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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 development and particularly more recently within health professionals. 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 not avoid addressing emotional issues in midwifery practice. Raising the profile of EI in maternity care will enhance the effectiveness of midwives and strengthen relationships to deal with pressures and develop effective relationships with colleagues and women (Hunter, 2004).

Key words: Emotions, intelligence, recognition, feelings of understanding, 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; Cadman and Brewer, 2000; Akerjordet and Steverinsson, 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 Stickle, 2004: 91).

EI and failure to understand outcomes on the health and well being of midwives (Gould, 2003; McMullen, 2003; Hunter, 2005) 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 (Slovoy and Meyer, 1999; Barr-Or, 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 academic intelligence. EI is an important social skill which 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, 2006) and the 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 midwives need to recognise their own feelings and those of others. EI is an important social skill which 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, 2006) and the 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).

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EI and the intellect

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 parts of the brain (Goleman, 1995; Bardzil and Salaski, 2003; Moriarity 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 academic intelligence. EI refers to an individual’s 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 not avoid addressing emotional issues in midwifery practice. Raising the profile of EI in maternity care will enhance the effectiveness of midwives and strengthen relationships to deal with pressures and develop effective relationships with colleagues and women (Hunter, 2004).

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Introduction

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EI and failure to understand outcomes on the health and well being of midwives (Gould, 2003; McMullen, 2003; Hunter, 2005) 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 (Slovoy and Meyer, 1999; Barr-Or, 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...
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. This led to a significant increase in 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, 1999). Hunter (2005) acknowledged the importance of emotional support in the mother-midwife relationship and its impact on the outcome of labour. The human element is critical and it 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 normal 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 regarded. Conceptualisation 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 for emotional intelligence (EI) and the importance of the midwife-woman relationship (Kirkham, 2000; Wiggins and Newburn, 2004; DH, 2007; Scottish Government Health Directorates (SGHD), 2010).

**EI and emotional labour (EL)**

In midwifery practice, therefore, EI 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.

Emeralds challenge the potential to lead to psychological damage (Hunter, 2004). Hunter and Deery (2005), both examined the emotional aspects of midwifery using Hochschild’s (1983) theoretical framework of Emotional Labour (EL) and reported that midwifery was using Hochschild’s (1983) theoretical framework of EI enhances the experience of the woman, it must be acknowledged that in the past EL practitioners were discouraged from being emotionally involved since remaining aloof offers a certain degree of protection from such EL.

**Incongruent emotions**

Vitello-Ciccio (2003) highlights another area of stress and unhealthy emotions within the workplace. That is when practitioners force themselves to feel the expected emotions, for example, when stressed and busy midwives pretend to feel joy and satisfaction in their work in order to display a positive image to women in their care. Vitello-Ciccio, (2003) claims that ‘the only thing they receive is the feeling that what the practitioner actually feels and what they are expected to feel evolves into EL. If these emotions are not managed, they can result in burnout and psychological illness. This in turn is reflected in the quality of care, since burnout in health and nursing staff is linked with reports of patient dissatisfaction (Lester et al, 1998).

**EI and delivery of maternity services**

**Recruitment and retention**

Deery (2005) indicates that midwives not only display possible emotional congruence of empathy and caring to women but are sometimes required to suppress negative emotions which may emerge from areas of stress in the workplace. This may well be either directly or indirectly contributed to by EL. The evidence suggests that EI levels as a result of problems around recruitment and retention (Nursing and Midwifery Council (NMC), 2009a). The midwifery profession is still facing a staffing crisis with a reduced number of registered midwives and many are now due to retire (NMC, 2009a). Levels of staffing within maternity services is particularly relevant as it is evident that maintaining adequate staffing levels impacts on both quality of maternity services and on the level of satisfaction experienced by mothers (Hatem et al, 2008).

**Increased Birth Rate**

For the seventh successive year in England and Wales there has been an increase in the birth rate; in 2008 there were 701,714 live births compared to 690,013 in 2007 which the Office of National Statistics (2008) recorded as an increase of 1.6% (Office of National Statistics, 2010). This has been attributed by the fact that there is a continued rise in the proportion of births to mothers born outside the United Kingdom 24% in 2008 compared with 14% in 1998 (Office of National Statistics, 2010). This has led to difficulties in how midwives work due to problems which exist around communication because English is not the woman’s first spoken language. Added to this the cultural diversity affects the health and well being of many women in pregnancy (CMCE, 2007). In order to meet the demands of change and reform, effective transformational leadership throughout the profession is needed (Elliott, 2004; Coggins, 2005; Ralston, 2005). Evidence supports the link between EI and effective leadership. Goleman (2004) argues strongly that EI and leadership are interdependent and describes EI as the ‘sine qua non' of leadership. Bass (1990) stated that those with high EI are more successful in their role because, social and emotional competence which complements transformational leadership. Without EI, midwifery leaders will fail to be effective in meeting the needs of women, inspiring colleagues and implementing Government reform. Patterson D, Begley AM. (2011) An exploration of the importance of emotional intelligence in midwifery. Evidence Based Midwifery 9(3): xx-xx

