour
  - the ability to express emotions accurately and to express needs related to those feelings
  - the ability to discriminate between accurate and inaccurate expressions of feeling.

**Stage two** of the model then focuses more upon the emotional integration with cognition as the emotions enter active individual awareness. Here, emotions are labeled and influence cognitions either positively or negatively. Perceptions can also be altered.

- 2 Stage two involves the ability to use emotions to facilitate thinking as follows:
  - emotions prioritise thinking by focusing attention toward important information
  - emotions are sufficiently within the individual's awareness so as to be used in assisting judgment and memory concerning feelings

- emotions influence perspective encouraging consideration of multiple points of view
- emotional states influence specific problem-solving approaches.

**Stage three** of the model highlights emotional understanding as distinct from merely recognising emotions. Key abilities include truly understanding how emotions influence individuals and individuals within relationships over time.

- 3 Stage three involves the ability to understand emotions, emotional language, and the signals conveyed by emotions as:
- the ability to differentiate emotions
  - the ability to interpret the meanings that emotions convey
  - the ability to understand complex feelings that may be multiple and simultaneous
  - the ability to recognise possible movement of emotions from one emotional experience to another.

**Stage four** of the ability model focuses upon the management of the emotion. At this point it is important to note that this framework of understanding emotions is not about the denial and/or avoidance of emotions within personal or professional roles. Rather, it is uncovering how through recognising and understanding the emotions of ourselves and others that we can attain desired outcomes.

- 4 Stage four involves the ability to manage emotions so as to attain specific goals as:
- the ability to stay open to, yet not be overwhelmed by, emotions
  - the ability to engage or detach from emotion depending upon its use
  - the ability to monitor emotions in relation to oneself and others
  - the ability to manage emotion in oneself and others and flexibly choose a course of action that best fits needs (Mayer and Salovey 1997).

Mayer *et al.* (2008, p. 504) respectively describe other leading figures within the EI debate, such as Bar-On (2000), as including 'unrelated attributes' in his model of EI, and Goleman (1995) as being 'journalistic' (presumably as distinct from scientific) towards EI. Both are mixed approaches that see EI as a fusion of competencies and personality traits, rather than as an ability.

#### **The emotional intelligence model of Bar-On**

Bar-On (2000, p. 365) offers EI as a fusion of emotional and social competencies, skills and what Bar-on calls 'facilitators' that all combine to enable intelligent behaviours. Bar-On identifies assertiveness, stress management, self-awareness and flexibility all as being components of EI. Indeed, Bar-On (2000) extends EI into a 15-aspect model arranged in a five-level hierarchical structure:

**Level 1 Intrapersonal EI (self-awareness and self-expression)**

- self-regard (being aware of, understanding and accepting ourselves)
- emotional self-awareness (being aware of and understanding our emotions)
- assertiveness (expressing our feelings and ourselves non-destructively)
- independence (being self-reliant and free of emotional dependency on others)
- self-actualisation (setting and achieving goals to actualise our potential)

**Level 2 Interpersonal EI (social awareness and interaction)**

- empathy (being aware of and understanding how others feel)
- social responsibility (identifying with and feeling part of our social groups)
- interpersonal relationship (establishing mutually satisfying relationships)

**Level 3 Adaptability EI (change management)**

- reality testing (validating our feelings and thinking with external reality)
- flexibility (coping with and adapting to change in our daily life)
- problem-solving (generating effective solutions to problems of an intrapersonal and interpersonal nature)

**Level 4 Stress management EI (emotional management and control)**

- stress tolerance (effectively and constructively managing our emotions)
- impulse control (effectively and constructively controlling our emotions)

**Level 5 General mood EI (self-motivation)**

- optimism (having a positive outlook and looking at the brighter side of life)
- happiness (feeling content with ourselves, others and life in general)

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Central to Bar-On's position (2000, p. 373) is that EI is of its very essence the ability to understand, be aware of and also express emotions, and that while very closely related to social intelligence, it is separate from it.

