An exploration of the importance of emotional intelligence in midwifery


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An exploration of the importance of emotional intelligence in midwifery

Dorothy Patterson1 MSc BCh(Stored) JSP PGCFE RM, Ann M Begley1 PhD MPhil BA RGN AD DipFd

1 Midwifery Teaching Fellow, School of Nursing and Midwifery, Queen’s University Belfast, BT7 1NN, Northern Ireland Email: dorothy.patterson@qub.ac.uk
2 Lecturer in ethics, School of Nursing and Midwifery, Queen’s University Belfast BT7 1NN, Northern Ireland Email: a.m.begley@qub.ac.uk

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Abstract
Background: Recognition of the importance of Emotional intelligence dates 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 management where its ability to enhance the effectiveness of midwives and strengthen the capacity to deal with pressures and develop effective relationships has been acknowledged within the midwifery profession.

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; Gould, 2003; Akerjordet and Severinson, 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 emotions have significant negative outcomes on the health and well being of midwives (Gould, 2003; McMullen, 2003; Hunter, 2009). In spite of this Akerjordet and Severinson (2008), report that few articles on EI were set within an empirical or philosophical base. Furthermore Strickland (2000) and Goleman (2004) claim that EI is an important social skill and that it is not considered appropriate in midwifery to display emotions and acknowledges that there are times when midwives need to be able to articulate their feelings in a meaningful way. The importance of EI in midwifery practice

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 areas of the brain (Goleman, 1995; Bardiz and Salaski, 2003; Morriarty 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 material and that it involves a process in which learning takes place in the emotions and where information and understanding is stored in the memory banks of the neo-cortex. This is not so with EI which, as Hunter (2009) claims, is needed for the development of emotional awareness. Combining the management of emotions with self awareness is essential for the development of EI (Jordon and Troth, 2004). Goleman (2006) highlights the difference between learning theoretical material and learning to exercise practical wisdom and make sound judgements in practice. Theoretical subjects can be taught in the classroom while practical wisdom including competencies in EI requires experience and exposure to good role models. Midwives, therefore, need to be able 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 skilful feedback to other team members (Goleman, 2004).

Emotional intelligence in midwifery

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 (1995; 2004). In midwifery training programmes encouraged nurses and midwives to conceal their emotions and work behind a professional facade 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 ‘Patients will, if the patient is a dangerous virtue, meaning as it does, to suffer with someone.’ (Way, 1962: 13) and ‘Patients will, if the patient is a dangerous virtue, meaning as it does, to suffer with someone.’ (Way, 1962: 13) and ‘Patients will, if the patient is a dangerous virtue, meaning as it does, to suffer with someone.’ (Way, 1962: 13) and ‘Patients will, if the patient is a dangerous virtue, meaning as it does, to suffer with someone.’ (Way, 1962: 13) and ‘Patients will, if the patient is a dangerous virtue, meaning as it does, to suffer with someone.’ (Way, 1962: 13) and ‘Patients will, if the patient is a dangerous virtue, meaning as it does, to suffer with someone.’ (Way, 1962: 13) and ‘Patients will, if the patient is a dangerous virtue, meaning as it does, to suffer with someone.’ (Way, 1962: 13). 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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Historically midwifery care was community based, utilising recommendations the Peel Report (1970) recommended that hospital facilities should be available to 100% of women giving birth. It is significant that the emphasis was on 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 was that midwives were isolated and detraded, 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 quality of care midwives received. 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 more 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 valued in health care. 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 for a more holistic approach to the care of the midwife-woman relationship (Kirkham, 2000; Williams 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 EI 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). Hunter and Doery (2005), both examined the emotional aspects of midwifery using Hochschied’s (1983) theoretical framework of Emotional Labour (EL) and reported that midwifery was highly emotional work. She identified the lack of recognition and the lack of significance that is placed on emotions in the work place. This refers not only to emotions which are highly emotional work. This refers not only to emotions which are shown by midwives but in many cases those which they experience but do not disclose. Hochschied (1983) defined EL as the ‘induction or suppression of feelings to sustain the outer appearances that results in individuals feeling cared for and attentive to the needs of others’. (Hochschied, 1983 p.7). Hunter (2004) reported that midwives who were struggling and unable to provide women focused maternity care found the emotional work of midwifery difficult and they required support in managing their emotions. It is not being suggested that EL and EI are similar concepts, but McQueen (2004) states that the mental processes involved are similar. Reflecting on the work of Menzies (1999) we can see that midwives are in effect encouraged 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-Cicciu, (2003) suggests that workers feel left out of what is happening and that what the practitioner actually feels and what are expected to feel emotions. If midwives 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).

Recruitment and retention

Deery (2005) indicates that midwives not only display emotions of empathy and caring to women but are sometimes required to suppress negative emotions which may emerge from areas of stress in the work place. This may well be either directly or indirectly contributed to the levels of sickness absence, and the occurrence of the midwife-woman relationship (Kirkham, 2000; Williams and Newburn, 2004; DH, 2007; Scottish Government Health Directorates (SGHD), 2010).

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 were recorded and reported to England and Wales in that year (Office of National Statistics, 2010). This has been compounded 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 where English is not the woman’s first spoken language. Added to this are the higher levels of non-English midwives (Muller-Smith, 1999, 2000). In order to meet the demands of change and reform, effective transformational leadership throughout the profession is needed (Elliott, 2004; Coggins, 2003; 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) states that those with high EI are more likely to be effective leaders. Goleman (2004) and Slaski and Cartright (2002) state that organisations which develop the EI of their staff will reduce the negative aspects of work life, for example, stress, low morale and poor work satisfaction. Goleman (2004) and Slaski and Cartright (2002) state that organisations which develop the EI of their staff will reduce the negative aspects of work life, for example, stress, low morale and poor work satisfaction. It can be seen that midwives are required to display leadership qualities which are emotionally responsive to dealing with stress caused by both against the workplace. This will assist in creating a safe environment where midwives can feel supported and where their emotional needs are being recognised (Hunter, 2004).

EI is needed for transformational leadership

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References continued


