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Developing Emotional Intelligence for Healthcare Leaders

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1. Introduction

Skills in emotional intelligence (EI) help healthcare leaders understand, engage and motivate their team. They are essential for dealing well with conflict and creating workable solutions to complex problems. EI skills are grounded in *personal competence*, upon which build the skills for *social competence,* including social awareness and relationship management. The leader's EI skills strongly impact the culture of the organization. This article lists example strategies for building seventeen key emotional intelligence skills that are the foundations for personal and work success and provides examples of their appropriate use as well as their destructive under-use and over-use. Many examples are those incorporated into our healthcare-related leadership development institutes offered at the University of North Carolina's Gillings School of Global Public Health.

2. EI and EQ in healthcare leaders

"More than prescriptions, medicine involves communication, tolerance, flexibility, listening, hard work and a passion for the practice."

--Floyd Loop, MD (Loop 2009)

In the world of healthcare, as with many other sectors, equating intelligence with leadership can be a significant error. While intelligence is a critical building block of success for healthcare leaders, and for physicians in particular, to rely upon sheer intelligence to manage the complexities inherent in modern healthcare is tantamount to inviting career derailment. Healthcare as a field is cast against a background of patient and family anxiety, often challenging diagnosis and treatment, and financial as well as regulatory complexity. Intellect is helpful, but is only one of many keys to success for healthcare leaders.

In considering challenging work situations encountered by physicians, nurses and other healthcare leaders with colleagues or staff, many center on: 1) misunderstandings of either word or intent; 2) the inability of an individual to grasp the impact of their actions on others; or 3) the "grit-in-the-gears" hurdles created by organizational culture issues. While healthcare leaders face clinical and financial challenges, interpersonal issues frequently

prove the most time- and resource-consuming (Pfifferling 2008, Freshman & Rubino 2002, Gifford, et al 2002, Cummings 2009).

Tools required for healthcare leaders to succeed generally fall into two categories: *hard* and *soft* (Klaus 2008). For physicians in particular, but also for many other healthcare leaders, "hard skills" are the technical skills traditionally emphasized in training. Medical schools and residency programs, as well as advanced nursing and allied health training programs, and public health focus on clinical fund-of-knowledge and clinical skill acquisition. For healthcare administrators these hard skills typically fall under financial, systems, and facilities management. Development of these skills requires an intellectual capacity to absorb, process, and integrate knowledge which, at times, is referred to as the intelligence quotient or "IQ".

The "soft skills" are more nuanced and include interpersonal and communication skills and professionalism (Porath & Pearson 2009, O'Toole & Bennis 2009, Awad 2004) which, until recently, have received far less attention in formal training for either medicine (Awad 2004, Horwitz 2008, Mrkonjic & Grondin 2011, Wagner 2002), nursing (Cummings 2009), or healthcare administration (____ 2011). These skills are strategic in nature, and as such, cross disciplines rather than being the province of any single profession. Differentiated from IQ, these skills rely much more on "emotional intelligence", sometimes referred to as EI, or emotional quotient (EQ). Emotional Intelligence as a differentiated construct is made up of the personal-emotional-social components of general intelligence (Bar-On 1997, Bar-On 2002, Pearman 2003). Thus, EI generally refers to a broad range of competencies, often addressed from a theory standpoint. By contrast, EQ generally refers to a quantification of skills in practice, and in particular to measures of emotional intelligence captured by commonly used psychological assessment instruments (Ackley 2006, Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003, Stein 2011).

In practice, and axiomatically, leaders can only get things done by working with and through others. While the most senior clinical leaders in healthcare may be marginally involved in the actual clinical setting, most healthcare leaders coordinate or oversee the direct-care efforts of their teams or organizations. At all levels, leaders set the EI culture in their enterprise and this culture directly impacts patient relationships (Levinson 2002, Mrkonjic & Grondin 2011, Wagner 2002), staff morale (Freshman & Rubino 2002), turnover (Gifford, et al 2002, Hill 2002), and relationships with colleagues (Freshman & Rubino 2002, Porath & Pearson, O'Toole & Bennis 2009, Cummings 2009, Awad 2004, Mrkonjic & Grondin 2011). When development of the EI of the culture is ignored in favor of a view that "intellect rules", organizations make themselves susceptible to disruptive behavior—from incivility to outright hostility (Porath & Pearson 2009, Loop 2009, Lewis 2010). This disruptive behavior often provides examples of poor application of emotional intelligence skills, which can cause direct organizational harm. For example, when leaders fail to deal directly with disruptive physician behavior, it negatively impacts medical quality, safety, team work, creativity, and commitment (Porath & Pearson 2009, Pfifferling 2008). Consequently organizations expend an inordinate amount of effort and resources in stopping, neutralizing, or correcting disruptive behavior, (Pfifferling 2008, Loop 2009). An overt disruptive behavior and those cultures failing to embrace and implement emotional intelligence directly cause significant detrimental effects to the bottom line of an enterprise (Porath & Pearson 2009, Pfifferling 2008). Creating leadership environments that are non-

relational (task focused) has been related to poorer emotional health and emotional exhaustion in nurses, while creating those that are founded upon EI-associated relational leadership has been found by many studies to enhance nurse satisfaction, recruitment, and retention (Cummings 2009). Poor application of EI in healthcare settings specifically will harm the organization's reputation, its patient care, and increase staff turnover, all of which can impact financial health (Porath & Pearson 2009, Pfifferling 2008).

Recent work from the Center for Creative Leadership (CCL; Greensboro, NC) reports that the healthcare sector's top priority for leadership development is improving the ability to lead employees and work in teams (CCL 2010). However, this skill, along with self-awareness, was rated *lowest* of skills actually *demonstrated* by healthcare leaders (CCL 2010). Other recent CCL research indicates that the interpersonal soft-skills are rising in importance among leaders, with participative management, building and mending relationships, and change management replacing former top-rated skills such as resourcefulness, decisiveness, and "doing whatever it takes" (Martin 2005). Clearly EI is a foundational skill that is a pre-requisite for good leadership in healthcare situations (Horowitz 2008, Schwartz 2000, Levinson 2002, Lattore 2005).

