An exploration of the importance of emotional intelligence in midwifery


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Abstract
Background: Recognition of the importance of Emotional intelligence back as far as Aristotle (350BC). More recently the notion of emotional intelligence features in social psychology literature; it has also been embraced within personnel and human resources management. The concept of Emotional intelligence involves possessing the capacity for motivation, creativity, the ability to operate at peak performance and the ability to persist in the face of setbacks and failures. Emotional intelligence refers to the ability to recognise our own feelings and those of others and it enables us to manage emotions effectively in ourselves and in our relationships. Aims. Overall the aims of the paper are to define emotional intelligence and to present an original framework for reflection on the significance of this attribute in midwifery. This framework illustrates the impact of emotional intelligence on practice, particularly in relation to improving the quality of care delivered to women, and enhancing our relationships with colleagues.

Method. Midwives are constantly responding to change and challenges within maternity services. This paper examines how emotional intelligence can assist midwives in dealing with pressures which involve delivering the Government reforms, providing choice to women and facing current issues within the midwifery workforce. Conclusion. EI refers to midwives’ ability to recognise our own feelings and those of others. Midwives need to develop self awareness and self awareness of emotional intelligence in midwifery practice. Raising the profile of EI in maternity care will enhance the effectiveness of midwives and strengthen the ability to deal with pressures and develop effective relationships with colleagues and women (Hunter, 2004).

Key words: Emotions, intelligence, reflection, understanding of emotions, empathy, communication, effective working.

Introduction
Emotional intelligence (EI) is featuring more prominently in health service literature and its importance is now being acknowledged in practice (Carrothers et al, 2000; Carrothers and Brookes, 2003; Akerjordet and Severinsson, 2008). It is ‘generally accepted that very little of our lives is governed by logic alone. It is rather our emotional world that motivates our decisions and actions’. (Freshwater and Stickley, 2004: 91).

EI and failure to understand emotional outcomes can have significant negative outcomes on the health and well being of midwives (Gould, 2003; McMullen, 2003; Hunter, 2005; Moriarity and Buckley, 2003; McQueen, 2004). This is because emotionally intelligent midwives are able to interpret the feelings of others, which is essential to their effectiveness. Emotionally intelligent midwives are able to interpret the feelings of others and are able to process emotions and feelings accurately, thus being better able to understand and respond to the needs of women and other midwives. EI, however, Hunter (2009) acknowledges that it is essential for effective midwifery practice, since midwives need to respond to women on a personal level when they need to be able to articulate their feelings in a meaningful way. Work by Hunter and Deery (2005) suggests that midwives who failed to acknowledge the importance of empathy and emotional intelligence tended to take an ‘in the moment’ approach which can be described as ‘affective neutrality’. This involves the development of coping strategies, becoming professionally detached, avoiding emotional issues and focusing on practical tasks. These traits paint the picture of the midwife as a cold automaton and they do not facilitate a woman centred approach to midwifery practice.

EI in midwifery practice
Midwives and the acknowledgement of emotions in practice
Hunter (2005) refers to ‘social norms’ regarding displaying emotions and acknowledges that there are times when it is not considered appropriate in midwifery to display emotions. This supports the Aristotelian approach that emotions must be expressed in the appropriate circumstances (2004). Emotional intelligence is an important concept in midwifery training programmes encouraged nurses and midwives to conceal their emotions and work behind a professional façade which protected them from the emotions of patients (Menzies, 1960). This is illustrated in the following extracts from Way (1962): ‘Sympathy with the patient is a dangerous virtue, meaning as it does, to suffer with someone’ (Way, 1962: 13) and ‘Place will, then, be more important to you let them... tell you all their problems and monopolise your time.’ (Way, 1962: 16). This implies that it would be a weakness on the part of the practitioner if time was spent engaging with clients at this level (Begley, 2006).