**Box 1.6 Reflection activity**

Compare and contrast aspects of Bar-on and Mayer *et al.* models and identify areas of possible contrast or crossover. For example, both models have self-awareness at the beginning, suggestive that this is essential to enable the remaining components of the EI capabilities. Conversely, Mayer *et al.* would possibly shun the idea of having a general mood component highlighting happiness and optimism.

**The emotional intelligence model of Goleman**

The third and final EI model to be explored is that of Daniel Goleman (1995), who arguably moved EI into a wider public awareness with emphasis on organisations, and

leadership in particular. His broader interpretations of EI include self-motivation, empathy and relationship skills, as well as impulse control, problem-solving and social responsibility (Goleman 1995, p. 26). The Consortium for Research on Emotional Intelligence in Organisations (1998) and Boyatzis *et al.* (2000) offer a structured framework of EI arising from Goleman's original work.

This framework separates EI capabilities into 4 areas:

- 1 the capability to *recognise* features of EI within *self*
- 2 the capability to recognise features of EI constructs within others
- 3 the capability to *regulate* features of EI constructs within *self*
- 4 the capability to *regulate* features of EI constructs within *others*.

Expanding upon these key EI capabilities from Goleman's model as detailed by Cherniss *et al.* (1998) demonstrates a notable volume of EI capabilities (See Table 1.1 below).

When viewing this quadrant observe how EI capability is initially separated into capabilities focused toward self and others. In turn, this is again separated into EI capabilities to have awareness toward self and others and then separated again into regulating self and others. Table 1.2 offers a more detailed description of the EI capabilities within this model.

What is highlighted by the competencies in the above tables is that the application of EI extends beyond clinical considerations alone and into the dynamic environments where care is delivered. This environment is frequently complex and subject to rapid and at times unpredictable change. Health and social care often struggle to respond quickly to such changes, placing the onus on the staff who work

**TABLE 1.1** EI capabilities (adapted from Consortium for Research on Emotional Intelligence in Organisations, 1998)

	<i>Self: personal competence</i>	<i>Other: social competence</i>
<b>Recognition</b>	<b>Self-awareness</b> <ul style="list-style-type: none"> <li>• Emotional self-awareness</li> <li>• Accurate self-assessment</li> <li>• Self-confidence</li> </ul>	<b>Social awareness</b> <ul style="list-style-type: none"> <li>• Empathy</li> <li>• Service orientation</li> <li>• Organisational awareness</li> </ul>
<b>Regulation</b>	<b>Self-management</b> <ul style="list-style-type: none"> <li>• Self-control</li> <li>• Trustworthiness</li> <li>• Conscientiousness</li> <li>• Adaptability</li> <li>• Achievement drive</li> <li>• Initiative</li> </ul>	<b>Relationship management</b> <ul style="list-style-type: none"> <li>• Developing others</li> <li>• Influence</li> <li>• Communication</li> <li>• Conflict management</li> <li>• Leadership</li> <li>• Change catalyst</li> <li>• Building bonds</li> <li>• Teamwork</li> <li>• Collaboration</li> </ul>

**TABLE 1.2** An expanded view of the framework of emotional competencies (adapted from Consortium for Research on Emotional Intelligence in Organisations 1998)*Self: personal competence***Self-awareness**

- Emotional self-awareness: know which emotions they are feeling and why; have a guiding awareness of their values and goals
- Accurate self-assessment: show a sense of humour and perspective about themselves; reflective, learning from experience
- Self-confidence: be able to make sound decisions despite uncertainties and pressures; present themselves with self-assurance

**Self-management**

- Self-control: manage impulsive feelings and distressing emotions; think clearly and stay focused under pressure
- Trustworthiness: build trust through reliability and authenticity; admit one's own mistakes and confront unethical actions in others
- Conscientiousness: meet commitments and keep promises; hold self accountable for meeting his/her objectives
- Adaptability: smoothly handle shifting priorities and rapid change; adapt responses and tactics to fit fluid circumstances
- Achievement drive: results-oriented with a high drive; set challenging goals and take calculated risks
- Initiative: pursue goals beyond what's required or expected; mobilise others through unusual, enterprising efforts