At the University of North Carolina at Chapel Hill, the Gillings School of Global Public Health is heavily invested in teaching leadership skills to health system professionals. As an essential component of leadership, our development programs for physicians, nurses, allied health, public health, public academic institutions, and health administrators all center on the concept of emotional intelligence. Reuven Bar-On, a pioneer researcher in the field of EI, offers a compelling definition of emotional intelligence as, "*an array of non-cognitive* (emotional and social) *capabilities, competencies, and skills that influence one's ability to succeed in coping with environmental demands and pressures*" (Stein & Book 2006, Bar-On 1997, Bar-On 2006, Pearman 2003). Certainly healthcare and public health as well are fields fraught with environmental demands and pressures with which leaders must endlessly cope. EI skills are essential tools for healthcare leaders since they enable groups to advance interests that serve the team. These skills are crucial because healthcare is rarely delivered in isolation of the rest of a team. Indeed, even the currently heralded medical home model is patient-centered and community-connected (Rosenthal 2008, O'Malley et al 2008, Fisher 2008): a strong blend of the values of both the health care and public health fields.

Emotional Intelligence is a strong tool for building bridges and alliances and, importantly, for repairing those relationships when they are damaged (Fernandez 2007a). Leaders in healthcare and public health must realize the challenging nature of distributing scarce resources in difficult times: relationships can become frayed due to internal competition for those resources, recognition, or opportunity. However, the same groups that compete in one arena often need to partner in another or at another time to survive. The ability to mend relationships is particularly crucial to leaders in today's rapidly changing healthcare world (Lombardo and Eichinger 1989).

Goleman, another leading researcher in EI, suggests that 67% of the competencies needed by successful leaders fall into the emotional intelligence realm (Goleman 1996). In The EQ Edge, (Stein & Book 2006) Stein and Book report on one of the first studies to use a valid measure of emotional and social intelligence to examine the relationship between intelligence and self-perceived success at work. They found that IQ predicted an average of

6% and EQ an average of 27%-45% of success in a given position. Stein and Book conclude, "regardless of how brainy we may be, if we turn others off with abrasive behavior, are unaware of how we are presenting ourselves or cave in under minimal stress, no one will stick around long enough to notice our high IQs" (Stein & Book 2006).

While EI skills might not be innate, they can be developed, learned and taught (Porath & Pearson 2009, CCL 2010, Stein & Book 2006, Bar-On 1997, Bar-On 2006, Goleman 1996, Fernandez 2007a, Lombardo & Eichinger 1989, Mayer et al 2002, Lynn 2002, Pearman 2002, Goleman 2000, Goleman 2001, Goleman 2008, Thumm 2008). When engaging in leadership development of healthcare leaders, regardless of the discipline, basing skill development on both a theoretical *and* practical basis of EI skills is crucial (Pagnini 2009). Two components should be taken into consideration: the development program itself, with the elements of skill development incorporated, and the desire of the participant to learn and grow. In particular, EI development requires a desire for self-improvement, a willingness to face personal blind spots or shortcomings, and a sense of humility. When mastering cognitive or hard skills, an error can be corrected by simply learning facts or honing a behavioral skill, like suturing, wound dressing, budget reconciliation, or statistical analysis. In contrast, when correcting an EI problem the feedback can feel far more personal, identity-based, or even painful to the individual. It can be perceived as being about the individual and not simply about the behavior or the executed skills of the individual. Thus, creating a learning environment that is safe, non-judgmental, and conducive to self-insight without fostering a sense of shame is crucial.

For EI self-improvement in our work, the focii are *personal competence* and *social competence*. Personal competence is characterized by a broad range of abilities, including how one perceives and expresses oneself, makes decisions and manages stress. In our construction of development programs and coaching these basic skills serve as the foundation for *social competence*, which itself is comprised of *social awareness* and *relationship management* (CCL 2010, Stein & Book 2006, Bar-On 1997, Bar-On 2006, Goleman 1996). Based on our review of the literature (Goleman 1996, Goleman 2000, Goleman et al 2001, Stein & Book 2006, Bar-On 1997, Bar-On 2006, Collins 2001, Pearman 2003, Heifetz 1994) and assessment tools, our work with hundreds of physician leaders through six years of providing leadership development institutes, and our work with hundreds of public health, allied health, health system, and public sector leaders, we have created an EI development model (Figure 1). This model is the foundation for our leadership skills development work with healthcare and other leaders. These programs are offered as intensive training leadership institutes offered at or in conjunction with the Department of Maternal and Child Health, the Gillings School of Global Public Health, at the University of North Carolina at Chapel Hill.

It is easier to "talk the EI talk" than to "walk the EI walk" and putting EI into practice requires an understanding of how to execute the related skills, particularly in difficult or uncomfortable situations. This chapter will focus on the major components of EI, how weak and strong skills might manifest in the workplace, and how EI skills can be enhanced. For this exploration we will use the model of EI that serves as the basis for the construction of our programs (Figure 1). This model has been inspired by and adapted from the research of Goleman, Bar-On, Stein, and others. Examples of EI skills development from the leadership training institutes will be offered as EI development strategies. One important point is that

EI skills can be *over*-used as well as *under*-used—especially when not used in balance. When under-used the effects are often dramatic and easy to observe. Although over-use can manifest more subtly, the results can be equally problematic to the individual and the organization, though perhaps harder to identify or "diagnose". Several examples of both effective use of EI skills and potential EI "mis-steps" are presented below.

Fig. 1. The Model of EI for physician leaders that serves as the basis for UNC's Leadership Development Institutes

3. Personal competence

Personal competence is the foundation of EI and is characterized by knowing, understanding and expressing oneself. In terms of operationalizing these concepts we embrace the EQ-i theory as originally proposed by Bar-On (Stein & Book 2006, Bar-On 1997, Bar-On 2006) and recently updated as EQ-i $^{2.0}$ (Stein 2011). Personal competence can be sub-divided into categories of 1. *Self-Perception*, 2. *Self Expression*, 3. Stress Management skills, and 4. Decision Making (Stein 2011) In many ways these skills successively build on one another, with skills in self perception being necessary for those in self expression, and those serving as a basis for stress management. Stress management, itself helps lay the groundwork for skills in decision making. In this way, our model is a "stacked" one, in which some skills create leverage points for the development of others. In our leadership programs we focus on the development of those leverage skills prior to addressing the more sophisticated and advanced ones at the higher levels of the pyramid.