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Defining Emotional intelligence
EI refers to our ability to recognise our own feelings and those of others and encompasses managing emotions effectively in ourselves and in our relationships. It also involves possessing the capacity for motivation, creativity and the ability to perform at an optimal level when completing tasks. It provides the ability to persist in the face of setbacks and failures (Steiner, 1997; Goleman, 2004). Interest in EI, dates back to Aristotle in 350BC when it was suggested that EI was crucial to the ability to make wise judgements (Aristotle Translations, 1976). Aristotle in the Doctrine of the Mean said that emotions can be good only if expressed to the right degree in the appropriate circumstances and towards the appropriate person (Thompson, 1976). The concept of EI has re-emerged in social psychology literature and particularly more recently within neurobiological sciences where intelligence and emotions have been studied as components of cognitive, physiological and behavioural responses of individuals to particular life events (Slovey and Meyer, 1990; Bar-On, 2003; American Psychological Association (APA), 2007; Akerjordet and Severinsson, 2008). Within nursing literature EI has become prevalent but Bulmer Smith et al, (2009) cautions that the concept is sometimes poorly defined, overrated and has not been measured. In healthcare there is an acknowledgement of the value of EI and the impact of reflective practice which both influence organisational work and the building of caring patient relationships. These ultimately lead to more patient centred care (George, 2000; Mann, 2005). Within management EI is thought to contribute to the development of effective transformational leadership skills. It has also been used as a predictor of job performance, team working and effective communication and is widely used as a tool for personnel training and hiring of staff (Akerjordet and Steverinsson, 2008; Jordan, 2009). EI helps midwives, therefore, need to lead by example and nurture EI in students. This involves approaching clients and colleagues in a positive manner, listening to them attentively, transferring information more effectively and giving skillful feedback to other team members (Goleman, 2004). Furthermore Strickland (2000) and Goleman (2004) claim that EI is more important than intellectual intelligence, since having high levels of intellectual intelligence is unlikely for someone who needs to make high levels of interpersonal interactions and the higher levels of interactive skills, are more co-operative and work more collaboratively in a group. Hunter (2009) argues that Goleman’s (2004) views on EI are ‘simplistic’ because they do not demonstrate a research evidence base. Hunter (2009) promotes the thinking of Fineman (2003) who refers to ‘emotional sensitivity’ which relates to responsive leadership, intuition and the process of emotional expression. In spite of the debate surrounding what EI is, however, Hunter (2009) acknowledges that it is essential for effective midwifery practice, since midwives need to respond to women on a personal level when they need to be able to articulate their feelings in a meaningful way. Work by Hunter and Deery (2005) suggests that midwives who failed to acknowledge the importance of empathy and emotional intelligence tended to take an ‘in the moment’ approach which can be described as ‘affective neutrality’. This involves the development of coping strategies, becoming professionally detached, avoiding emotional issues and focusing on practical tasks. These traits paint the picture of the midwife as a cold automaton and they do not facilitate a woman centred approach to midwifery practice.

There is a need to explore the nature of EI vis a vis general intelligence. Intelligence is normally associated with intelligence quotient (IQ) (Goleman, 2004). EI differs, but also complements intellectual intelligence. Emotional and intellectual intelligence are situated in different areas of the brain (Goleman, 1995; Bardizl and Salaski, 2003; Morrarity and Buckley, 2003; McQueen, 2004). This is further supported by evidence from LeDoux (1998) who demonstrated that there are specific areas in the brain where emotional processing takes place. Goleman (2004) suggests that the process of learning EI is different from learning IQ. Ming et al (2006) states that emotional intelligence needs to be developed alongside IQ, as well as the development of emotional intelligence is a core concept (Hunter, 2009) promotes the thinking of Fineman (2003) who refers to ‘emotional sensitivity’ which relates to responsive leadership, intuition and the process of emotional expression. In spite of the debate surrounding what EI is, however, Hunter (2009) acknowledges that it is essential for effective midwifery practice, since midwives need to respond to women on a personal level when they need to be able to articulate their feelings in a meaningful way. Work by Hunter and Deery (2005) suggests that midwives who failed to acknowledge the importance of empathy and emotional intelligence tended to take an ‘in the moment’ approach which can be described as ‘affective neutrality’. This involves the development of coping strategies, becoming professionally detached, avoiding emotional issues and focusing on practical tasks. These traits paint the picture of the midwife as a cold automaton and they do not facilitate a woman centred approach to midwifery practice.