**Other: social competence****Social awareness**

- Empathy: show sensitivity and understand others' perspectives; help out based on understanding other people's needs and feelings
- Service orientation: gladly offer appropriate assistance; grasp a customer's perspective, act as a trusted advisor
- Leverage diversity: respect and relate well to people from varied backgrounds; understand diverse worldviews

**Relationship management**

- Develop others: identify people's needs for development; mentor and offer assignments that challenge and grow a person's skill
- Influence: use complex strategies to build consensus and support; orchestrate dramatic events to make a point effectively
- Communication: listen well, seek mutual understanding; foster open communication and stay receptive to bad news as well as good
- Conflict management: handle difficult people and tense situations with diplomacy and tact; spot potential conflict and deescalate
- Leadership: guide the performance of others while holding them accountable; lead by example
- Change catalyst: recognise the need for change and remove barriers; challenge the status quo to acknowledge the need for change

*(Continued)*

**TABLE 1.2** An expanded view of the framework of emotional competencies (adapted from Consortium for Research on Emotional Intelligence in Organisations 1998) (Continued)

<i>Self: personal competence</i>
<ul style="list-style-type: none"> <li>• Building bonds: cultivate and maintain extensive informal networks; seek out relationships that are mutually beneficial</li> <li>• Teamwork: model team qualities like respect, helpfulness and cooperation; draw all members into active and enthusiastic participation</li> <li>• Collaboration: balance a focus on task with attention to relationships; collaborate by sharing plans, information and resources</li> </ul>

within them to adjust (Hurley and Linsley 2007, Limerick *et al.* 2002, p. 83). It is from within this challenging environment that health and social care practitioners must have the intrapersonal and interpersonal capabilities to respond to their clients' needs, as well as their own needs.

#### **Box 1.7** Social activity

At this point there is some worth in stopping to apply how the abilities described in this EI model have pertained to your own practice-based experiences, and experiences within other social roles you have. Review the list of capabilities in this EI model with a trusted peer and how you have used these capabilities (or not).

\* Having an understanding of EI now means that you can begin to develop aspects of your own EI. When doing the social and reflective activities in these chapters, identify any of your own emotions that will emerge. For example, when asked to reveal aspects of yourself with a trusted peer, what did you feel: did you choose that peer or did he choose you, and what might that be about? Did your feelings impact on your actions such as possibly feeling fearful of sharing and hence not participating?

#### **Emotional intelligence measures**

Some of you may be wondering how to resolve the differences between the models of EI that we have explored, while perhaps others may be intrigued to know what level of EI you may have. Both these issues can be addressed through a very brief look at the measurement of EI. Within this consideration is the question of whether what is being measured is actually something new, i.e. EI, or is it measuring a repackaging of personality traits already effectively measured by psychometric tests that we simply label as EI?

Mayer *et al.* (2000, 2004) identify EI as ability and view other competence EI models that include leadership or assertiveness as failing in content

validity with their measures. In other words, Mayer *et al.* (2000, 2004) claim they are measuring EI while others are simply measuring personality traits. They offer empirical support for their EI model through their 'Mayer, Salovey, Caruso Emotional Intelligence Test' (MSCEIT). The MSCEIT reflects the working theory that EI is a specific ability to process the information pertaining to emotional perception, emotional facilitation of thought, emotional understanding and finally, emotional management. As such the MSCEIT is a performance measure, as it directly connects intelligence to ability. In common with other ability measures it has a higher correlation to cognitive ability than the mixed EI models such as Bar-On (2000) and Goleman (1995) (Van Rooy *et al.* 2005).

By contrast, Bar-On's self-report measure, the 133-itemed Emotional Quotient Inventory (EQ-i) – based upon a Likert Scale – culminates in a global EI score, as well as individual scores for each composite item that constitutes Bar-On's model of EI. This self reporting tool has internal validity indicators and has been normed across international populations (Bar-on 2000). The EQ-360, a multi-rater tool, has also been developed.

