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Emotional Intelligence and Spiritual Well-Being

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ABSTRACT: *Understanding factors that influence spiritual well-being may improve nurses' spiritual caregiving. This study examined relationships between emotional intelligence (EI) and spiritual well-being (SWB) in undergraduate and graduate nursing students. Using the Mayer–Salovey–Caruso Emotional Intelligence Test (MSCEIT) and the Spiritual Well-Being Scale (SWBS), relationships were found between managing emotion and spiritual well-being, and managing emotion and existential well-being. Implications for education and practice are discussed.*

KEYWORDS: *emotional intelligence, MSCEIT, nursing students, spiritual care, spiritual well-being, SWBS*

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EMOTIONAL INTELLIGENCE AND SPIRITUAL WELL-BEING:

Implications for Spiritual Care

Many nurses indicate they are uncomfortable with spiritual care in the clinical setting. What factors are related to or might enhance nurses' spiritual caregiving? In the last decade, researchers have identified relationships between ability and ease with spiritual care, and nurses' spirituality, spiritual well-being, and emotional intelligence (Geula, 2004; Habib, Riaz, & Akram, 2012; Kaur, Singh, & Singh, 2012; King, Mara, & DeCicco, 2012; Pizarro & Salovey, 2002; Scheindlin, 2003; Tischler, Biberman, & McKeage, 2002). This study explores potential relationships between emotional intelligence and spiritual well-being in nursing students.

EMOTIONAL INTELLIGENCE AND SPIRITUAL WELL-BEING

The concept of emotional intelligence, first named by Salovey and Mayer (1990), was initially described as a group of interconnected abilities that assist with processing of information about emotions as a guide to cognition and behavior (Mayer, Salovey, & Caruso, 2008). Salovey and Mayer later revised their model, defining emotional intelligence as the capacity to reason with emotion in four areas: perceive emotion, integrate emotion in to thoughts, understand emotion, and manage emotion (Mayer & Salovey, 1997).

Emotional intelligence gained the public attention in the mid-90s when the book *Emotional Intelligence* was released (Goleman, 1995). Goleman conceived emotional intelligence to be a mixed model that included social behaviors, traits, and competencies. Goleman broadened the definition of emotional intelligence as the ability to identify the feelings of self and others, to motivate oneself, and to adequately manage one's emotions as well as the emotions in relationships (Goleman, 1998).

Spiritual well-being implies the existence of an emotional relationship with God (Geula, 2004). Emotional relationship may be linked to emotional intelligence as relationship requires the ability to appreciate the feelings of others, to develop and maintain interpersonal relationships, and

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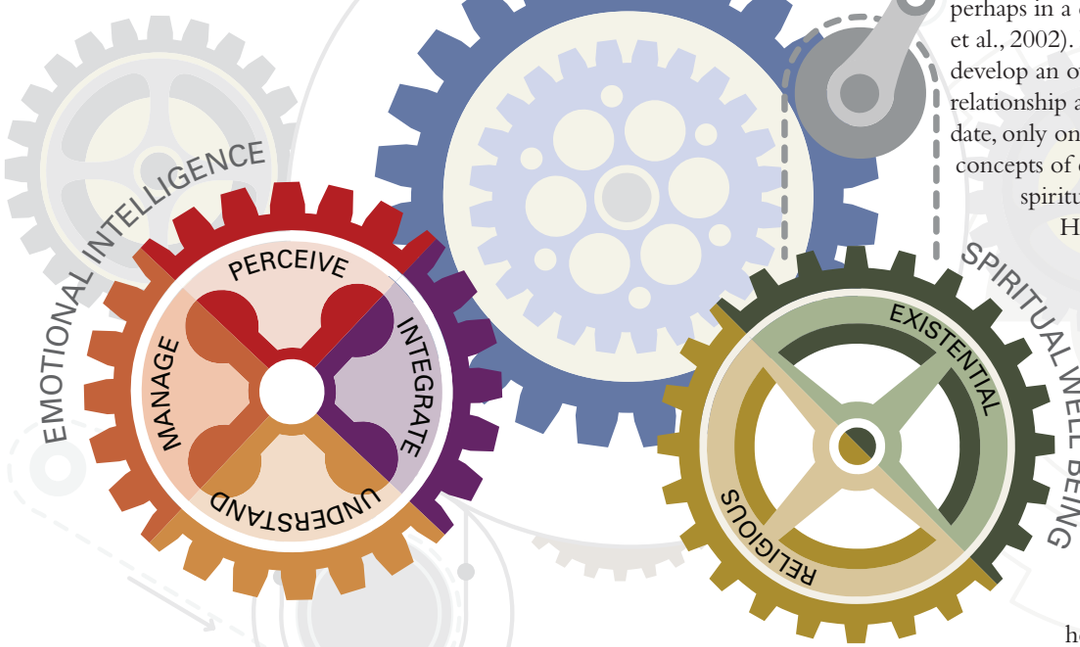