EI and the intellect
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Historically midwifery care was community based, until recommendations the Peel Report (1970) recommended that hospital facilities should be available to 100% of women giving birth. Significant changes occurred as a result to the delivery of maternity services (Department of Health (DH), 1970). This gave rise to medical control of childbirth, greater use of technology and, most significantly, it resulted in midwives working in a fragmented manner with their skills being underutilised (Mander and Reid, 2002). The results of control and medicalisation when birth was moved from the family setting to institutions were that midwives were isolated and detached from the women they cared for (Donnison, 1988; Currell, 1990). Hunter (2005) acknowledged the importance of emotional support in the mother-midwife relationship and its impact on the quality of care provided. She states that the evidence suggests that the support women receive from midwives today, particularly in conventional hospital based midwifery as opposed to community settings, varies in quality. The reason for this, it has been suggested, is that the working environment in hospital is driven by the needs of the service. In contrast to this the community offers a more natural approach to childbirth where midwives can manage emotions more effectively.

In recent decades, concepts which incorporate involvement and commitment on the part of the midwife are now more highly valued in the workplace. Concepts such as the named midwife, integrated midwife-led schemes of care, continuity of care, working in partnership with women and midwives as a first point of contact all emphasise the need to care for the individual and optimise the experience of the midwife-woman relationship (Kirkham, 2000; Wingsberg and Newburn, 2004; DH, 2007; Scottish Government Health Directorates (SGHD), 2010).

El and emotional labour (EL)

In midwifery practice, EL is acknowledged as an essential attribute of the effective practitioner. While EL enhances the experience of the woman, it must be acknowledged that it can have a negative impact, such as burnout, on the midwife.

Emotional challenges have the potential to lead to psychological damage (Hunter, 2004). This has led to difficulties in how midwives work in the workplace in hospital is driven by the needs of the service. In contrast to this the community offers a more natural approach to childbirth where midwives can manage emotions more effectively.

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Patterson D, Begley AM. (2011) An exploration of the importance of emotional intelligence in midwifery. Evidence Based Midwifery 9(3): xx-xx

EI and Pre-registration Midwifery Education

Nurturing emotionally intelligent midwives for the future is challenging and it could be said that traditional pre-registration midwifery education (Begley, 2004) often misses the opportunity to develop the range of emotional skills and knowledge within the class room that failed to enhance this essential attribute. These models of learning promoted surface learning rather than deep learning (Entwistle and Ramsden, 1993). Programme review, such as that of Akerjordet (2007) recommends that EI is integrated into nurse education by means of a transformational learning model which focuses on both emotional and rational development. Freshwater and Stickley (2004) state that it is not enough for the rational mind to attend to practical and technical tasks as the rational mind does not intuitively sense the needs and emotions of the person at the receiving end of care’ (Freshwater and Stickley, 2004: 93).

For example, Freshwater (2003) suggests that communication skills, if taught separately from emotional interactions, then become similar to any other technical intervention and emotions are often ignored or disregarded. Other attributes highlighted within the model are the development of empathy and its relationship with good client outcomes, the development of unconditional positive regard and its association with therapeutic change and also developing an understanding of oneself through self reflection. These attributes can assist the midwife in creating therapeutic relationships with others (see framework of reflection on EI). In addition to this Akerjordet (2007) suggests, that students will become more emotionally intelligent if they are given opportunities to develop their own professional identity along with other disciplines through the process of multidisciplinary learning.

Conclusion

EI appears to be crucial for midwives in the maternity care setting by supporting midwives and colleagues with their role within the multidisciplinary team.

EI refers to our ability to recognise our own feelings and those of others and encompasses managing emotions effectively in ourselves and in our relationships.

In the workplace women and provide women centred care, midwives need to develop self awareness and become emotionally intelligent and not avoid addressing emotional issues in midwifery practice

Raising the profile of EI at maternity care will enhance the effectiveness of midwives and will impact on the quality of care that women and their families receive (Hunter, 2004).

Increasing EI will provide additional support for midwives within the workplace enabling the capacity to deal with workplace pressures and develop effective relationships with colleagues and women (Hunter, 2004). Emotional Intelligence needs to be acknowledged and included in pre-registration curricula. As educationalists, we have a responsibility to potential employers and the general public to prepare midwifery students for not only the clinical and theoretical demands of practice but also the emotional challenges which arise in complex life situations which exist in midwifery practice (McQueen, 2004). Expertise in relation to EI in maternity care undermines the quality of care and does not lend itself to effective engagement with women or colleagues. Midwives who are emotionally intelligent will become accustomed to managing emotions in practice enhancing both the midwife and mother experience.

References


References continued