Boyatzis *et al.* (2000) outline the Emotional Competence Inventory (ECI), a measurement tool reflecting Goleman's model of EI (1995). As with the other EI approaches, the measurement tool was worked outwards from the model, strengthening the validity of outcomes. The ECI 2.0, also based on Goleman's model, is a multi-rater, 360-degree tool designed to assess the emotional and social competencies of individuals in organisations.

The ECI, as with all the other mixed measurement tools, appear to show that there is both a crossover between existing understandings and measures of personality and that of EI; these tools also find areas distinctive to EI (Byrne *et al.* 2007). Additionally, mixed measurement tools show a greater correlation with personality and a lower correlation with cognitive capability than ability or performance tools (Van Rooy *et al.* 2005).

While the view of EI is partially opaque, there arguably exists enough clarity and agreement upon EI capabilities to proceed with a cautious exploration of EI in relation to the roles of practitioners. Before commencing this exploration one final question needs to be addressed; that of 'Can EI capabilities be improved?'

### **Education and training for emotional intelligence**

Having offered both an understanding of EI and some initial links between EI and professional roles it is important that we consider if your EI capabilities can be altered through education and/or training.

Cherniss *et al.* (1998) sought responses to this question through a robust exploration of literature. As a result of this reviewing it emerged that the process of developing EI requires motivation to change, and that the change sought is

the change within and about oneself, and oneself in relation to others. Successful enhancement of EI capability also requires educational approaches that are individually packaged and self-directed. Individual learning styles need to be catered for and the learner positioned to be in charge of the program. Other key areas of educating for improved EI include:

- setting specific behavioural goals that are clear and challenging
- practising the behavioural goals over a period of months both at work and in life utilising naturally occurring opportunities
- utilising experiential methods that are active and concrete
- genuine modelling from high-status persons within on-the-job contexts
- enhancing self-awareness that is central to developing EI, which is the cornerstone of emotional and social competence
- generating an organisational culture that is safe for experimentation with the new behaviours (Boyatzis 2002, Cherniss *et al.* 1998).

### CHAPTER SUMMARY

This chapter has hopefully triggered some thinking about the importance of health and social care practitioners having a range of inter- and intrapersonal capabilities to adequately fulfil their professional roles. The chapter has also introduced you to the idea that there are multiple ways of understanding what intelligence is, and that this multiple understanding includes EI.

EI can be understood as being either separate from or partially overlapping with the construct of personality depending upon the EI model. Regardless of the EI model adopted, this chapter has pinpointed specific EI capabilities that are essential to successfully engage in caring for others, and that it appears to be very possible to become better at being emotionally intelligent when motivated to do so and supported by your environment.

The subsequent chapters of this book now seek to not only build on your motivation to improve your EI capabilities, but to also offer ways to do so.

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mean that there are very few leaders, each with a small disparate army of followers. Defenders of such approaches will argue that throughout history the only constant within health and social care settings has been change, and that these highly directive leadership approaches undertaken by an elite few and supported by intensive management systems are the only way to get the job done. History perhaps suggests that while hitting the target, they frequently miss the point.

However, there are in fact ways of leading people and still getting the job done: this is true, even in big organisations. The National Health Service (NHS) across the United Kingdom is the largest organisation to be found in Europe and it has gone through significant periods of change, the most conspicuous one coming with devolution in 1999. This saw the end of (if it ever existed) a single vision of what the NHS should be and the underlying principles upon which services are delivered. Devolution brought a closer alignment between the individuality of party politics (notably those in power in each of the four home countries) and how services were run in each of the home countries. Within Scotland in particular it saw a greater politically driven focus on leadership within the NHS, as its chief executives and other top positions are appointed through a process that requires political approval. It also heralded, within a Scottish context, the return of healthcare based on values and clinical engagement; a system more focussed on clinical leadership than other areas of the UK. Within England in particular, professional managerialism emerged as the preferred way of getting health and social care to people.

