CHAPTER 3

Emotionally Intelligent Leadership in Nursing and Health Care Organizations

Susan H. Taft

LEARNING OBJECTIVES AND ACTIVITIES

- Define emotional intelligence (EI).
- Distinguish between emotional intelligence and emotional competencies.
- Name the four emotional intelligence clusters.
- Identify the 18 emotional competencies discussed in the emotional intelligence clusters.
- Identify factors that may enhance or diminish one's innate emotional intelligence and learned emotional competencies.
- Describe the five core competencies and why they are considered crucial.
- Discuss why nursing settings are intensely emotional.
- Identify the desirable characteristics and capabilities of middle- and executive-level nurse leaders and how to select for these qualities.
- Discuss the emotional competencies that may be most important to practicing nurses.
- Identify the emotional intelligence strengths and weaknesses of the nurses in these case studies: Figures 3-2, 3-3, and 3-6.
- Describe how to develop emotional competencies.
- Examine the EI characteristics of best and worst bosses you have known.
- Identify areas of research—from nursing and other disciplines—that support emotional competencies as predictors of leadership success.
- Describe how middle- and executive-level nurse leaders might use emotional competencies in different situations.
- Discuss how emotionally intelligent nurse leaders might improve nursing work environments.
- Identify how emotional intelligence relates to national leadership standards and advancement of the nursing profession.

Quote

My continuing passion is to part a curtain, that invisible shadow that falls between people, the veil of indifference to each other's presence, each other's wonder, each other's human plight.

—Eudora Welty

CONCEPTS

Emotional intelligence, emotional competency, socioemotional leadership, effective and ineffective leaders, work engagement, self-awareness, self-assessment, self-confidence, self-control, trust and trustworthiness, adaptability, achievement drive, initiative, optimism, empathy, influence, organizational politics, service orientation, developing others, inspirational leadership, change agent, conflict management, teamwork, collaboration, nurse manager, leader competencies

SPHERES OF INFLUENCE

Unit-Based or Service-Line-Based Authority: Managing oneself successfully, relating effectively to others, assuming accountability, acting ethically and with integrity, leading change initiatives and other people, communicating effectively, modeling professionalism, managing relationships and diversity, sharing decision making, improving performance, influencing, maintaining patient safety, understanding and working with organizational politics, building trust, promoting teamwork and collaboration, selecting and developing staff, and managing conflict. All behaviors are strengthened with greater concentrations of emotional competencies.

Organization-Wide Authority: Includes all behaviors expected of nurse managers plus assuming organization-wide scope of responsibility and engaging in strategic planning.

Introduction

Opportunities abound! The imperative for leadership practice by nurses has never been greater. Rapidly advancing knowledge and technologies in the healthcare sector are creating new priorities for the nursing role. The 2011 Institute of Medicine (IOM)[1] report calls for, among other developments, markedly expanded leadership by nurses. Members of the nursing workforce are needed to assume leadership activities and positions across all types, levels, and locations of healthcare settings. Nurse leadership capabilities will increasingly become part of the knowledge and skill set of all practicing nurses—not just those holding formal positions. To expand leadership capacity, nursing educational institutions must incorporate leadership development throughout all levels of study, with the necessity for doing so most compelling in baccalaureate and higher degree programs. The American Organization of Nurse Executives, the premier nursing leadership organization in the United States, has called for baccalaureate and master's degrees as the minimal educational preparation of nurse leaders and doctoral degrees for those in executive positions.[2]

Effective nursing leadership in organizations requires numerous talents, skills, competencies, and types of knowledge, as the existence of this textbook demonstrates. At its core, leadership is about relationships with other people. Leaders' accomplishments are largely achieved through the individual and coordinated efforts of others. Without followers, there are no leaders.[3]

Leadership theories have developed since before the time of Machiavelli, but the most recent theories originated in the industrialized world of the 20th century. In the works of scholars, researchers, exemplary leaders, and undistinguished nonleaders alike, there are few topics in management about which more has been written. Since the 1950s, research has tended to focus on Western methods of leadership in traditional industries. More recently, leadership research has expanded our traditional

understanding by focusing on leadership behaviors at different levels and within different functional areas of organizations, women's leadership styles, leader diversity as a competitive advantage to organizations, multicultural and global leadership, the role of leaders in attaining safety and quality outcomes, and an acknowledgment that "no one size fits all" practicing leaders. But consistently throughout time and across cultures, leadership has been recognized as a people-oriented business.[4]

This chapter is devoted to exploring the people skills of good leaders—leaders who enable "their people" to be happy and productive workers and engaged employees, who support employees to grow and develop to their full potential, and who themselves work successfully as committed organizational agents. As the standard bearers for high performance, effective leaders empower good performers but also counsel irretrievably poor employees to leave a setting where they perform poorly. The leadership framework discussed in this chapter is emotional intelligence, a composite of 18 intra- and interpersonal competencies that predicts successful leadership at work.[5]

WHAT IS EMOTIONAL INTELLIGENCE?

Emotional intelligence is defined as "the capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in others."[6] Emotional intelligence (EI) includes capabilities distinct from, but complementary to, intelligence or the purely cognitive capacities measured by intelligence quotient. Emotional competencies are defined as "learned capabilities based on emotional intelligence that contribute to effective performance at work."[7] From extensive research conducted by Goleman and his associates and by The Hay Group of Boston, emotional competence has been found to matter twice as much as intelligence quotient and technical skill combined in producing superior managerial job performance. The nursing literature shows widespread support for EI as central to nursing practice.[8]

Emotional intelligence develops in humans as a result of genetic inheritance and the socializing influences of childhood, adolescence, and adulthood; emotional competencies are a result of emotional intelligence plus opportunities we have to develop related competencies. They are capabilities we can learn and expand. Thus an individual born with average emotional intelligence might become exceptionally emotionally competent in adulthood if she had parents who, during her upbringing, tuned in well to her feelings; practiced leadership in college through her sorority; and worked with emotionally competent managers (positive role models) in her early work experiences. Similarly, it is possible to have life experiences that erode one's emotional intelligence. An individual born with high natural emotional intelligence could become limited in emotional competencies if he came from a home in which a parent was an alcoholic, suffered taunting or hazing in school, or had previous bosses who were abusive (negative role models).