1. *Self-Perception* is an essential component required for effective EI skill development and consists of *self-regard, emotional self-awareness,* and *self-actualization*.
    a. *Self-regard*, is "the ability to respect and accept (one)self as basically good" (Stein & Book 2006), and that one has strengths and weaknesses (Stein 2011). Consider, as an example, knowing that one remains a good person, a caring and competent nurse or physician, even after facing disappointment in a job search, being laid off during a health system's downsizing, or experiencing a divorce. The ability to maintain respect for oneself and to identify with ethically grounded principles and values while facing the common difficulties of life, or even failing at some of them, is key to maintaining integrity of self, personal identity, and a feeling of self-confidence. The capacity to see oneself as good is essential for relating well to others. If over-used or over-developed, self regard may be interpreted by others as arrogance or cockiness, egotism, and ignoring feedback (Bar-On 1997, Bar-On 2003, Mayer et al 2002, Pearman 2003)–when behaviors are seen in this light leadership derailment is a risk (Lombardo & Eichinger 1989).

The leadership training programs offered through our Department of Maternal and Child Health work to support and develop each of these components of emotional intelligence. In terms of *self-regard*, there are many strategies used to role model this foundational component of EI. The programs are held at executive education centers or resort-type hotels, which cater to individual dietary or disability needs. Conducting the programs at these type of facilities is based on the concept that people learn better when the environment is conducive to the program purpose (learning) and individual comfort. Less-than-comfortable and adequate surroundings strongly distract from the ability of participants to fully focus and learn. Participants are treated respectfully and with exceptional care by the Institute staff: those behaviors are taught and reinforced in training exercises, becoming a behavioral norm. All program content areas are delivered from a non-judgmental perspective, with sessions placing a strong value on cultural competence, tolerance, mutual understanding, and creating a culture of thought diversity (Fernandez 2007b). Participants receive extensive feedback on a variety of psychological and leadership assessments and individual coaching from both the Institute staff and external professional executive coaches—all of which comes from a non-judgmental, supportive, confidential, and positive perspective.

    b. *Emotional self-awareness* is the ability to understand how one is feeling and why (Stein & Book 2006). It further allows one to grasp the nuance of emotions and the potential "impacts they have on the thoughts and actions of oneself and others" (Stein 2011). Decades ago, Eskin noted the concept of self awareness (understanding the self in terms of beliefs, attitudes, norms, and values) as an essential and fundamental quality for a physician to act as a change agent and related lack of these qualities as detrimental to the physician's ability to serve in that capcity (Eskin 1980). Understanding how one personally feels may help one to effectively support oneself and then be able to support others through difficult times. Emotional self awareness allows one's contributions to conversations to revolve around the root issues, rather than to be distracted by the behaviors that can result from the issues. However, when over-used, emotional self-awareness can lead one to being seen as weak or self-absorbed, focused on negativity, melodrama or threats (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Leadership

development institutes for healthcare-related professions should not only help participants understand how they are feeling, they should also teach how those feelings are similar to and dissimilar from the feelings of others. Our experience indicates that physician leaders tend to be aware of their own emotions—yet they can be surprised that while their feelings and perceptions are logical to them they are not necessarily the same as others whom they admire and respect. We use a variety of psychological assessment instruments to great effect in teaching diversity of perspective, and these contribute greatly to participants' emotional self awareness. For example, our Leadership Institute programs teach differences in how people gather information, make decisions, and deal with change (Jung 1971, Myers and McCaulley 1985, Musselwhite & Ingram 2003, Musselwhite and Jones 2004)—and examine the emotions that arise over these differences. The programs support the value of decision making both from a logical/critical thinking standpoint as well as a values/feeling oriented one (Jung 1971, Myers and McCaulley 1985).

c. *Self-actualization,* is "the ability to lead a rich and meaningful life", and an enjoyable life, through the willingness to persistently strive to improve oneself towards the maximum development of one's abilities and talents (Stein & Book 2006, Bar-On 1997, Bar-On 2006, Stein 2011). Poor EI skills in this area leave one feeling as though life is a treadmill, with no inherent meaning or purpose. One can develop this ability through learning new skills (related or unrelated to clinical practice or administration) or through engaging in selfless activities that benefit others. Many find such personal fulfillment and meaning through volunteer, charity, or medical mission work. When over-used, leaders can appear resistant to the ideas of others, overly self-assured, or intolerant. Healthcare leaders are in danger of personal burnout when very engaged yet going it alone (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). In our leadership training programs, the nature of support, connection with others, and creation of meaning in life is approached through outdoor experiences and low-ropes course training as well as other team building exercises and sessions that are specifically designed to teach through the experience of fun. Some of our leadership programs include artistic expression and reward as well.

2. *Self-Expression* is the second core area of Personal Competence and contains three elements: *emotional expression, assertiveness, and independence*.
   a. *Emotional expression* is a constructive expression of emotions based in an ability to openly convey one's feelings both verbally and non-verbally (Stein 2011). The basic ability to *perceive* these emotions (described above) undergirds the ability to give expression to them. Poor skills in emotional expression leave one with either unexpressed or inappropriately expressed feelings, which can lead to isolation, disengagement, anger or unfounded anxiety. The professional is at risk of being regarded as moody, emotional, too tough or too weak to function appropriately in the organization. At its worst, underdeveloped skills in emotional expression can result in abusive outbursts that are rooted in personal frustration—and clearly lead to derailment (Porath & Pearson 2009, Loop 2009, Pfifferling 2008, Lombardo & Eichinger 1989). Overused skills in this area can lead to team members feeling overwhelmed by the depth of self-revelation (Bar-On 1997, Bar-On 2002, Mayer et