Two points should hopefully be emerging as you read this; one is that there is a significant difference between being a leader and being a manager, a difference we will explore a little later. The second point is that the political systems of the country in which you work directly shape the services you work in, which in turn shapes the type of leadership expected of you in your professional roles. The NHS example within the UK highlights this. The NHS can be seen as delivering a market-driven economy loosely based on the principle of 'healthcare free at the point of delivery' (Greer 2004, Greer and Rowland 2008). However, Klein (2008) suggests: *'The NHS is a remarkable monument to institutional stability and political consensus. The old building has been massively remodelled, but the basic architecture remains intact'*. This professional managerialism creates a different focus from the professional clinical leadership more evident in the Scottish (and to a lesser extent the Welsh) system, which emphasise clinical autonomy, creativity and to an extent diversity built on clinical evidence and/or professional judgement.

Professional managerialism negatively impacts on the underlying principle of person-centredness and human rights, the foundation of the Scottish system and indeed Scottish mental health legislation (Mental Health (Care and Treatment) (Scotland) Act 2003, Millan principles SEHD 2004). Critically, systems such as those in Scotland also place on its managers and clinical leaders an irrevocable responsibility to work together to bring stated values into delivered values – a task not always achieved or even consistently achievable. It could be argued that less

managed (as distinct from over-managed or unstructured) systems support this delivery of value-driven health and social care. Additionally, it is suggested that it also requires EI competent leaders focussed on people rather than simply on targets.

### CONTEXT OF CHANGE

Regardless of your national context, health services have gone through, and continue to go through, significant and rapid cycles of change that require a high level of resilience from everyone. This change is not unrelated to the significant public finance investment it takes to run these systems as a proportion of the nation's entire budget. This leads to a semi-constant state of political flux related to the cycles of elections and political expedients of the government of the day. This issue of change provides a very important and common context in which health and social care leadership is situated. This resilience to the effects of organisational change is perhaps more important for the clinician as leader, who often does not manage services but is frequently required to influence without authority, while still being able to share and lead the vision of continuous improvement and deliver high-quality, person-centred care. Indeed, there can be few clinical leaders who have not gone through and had to cope with significant organisational restructurings (Dooley 2002).

The role of the emotionally intelligent leader can significantly mitigate the impact of these restructurings and workforce changes (Cummings *et al.* 2005). Cummings *et al.* (2005) found that leaders with what is called a 'resonant leadership' style reduced the negative emotional impact that change had on staff. Resonant leaders were empathetic and supportive to the needs of their teams while also effectively taking notice and control of their own emotions. They were able to manage and develop relationships with others through a strong sense of self-awareness and self-management. Cummings *et al.* (2005) describe some characteristics of the dissonant leader (as distinct from resonant) as '*pace setting and commanding*'; the dissonant leader destabilises the emotional underpinnings that support teams and deliver success. They frequently respond to change in a manner that 'burns out' their teams and ultimately the staffs within the teams do not own the innovation or changes, but rather feel imposed upon. As noted previously in this chapter, they hit the target, but miss the point. Health and social care services are about people – those we serve and those that do the serving; we ignore both at our peril. The dissonant leader's need to achieve the target overrides any understanding of the humanity of their teams or indeed the people they serve.

What must be understood here is that resonant leaders also deliver change and innovation and are often at the very forefront of development; it is the 'how' of delivery that is different. The resonant leader supports their staff to work through the change, to develop solutions, to own what is happening. Staff that are given ownership of change and have the ability to influence change frequently deliver more than was asked of them – often termed the discretionary effort. The sense of

ownership impacts on the emotional well-being of teams and the individuals within the teams. Segal (2002) suggests that emotionally intelligent healthcare leaders not only contribute to the wellbeing of those that they come into contact with as part of their work, but also contribute to the overall wellbeing of the institution itself.

The resonant leader is not afraid to surround himself with people that know more than he does – it is not his role to know everything. Conversely, the dissonant leader has an unshakeable need to be the one that knows the answers, to be able to command and control both the direct and the pace of change. Within themselves they are frequently challenged by people who know more than they do.