The nursing profession requires a high degree of emotional labor—the ability of nurses to regulate their own emotions and the expression of emotions for the sake of their patients' needs.[9] Nurses are expected to display emotions that convey caring, understanding, and compassion toward patients while regulating their own feelings. For newly graduated nurses, the added emotional burdens of coping with the transition from school to work are enormous.[10] The role of the nurse leader, then, becomes critical "in creating a supportive and positive work environment to help nurses cope with the stress of managing their own and others' emotions" concurrently.[11] The American Nurses Association defines the nurse administrator as one who "orchestrates and influences the work of others in a defined environment . . . to enhance the shared vision of an organization,"[12] and identifies emotional intelligence as one of nine frameworks for administrative practice. The emotional intelligence framework provides for understanding the ways in which leader behaviors are necessary for the creation of a positive emotion-intensive work environment.[13]

Emotional Intelligence Framework

The emotional intelligence framework consists of two dimensions: the ability to understand and manage oneself and the ability to understand and relate well to others. These dimensions are further subdivided into self-awareness and self-management and social awareness and relationship management. In each dimension the ability to manage oneself or others is predicated on the awareness one has of self and others. **Figure 3-1** shows the framework of the emotional intelligence competencies.

Self-awareness can be considered the inner barometer, or rudder, people have to understand and direct the moment-to-moment and situation-to-situation variation in internal emotions. Humans are emotional animals, constantly reacting to internal and external stimuli. These stimuli may cause feelings that are positive or negative, uplifting or discouraging, threatening or pleasing, exciting or boring, and so on. An emotionally intelligent individual is aware of feelings as they emerge, understands them accurately, and has the self-confidence to continue activity within their context regardless of his or her emotions. Self-management extends one's emotional intelligence by allowing for self-control of emotions, maintenance of one's integrity, and adaptability to emerging situations. Individuals low in self-awareness or emotional self-management or both may "blurt" reactions in social situations, show rigidity or brittleness when faced with differences of opinion, be defensive to criticism, act contrary to their espoused values, or project insecurity when around others (**Figure 3-2**).

Emotionally intelligent interactions with other people depend and build on an individual's strengths in self-awareness and self-management. Without a solid base of self-understanding, self-control, emotional security, trustworthiness, and adaptability, it is virtually impossible to be open to others and constructive in work relationships. Thus, good leaders must know themselves well and be able to choose how they will respond in social situations. These strengths then provide the foundation for working effectively with others.

Good relationships with others are shown through social awareness and relationship management. These qualities are considered "social radar"—the ability to understand others and work with them productively. Social awareness is grounded, most directly, in the skills of empathy: sensing others' feelings, needs, and concerns and taking an active interest in them. Social awareness in work settings extends into the ability to use good political skills and an active, principled orientation to service toward customers or patients. To exhibit political astuteness at work and to serve patients with sensitivity, the nurse draws on his or her empathy for others, whether individuals or people in groups. Relationship management includes areas frequently depicted in books and journal articles about leadership. Of all the emotional competencies, these are the most readily learned, either through study, reading, and practice or through leadership development programs. Relationship management encompasses competencies in inspiring and influencing others, visioning, developing others, collaboration and teamwork, leading change initiatives, and managing conflict. The effective use of relationship management at work involves leadership that builds individual, group, and organizational engagement toward future accomplishments (see, for example, **Figures 3-2 and 3-3**).

FIGURE 3-1 Framework of Emotional Intelligence

Self	Others
Self-awareness	Social awareness
Self-management	Relationship management

FIGURE 3-2 The New Nurse Manager

Tiffany worked in a large university medical center. She completed her BSN 3 years ago and in her first job as a staff nurse on a complex surgical unit rapidly proved herself to be a competent staff nurse. Because of her capabilities and positive attitude, she was promoted to charge nurse after 1 year. In her third year she was promoted to unit manager when the previous manager left to direct an ambulatory surgery center within the medical center system. Although a "quick study" in managing the logistics of her unit, she lost trust among the nurses in the unit when she reacted defensively and impatiently to criticisms and complaints from the staff, tended to give summary orders, and projected an "I'm too busy to talk to you now" response to staff concerns. For the first time since she started on the unit, Tiffany began to dread going to work. She believed that her former colleagues had turned against her and didn't appreciate how hard she worked for them. She often saw their concerns as petty and viewed them as not taking enough responsibility for their own roles on the unit. She talked to her nursing director regularly about the staff issues, but the director just laughed and told her that the "honeymoon was over" and that things would even out in time. After 6 months her relationship with her staff had deteriorated to the point that Tiffany, feeling betrayed, scapegoated, and disillusioned, left the medical center to work in a position with an insurance agency.

FIGURE 3-3 The Quality Manager

Joe had worked as a staff nurse on medical floors at two different institutions for 6 and 5 years, respectively. When his first child was born, he decided to accept a job offer as the quality manager for a suburban community hospital so that he could enjoy regular hours and arrange his schedule to coordinate with the working hours of his wife. The position he accepted turned out to have more challenges than he anticipated: uneven patient quality outcomes on different nursing units, physicians angry with implied "report cards" on their medical practices, a new nurse executive who was trying to surmount the multiple demands of her position, a recently completed Joint Commission on Accreditation of Healthcare Organizations survey that enumerated more than a dozen deficiencies that needed correcting within 6 months, and declining patient satisfaction scores in many areas. His first meeting with the executive team of the hospital, in which his charge to "fix things" was laid out, was a demoralizing and overwhelming experience. For a day, Joe regretted having left the comfort of staff nursing, where he knew what to do and how to do it. As a staff nurse, problems could be addressed one patient at a time.

After talking with several nurse manager colleagues from his previous place of work and with a nurse educator at a local university where he had enrolled for master's study, Joe began to get a handle on how to approach his new responsibilities. He understood hospitals. He trusted his own ability to learn what he needed to learn and to move forward one step at a time, and he recognized that the amount he needed to accomplish required a systematic and comprehensive plan. Over the next week he talked to many different employees of the hospital and some of the physicians in leadership positions. Some of his meetings involved listening to people venting about the problems they faced in their work or the people they worked with; several included angry accusations about the perceived "quality agenda" of the chief executive officer. Joe made no attempt to counter the comments he heard, nor did he allow himself to get defensive and angry in return. Instead, he reiterated frequently that he was just trying to learn about the issues the hospital faced so that he could put together some ideas on how to move forward.

