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Impact of emotional intelligence and spiritual intelligence on the caring behavior of nurses: a dimension-level exploratory study among public hospitals in Malaysia

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ABSTRACT

Purpose: The purpose of this research is to study the impact of individual factors such as emotional intelligence (EI) and spiritual intelligence (SI) on the caring behavior of nurses.
Methods: A cross-sectional survey using questionnaire was conducted by sampling 550 nurses working in seven major public hospitals in Malaysia. Data were analyzed using structural equation modeling (SEM).
Results: The main findings are: (1) critical existential thinking and transcendental awareness dimensions of SI have significant impacts on assurance of human presence dimension of caring behavior; (2) personal meaning production and conscious state expansion dimensions of SI have significant impacts on perception of emotion and managing own emotions dimensions of EI; and (3) managing own emotions dimension of EI has significant impacts on respectful deference to other and assurance of human presence dimensions of caring behavior of nurses.
Conclusion: The results can be used to recruit and educate nurses.

1. Introduction

Nurses are among one of the largest groups of health care providers. As pivotal figures in patient care who interact with patients more frequently than other health care providers, nurses have a major caring role (Khademian & Vizeshfar, 2008). Nurses spend more time with hospitalized patients than do other groups of health care providers and therefore have a significant impact on patients' perceptions about their hospital experience. They are present 24 hours a day, 7 days a week regardless of the physical setting in a hospital (Nussbaum, 2003). Therefore, caring behavior of nurses contributes to the patients' satisfaction, well-being and subsequently to the performance of the healthcare organizations.

Literature suggests that (1) antecedents of caring behavior have not been identified and investigated extensively (Kaur, Sambasivan, & Kumar, 2013; Rego, Godinho, McQueen, & Cunha, 2010) and (2) individual factors have a telling effect on the work outcomes (Kaur et al., 2013). This study considers emotional intelligence (EI) and spiritual intelligence (SI) as two important individual factors that affect caring behavior of nurses. Greenhalgh, Vanhanen, and Kyngas (1998) defines caring behaviors as "acts, conduct and mannerisms enacted by professional nurses that convey concern, safety and attention to the patient" (p. 928). The dimensions of caring behavior are: (i) respectful deference to other (RDO), (ii) assurance of human presence (AHP), (iii) positive connectedness (PC), and (iv) professional skill and knowledge (PSK) (Wu, Larrabee, & Putman, 2006).

Emotional intelligence is a key component of competent nursing practice (Akerjordet & Severinsson, 2007; Warelow & Edward, 2007) and it enables a nurse to think and function in a constructive and rational way in the clinical setting (Akerjordet & Severinsson, 2007; Kaur et al., 2013). Sumner and Townsend-Rocchiccioli (2003) have asserted that the ability to effectively manage one's own and others' emotions is critical to the provision of excellent patient care. Therefore, EI can have a significant impact on the caring behaviors of nurses. Despite the theoretical support, empirical studies that link the concept of EI and caring behaviors are scarce (Akerjordet & Severinsson, 2007; Kaur et al., 2013; Rego et al., 2010).

Spirituality is seen as an inherent aspect of human nature and is considered as the source of all thoughts, feelings, values and behaviors of individuals (Hosseini, Elias, Krauss, & Aishah, 2010). The concept of spirituality is important and forms the basis of nursing actions (Van Leeuwen & Cusveller, 2004). However, very few empirical studies have provided supporting evidence that spirituality is correlated with the caring behaviors of nurses (Kaur et al., 2013). In this research, SI is defined as "as a set of mental capacities which contribute to the awareness, integration, and adaptive application of the nonmaterial and transcendent aspects of one's existence, leading to such outcomes

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as deep existential reflection, enhancement of meaning, recognition of a transcendent self, and mastery of spiritual states" (King & DeCicco, 2009: p. 69).

The contributions of this research are twofold. First, this study extends existing research about EI and SI and is one of the very few studies that empirically examine the influence of dimensions of SI on the dimensions of EI. The results can enrich the theories related to EI and SI. An earlier study by Rego et al. (2010) has studied the impact of dimensions of EI on caring behavior of nurses. A recent study by Kaur et al. (2013) has studied the impact of SI, EI, burnout, and psychological ownership on the caring behavior of nurses. However, the authors have studied the relationships at the construct level. This research analyzes (1) the impact of the dimensions of EI and SI on the dimensions of caring behavior of nurses and (2) inter-relationships between the dimensions of EI and SI. Second, this research has been carried out in a fast developing country in South-east Asia, Malaysia. Specifically, the samples were taken from seven large public hospitals. Studies from this part of the world are a rarity.