### **LEADING SELF AND OTHERS**

Good leadership with the health and social care setting has key characteristics in common with leadership in any sphere of work, for example:

- commitment to service excellence
- integrity
- approachability
- visionary ability
- visibility
- intelligence
- sound judgement
- decisiveness
- knowledge
- fluency
- personality
- adaptability
- alertness
- integrity
- non-conformity.

Good leadership does, however, have features that differentiate it from many other walks of life. Leadership within health and social care needs to inspire and motivate others within workplace environments characterised by expressed emotion, co-existing with the need to think rationally and creatively. Unlike most other walks of life, healthcare clinical leaders are dealing with life and death as well as risk and vulnerability as a day-to-day factor, consequently impacting on those using services, as well as those that deliver the services.

To a different extent leaders within social care also deal with life and vulnerability as central components of their day-to-day life. Contact with health and social services is, in the main, related to ill health or areas of health/care deficit – this impacts therefore on the underpinning emotion of the episode of engagement and the impact this can have on the staff dealing with that emotion. Although a recovery

approach has emerged as the central philosophy of both health and social care service, this perspective acknowledges the underlying tenet that services are focussed on people during an illness or deficit stage of their life. The leader therefore has to deal with the emotion generated from those using the service as well as the emotion of staff providing the episode of care. Indeed, emotion and emotional engagement is threaded throughout the relationships that exist across health and social care, with the use of the personal/professional self being a key fundamental capability to achieving improved clinical and social outcomes (Lynch and Trenoweth 2008).

Perhaps by now you are asking the question – am I or would I be a dissonant leader? Am I the type of leader who through a drive to accomplish goals and tasks would not actually lead at all, but be in fact pushing? These questions direct us toward seeing leadership as being pertinent to all of us engaged in health and social care delivery, rather than applying only to an elite few. Leadership commences with leading ourselves and being a collaborative individual, a term we will expand upon shortly. By being able to lead ourselves we are in a much better place to respond to the key question asked of effective leaders: ‘Why should I be led by you?’ (Jumaa 2008).

**Box 6.1** Reflection activity

Who would be your favourite or most respected leadership figure? Try and relate this to someone you have worked with or encountered in real life.

Write down at least six key characteristics of that leader. Include his/her values and attitudes as well as what he/she actually did.

Compare your list of key characteristics with the EI capabilities outlined in Chapter 1. Is there compatibility between the two?

**Box 6.2** Reflection activity

Now write down six key characteristics of poor leaders you have encountered.

In comparing the characteristics of the good and bad leaders, what would you say are the underlying differences?

Finally (and perhaps the most important) reflective activity to undertake and respond to honestly in some depth is: ‘in both your personal and professional roles how will you ensure you inspire people to believe in you as a leader?’ Of great importance here is the recognition that ‘leadership’ is not a destination, it’s not something you get promoted into, it exists at all levels in an organisation – it has been said before that an organisation with one leader is short on leadership.

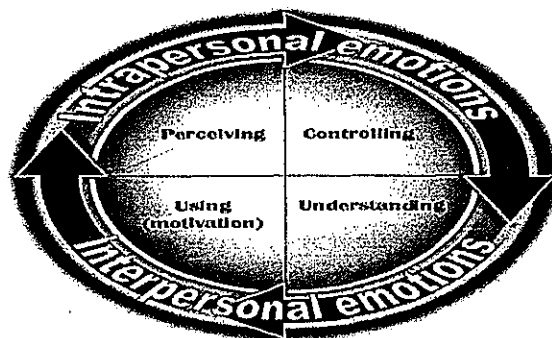
### YOU ARE THE NEW GENERATION OF LEADERS

As an undergraduate or recently qualified professional you will directly contribute to the way the job gets done within your own clinical or educational setting. You have real choice on how you as both leader and follower interact with those around you. This choice can be to continue the historically dubious ways of leading and following, or as we hope, to be part of building an expanding mass of professionals who truly lead, i.e. those who lead without the need to dictate or bully.