al 2002, Pearman 2003). In many organizational cultures having too low a threshold of privacy or confusing honesty with candor can lead to derailment or limited opportunities for advancement as well. The task for the leader is to titrate their degree of emotional self awareness and their response to it, taking into consideration the situation, others involved, the culture of the individuals and their personality as well as the culture of the organization. Circumstances in the healthcare or academic workplace can create a bevy of negative feelings, particularly when organizations or policy issues are undergoing significant change or budgets are strained. In our leadership development programs, we operationalize this construct of emotional expression by teaching participants to "speak the language" of those who see the world differently, building upon the basic investigation of interpersonal differences, as described above (Jung 1971, Myers and McCaulley 1985, Musselwhite & Ingram 2003, Musselwhite and Jones 2004, Fernandez 2007b). We build skills in managing difficult conversations (Fernandez 2010b) and in helping others to gain insight and understanding through negotiation and conflict resolution skills. The programs support the value of decision making both from a logical/critical thinking standpoint as well as a values/feeling oriented one. Creating strong organizational cultures that maximize thought diversity (Fernandez 2007b) is a central tenet of all the leadership programs we offer. Tolerance, respect and civility are behaviors that are often commonly associated with emotional intelligence (Lewis 2010, Fernandez 2010a) and have a strong root in well managed emotional expression.

b. *Assertiveness* is the ability to openly communicate feelings, beliefs, and thoughts and defend personal rights and values in a socially acceptable, non-destructive, non-offensive manner (Stein 2011), and to maintain the ability to do so even if the stance taken is not necessarily admired or accepted by others as the norm (Stein & Book 2006, Lombardo & Eichinger 1989). Certainly, honesty and candor are needed in order to support transparency and information sharing during decision making (O'Toole & Bennis 2009). EI helps one share information and self-advocate with eloquence and grace. When done appropriately, assertiveness allows individuals to respectfully disagree with others and helps in the defense of deeply held beliefs without resorting to subterfuge (Stein & Book 2006). However, when assertiveness is misused individuals may be seen as blunt, abrasive, intimidating, and alienating (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Those who are overly zealous can be interpreted or labeled as not being a team player or as a poor listener (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). The UNC-based leadership training programs teach concepts such as "Managing Difficult Conversations", "Negotiation Skills", "Advocacy", and "High Stress Communications". Each of these sophisticated sessions gives skills-based practice and feedback in appropriate EI-based implementation of assertiveness.

c. *Independence* is being self-controlled and self-directed in one's actions. Freedom from emotional dependency is central to independence (Stein & Book 2006, Bar-On 1997, Bar-On 2006), as is the ability to autonomously engage in decision making, planning and daily tasks (Stein 2011). When independence is under-used or even under-developed, one is more likely to "go along to get along", to succumb to peer pressure, or to refrain from speaking up. When overused, independence is

similarly dysfunctional and can lead to isolation, an inability to function well on teams, alienating others, failing to ask for help when needed, or a fear of loss of control (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). This latter quality may manifest as micromanaging or failure to delegate appropriately. Resisting the bureaucracy inherent in many healthcare organizations—to the detriment of communication and data management—can also be a manifestation of overly relied-upon independence. Our healthcare leadership development programs foster confidence-building and self-efficacy through skills-based training sessions, such as Peer Coaching, which help participants understand the degree of influence they allow from others and how they might work more collaboratively. Sessions that focus on building thought diverse cultures also help those participants who might over-rely on independence to become more collaborative.

3. *Stress Management* is characterized by the ability to weather difficult situations without becoming overwhelmed (Stein & Book 2006), and is the third core area of Personal Competence. As with the other dimensions of EI it also contains three sub-components: *optimism, stress tolerance,* and *flexibility.*
    a. *Optimism* is an indicator of one's positive attitude and outlook on life. It is related to remaining resilient and hopeful despite occasional setbacks (Stein 2011), and characterized by the ability to weather difficult situations without becoming overwhelmed (Stein & Book 2006). Adversity and challenge do not defeat or demoralize those who see the proverbial "light at the end of the tunnel". Optimism in the face of stress greatly facilitates learning from mistakes and is positively associated with success, both for the individual and for the group (Stein & Book 2006, Seligman 1998). Optimistic people are sure of themselves in most circumstances, believe they can stay on top of difficult situations through their ability to handle even upsetting problems. When over-used, this skill manifests as a "Pollyana-ish" or unrealistic perspective in which the individual is at risk of failing since they do not take issues seriously enough (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). When under-used, individuals can become cynical or jaded (Heifetz et al 2009, Pearman 2003). In our physicians leadership training program in particular, optimism is addressed through motivational sessions with prominent athletic coaches, who use a great deal of inspiration in their work with team members. Participants also meet privately with a professional executive coach who can help them explore their own feelings and perceptions as well as their feedback from others.
    b. *Stress tolerance* is the ability to withstand adverse events and stressful situations without falling apart by actively and positively coping with stress (Stein & Book 2006, Stein 2011). Another term for stress tolerance is "resilience". The risks of having inadequate stress tolerance skills are obvious, yet many are surprised when they learn that these could be over-used as well as under-used. When coping skills are over-used, one does not react with the appropriate sense of urgency or is unaware of being overloaded (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). This method of coping can lead to burnout and failure to deliver on objectives, a major cause of derailment (Lombardo & Eichinger 1989). Indecisiveness can also result from poor EI skill development in this area (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Our leadership training

programs offer the opportunity for participants to discuss stress management in their individual coaching sessions as well as to receive feedback on stress management-related behaviors via 360-assessment tools. Some of our programs offer segments in stress management theory and skills.

c. *Flexibility* is the ability to adjust one's thoughts, emotions, and behavior to dynamic circumstances that are unpredictable or unfamiliar (Stein 2011, Stein & Book 2006). Being able to see a situation objectively, as described below in *reality testing*, is related to the ability to capitalize on this EI skill of *flexibility*. Martin (Martin 2007) holds that the ability to hold two opposing ideas in mind and generate a new idea "that contains elements of the others but is superior to both" is a hallmark of exceptional leadership. This ability requires a keen flexibility of the mind. When executed well, flexibility leads to openness and tolerance (Stein & Book 2006, Bar-On 1997, Bar-On 2006, Lewis 2010). Additionally, flexibility allows the iterative process of seeing and embarking on a defined course, re-assessing its effectiveness, and re-directing beliefs and feelings in the light of data accordingly and as necessary. When executed poorly, there is over dependence on routine, a lack of desire to learn new skills, or a refusal to make changes despite the clear need to do so. Over-use of flexibility can result in being taken advantage of, being scattered, or being too easily swayed from one's own good ideas (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Participating in a leadership retreat is itself an exercise in flexibility. Program Fellows must constantly adapt to new learning situations, simulations, participative events, and styles. Understanding thought diversity (Fernandez 2007b) and valuing the contributions brought by others who have different skills or perspectives is a foundation of the programs and fosters flexibility. Further, receiving assessment feedback data and understanding how others experience the world or view interpersonal interactions differently from oneself helps many participants become more flexible and less rooted in their own perspective or experience.