Emotional Competencies

Emotional competencies are developed from life experiences in combination with an individual's innate emotional intelligence. Humans tend to become increasingly emotionally competent with age as we accumulate experiences that help us understand ourselves and others better. We learn from positive as well as negative experiences. Who has not made political mistakes in a job early in a career? How many haven't suffered through a performance appraisal that found them less than perfect? Who has not failed to influence a peer group to do something they thought was an obvious "no-brainer"? To our benefit or detriment, we learned from these experiences. Similarly, almost everyone can identify a teacher who helped us to know ourselves better and, in the process, improved us, or a leader whom we would follow anywhere. Parenting, socialization experiences, role models, and the practice of new behaviors all help or hinder us in developing emotional competence. Life experiences create positive or negative influences on any individual depending on the nature of the experience and how it is processed by that person. The fields of child and adult development focus on how one's natural endowment, culture, central figures, and life experiences interact to create the unique mature individual.

Eighteen work competencies, depicted in **Figure 3-4**, constitute the emotional intelligence framework. Four clusters—self-awareness, self-management, social awareness, and relationship management—contain lists of the emotional competencies relevant to self and others.[14] Though all competencies are considered important for leadership effectiveness, five are core competencies on which all the other competencies depend. For knowing and managing oneself, core competencies include emotional self-awareness, accurate self-assessment, emotional self-control, and self-confidence, and, for working effectively with others, empathy. Without these core competencies, one cannot effectively exercise leadership. For example, one must be self-aware—in tune with one's own emotions—to practice emotional self-control. Emotional self-control is essential to collaborate with others, build work teams, or manage conflict.[15] Empathy is required to develop others constructively, understand organizational politics, or respond proactively to customer needs.

FIGURE 3-4 The Emotional Intelligence Framework & 18 Competencies[5]

Personal Competence	Social Competence
Self-awareness	Social awareness
Emotional self-awareness*	Empathy*
Accurate self-assessment*	Organizational awareness
Self-confidence*	Service orientation
Self-management	Relationship management
Emotional self-control*	Developing others
Transparency	Inspirational leadership
Adaptability	Change catalyst
Achievement orientation	Influence
Initiative	Conflict management
Optimism	Teamwork and collaboration

Note: *Core competencies, on which the remaining 13 competencies depend.

Source: Goleman, 1995, 1998a; Goleman et al., 2002; The Hay Group, 2004.

In Figure 3-2 Tiffany's behavior as a new nurse manager reflects limitations in emotional self-awareness, self-control, adaptability, and self-confidence in how she understands and manages herself. In working with others, Tiffany's empathy, organizational awareness, development of others, inspirational leadership, conflict management, and teamwork and collaboration all appear to be weak. Although she has been a competent and effective staff nurse, Tiffany lacks the skills and emotional competencies to move effectively into a management role. It is common in all industries, including health care, for good workers to be promoted into management positions with little or no additional training or mentoring. Sometimes these promotions work well, but often they do not. It is a management myth that the best staff workers make the best leaders. Leading people requires skills and knowledge that even the most talented employees can lack.[16] Emotional intelligence is just one of many areas in management in which proactive planning for human resource development is critical for leader success.

Because the core emotional competencies are essential leadership traits, they are the areas in which leadership development should, in the case of deficiencies, begin. Once integrated well into leadership behavior, the core competencies can be used to support or leverage further emotional competency development.

Figure 3-3 gives the scenario of Joe, the new quality manager at a community hospital. Like Tiffany, Joe came from a staff nurse position to a management role. Unlike Tiffany, Joe demonstrates a number of emotional competencies as he takes on a difficult work assignment: Although initially overwhelmed and discouraged by his new responsibilities, he is aware of his emotional reactions to those responsibilities. Rather than recede into self-doubt and make a choice to resign, he shows confidence in his own abilities to learn and move forward. He adapts to the magnitude of the job, seeks counsel from others (initiative and optimism), and sets out to gather information necessary for him to succeed (achievement orientation). His meetings with others in the organization are conducted with good political insight (organizational awareness) and empathy. He avoids responding emotionally to the comments he hears (emotional self-control). Joe recognizes that the job requires him to be a champion of change and that it takes collaboration and teamwork, plus development of others, to be effective. Within a reasonable period of time, Joe creates a vision for quality improvements at the hospital. In the near future, he stands a good chance of becoming an influential and inspirational leader for quality improvement.

Why was Joe so much more effective than Tiffany? We cannot say for sure, but some combination of innate emotional intelligence, socialization, positive role models, and age and experience probably provided him with the opportunities to develop his emotional competencies. In contrast, Tiffany came to her new position with serious limitations and, presumably, less positive prior growth opportunities relative to leadership. Nurse leaders who are responsible for selecting, hiring, and promoting personnel need to be aware of the great variation in emotional intelligence that exists among employees. Though Joe needed some coaching in his new position, which he obtained primarily from external sources, Tiffany required far greater development in house to become a successful nurse manager. At a minimum, management classes and good mentoring would have provided Tiffany with some necessary initial support to face the challenges she encountered in her new position. In her organization, Tiffany's development needs were not identified and no coaching provided, so she floundered and failed, carrying negative views of leadership with her to future jobs. Most likely, the harm done to her as a potential leader will need to be "unlearned" before she can develop leadership capabilities later in her career.

The 18 emotional competencies that constitute emotionally intelligent leadership are summarized in **Figure 3-5**. In the upper left cell are the competencies of self-awareness: emotional self-awareness, accurate self-assessment, and self-confidence. They are the foundation for effective leadership. Self-awareness gives an individual a constant internal monitoring system. It reports feelings and reactions to experiences in the present but also includes knowing and anticipating situations in which one is apt to feel stress, joy, anger, insecurity, defensiveness, impatience, and so on. Self-awareness is a prerequisite for the social competency of empathy. The individual who is emotionally self-aware or has accurate

FIGURE 3-5 Emotional Competencies Constituting Emotionally Intelligent Leadership[5]

Personal Competence	Social Competence
Self-awareness One's "inner barometer," rudder	Social awareness One's "social radar"
Emotional self-awareness* A fundamental and essential emotional competence Recognizing your own emotions and their effects Knowing where your "buttons" are	Empathy* Sensing others' feelings, needs, concerns and perspectives and taking an active interest
Accurate self-assessment* Knowing your strengths & weaknesses Seeking out and "taking in" feedback from others	Organizational awareness Reading a group's emotional/political currents and power relationships, and acting on this awareness
Self-confidence* Sense of self-worth & capabilities that can sustain you during failures & defeats; having "presence"	Service orientation Anticipating, recognizing, and meeting customers' needs, and the motivation
Self-management Enables one to resist the tyranny of emerging moods	Relationship management Enables one to act in the interests of others without tripping over his or her own ego
Emotional self-control* Being unfazed in stressful situations; influenced by biochemistry and neurological system	Developing others Sensing others' development needs and bolstering the development of others' abilities
Transparency Trustworthiness, credibility, accountability for self; others can count on you High integrity: acting consistently with your own values	Giving timely feedback
Adaptability Ability to let go of previous ways of doing things, willingness to try new ways	Inspirational leadership Having vision; inspiring and guiding; communicating often and effectively
Achievement orientation A drive to accomplish goals, stretch for high performance; sets apart high achievers Core for entrepreneurs	Change catalyst Recognizing the need for change; removing barriers; communicating widely; modeling
Initiative Motivation; seeking out new ideas and methods; taking responsibility; readiness to act	Influence Winning people over; indirectly building consensus and support; orchestrating effective tactics of persuasion; good communication Fine-tuning presentations/appeals to fit the audience
Optimism Persisting despite obstacles and setbacks; not fearing failure	Conflict management Understanding all perspectives and negotiating with these in mind; does not mean suppressing conflict
	Teamwork and collaboration Working toward shared goals using individual strengths and group synergy; nurturing relationships, building esprit de corps, sharing credit lavishly Includes managing meetings well