to empathize as well as foster a sense of social responsibility (Kaur et al., 2012). In particular, certain emotional intelligence abilities are seen as a general mechanism that serves a critical role in spiritual well-being (Pizarro & Salovey, 2002; Scheindlin, 2003; Tischler et al., 2002). The two emotional intelligence abilities identified as key components in spiritual well-being are *empathy and regulation of emotion*.

Salovey and Mayer (1990) identified the significant role of empathy in emotional intelligence as empathy is an essential factor in the assessment of others' emotion (King et al., 2012). They defined empathy as the capacity to understand another's emotions and to feel those feelings in oneself. Being mindful of one's thoughts and feelings and developing empathy have likewise been noted as an integral part of spiritual well-being (Vaughn, 2002). Empathy may be a product of spiritual well-being and self-transcendence (King et al., 2012). Vaughn suggests that developing empathy is an important part of developing one's inner spiritual life, essentially connecting the emotional and spiritual skill sets. Spiritual well-being relies on the ability to see things from different perspectives and to understand the connection between perception, belief, and behavior (Vaughn, 2002).

Emotional regulation is at the core of positive personal growth and development, education, self-discipline, self-mastery, and development of divine-like qualities (Guela, 2004). Pizarro and Salovey (2002) suggest that one can increase the ability to engage in effective emotional regulation through religious belief and participation, which in turn may influence one's spiritual well-being. Individuals with spiritual well-being may have better access to structured outlets such as confession, sharing troubles with clergy, or pastoral counseling for emotional disclosure and help with emotional regulation. In addition, they may be involved in practices such as prayer, meditation, and rituals like morning devotions that change the intensity of emotions and permit regulation of feelings (Guela, 2004; Pizarro & Salovey, 2002).

EI AND *SWB* LINKAGES

Emotional intelligence and spiritual well-being appear to aid in the development of similar competencies but perhaps in a different manner (Tischler et al., 2002). It might be helpful to develop an overall understanding of the relationship among these factors. To date, only one study has examined the concepts of emotional intelligence and spiritual well-being together. Habib et al. (2012) found that spiritual wellness mediated the relationship between emotional intelligence and life satisfaction among nurses. One additional study by Hooda, Sharma, and Yadava (2011) examined the relationship between emotional intelligence and spiritual health (not spiritual well-being) among 300 adults and reported a significant correlation between spiritual health and several components of emotional intelligence.

The purpose of this study was to examine relationships between emotional intelligence and spiritual well-being in nursing students. A nurse's spiritual well-being has been linked to his or her ability to care for a patient's spiritual needs (Stranahan, 2001; Tiew & Creedy, 2010); thus, understanding factors that influence spiritual well-being has the potential to improve nurses' spiritual caregiving.

EI AND *SWB* IN NURSING STUDENTS

Utilizing a descriptive correlational design, a convenience sample of undergraduate and graduate students was recruited from all nursing students enrolled at a New England Catholic university. At the time of the study the university had 244 undergraduate, 272 graduate, and 516 total students enrolled in nursing programs. Power analysis revealed that 109 subjects were needed to assess for correlations between emotional intelligence and spiritual well-being (Faul, Erdfelder, Buchner, & Lang, 2009).

The Mayer–Salovey–Caruso Emotional Intelligence Test (MSCEIT), the Spiritual Well-Being Scale (SWBS), and a background data sheet were used to assess participants' emotional intelligence, spiritual well-being, and demographic characteristics.

The MSCEIT is an ability-based measure of emotional intelligence containing 141 items and takes about 30 to 40 minutes to complete. The MSCEIT evaluates total and four branches of emotional intelligence: perceiving emotions (correctly identify how people are feeling), utilizing emotions to aid thought (create emotions, integrate feelings into the way you think), understanding emotions (understand the causes of emotion), and managing emotions (determine effective strategies that use emotions to help achieve goals rather than being used/controlled by emotions) (Caruso, 2009; Mayer, Salovey, & Caruso, 2002; Mayer, Salovey, Caruso, & Sitarenios, 2003). MSCEIT scores are reported on a scale that suggests level of emotional skill. A recommendation is made to: develop an emotional skill (0 to <70), consider developing a skill (70 to <90), one is competent in the skill (90 to <110), highly skilled (110 to <130), or one shows expert performance in a skill (>130). So one might be competent in perceiving emotions, be recommended to consider developing their skill to use emotions in thinking, be competent in understanding emotions, and skilled in managing emotions (Caruso, 2009). Validity and reliability of the MSCEIT have been confirmed by prior research (Brackett & Mayer, 2003; Mayer, Salovey, & Caruso, 2000).