4. *Decision Making* is the fourth core area of Personal Competence, containing three sub-elements: *reality testing*, *impulse control*, and *problem solving*.

   a. *Reality testing* is the capacity to remain objective by seeing things as they really are (Stein 2011). The ability to recognize when emotions or personal bias can cause one to be less objective is key to this EI construct as well (Stein 2011). This skill includes one's ability to accurately and objectively "size up" a situation (Stein & Book 2006). For example, the ability to depersonalize a situation and gain "a balcony perspective" is a sentinel leadership skill (Heifetz 2009, Linsky & Heifetz 2002, Heifetz et al1994). Increased reality testing proficiency requires taking a step back from situations and refraining from making judgments about them, yet still confronting the truth and facts that are evident (Collins 2001). Effective reality testing can include observing others by their actions and words, and considering the perspectives, needs, biases and beliefs that motivate them. When used poorly, this EI skill appears as overly linear thinking or too "all or none" (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Poor reality testing can cause cynicism, pessimism, and over analysis, which can deflate team morale and effectively destroy innovation (Bar-On 1997). UNC leadership development retreats support reality testing through inclusion of several valid and reliable leadership assessment

tools, including 360-degree assessments, and tools that measure emotional intelligence. These assessments help participants understand how others view a situation, thus promoting gaining that "balcony perspective". Institutes also include data and fact-based discipline-related sessions, teaching participants how to make decisions and recommendations based on complex data. The ability to use data and fact to depersonalize a situation can help improve reality testing skills.

b. *Impulse control* is the ability to resist or delay an impulse, drive or temptation to act (Stein 2011). It involves managing a temptation, halting an angry or aggressive outburst, or avoiding a hostile or irresponsible behavior (Stein & Book 2006). Examples of poor impulse control include angry outbursts, emotional tempers, insensitive statements, vindictiveness, passive aggressiveness, incivility (Porath & Pearson 2009, Lewis 2010), or uncontrolled passions: these examples are hallmarks of poor emotional intelligence. Low impulse control can have serious implications for organizational culture and productivity. In Leadership and Medicine, (Loop 2009) Loop makes the connection between problematic behavior and career derailment, noting that deficits in impulse control were the biggest executive management problem experienced in the Cleveland Clinic health system (Loop 2009). There is a highly destructive link between incivility and team work, creativity, innovation and commitment (Porath & Pearson 2009, CCL 2010, Lewis 2010). Poor EI skills are evident when one acts in haste, is overly spontaneous, or quick to jump to conclusions. It may seem surprising that impulse control can be over-utilized as well as under-utilized. However over-used impulse control risks failing to react quickly enough, being too aloof, being seen as too unengaged, not being committed to the team, or being unable to be in the present moment (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Too much control of self can manifest as inhibition and dissuade one from using assertiveness skills (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003), which, for example, can impair a leader from successfully implementing an organizational culture allowing for zero tolerance of incivility or hostility (Porath & Pearson 2009, Lewis 2010). Similar to stress management skills, the leadership training programs we provide give feedback on many impulse control-related behaviors via 360-assessment tools. Experiential learning sessions and simulations also illicit behaviors around this skill area, allowing the participant to both see the effects of their behaviors and to receive constructive feedback on them.

c. *Problem solving* is "the ability to find solutions to problems in situations where emotions are involved" (Stein 2011). It involves generating and implementing potentially effective solutions (Stein & Book 2006) that take into account how emotions impact decision making (Stein 2011). Problem solving has seven steps, including identifying that a problem exists and gathering the necessary information about that problem (both subjectively and objectively). Subsequently, a list of solutions (assessment/analysis) are generated, and then the alternatives are evaluated. The next steps involve choosing an optimal solution and then implementing it (planning), followed by assessing the outcome. Clinicians, in particular, may relate clinical problem solving with the "SOAP" process, which looks at the Subjective (what the patient says), the Objective (what the clinician measures), the Assessment (what the clinician deduces), and the Plan (diagnostic

work up plan, treatment, etc). While this approach is an imminently useful framework for clinical settings, it has more limited uses in general interpersonal situations. Emotional Intelligence skills relate to non-clinical situations as well as clinical ones, and this seven step process an iterative one. Implemented plans need subjective and objective review. At the same time, understanding that some implemented plans are adaptive and require human behaviors for success, achieving changes may need persistence and heavy reliance in EI skills (Heifetz et al 2009, Linsky & Heifetz 2002, Heifetz 1994).

However logical and constructive this skill may seem, common symptoms of overuse are focusing on minutiae, over-analysis, and apparent indecisiveness. At the other extreme, over-reliance on intuition, without sufficient investigation and data gathering, may lead to derailment (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003).

As an example of one strategy for supporting EI problem solving skills, the UNC-based leadership training institutes teach participants to make decisions from a 4-point perspective and to utilize viewpoints that might not be innately natural to them. They are taught how to assess the decision making process in groups, to ascertain when the quality of thought is too homogeneous, and how to introduce questions that will broaden the considerations when solving problems and making decisions (Fernandez 2007b). Additionally a series of outdoor, physical activities force physician leaders to solve complex problems facing the group. These specific situations are designed to lead to team success only when the physicians function as participating and contributing team members—individual, competing leadership styles in these team situations will lead to team failure. Physician leaders engage their problem solving skills and many other EI assets during these exercises.