Note: *Core competencies.

Source: Goleman, 1995, 1998a; Goleman et al., 2002; The Hay Group, 2004.

self-assessment knows his or her strengths and weaknesses and is comfortable "owning" them around other people. Comfort with one's own capabilities, values, and skills—both those that are strong and those that are limited—leads to self-confidence and the potential for behavioral integrity. The self-confident leader uses these competencies to support his or her self-assurance and self-efficacy, and often they enable acts of courage to voice unpopular views in the workplace. Any leader in today's healthcare settings needs to have some "toughness" to survive; self-confidence is a core component of a good survival strategy.

The capacity for good self-management, shown in the lower left cell, includes the emotional competencies of emotional self-control, transparency, adaptability, the drive to achieve, initiative, and optimism. Emotional self-control prevents us from being hijacked by our feelings, but it does not imply that the expression of all emotions at work is undesirable. There are many experiences in the workplace that call for the appropriate expression of feelings, such as events that stimulate anger, sadness, frustration, humor, or happiness. The key to self-control is that the individual is aware of his or her feelings and makes a choice as to whether to express them or keep them submerged from view. Thus a nurse might choose to let a manager know when he or she is frustrated with an ongoing lack of supplies to care for patients but decide not to express indignation when a coworker makes a mistake with a patient, as the latter case may be more constructively dealt with through subsequent rational discussion.

The rules for emotional expression or emotional control vary greatly across ethnic groups, cultures, national origins, social class, organizations, and other contexts. Some organizations enable both staff and leaders to be frank and open in the expression of feelings, whereas others maintain codes of formality that tend to limit the sharing of feelings. Leaders need to understand the norms of their own workplaces and use these to guide how they manage their own feelings and those of others.

Transparency—being honest, open, trustworthy, and authentic—is the competency that most supports an individual's integrity. Transparent leaders can be depended on and trusted.[17] They model ethical behavior. When pressured to do something they believe to be wrong, transparent leaders demonstrate courage by standing up against it, even when taking a stand may be personally risky. Almost everyone would like to have a transparent leader because he or she engenders trust. Such leaders live and model the behaviors they expect of others,[18] in the process enabling others to act with integrity. Trust in a leader gives rise to positive emotions in employees, and positive emotions are what attach people to their work.

The emotional competency of adaptability enables leaders to be flexible in changing situations or in overcoming obstacles to getting work done. It provides for emotional resilience in the face of multiple demands, complex or ambiguous situations, shifting priorities, and painful realities. Though people who lack adaptability may be ruled by anxieties and fears about change, it is also true that an adaptive response to every challenge is not always desirable. There are values and principles to which leaders should adhere, and too much flexibility on these may be the wrong choice. Examples include nurse executives who hold to a floor of safe staffing rather than agree to budget cuts that could result in dangerously low nurse-to-patient ratios, an agency director who rejects requests for special treatment for family members of local politicians, or the medical department head who refuses gifts to his department offered by pharmaceutical representatives in exchange for the promotion of specific brand-name drugs. Because healthcare organizations are complex, fast moving, and concerned with the health of humans, adaptability is important for any nurse leader, but equally important is knowing those areas in which existing practices should be maintained.

The ability to harness internal motivation, the readiness to take responsibility and to persist, and the drive to stretch for high performance, take risks, and accomplish goals typify leaders high in achievement orientation and initiative. High achievers are inwardly directed, holding challenging standards for themselves. They are proactive, love to learn, seek challenges, and are willing to bend rules. In the business world entrepreneurs tend to have these characteristics to an extreme degree, although they

often lack some of the other important leadership competencies associated with social awareness and relationship management. In health care, high achievers/initiators operate in a constant state of readiness. They are frequently results oriented and focus on performance improvements by mobilizing themselves and others.

People at work take their emotional cues from their leader(s). Because positive or negative emotions from a leader powerfully penetrate the work climate, the presence of the former is clearly preferable to the latter. An optimistic leader is one who carries a "can do" attitude and who persists despite obstacles and setbacks. Optimism enables a leader and his or her employees to learn from mistakes and move forward. He or she is a carrier of hope.

Displayed in the upper right cell of Figure 3-5 are the competencies of social awareness: empathy, organizational awareness, and service orientation. As a core competency, empathy provides the foundation for the remaining two competencies in this cell as well as the ability to manage relationships (as shown in the lower right cell). Empathy is the "sine qua non of all social effectiveness in working life,"[19] a critical competency for working with a diverse group of people and those from different cultures. Every organization has an invisible nervous system of connection and influence.[20] Political astuteness, a part of the competency of organizational awareness, derives from being attuned to individuals, groups, and organizational power dynamics; detecting social networks and unspoken rules; and knowing how to use other people and processes to advance one's own interests. For middle managers, awareness of politics needs to include those above and below them. The politically aware leader tends to have an organizational, as opposed to subunit or departmental, perspective. Even for empathetic leaders, this perspective may be the most difficult of emotional competencies to learn. As an educator, I have found that the competency of organizational awareness is best learned by my graduate students through mentoring experiences with politically gifted leaders.

Service orientation, whether customers are patients or members of other departments, draws on the ability of the leader to grasp the customer's perspective and to create actions responsive to that perspective. He or she seeks ways to increase satisfaction and loyalty.[21]

The lower right cluster of Figure 3-5 lists the emotional competencies of relationship management: development of others, inspirational leadership, change catalyst, influence, conflict management, and teamwork and collaboration. These too are built on a foundation of the core competencies of emotional self-awareness, accurate self-assessment, self-control, self-confidence, and empathy.