**Bullying**

If we are to address the needs of an already stretched workforce we need EI to manage relationships with colleagues and provide social support (Ellman, 2006). At all levels we need skill in dealing with conflicting emotions in the workplace such as EI. As Carter and West (1999) found, midwives who worked in effective teams had lower levels of stress than those who did not. Yor and Tucker (2000) examined the EI of teams and found that a higher level of EI in teams related to greater team success. Midwives can further deal with work place pressures by developing emotional awareness. Hunter (2004) states, that in light of her previous research (2002), EI is the key component in managing EL. This can be achieved in midwifery practice by the process of perceiving, identifying and integrating emotions into thought processes which will result in a deeper understanding of emotions and consequently more effective management of emotional situations (Goleman, 2004). Further research further suggests that midwives can develop their emotional awareness by developing an insight into their own personal feelings and the feelings of others, by attending counselling and assertiveness courses. She also highlights the pivotal role of supervisors of midwives in supporting midwives through emotional aspects of practice. Deery (2005) reported that group clinical supervision could be effective in developing an increased self awareness in midwives and facilitating support to meet the emotional demands of their role.

**Midwives can learn to be emotionally intelligent**

Studies have shown that it is possible to learn EI skills (Muller-Smith, 1999; Goleman, 2004) and although emotionally intelligent midwives may be rare they have been developed and changed in later life (Daluzewicz and Higgs, 2000). Indeed EI can develop with age and experience (Mayer et al, 1999). Competencies discussed by Muller- Smith (1999) are self-awareness, involving emotional awareness, self assessment and developing self confidence. Bardzil and Slaski (2003) argue that these are essential for attitude and behaviour changes and also for enhancing social skills. As noted earlier, the development of EI, unlike intellectual intelligence, requires experience and is enhanced by mentors and good role models (Begley, 2006). Sometimes young or inexperienced midwives lack this insight into...
the needs of women. This problem can be overcome by using literature to nurture insight into issues facing others. For example, Heaney’s poem (1969) Elegy for a Still Born Child WHICH focused on the experience of losing a child. Heaney who has experienced the loss of a child. Literature is a ‘two way through which we can see into the experiences of others’ (Begley, 2003: 129).

Testing of EI

There is, of course a scepticism in relation to the nature and importance of EI. It has been suggested that EI can be explained by personality traits and cognitive abilities (Landy, 2005). However several tests which employ self report devices and psychometric measurements that can quantify psychological qualities have been developed to measure EI (Akerjordet and Steverinsson, 2007). The Bar-On EQ-i (Bar-On, 2002) is a self report questionnaire which is a recognized internationally to measure EI. The EQ-i comprises of a list of non-cognitive competencies, or personal qualities and EI that demonstrate the individual’s capacity to cope with environmental pressure. This test was used in a study by Fletcher et al (2009) to measure EI in 3rd year medical students following EI training. The intervention group demonstrated significantly higher change in EI than the control group (Fletcher et al, 2009). The test was reported to have a sound theoretical base, good psychometric properties and it has been used in many different nursing settings (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 seen as a separate task. 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 among other disciplines through the process of multidisciplinary learning.

Conclusion

EI appears to be crucial for midwives in the maternity care setting with colleagues and women (Hunter, 2004).

Emotional Intelligence needs to be acknowledged and included in pre-registration curricula. As educationalists, we need to train emotional strength and emotional intelligence as public service skills in midwifery and other health care settings. However, midwifery needs to establish effective interpersonal skills that will not only the clinical and theoretical demands of practice but also the emotional challenges which arise in complex situation which exist in midwifery practice (McQueen, 2004). Scrupulousness 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 training emotions in practice enhancing both the midwife and the client perspective.

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 programmes which focused on a didactic approach of nursing knowledge and skill within the class room failed to enhance this essential attribute. These models of learning promoted surface learning rather than deep learning (Entwistle and Ramsden, 1993).

This framework asserts that it is not sufficient to teach the theory and feminist epistemology which promotes a reflexive holistic approach and includes interpersonal skills training and personal development (Freshwater and Stickley, 2004). Hunter (2007) states that this is not sufficient to address the complex emotions which may arise in practice. Communication is an essential skill which was introduced into midwifery training following the review of pre-registration midwifery education by the Nursing and Midwifery Council (2006). It will be interesting to assess if achievement of this competency as an essential skill in training will assist to prepare midwives to deal with emotional issues in practice. Hunter (2009) endorses raising the profile of emotional awareness in pre-registration midwifery programs by incorporating role play, theatre and drama within a supportive environment. The introduction of these, in addition to appropriate literature and poetry (Begley, 2006) into programs will facilitate the exploration of a range of emotional issues which may arise in practice. This method of engaging the emotions and nurturing insight has proved successful in nursing students (Baird, 2000) and students (Baird, 2002).

Bulmer Smith et al (2009) insisted that methods of nurturing EI need to be included in pre-registration curricula. Students need to understand the emotional nature of practice, they need emotional intelligence in professional practice and they need EI to deal with stressful working environments. Akerjordet (2007) recommends that EI is integrated into nurse education by means of a transformatory 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 ‘intrinsically sense the needs and emotions of the person at the receiving end’ (Freshwater and Stickley, 2004: 93).

References


References continued