A building block in achieving this shift is to be a person centred and emotionally intelligent leader, rather than one who in future years relies solely on organisational rank. Alimo-Metcalfe and Alban-Metcalfe (2008) present significant evidence from their research that underlines the 'person centredness' of the good leader. They describe the central component of what they call the transformational leader as showing genuine concern for others. The transformational leader exerts an influence on those around them, often through strong role modelling of behaviours. She inspires others to new possibilities, and rather than focussing on what is wrong, she is more tuned to 'how to make things better'. The transformational leader draws out the strengths she has and communicates a vision of what might be; she takes an active part in building and maintaining the reality of that vision. The transformational leader looks to the future, but lives in the present.

Figure 6.1 helps us to picture that interrelatedness of self and others – leaders and followers.

The leader needs to own, understand and be aware of these internal emotions alongside the interpersonal emotions, i.e. those of others the leader is in touch with. It is the awareness of this interlinking that enables the leader to function effectively. It is also this awareness that enables the leader to effectively support his followers, without losing the 'detachment' (yet remaining engaged!) required to respond empathetically rather than sympathetically. Of note, however, is that the dimensions of 'intra' and 'inter' personal do not exist in isolation; the critical factor is the self-awareness, from which the others flow.



**FIGURE 6.1** The interlinked aspects of intrapersonal emotions in leadership

### **Intrapersonal**

The perceiving quadrant in Figure 1 relates to the leader's ability to self-reflect, to consider and to understand the impact he or she has on others. It is here the leader needs to understand his own emotions, especially in terms of why he is having that emotion at that particular time. She is aware of her own strengths and weaknesses and is able to take that awareness and use it to reflect on situations from the perspective of self-learning. Additionally, he is open to feedback from others. While some might find this a disconcerting task, once you accept that you, like those around you, are not perfect, and that you trust the person providing feedback, then it is a fantastic way to learn how to be a better leader; this does, however, require self-honesty as well as self-control. It requires an openness to one's own emotions and self-honesty in their management. The transformational and emotionally intelligent leader will also stay composed in the face of adversity – a situation all practitioners will face throughout their careers. It would be foolish to underestimate how difficult this can be at times; however the rewards, in terms of the leadership journey, are worth the effort. Unhelpful emotions are, unsurprisingly, the most challenging to address – human emotions such as disappointment, anger or anxiety also affect leaders, but it is what they do with these emotions that set them aside from others. Goleman, Boyatis and McKee (2002, p. 57) describe '*good hygiene*' as that ability, or indeed need, of the emotionally intelligent leader to deal with his or her own emotions through reflection. The leader has few opportunities to make a mistake with her own emotions before losing a level of credibility with followers.

### **Interpersonal**

The interpersonal quadrants in Figure 1 relates to how we engage with others. At the very centre of **understanding** is the attribute of empathy. Empathy describes the ability to sense or feel what another person may be experiencing as if you were that person – the key is without losing the 'as if' quality. The following is an old tale to demonstrate this, which has been recited many times:

Someone falls into a hole 10 feet deep. He has hurt his leg, it's cold and it's getting dark. To sympathise with him would be for you to jump into the hole with him, wrap a blanket round him and share words of comfort – before long you would be just as miserable, just as cold and unable to get out of the hole. To empathise with them you would be to call down to them, agree with them that it must be pretty rough stuck down there in the hole, that you understand how cold it must be and that they are in pain, you may throw a blanket down to them – then you can go and get the fire brigade to get a ladder and help them out.

This is an overly simplistic story to help demonstrate a complex concept. The emotionally intelligent or transformational leader with this attribute would be recognised by followers as approachable, while perceptive to the emotions of the follower – both positive and negative. She is able to remain attentive to the emotional

cues of her teams, active listening is a skill at which she is adept. This demonstrates an understanding of the perspective of others and shows a sense of sensitivity to it.