Healthy organizations cultivate formal and informal leadership throughout the system by developing leaders. Nurse executives, for example, play a pivotal role in the development of nurse managers. In performance-oriented cultures, all staff are considered worthy of development. This can be informally addressed through coaching and feedback—giving accurate, specific, timely, descriptive feedback that the receiver can use effectively and from which he or she can grow.[22] Such cultures disparage the singular use of "overly nice" feedback that excludes critical, but important, appraisal information.

To guide others, leaders must first have a clear sense of their own direction, values, and priorities. Inspiring leaders rely on core values to orient decisions; they are intentional and authentic,[23] leading by example, whether supporting people through day-to-day work challenges or episodes of difficult change. They value and nurture the relationship between leader and followers, typically creating an empowered staff.[24] Honest, authentic, frequent two-way communication enables trust development and is the hallmark of the inspirational leader.[25] It is an "emotional craft."[26] Some research has found that the intent of staff nurses to leave their organizations is negatively correlated with their leader's transformational leadership style[27]—that is, transformational leadership contributes to nurse retention.

Any leader in health care is a change agent: it comes with the job. Most healthcare leaders essentially lead change all the time. No longer is most change "planned"; it usually originates outside of healthcare organizations in the form of government regulations, alterations in reimbursement, technological innovation, shifts in the economy and demographics, and so on. More often than not, we respond

to changes beyond our control. All changes in organizations evoke some resistance. The best change agents do not give ultimatums; they use the competencies of self-awareness and self-management, as well as empathy, politicking, influence, visionary leadership, conflict management, and teamwork and collaboration, to engage employees and lead successful change efforts. Because changes are always occurring, the skills and abilities of change managers need to be fully integrated into the daily practices of managers.

The desire to exert influence can be directed at individuals or groups. Skills in influencing others in the workplace are not routinely taught in nursing school, nor do staff nurses typically learn to be influential through their work except in the area of patient care. Influence skills are built on self-awareness and empathy—being in touch with your own priorities and sensing how others are likely to respond, then fine tuning your appeal to engage others. Nurses use these skills frequently to influence medical and administrative staffs. The persuasive leader intentionally uses her or his emotions and body language to affect the emotions of others. This requires good communication skills,[28] a collaborative stance, trust, and both direct and indirect methods of influencing others. Indirect methods may be especially useful, as when one builds support for an idea before presenting it to the intended audience.

Managing conflict in organizations can include such actions as intervening in interpersonal or group frictions, confronting one's boss, addressing interdepartmental conflicts, facilitating a restructuring, and bargaining with labor unions. Facility in handling difficult people and tense situations constructively is not a widely distributed skill in American society. It is one of the most demanding of emotional intelligence competencies, requiring all the competencies of self-awareness and self-management, as well as empathy, organizational awareness, the ability to develop others and exert influence, and collaboration. Although organizations rife with conflict are unhealthy work environments, the most dysfunctional organization is often one where differences are suppressed and conflicting views are disallowed. Differences of opinion and the emotions that accompany them can become toxic if not addressed. In most cases conflicting views can be expressed, acknowledged, and addressed in positive ways. Part of Victoria's difficulty in **Figure 3-6** was that she never surfaced and addressed differences in perspectives between the chief operating officer and herself. A politically savvy leader often anticipates where and when conflicts are likely to surface and prepares to address them.[29] The insightful use of varying viewpoints can enable the leader to channel strong feelings into problem solving and creative solutions.

Across all types of industries, teamwork is one of the most consistently valued attributes of managers. Teamwork and collaboration are related to the emotional intelligence of groups and are the means by which virtually all work is accomplished in healthcare organizations. Collaborative styles typically reflect an equal focus on task accomplishment and concern for relationships. Individuals able to function effectively as team players do so as a result of emotional intelligence, especially the competencies associated with self-awareness and self-management, plus empathy and service orientation. Cognitive intelligence, technical expertise, or ambition alone do not make people collaborative. As a result of the synergies of "social intelligence," well-functioning teams consistently outperform the contributions of skilled individuals. Combined talents and knowledge on a healthy team interactively and unpredictably catalyze the best in everyone, leveraging the full capabilities of the team members.[30] Thus leaders who are good team builders and facilitators (i.e., running meetings well, building esprit de corps) greatly enhance work performance while generating an atmosphere of friendly collegiality. Group cohesion has been found to be partially predictive of nurse job satisfaction, as has nurse–physician collaboration.[31]

It is important to note that all forms of interactions at work need to be considered relevant to emotionally intelligent behaviors. This means that e-mails, faxes, voicemails, and written memos or reports are all improved by the same sensitivities that the emotional competencies employ. An example of this is using empathy when sending an e-mail or writing a memo; the emotionally intelligent sender is aware of what the recipient knows and thinks before framing the message. Often, providing a sentence or two of background before stating a message, or stating at the outset what the sender wants from the

FIGURE 3-6 The Remote Nursing Agency Director

Victoria was the director of nursing for a large, multidisciplinary home health agency serving 12 acute care hospitals in a multicounty region. Her boss, the chief operating officer (COO), was a physician who worked offsite because of numerous other responsibilities with one of the medical centers. Victoria saw the COO about one or two times a month; otherwise, they communicated by telephone, e-mail, and fax. The COO was erratic in his oversight of the agency. Most of the time he let it "run itself," but at other times he would arrive unannounced and demand data and financial reports all at once, often grilling the directors about what he found. Victoria and the other directors of the agency didn't like the COO's style, but they were content because, most days, he didn't meddle with them. Although not yielding much profit, the agency nonetheless covered its costs, had reasonable patient and family satisfaction scores, and continued to have a steady flow of referrals.

As time went on, Victoria focused on her staff nurses and team leaders, patient care needs, interdisciplinary coordination, and referring hospitals. She attended to accreditation preparedness and compiled required reports in collaboration with her codirectors. Staff at the agency was reasonably content, although scheduling and salary complaints never seemed to go away. E-mails and faxes from the COO came frequently but were primarily concerned with issues of regulation, quality developments in health care, and cost-saving ideas. Victoria responded to these when she had something to share back with the COO, but mostly she filed or saved his communications for future reference. He knew little about home nursing care and was not much of a team player when he interacted with others, so she tended to avoid discussions with him when possible.