The SWBS is a self-administered tool containing 20 six-point Likert rating scale items and takes 10 to 15 minutes to complete. The SWBS evaluates overall perceived spiritual well-being as well as two dimensions of spirituality: religious well-being (RWB; 10 items) and existential well-being (EWB; 10 items) (Ellison, 1983; Paloutzian & Ellison, 1982). The RWB subscale provides a self-assessment of the person's relationship with God or a higher power and the EWB subscale provides a self-assessment of the person's sense of life purpose and satisfaction with life. The SWBS items are nonsectarian and can be utilized with people from a wide range of backgrounds and beliefs (Ellison, 1983; Life Advance, 2009). Scores on the SWBS can range from 20 to 120 and on the RWB and EBW from 10 to 60, where lower scores represent lower spiritual, religious, and existential well-being and higher scores represent higher well-being.

Background demographic data collected from participants included age, gender, marital status, ethnicity, religious preference, nursing program (undergraduate or graduate), and current grade point average. All demographic data were self-reported by participants.

After Institutional Review Board (IRB) approval from the university, email distribution lists for all nursing students were obtained. An IRB-approved invitational email was sent to students requesting their participation and providing the web link to the study. Faculty members were requested to make an announcement about the study in their classes. Participants were notified that the researchers were faculty members and told no names or distinguishing information would be collected that could connect them to the answers they supplied. Data collection occurred over a 2-month period.

After reading the email invitation, interested students clicked on an enclosed link that directed them to the study website where a consent form was displayed. Potential subjects were instructed that they needed to be 18 years of age and to read the information carefully. Only after a participant provided consent were they permitted to complete the demographic information, the SWBS, and submit their responses. The demographic survey and the SWBS were provided on SurveyMonkey™.

After participants submitted their demographic information and completed the SWBS, they were immediately given a web link to access the MSCEIT on the publisher's website. The last four digits of the students' social security number were utilized to link the databases.

ANALYSIS OF RESPONSES

The MSCEIT was scored by its publisher Multi-Health Systems Inc. (MHS). MHS provided a report with raw data and standard scores in an Excel spreadsheet, which were downloaded into the PASW Statistics 18 program (Predictive Analysis Software) (SPSS Inc., 2009). The raw data remained at MHS except for the spreadsheet that was sent to the researcher. SurveyMonkey™ results were downloaded in raw and summary forms in Excel format and downloaded into PASW Statistics 18. MHS did not have access to the demographic or SWBS data. Descriptive statistics and Pearson correlation coefficients were computed using PASW Statistics 18.

One hundred and eighty-six of the school's 516 undergraduate and graduate nursing students (36%) responded to the first website survey. The final response rate decreased as 44 students did not go on to complete the second website and 18 either did not follow proper coding procedures or had duplicative last four-digit social security numbers so that their data could not be confidently matched. The final sample consisted of 124 nursing students (N = 124, 24% response rate).

A total of 73 undergraduate students and 50 graduate students participated

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in the study. The mean self-reported grade point average reported was 3.52 on a 4.0 scale. Demographic characteristics for the sample are presented in Table 1.

The mean total score (scaled) for the 124 participants on the MSCEIT measure of emotional intelligence was 95.75 (*SD* ± 12.61, range 59–120) suggesting moderate emotional intelligence in the competent range. The mean MSCEIT Branch 1 score that relates to perceiving emotion was 99.23 (*SD* ± 15.291, range 67–132). Branch 2 that relates to using emotion had a mean score of 94.12 (*SD* ± 14.857, range 36–128). The mean score for Branch 3 that relates to understanding emotion was 96.67 (*SD* ± 9.984, range 53–115). The Branch 4 mean score that relates to managing emotion was 95.84 (*SD* ± 12.105, range 55–115).

The mean SWBS score for the participants (*N* = 124) was 91.08 (*SD* ± 16.94) indicating a sense of moderate spiritual well-being. The mean RWB score was 41.23 (*SD* ± 12.105) indicating moderate religious well-being. The mean EWB score was 49.85 (*SD* ± 7.007) indicating a moderate existential well-being.