In addition to being empathetic, EI leaders are able to develop those around them; they are able to recognise the strengths of others and to support the development of individuals and teams. They are able to see and 'read' relationships about them – this is important in terms of collaboration and on occasions conflict management. They support mutual understanding of issues through their tact and diplomacy; a key feature is their ongoing desire to achieve a win-win outcome from a situation (including conflicts). This approach is possible through a balance between the 'task' and an appropriate focus on relationships, through which they are able to build a rapport with others. They are able to spot opportunities for collaboration and develop these toward shared outcomes.

**Motivating** – in the exercise undertaken earlier in this chapter it is likely that you will have used the word 'motivating' in relation to one of the 'five key characteristics of good leaders you have encountered'. The EI leader inspires and motivates others to go beyond just doing the job. In engaging with those around them the leader doesn't simply empower them to reach beyond the norm to achieve extraordinary things; they inspire them to take that 'empowerment' for themselves – it becomes the norm, it is not something 'given', which of course can then be taken away. This inspirational motivation is not the charismatic, heroic leaders we can see quoted as 'saving companies' (Alimo-Metcalfe and Alban-Metcalfe 2005, Mintzberg 1999) – this 'charismatic/heroic' type of leadership is more frequently associated with self-promotion, which divides rather than builds bonds with others.

Goleman *et al.* (2002) regarded the above as traits and skills, whereas Mayer *et al.* (2004) talked about abilities that then cross over into personality. One could argue that these are semantics and in the real world of applying these there is little actual difference. What is more important is the question whether, unlike intelligence quotient (IQ), EI can be learnt – if EI skills and abilities can't be learnt or adapted, it raises many questions around the value of trying to teach leadership at any level in any organisation; indeed it could be asked why you would be reading this book. From the authors' personal experiences of working with nurses over several years, we are in no doubt that EI can be learnt. Some will always be more skilled in its application than others, in much the way as any other skill where some will undoubtedly reach a higher level of proficiency than others.

### **Box 6.3** Reflection activity

Reflect on an experience of change you have witnessed – perhaps ward restructuring or a community team redesign.

- Did the process simply focus on what was wrong?
- Did the process focus on the abilities of the team to deliver change?

Now consider this from a personal perspective. When you have been involved in planning care with someone, perhaps via a care plan – did you focus on the illness or deficit that caused the person to come into contact with the service, or did you focus on the strengths the individual had to assist them overcoming the deficit?

High achievement takes place in an environment of high expectation – if there is constant focus on the weakness/deficits of a team or individual the likelihood is those teams/individuals will simply live up to the expectations placed upon them, i.e. what they aren't able to do will become their own limiting self-belief.

EI health or social care leaders therefore work in an intensely emotional environment. They are role models within their services and teams. They demonstrate respect and co-operation for teams and individuals; they are consistent in their approach and approachability – they are also able to admit their mistakes, while being willing learners. Within the health and social care environment they are able to handle multiple tasks and interruptions to a range of changing priorities without losing the person at the centre of the care experience.

### LEADERSHIP QUALITIES AND EMOTIONAL INTELLIGENCE

There are a number of qualities that staff associate with effective leadership and the use of EI. Ruderman *et al.* (2004) were able to identify 10 areas associated with EI and effective leadership; these are:

- **participative management:** getting buy-in from colleagues at the beginning of an initiative by involving them in the process and building consensus, engaging them through listening and communicating, influencing them in the decision-making
- **putting people at ease:** gets at the heart of making others relaxed and comfortable in your presence; provides meaningful engagement with others
- **self-awareness:** describes those managers who have an accurate understanding of their strengths and weaknesses; communicating and working within these; demonstrating a willingness to improve their own skills and capabilities
- **balance between personal life and work:** measures the degree to which work and personal life activities are prioritised so that neither is neglected; this is another way of demonstrating that the person is a capable manager
- **straightforwardness and composure:** refers to the skill of remaining calm in a crisis and recovering from mistakes; associated with stress tolerance, social responsibility and optimism (the ability to maintain a positive attitude even in the face of adversity)
- **building and mending relationships:** is the ability to develop and maintain working relationships with various internal and external parties and to negotiate work-related problems without alienating people