After 18 months in her position, Victoria came in on a Friday morning to find the COO and the director of human resources waiting for her. They took her into the conference room, where the COO informed her that she was being relieved of her duties. He had completed a performance review about her that stated he had found her resistant to direction, aloof, unwilling to innovate, and stuck in a "narrow nursing frame of mind." He indicated he had lost confidence in her. Shocked, Victoria responded as calmly as she could manage, noting that the agency's referrals, nursing statistics, cost per visit, patient satisfaction, profitability, turnover rates, and staff satisfaction ratings were all as good as, if not better than, those of similarly sized home health agencies. Since her departmental outcome measures were better than acceptable, how could he justify firing her? He told her the nursing department needed a change of leadership, so that's what he was doing. He then gestured to the director of human resources, who had said nothing to this point, and indicated that she and the director could work out her termination arrangements. After their meeting, the director walked Victoria to her office for her personal items and then to her car, collecting the agency's keys before she indicated that Victoria should leave and not return to the premises.

receiver, helps the message reach the receiver. For example, as a nurse educator, it is not unusual for me to get e-mails from my undergraduate students that contain no signature at the end of the message. If I don't recognize the e-mail address, I often have no idea who sent me the message. In these cases, clearly the student is focused entirely on his or her needs and not thinking about my ability to interpret the message.

No leaders, good or bad, have equal strengths or equal weaknesses in all 18 emotional competencies. Leaders and managers have their own unique constellations of the components of emotional intelligence.

Best and Worst Bosses

In training individuals in emotional intelligence, I have worked with healthcare professionals from many different organizations. I often ask people to list the characteristics of their best and worst bosses, and I have found that the results of this exercise are very consistent across settings. People tend to list variations of the behaviors shown in **Figure 3-7**.

FIGURE 3-7 Characteristics of My "Best" and "Worst" Bosses

Best Bosses	Worst Bosses
Understands my strengths and weaknesses	Poor listener
Always has an open-door policy	Micro-manager
Is available and accessible	Is too busy to help me
Is genuinely interested in others	Gives orders and expects them to be carried out without question
Works with me on difficult projects	Gives negative feedback but rarely says anything positive
Has a good sense of humor	Gets angry easily; tends to "shoot the messenger"
Admits to own mistakes; open to feedback	Has no insight into him or herself
Expects effort and conscientiousness but not perfection	Gives unclear instructions and then blames others when it's done wrong
Willing to change plans based on input from me and others in my workgroup	Doesn't want to know my opinion
Gives an assignment and then lets us do it; doesn't meddle	Prefers to fire off e-mails rather than sit down and talk
Is positive and upbeat	Incompetent; can't acknowledge own weaknesses; is insecure
Often brings in bagels or fruit for us	Wants to look good to his or her boss at all costs
Is quick to give credit to others for good work	Is unavailable, inaccessible, never "around"
Takes a lot of stress from upper management but never brings it back to us	Is often in a bad mood
Always has our department's best interests at heart	Lazy; I have absolutely no idea what he or she does all day
Really cares about how our patients are treated	Is unethical
Will "handle" anyone who is abusive to one of us on the unit; won't back down or let us down	Will lie or misrepresent things rather than admit she or he made a mistake
Works harder than anyone else	Takes credit for the work that others do
Has high standards, sticks to values	Is clueless about our feelings about things
"Walks the talk"	Can't deal with conflict, so avoids it
Understands the "big picture;" is visionary	Seems unhappy with in home life, and brings a lot of that into work
Always looks for new and better ways to do things; is open	Changes direction all the time
Knows a lot about what's going on in other organizations like ours and brings new ideas back to us	Is rigid and defensive
Treats everyone fairly and equally	Is cold and distant
Gives feedback—all kinds—frequently; is collaborative	Holds grudges
Encourages us to have different points of view and to express them; helps us find resolutions	Doesn't advocate for us at higher levels or with other departments; "sells out"
Will sit down with two people who are not working well together and get them to work it out	Doesn't tell me how he or she thinks I'm doing until I get slammed in my annual performance evaluation (which is usually months late)
Shares information; is upfront with us when something can't be changed	Listens to gossip (and selectively believes it)
Encourages us to come up with our own solutions to problems; will intervene if we're stuck	Has "favorites" (who get special treatment)
Is creative; willing to take risks	Is not a team player
Is very well liked and respected by people in other departments	Doesn't deal well with office politics
Makes us want to follow him or her	Doesn't address important issues, even when they go on for months or years
	Talks all the way through meetings without letting anyone else say anything
	Doesn't want to change anything—or the opposite: makes changes willy-nilly without thought
	Poor/no communication
	Has no vision, no charisma

Note that the characteristics of best and worst bosses tend to be the opposites of each other: creative versus rigid, gives credit versus takes credit, shares information versus withholds information, advocates versus sells out, and so on. What people report seeing and valuing in a best boss includes the competencies associated with emotionally intelligent leadership.

Although we know that knowledge, skills, and capabilities, in addition to those characteristics listed in Figure 3-7, are necessary for good leadership and management (e.g., the ability to secure and distribute resources for work tasks or the use of sound staffing and scheduling principles), it is noteworthy that how others evaluate their leaders rests disproportionately on the followers' perceived relationships with those leaders. This strikingly illustrates the basis for the importance of emotionally competent leaders.[32] Because nursing in all its forms is a people-oriented business, top-performing nursing work groups are powered by their leaders' abilities to manage themselves and work well with others.

RESEARCH AND PROFESSIONAL SUPPORT FOR EMOTIONALLY INTELLIGENT NURSING LEADERSHIP

The American Organization of Nurse Executives (AONE) sets research and education priorities that address critical issues facing the profession. The AONE, which represents the perspectives of nursing leaders across the United States, consistently calls for professional leadership and leadership development at all levels of nursing activity. Strong, effective executive leaders in nursing can be scarce commodities, but even where they exist their organizations frequently have inconsistent nurse leadership strength throughout the ranks. The AONE executive leadership competencies call for strengths in professionalism, leading change, and communication and relationship building with all stakeholders. At the nurse manager level, the critical art of leading others includes a cluster of relationship and diversity management capabilities, influence, human resource management, and shared decision-making competencies.[33]

The American Nurses Association's Scope and Standards for Nurse Administrators call for knowledge and qualifications that, in part, fall within the domain of the emotional competencies framework, e.g., leading customer service; integrating ethical principles; exhibiting trustworthiness, honesty, and integrity; facilitating difficult conversations; facilitating interpersonal, interdisciplinary, and inter/intraorganizational communication; employing conflict resolution abilities; utilizing organizational behavior and development; teambuilding; leading performance improvement; creating environments of practice and practice innovation; managing change; empowerment; coaching and mentoring; correcting poor performance; competence with cultural diversity; self-management and self-improvement; social competence; adaptability; promoting learning; inspiring and motivating others; and committing to excellence. The standards reflect the values and priorities of the profession, direct the leadership of professional nursing practice, and identify areas in which nurse leaders are accountable.[34]

A growing research base documents the relationship between nursing, environments of care, staffing ratios, and nurse education levels and patient outcomes.[35] Most of this research focuses on hospital nursing and appears in journals such as *Health Affairs*, the *Journal of Nursing Administration*, *Nursing Economic$*, and *Policy, Politics, & Nursing Practice* as well as in specialty nursing journals. Additionally, national foundations, such as the Robert Wood Johnson Foundation, and government agencies, such as the Agency for Healthcare Research and Quality (part of the U.S. Department of Health and Human Services), periodically issue reports on patient safety and outcomes research they have funded.[36] The documented importance of nursing to high-quality care is evident throughout these studies and, with it, the necessity for effective nursing leadership at all levels of healthcare organizations.