Total emotional intelligence was not significantly correlated with total spiritual well-being. Relationships between emotional intelligence branch scores and the SWBS scores were examined. Branch 4 (managing emotion) score had a weak but statistically significant correlation with total SWB, r (122) = .191, p = .034. The other branch scores were not significantly correlated with total SWB. These results are presented in Table 2. The relationship between emotional intelligence branch scores and the SWB subscales RWB and EWB were identified. The Branch 4 (managing emotion) score had a moderate but statistically significant correlation with EWB, r (122) = .308, p = .000 (see Table 3).

TABLE 1: *Demographic Characteristics of Participants*

CHARACTERISTIC	*n*	% of Sample (*N* = 124)	# of Students Enrolled	% of Students Enrolled
TOTAL: (*N* = 124)			**516**	**24%**
GENDER:				
Female	120	97%		
Male	4	3%		
AGE:				
Range = 18–59 years Mean = 30 years, *SD* 12.5 Between 18 and 30 years	80	65%		
MARITAL STATUS:				
Single	80	65%		
Married	36	29%		
Divorced	6	5%		
Widowed	1	1%		
Not identified	1	1%		
RACE:				
Caucasian	109	88%		
Asian	1	1%		
Hispanic/Latino	5	4%		
African American	8	7%		
Hawaiian/Pacific Islander	1	1%		
RELIGIOUS PREFERENCE				
Catholic	80	65%		
Protestant	10	8%		
Jewish	2	2%		
Christian	10	8%		
Nondenominational	10	8%		
Other	12	10%		
UNDERGRADUATE STUDENTS:	**73**	**59%**	**244**	**30%**
Sophomores	5	4%	60	8%
Juniors	39	32%	51	76%
Seniors	26	21%	58	45%
RN to BSN	3	2%	75	4%
GRADUATE STUDENTS:	**50**	**41%**	**272**	**18%**
Family Nurse Practitioner	13	11%	96	14%
Patient Care Service Admin.	10	8%	37	27%
Clinical Nurse Leader	7	6%	60	12%
Education	6	5%	36	17%
Doctor of Nursing Practice	14	11%	43	33%

MANAGING EMOTIONS AND *SWB*

Study results reveal that EWB and overall SWB were significantly correlated with managing emotions in the sample of nursing students. This finding was not unexpected as it supports the theory that the emotional intelligence ability of managing emotion can be seen as a general mechanism that serves a role in spiritual well-being. This correlation does not necessarily support empathy as a key component in SWB. However, this is logical as empathy is not clearly delineated in the four-branch ability-based model of emotional intelligence.

The significant relationship between emotional intelligence (Branch 4 managing emotions) and spiritual and existential well-being in this study supports statements in the literature that spirituality is related to both emotions and the rational application of those emotions (Scheindlin, 2003). These results may support Hooda et al.'s (2011) findings of a positive relationship between emotional intelligence and spiritual health, which is related to spiritual well-being.

TABLE 2: *Correlations Between Emotional Intelligence and Total Spiritual Well-Being (SWB) Scores (N = 124)*

	Total Spiritual Well-Being
Emotional Intelligence Total	**0.092**
Branch 1 perceiving emotion	0.015
Branch 2 using emotion	0.115
Branch 3 understanding emotion	0.110
Branch 4 managing emotion	0.191*

*Correlation is significant at the 0.05 level (two tailed).

TABLE 3: *Correlations Between Emotional Intelligence and Existential Well-Being (EWB) Scores (N = 124)*

	Existential Well-Being
Emotional Intelligence Total	**0.165**
Branch 1 perceiving emotion	0.087
Branch 2 using emotion	0.093
Branch 3 understanding emotion	-0.035
Branch 4 managing emotion	0.308*

*Correlation is significant at the 0.05 level (two tailed).

Several limitations of this study should be noted and the findings cautiously generalized. Participants may not have been reflective of student nurses in general. Furthermore, the study was set in a private Catholic university, which is not reflective of the settings of all nursing programs and may have affected the spiritual well-being scores. A Catholic university may offer spiritual support differently than a nonreligiously affiliated university. Similarly, nursing students who feel a spiritual bond may be more apt to attend a religiously affiliated university. An additional limitation is related to the self-reporting, which can be subject to bias. Finally, a procedural limitation involved the mandate for participants to visit two websites to complete the study, which may have adversely affected the response rate.