4. Social competence

As depicted in Figure 1, in the EI development model we follow *Personal Competence* provides the psychological foundation upon which the skills of *Social Competence* are built, following the theories of Goleman (Goleman 1996, Goleman 2000). Social competence is a complex of *social awareness* and *relationship management* that allows a healthcare leader to understand the emotional tenor of her or his group, to communicate effectively and compassionately with members of the group, and to solicit input from them. The ability of healthcare leaders to manage relationships is crucial to their capacity to create impact in their organizations and communities—and for providers, with their patients. In the end, much of success is rooted in successfully managing relationships.

1. *Social awareness* is the ability to understand the social networks and unspoken norms of a group, often through attending to both verbal and non-verbal cues. It is appreciating a group's values and culture (Goleman 2008) and considering the motivations, allegiances and stakeholders which affect others (Heifetz et al 2009, Heifetz 1994). Well-developed EI in this arena allows one to speak with tact and empathy, implementing skills in cultural competence and cultural elasticity. Skills in social awareness allow one to ask for the perspectives of others while listening attentively and non-judgmentally. While critically important for leaders, particularly those in diverse communities or who serve as boundary spanning ambassadors for their organizations, over-use of this skill can lead to unnecessary deference to the group norms and an inability to push group

members with competing or incompatible views toward solutions (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Over use of this skill, particularly in combination with poorly used assertiveness and relationship management skills, can lead to organizations that are less culturally competent, flexible, and elastic, and can contribute to "groupthink". (Janis 1972, Janis 1982, Fernandez 2007b, Bosjoly 1987, NASA). In addition to our sessions teaching the concepts of thought diversity, the group-based leadership risk-taking activities and the outdoor experience of low ropes gives participants concrete practice in concepts, behaviors, perspectives and skills around social awareness.

a. *Empathy.* A subcomponent of S*ocial Awareness* that bridges to *Relationship Management* is *empathy,* which is the ability to recognize, understand, and appreciate the way others feel (Stein 2011). This is considered by many to be a crucial leadership skill (Stein 2011, Stein & Book 2006, Goleman & Boyatzis 2008, Ackley 2006, Goleman 2000, Cummings et al 2010, Levinson et al 2002, Wagner et al 2002). When underused, one risks being perceived as cold, uncaring, self-centered or overly task-focused (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Lack of empathy can cause a lack of trust from others or lack of confidence in the ability to confide in the leader. Poorly developed skills in empathy can lead one to be surprised in other people's reactions as well (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). However, empathy can be overused, causing challenges in separating feelings from business, inability to make tough decisions, an inability to say no, and denying one's own feelings (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). In our leadership development programs, physician leaders gain skills in empathy through dialogue and psychological assessment feedback instruments as well as coaching. A variety of interactive exercises, as well as intensive emotional exploration around communication and the feelings of others during the outdoor activities promote development of this EI skill.

b. *Interpersonal Relationships* is also an EI skill that bridges the gap between *Social Awareness* and *Relationship Management*, and exists within the larger domain of *Social Competence*. This component is based on developing and maintaining mutually satisfying relationships that are characterized by trust and compassion (Stein & Book 2006, Stein 2010). When this skill is underdeveloped or under-used individuals can be seen as self-absorbed, being more concerned with their own interests or welfare than with that of the team (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). They can also been seen as cautious when it comes to human interactions and potentially secretive. Conversely, when overused as an EI skill, one can struggle with individual performance and seem incapable of working without a team. Failure to progress with tasks becomes a risk. When so poorly developed that derailment becomes an issue, the behaviors seen can manifest as providing too much personal information, using work relationships inappropriately, violating the personal space of others, or sexual harassment (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Our physician leadership programs foster interpersonal relationship skills through 360-feedback, individual coaching, team building exercises and simulations around negotiation skills, and leadership success and derailment, among others.

2. *Relationship management* is the pinnacle of our EI pyramid: as the most sophisticated of the EI skills it relies heavily on the hierarchy of skills upon which it is built (Figure 1). In *relationship management*, one attends to and nurtures interactions with others to create an environment where group behavior can be directed towards a positive course and/or effectively meet difficult challenges. The ability to manage relationships fosters information sharing (O'Toole & Bennis 2009) and creativity (Amabile & Khaire 2008). When relationship management is poorly developed or executed, group competition abounds and problem solving comes from a narrower perspective. When poor relationship management is combined with poor impulse control skills, passive aggression or explosive behavior is likely to manifest. To develop and hone relationship management, a healthcare leader can practice articulating a compelling and unifying vision for the group and specifically one that is grounded in shared values and shared success. Effective mentoring, including providing tactful, sympathetic, contextualized and useful feedback will further support relationship management in professional settings. Cultivating a positive emotional tone among the team, creating a safe environment where ideas can be shared non-judgmentally, and supporting members while fostering their cooperation will likewise further one's relationship management skills and so improve team performance. (Pfifferling 2008, Fernandez 2007a,Goleman 2000, Goleman 2008, Goleman 2001,Thumm 2008). Our UNC-based leadership programs foster relationship management skills through team building exercises and simulations around negotiation skills, among others. Programs also include a mentoring session, which address how to be both a successful mentor as well as mentee.
    a. *Social Responsibility.* The final construct that we capitalize upon in our leadership development programs is social responsibility, which reflects behaviors of willingly contributing to society, to one's social groups, and generally to the welfare of others. It includes acting responsibly, having a social consciousness and showing concern for the greater community (Stein 2011). We find that this is a common strength in our physician leaders, who are all engaged in leadership on an unpaid, volunteer basis, to advocate for the welfare of the patients they serve. In general when this skill is underused or under-developed individuals can be seen as overly self-reliant, willing to bend the rules to favor their own desired outcome, or having a lack of involvement with the greater organizational community or team (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). When this is an overly-relied upon skill, it can manifest as burnout through taking on too many tasks, adopting other's problems as one's own, making an incorrect—yet popular—choice, or having no tolerance for rule flexibility even when warranted (Bar-On 1997, Bar-On 2002, Mayer et al 2002, Pearman 2003). Leadership development can address issues around social responsibility through interactive values-based exercises. We use a Peer Coaching interaction to approach organizational problems and social responsibility issues, as well as 360-feedback and sessions on leadership success and derailment.