Several areas of need for emotionally intelligent nursing leadership are especially prominent in the research literature: recruiting and retaining qualified staff and limiting stress, transfer, grievance, turnover attrition, and nurses leaving the profession; promoting positive work climates; promoting nurse

participation in decision making and enhancing power and control; improving nurse recognition, advancement opportunities, and lifelong learning; enhancing management responsiveness to and communication with nurses; and providing better administrative support for nursing activities. These areas of need are especially critical because of the shortage of nurses nationwide, the costs of turnover, and the disruptions in organizational effectiveness and patient care quality associated with unstable staffing.[37]

In spite of the common practice of promoting nonmanagement-prepared staff nurses into charge and leadership positions, the need for well-prepared managers is well established in the nursing literature. Nurse leaders make a significant difference in how nurses perceive and perform in their jobs. Repeatedly, effective behaviors and practices of nurse leaders have been found to influence work environments in innumerable ways, resulting in greater levels of staff nurse job satisfaction and organizational commitment.[38] With the proper infrastructural support,[39] exceptional nurse executive leadership, positively influences the entire climate of nursing work in an organization. And because nurse middle managers can "make or break" the care delivery process, there is growing evidence that well-run nursing units provide higher levels of care quality.

Nurse executives in any healthcare setting establish standards, provide resources, buffer staff nurses from the effects of ongoing uncertainties in the healthcare industry, lead with high expectations, and negotiate with other professional groups for control over nursing practice. Additionally, top-level emotionally intelligent nursing leadership is necessary to support the effective selection and development of nurse middle managers. In turn, nurse executives need support from their executive colleagues to create work environments that enable professional practice by nurses. Nationally, the strongest nursing organizations have tended to be those in which the chief executive officer understands and values nursing and "gets it" in regard to what is needed to maintain a strong base of nursing practice. He or she trusts and grants full authority to the nurse executive to run the nursing operation (**Figure 3-8**).

HOW TO DEVELOP YOUR EMOTIONAL COMPETENCIES

All emotional competencies can be learned and developed.[40] The core competencies—emotional self-awareness, accurate self-assessment, self-confidence, emotional self-control, and empathy—are fundamental and therefore the most important. A leader deficient in the core competencies will encounter difficulty mastering any of the remaining 13 competencies. In Figure 3-6 Victoria appears to have the competencies associated with self-awareness and self-management. She knows that she doesn't like the chief operating officer and his leadership style, is able to maintain self-control in his presence, and is confident of her abilities to run the nursing component of the home health agency. Her crucial mistake, however, is her lack of empathy for the chief operating officer. She didn't really know what motivated him or what was important to him, nor did she have any idea how he might be viewing her performance. It is likely that the chief operating officer, though not often present, had expectations that his direct reports would demonstrate attention and responsiveness to his communications, regardless of how important (or irrelevant) his direct reports believed those communications were. When Victoria ignored or deflected a good number of his e-mails and faxes, the chief operating officer probably found her behavior disrespectful, perhaps even offensive. As a result, he interpreted her behavior as resistant, aloof, and not innovative. Had Victoria been more aware of the chief operating officer's expectations and what his unique leadership behaviors meant to him, she could have been more astute in managing the politics with her boss. The competency of organizational awareness, which concerns one's political savvy at work, cannot be developed without first having the ability to empathize with the needs and feelings of other individuals and groups. Victoria used her own frame of reference to determine what was important in her job, giving little thought to what her chief operating officer viewed as important. She also let his relatively infrequent appearances on site lull her into a false sense of security.

FIGURE 3-8 Emotional Intelligence at Work

For nearly 30 years, until the managed care decade of the 1990s, the Beth Israel (BI) Hospital in Boston served as an icon for the empowerment of nursing. With its chief nurse executive, Joyce Clifford, working in a unique partnership with CEO physician Mitchell Rabkin, the BI helped to pioneer an innovative model of nursing care . . . . The hospital . . . employed an almost all registered nurse staff, hired only RNs with bachelor's degrees, and was committed to enhancing the collaboration between nurses and physicians and giving nurses a greater voice in their institution . . . . [T]hose nurses received institutional support from the highest levels . . . . [N]ursing care does not depend on the personal kindness or the moral virtuousness of the nurse. Instead it depends on education and experience and on the institutional support that nurses receive from the hospital in which they are employed . . . . Nurses there were among the most satisfied in the nation.[40]

Historically, Beth Israel had been one of the best hospitals in the world in which to practice as a nurse. Organizational features that both enhanced nurses' work satisfaction and improved patient outcomes included support for nurses' stature and representation in the hospital, control over the resources required to perform their work, autonomy in decisions about how to care for their patients, and teamwork and collegiality with physicians.[41] This did not happen by chance—all of its great accomplishments were voluntary creations constructed over years[42] by the collaborative relationship between the chief executive officer and chief nursing operator.