SIGNIFICANCE TO NURSING

Before nurses can tend to their patient's spirituality, they need to be aware of their own spiritual beliefs and have some sense of spiritual well-being (Carson, 2013). Spiritual well-being includes acquiring and fostering life-affirming connections with other people and a relationship with God or a higher power (McEwen, 2005). Essential to the concept of spiritual well-being is that humans need to concentrate on something that transcends them, which in turn will help support the notion that life has meaning (McEwen, 2005; Paloutzian, 2002). Individuals who concentrate solely on their own needs tend to lose themselves in the process (Paloutzian, 2002). On the other hand, individuals who focus on goals and values derived from God or a higher power will transcend themselves thereby finding themselves (Paloutzian, 2002). This is referred to as the need for transcendence (Ellison, 1983). Spiritual well-being involves the following characteristics: a belief in a higher power, the desire for meaningful connections, inner peace, self-determination, adequate support systems, an admiration of nature, and a feeling of connectedness with others and the universe (McEwen, 2005; Peri, 1995).

For example, a study by Stranahan (2001) examined the relationships between spiritual perceptions, attitudes concerning spiritual care, and spiritual care practices in nurse practitioners. The results support that a nurse's spiritual perception is associated with spiritual care practices (Stranahan, 2001). According to Cerra and Fitzpatrick (2008), there is a need for nurses to better comprehend their spirituality and to be mindful of their rapport with patients regarding their spiritual care. Furthermore, nurses cognizant of their own spirituality tend to be more receptive and inclined to engage at an individual level with their patients.

Despite spiritual well-being's connection with the spiritual care practices of nurses, many nurses indicate that they do not feel competent to deliver spiritual care (Newbanks & Rieg, 2011; Pesut, 2002; Stranahan, 2001; Taylor, 2005; Tiew & Creedy, 2010). Some scholars indicate that nurses' uneasiness regarding spiritual care may be related to minimal coverage of spirituality in nursing education curriculum (Cerra & Fitzpatrick, 2008; Wallace et al., 2008). Fortunately, when educators make a concerted effort to integrate spiritual content into the curriculum (So & Shin, 2011; Wallace et al., 2008) as well as when hospital educators provide in-service programs (Cerra & Fitzpatrick, 2008), there has been a positive effect on nurses' spiritual perspective, knowledge, and attitudes. This is hopeful as it supports the notion that spiritual well-being can change with education.

Education that can enhance nurses' spiritual well-being and the ability to provide spiritual care could be incorporated into the curriculum via teaching strategies that utilize emotional intelligence abilities. As noted, the teaching of spirituality and spiritual well-being relies heavily on emotions, which serve as a basis of awareness and connection with the world (Scheindlin, 2003). In fact, it is feelings, not cognition, that creates awareness of the moral and spiritual dimensions of life (Scheindlin, 2003). Capitalizing on the emotional dimension may help improve the way nurses are

educated about spirituality and may promote their spiritual well-being. Many of the teaching strategies noted in the literature involve an emotional component such as faculty acting as role models for students (Gallia, 1996), offering spiritual experiences that students can reflect and act upon (Wallace et al., 2008), utilizing case studies, and using targeted assessment tools (Brush & Daly, 2000). Providing spiritual care experiences that allow students to spend time in active conversation with patients allowing them to observe their emotions, attitudes, and behavior can allow the students to experience empathy with patients that can be rewarding (Koh, 2003; So & Shin, 2011). Fostering listening skills and self-reflection on their thoughts and emotions has been identified as a powerful tool in spiritual education (Como, 2007; Stephenson & Wilson, 2004; Taylor, 2005). Pesut (2008) recommends that when educating students about spirituality and spiritual well-being, instructors should make clear connections to other parts of the curriculum that promote the therapeutic use of self. Therapeutic use of self involves emotional intelligence abilities to promote both personal reflection and social interaction. Appreciating that the relationship skills which are the foundation of all nursing practice are the identical skills needed for spiritual well-being, and spiritual care might help counterbalance some of the feelings of incompetence in this area (Pesut, 2008).

CONCLUSION

Much can be learned by understanding spiritual well-being as an effective source of transmission of emotional skills (Pizarro & Salovey, 2002), as well as how emotional intelligence abilities can aid in one's spiritual well-being. Emotional intelligence may enhance spiritual development, well-being, and education as emotions are a basis of awareness and engagement within humanity. Research is needed to examine if strategies to enhance emotional intelligence can facilitate the process of increasing spiritual well-being with a test-retest design. Emotional intelligence and spiritual well-being ought to be examined in relationship to other outcome measures such as student performance, workplace performance, resilience, empowerment, and health benefits.

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