5. The role of well-being and happiness in emotional intelligence

Research in EI formerly characterized *Happiness* as a component of general mood, and a background skill that set the stage for EI development (Bar-On 1997, Stein & Book 2006).

However recent research characterizes *happiness* as an outcome of adequate EI development and an indicator of well-being (Stein 2011). As such it is now seen as separate from the central concept of EI skills (Stein 2011). Happiness is defined as "the ability to feel satisfied with (one's) life, to enjoy (one)self and others and to have fun" (Stein & Book 2006). While these abilities help leaders focus on and play to a team's strengths, there are also interesting supporting relationships between happiness and *self-regard, optimism, interpersonal relationships, and self-actualization* (Stein 2011). The ability to have fun positively impacts a work culture and improves work performance (Stein & Book 2006, Goleman 2008, Goleman 2001). The happiness of the team and its leaders can be a critical element of a healthcare team's success (Porath & Pearson 2009, Pfifferling 2008) and should not be overlooked as a leadership asset. Interestingly, happiness has been found to have a positive, if limited, relationship with physicians' scores on emotional intelligence instruments and patient satisfaction (Wagner et al 2002). In our programs we focus on life satisfaction and interpersonal relationships through a variety of teaching strategies, including one-on-one individual coaching, creating learning sessions that are fun in addition to challenging and thoughtful, and role modeling this perspective for participants. In particular, our physician's leadership development institute provides 35 hours of continuing medical education over a 3-½ day immersion. Despite this extremely intensive structure, the program is designed with a premise of fun, social interaction, group based learning, and networking. For six consecutive years physician participants have rated the experience an overall 5 out of 5 on all program evaluations. Participants leave motivated and "with their vessels refilled", as many comment. Our other leadership programs for allied health and public health follow a similar model.

Through the UNC department of Maternal and Child Health we work with about 200 mid- to senior-level leaders a year as of this printing. We strongly believe that leadership training programs can promote the broad array of EI-based skills and foster practical leadership skills in physicians, nurses, public health and other health-related and public sector professionals.

6. Conclusion

Early research in EI has shown that five areas measured by standardized EQ tests (Stein & Book 2006, Bar On 1997, Bar On 2006) relate to workplace success: self-actualization, stress tolerance, happiness, optimism, and assertiveness. While we hold that each of the areas discussed above are crucial for effective EI development, the data that these five areas relate to career success are most interesting. More research is needed to further validate these findings. Table 1 relates these specific five areas to strategies for improvement in both clinical and external-to-work settings. It would be helpful for research to focus on measuring improvement of practical EI skills development in these five areas, however it should be noted that the innate complexity of EI presents significant challenges to its measurement. Rigid tests that determine EI are not available in the same sense that clinical tests can determine the presence of a specific type of virus or a level of a health-risk indicator from a blood sample. Assessments of EI capture a more generalized picture of these *personal competence* and *social competence* skills, and thus research into methodology for developing strongly measureable EI skills, quantified in terms of EQ, remains in the relatively early stages. It may be that definitively measuring emotional intelligence will

prove elusive—far more elusive than capturing the interpersonal and organizational impacts on situations in which those skills are underdeveloped in leaders. This dichotomy—the ease of observing the absence of EI skills coupled with the extreme difficulty in measuring the EQ skills—presents interesting challenges to those interested in EI research.

Yet, strategies that facilitate strong EI skill development could prove exceptionally helpful to healthcare leaders, and particularly physician leaders and those in public or academic settings. Promoting one's own emotional intelligence can impact the observed emotional intelligence skills and behaviors of co-workers and team members (Porath & Pearson 2009, Goleman 2001). While the use of logic and reason in decision making and interaction are important, so is the recognition that humans are primarily emotional animals. Being able to give constructive voice to personal opinions while remaining optimistic, tolerating the stresses and challenges of the workplace, and being sensitive to the views and feelings of co-workers are essential skills that facilitate workplace success. We have found that using the model of EI presented herein as a theoretical basis for the creation of a variety of leadership institutes for those in medicine, allied health, academic organizations, and public health, has resulted in very highly rated experiences that are both meaningful to the participants as well as build practical skills for the healthcare and public sector workplace. Thus, in particular, this EI model serves as a helpful guide to creating interactive leadership development programs that build skills in key leadership personnel.

We are starting to evaluate the impacts of leadership training based on this EI model in our most mature programs, which include the physician leadership and academic leaders programs (each entering a seventh cohort in 2011-2012). In our academic leaders programs one of the largest measureable impacts has been professional career development and career progression. Fellows start in this 2-year program primarily at the Chair/Head or Assistant Dean level. As of 2011, 40% of graduates from the first five cohorts have moved into new positions of greater authority, including three serving as University Presidents, two as Provosts, seven as Vice President/Vice Provost, and nine as Deans of their schools. We also have a wealth of qualitative data supporting the effectiveness of these kinds of interventions on developing and honing interpersonal and leadership skills. This qualitative data is still in the collection stages and has yet to be published.

In our physician leadership development programs, one of the primary program goals has served as a measure of success: subsequent commitment to and participation in district and national-level activities in the partnering professional association. Since this participation requires volunteer time of these physicians, which impedes their opportunity for personal financial advancement, allocating time to the professional association requires considerable personal sacrifice. Willingness to make this personal sacrifice after attending the leadership institute has been seen as a strong measure of program success. Qualitative data gathered consistently links the program's personal impact with both the intent to participate and the subsequent participation in leadership activities in the organization. Currently, 21 of the 25 members of the leadership council have completed a district and/or the national leadership institute. Sixteen of these same individuals have completed the training at the national level. Implementation at the District level has been seen as an unexpected measure of success. While the program was initially offered only at the National level, graduates returned to their districts and advocated for this training to be more widely available and offered to the district level membership. As of 2011, half of the professional association's districts have

now offered a 1-day version of the larger program, with nearly all of the 11 districts planning to include it over the next few years. Another unexpected measure of success of this type of training occurred in 2009, when budgetary concerns called into question the continuation of the National program. Graduates led a campaign to endow the program themselves by making personal financial contributions. Their advocacy efforts ensured that the National leadership program was allocated for in the permanent budget of the association. While this does not demonstrate a measureable increase in EI skills, it clearly demonstrates the perception of impact and significance of the program by those who have completed the EI-promoting experience. We are currently looking at ways to qualitatively measure behaviorally-demonstrated skills in EI-related areas in participants.