I interviewed Dr. Rabkin in 1992 as part of Beth Israel's participation in the program Strengthening Hospital Nursing, a national initiative funded by the Robert Wood Johnson Foundation and the Pew Charitable Trusts. His support for nursing and nurses was both seriously and humorously relayed through the following comments:

> There are very few places, I think, where other than by some dictatorial policy, nursing is deemed to be co-equal with medicine, surgery, etc. My argument is that nursing is a clinical service just like medicine and surgery, OB/GYN, and so on . . . . Hospitals—not this place alone—are nursing institutions primarily, not doctoring institutions. Now if you don't have a truly professional nursing service, [empowering nurses] is not going to work. You need two things: one, you need nurses who are smart, because doctors don't tolerate people as colleagues who are not as smart as they are. You need to have smart nurses. The other thing is that they have to be true colleagues, and that comes about not only in nurses' education but also with their image of themselves, the capacity to understand what nursing really is, and I see that here [at Beth Israel].
>
> In fact, there was a marvelous incident a number of years ago, with a head nurse who couldn't have weighed more than 90 pounds, and this was with a new resident on the orthopaedic service; these kids [residents] rotate through all of the Harvard hospitals. This one had spent some 6 months at [another hospital], and literally within 30 minutes of his arrival at BI, he had some floor nurse in tears. The head nurse manager asked him to come into her office, and she said to him, 'You're new here, you've been [at the other hospital] for 6 months, and I've got to tell you that the way we do things around here is rather different, and what you've done is completely unacceptable. This is the way we work here [and she went on to explain the co-equal role of nurses at BI]. This is your first day and I realize it and we're certainly going to give you time to learn.' Then this pipsqueak put her finger on this guy's chest—he's about 6'2"—and she said, 'If you do not learn, we will send you back to the minor leagues where you came from.' The guy got beet red, stormed out, and then went to see the senior orthopaedic surgeon, who said, 'Well, maybe you've got something to learn.' About 3 or 4 days later he came back and asked to speak to the head nurse in private. 'I have to apologize,' he said, 'I had no idea that nurses were so good and so confident, and so capable, I really had no idea at all.' So they [new residents] learn. They also learn from role modeling by the other physicians. It's not only the nurses standing up for themselves; the nurses know that the administration backs them up.[42]

Rabkin's story suggests many aspects of the BI culture that support nursing practice, but it also illustrates an emotional intelligence characteristic of "best bosses"—"handling" anyone who is abusive to nurses.

Developing emotional competencies first requires an awareness of areas of strength and weakness and then an identification of what the ideal behavior would be in a targeted area of weakness (**Figure 3-9**). The individual needs to assess honestly his or her motivation to change and willingness to practice new behaviors. From a feasibility standpoint, it is important to focus changes on just one or two competencies.

FIGURE 3-9 Steps to Developing Emotional Competencies[43]

1. Determine your behavioral goals.
   - Ground them in your assessment of your emotional strengths and weakness, and use feedback from others who know you well. Make sure you understand the gaps between your actual and your preferred "ideal" behavior.
   - Build on and engage your strengths.
   - Develop clear, manageable goals; have them reflect your personal vision for self-development.
   - Pick no more than one or two areas (competencies) at a time. Determine whether your plans for self-directed change will fit smoothly into your life: Are there day-to-day events that can be used as a learning laboratory?
   - Honestly assess your commitment to working on self-development.
2. Create a plan to reach your behavioral goals.
   - Select a coach and establish a verbal contract.
   - Identify and agree on the developmental priorities and behavioral indicators.
   - Identify how behavioral development will facilitate your career goals.
   - Identify opportunities for trials and action, using ways that fit your learning style.
   - Identify times and places for the coach (and any others you choose to involve) to observe you and provide feedback.
   - Identify role models you would like to emulate.
   - Understand that self-development will take time and sustained focus. It doesn't happen overnight!
3. Monitor your progress regularly.
   - Practice, practice, practice; use work and outside settings.
   - Tune in to behaviors you need to unlearn in order to learn new ones.
   - Meet and talk with your coach. Ask questions to help clarify issues.
   - Seek feedback from others as possible.
   - Identify in which situations it is easier or harder for you to improve.
   - Don't "slip" in other strength areas of emotional competency while you are focused on development in new areas; avoid relapses.
   - Do reading and thinking on your own behavior and developmental goals.
   - Keep a written record of thoughts, feedback, insights, difficulties, and successes.
   - Assess your continued commitment.
4. Celebrate successes.
   - Give yourself credit for evidence of developmental improvements; reinforce your growth.
   - Seek ways to further sharpen your developmental progress.
   - Assess your continued commitment to behavior change.

Source: Based on research conducted by Goleman, 1995, 1998a; Goleman et al., 2002; The Hay Group, 2004.

Behavior change is most effective when it connects to activities in the individual's work life that are most in need of and likely to show improvements. Many young and inexperienced nurses, for example, are uncomfortable approaching physicians with recommendations for changes in patient management. Reticence with physicians can be a good starting point for behavior change: more self-assertion leads to higher impact for both the nurse and his or her patients. Self-development in such a situation might focus on self-awareness (exactly what is the staff nurse afraid of?) and self-confidence (in which conversations is the nurse more or less secure?). Nurse managers who are uncomfortable standing up and addressing groups might choose to work on empathy (anticipate what the members of the group might be thinking and feeling) and self-confidence (plan the presentation thoroughly, rehearse with a peer, and actively seek responses from the group members during the presentation). Even minor successes in self-directed behavior change can be highly motivating for continuing development efforts.

Change in behaviors driven by emotional habits requires that as we practice new behaviors, we actively seek to unlearn the old behaviors. The old behaviors become a source of resistance and backsliding unless they are identified, acknowledged, and actively transformed. This kind of change depends on the ability to engage one's own emotions in order to change them. For example, use self-awareness to monitor how you are reacting emotionally to giving up an old habit (e.g., avoiding conflict) while trying a new one (asking conflicting parties to express their differences).

The engagement of an emotionally competent coach, mentor, or friend to aid self-development efforts is essential. We cannot change what we do not see or know, so external observation and feedback provides indispensable external data. A coach also enables the individual to learn by talking over the situation, exploring alternatives, and reflecting on behavioral options. Importantly, the coach can also function as a motivator, encouraging and holding the person accountable for his or her self-development plan.

Behavior change requires practice, typically sustained over weeks and months—often up to 6 months—to develop a new competency. With extended practice, reflection, reinforcement, and success, mastery is possible. Supplementary activities can facilitate behavior change: reading and studying about leadership or emotional intelligence, self-reflection (journals, discussion, reflective learning groups), experiential learning exercises, and measurement feedback.[41] Like athletic performance, developing proficiency requires ongoing cycles of practice–trial–feedback and correction.

Finally, even without intentional behavior change, there is evidence that humans intuitively develop emotional competencies with age and experience.[42,43]

SUMMARY

Throughout life we observe leaders and learn about what makes them proficient. A complex phenomenon, leadership occurs in all work settings and is enacted through countless individual behaviors. In this chapter, I focus on those aspects of leadership that involve relationships between leaders and other people—the "people" skills of leaders. Using a framework of emotional intelligence, I address the relevance of 18 emotional competencies to the successful intra- and interpersonal work lives of nurse leaders. Evidence is presented that emotionally competent organizational leadership raises the level of performance for everyone, improves staff engagement and work environments, and enhances the patient experience.

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