Our public health-sector program is in its second cohort of Fellows and success will be measured by the community and organizational-based impacts of their individual leadership projects. Most of these projects involve coalition building and the creation of partnerships, both of which rely heavily on the successful use of EI-related skills. The impacts of these projects will become increasingly clear over the next few years and will be studied. In this program we are also undertaking an analysis of a "ripple effect" of training—that is how leadership training of one individual impacts the skill development of others in organizational settings. We hope to track the impact of improving EI-related interpersonal skills across organizations through associated learning in addition to tracking improvements in outcomes such as community partnerships and community health indicators.

While participants in our programs provide a wealth of qualitative data, as yet unpublished, of how they have implemented the leadership skills gained through programs based on this EI-model, for practical reasons we have yet to undertake a systematic review or conduct an analysis with a control group. In fact, we are unaware of any published studies that assess the impact of leadership training based on emotional intelligence which include a well-defined control group. However, there is research that evaluates other public-sector impacts of this kind of training that relate to successful implementation of the type of *personal* and *social competence* skills discussed in this chapter. A report by the Lewin Group provides stunning findings on the Management Academy for Public Health (MAPH), also offered at the University of North Carolina at Chapel Hill through the Gillings School of Global Public Health. This program offers leadership training through a practical business skills focus, not an exclusively EI focus, although many of the projects put forth by these public health teams require partnerships and coalitions. In 2003 the Lewin Group analysis reported that nearly 40% of MAPH alumni teams implemented business plans as a result of the Management Academy training. The Lewin Group found that these alumni teams generated $6 million in revenue with those plans, which represents a 300% return on investment of the approximately $2 million spent on the training (Lewin Group 2003). While results of EI-based leadership training would not likely be measured in such stark terms as revenue generated, this study supports the strong impacts that leadership training in general can have in non-profit, health-focused organizations, and how those impacts might be measured and captured.

The importance of the development of EI skills to successful leaders is clear and has been demonstrated in a variety of fields. Yet more research on *measureable strategies* to successfully develop EI-based leadership skills is crucial and would make a significant

contribution to the field, as would further research on refined measures of EI itself. Such research could further promote effective leader development and support inclusion of those strategies in succession planning and talent development programs across health care and other non-profit, public sectors.

EQ Skill: **Self Actualization** The ability to lead a rich and meaningful life by persistently striving to improve oneself towards the maximum development of one's abilities and talents (Stein and Book 2006, Stein 2011). *Examples:* • *Deciding to learn how to speak medical Spanish in response to a desire to pursue life long learning and because of an increasing number of Spanish speaking only patients coming from the community to the office for care* • *Learning new skills outside of medicine (dance class, scuba diving, art or music skills)* • *Engaging in selfless activities that benefit others*
EQ Skill: **Stress Tolerance** The ability to withstand adverse events without falling apart or becoming overwhelmed (Stein and Book 2006, Stein 2011). *Examples:* • *Coping with an operative complication and leading staff through the necessary steps to address the complication without panicking or yelling and doing so calmly.* • *Having an outlet for stress reduction (exercise, meditation, yoga, tai chi)* • *Managing difficult patients or patients' families without becoming negatively impacted* • *Practice the ability to "let go" of situations you can't control or that are in the past*
EQ Skill: **Optimism** The ability to maintain a positive attitude despite challenges and setbacks. *Examples:* • *Positively rallying staff and self to temporarily work longer hours than usual in response to receiving unexpected news that a fellow staff person will be out of the office schedule for 3 weeks due to a family emergency* • *Seeking the positive aspects of changes* • *Seeing conflict as an opportunity for change* • *Adapting to changing work environment (mastering a new skill)* • *Confront the truth and facts that are around you and remain firm in your belief that you will prevail in the end (Collins 2001)*
EQ Skill: **Happiness** The ability to feel satisfied with one's life, to enjoy oneself and others, and to have fun (Stein & Book 2006, Stein 2011). *Examples:* • *Taking time to enjoy lunch with staff after a busy office Monday morning and actively participating in the conversation on what everyone did for the weekend.* • *Engaging in an environment of teamwork* • *Creating camaraderie with staff & other colleagues*

EQ Skill: **Assertiveness**
The ability to openly communicate feelings, beliefs, and thoughts and defend personal rights and values in a socially acceptable, non-destructive, non offensive manner, and to maintain the ability to do so even if the stance taken is not admired or accepted by others as the norm, the ability to constructively self-advocate (Stein & Book 2006, Stein 2011) *Examples:* • *Professionally confronting a colleague who is always 15 minutes late to the clinic when s/he comes on call.* • *Pursuing promotion & tenure* • *Seeking a raise/bonus* • *Asking for recognition of one's achievements* • *Learning to delegate & work as a team* • *Maintaining principles/ethics even when asked by patient to bend the rules*

Table 1. Strategies for developing the specific EI skills related to work-based success, as measured using EQ instrumentation (Bar-On 1997, Bar-On 2002, Stein 2011).

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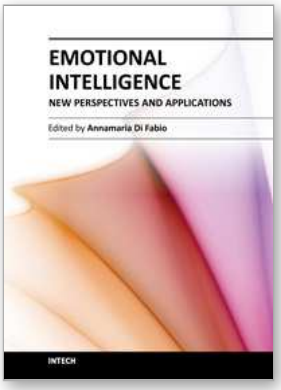

Emotional Intelligence - New Perspectives and Applications

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Emotional intelligence is an emerging construct for applied research and possible interventions, both in scholastic, academic and educational contexts, organizational contexts, as well as at an individual level in terms of people's well-being and life satisfaction. From the presented contributions, it emerges how this volume is characterized by an interest to give an international overview rich of stimuli and perspectives for research and intervention, in relation to a promising variable of current interest, such as emotional intelligence. The goal is that this book further contributes to the affirmation of a particularly promising variable, such as emotional intelligence, which requires a greater interest and attention in both research and application field.

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