2. Hypotheses development

2.1. SI and EI

Many researchers have argued SI as a core ability that penetrates into and guides other abilities (Ronel, 2008). Specifically, some authors have asserted that SI influences EI (Hosseini et al., 2010; Zohar & Marshall, 2000). The four dimensions of SI (King & DeCicco, 2009) are: (i) critical existential thinking (CET), (ii) personal meaning production (PMP), (iii) transcendental awareness (TA), and (iv) conscious state expansion (CSE). The four dimensions of EI (Schutte et al., 1998) are: (i) perception of emotion (PE), (ii) managing one's own emotions (ME), (iii) managing other's emotions (MOE), and (iv) utilization of emotion (UE). Based on the definitions by King and DeCicco (2009: p. 70), it is argued that CET (capacity to critically contemplate meaning, purpose and existential issues), PMP (ability to construct personal meaning and purpose in all experiences), TA (capacity to perceive transcendent dimensions of the self, others and of the physical world) and CSE (ability to enter spiritual states of consciousness at one's own discretion) help nurses understand and manage their own and other's emotions and utilize them in a manner that benefits the patients. Therefore, the hypothesis is as follows:

H1. SI and its dimensions have positive relationships with EI and its dimensions

2.2. SI and caring behavior of nurses

According to Kaur et al. (2013), spirituality and nursing "have been linked since the origins of the nursing profession" (p. 3194). The nature of nursing profession is such that the nurses are constantly bombarded by stressors at work and the environment. When stressors are at work it has been shown that the dimensions of SI can help reduce the negative impact of the stressors (King & DeCicco, 2009). This in turn helps nurses provide better care to the patients. Therefore, it is argued that SI and its dimensions have a positive impact on the caring behavior of nurses and the hypothesis is as follows:

H2. SI and its dimensions have positive relationships with caring behavior of nurses and its dimensions.

2.3. EI and caring behavior of nurses

According to Rego et al. (2010), researchers have suggested that "EI is crucial for building, nourishing, and sustaining the emotionally demanding labor that nurses are required to carry out in their interactions with patients" (p. 1421). Therefore, nurses with high levels of EI can provide better care to the patients (Akerjordet & Severinsson, 2007). These arguments lead to the following hypothesis:

H3. EI and its dimensions have positive relationships with caring behavior of nurses and its dimensions.

3. Method

Seven large public hospitals located in and around Kuala Lumpur, capital of Malaysia were chosen for the study. These hospitals have a total capacity of 6194 beds and employed 7446 nurses in different departments such as general surgical, general medical, pediatrics, obstetrics and gynecology, and orthopedics. A questionnaire was designed that captured the demographic characteristics of nurses, three constructs (SI, EI, and caring behavior of nurses) and their dimensions. A sample of 550 was selected at random from the seven public hospitals in different departments and the questionnaires were distributed through head nurses.

The permission to conduct the study was obtained from the Ethics and Research Committee of Ministry of Health (Malaysia) to conduct the study. The letter from the ministry helped the researchers gain access to the hospitals. The nurses were told that they were under no obligation to participate in the study and they contributed to the study of their own volition.

3.1. Measures

The questionnaire designed for the study consisted of four sections to capture the three constructs and the demographic information. The questionnaire items were made available in English and Bahasa Malaysia (national language of Malaysia). The back-to-back translations were checked by the experts and subsequently by the Ethics and Research Committee of Ministry of Health. Section One captured EI, and the scale with 33 items developed by Schutte et al. (1998) [Schutte Self-Report Emotional Intelligence Test (SSEIT)] was adopted in this study. Section Two captured SI, and the scale with 24 items developed by King and DeCicco (2009) [Spiritual Intelligence Self-Report Inventory (SISRI)] was adopted in this study. Section Three captured caring behaviors of nurses, and the scale with 24 items developed by Wu et al. (2006) was adopted in this research. Section Four captured the demographic data. Besides, this study also captured the patient satisfaction with overall nursing care to validate the findings on the nurses' own perception of their caring behaviors. This scale contained three items and was adopted from the study by Otani, Waterman, Faulknew, Boslaugh, and Dunagan (2010). Written permissions were obtained from all the authors before using their scales.

3.2. Handling common method bias

According to Podsakoff, MacKenzie, Lee, and Podsakoff (2003), common method bias is the bias that is "attributable to the measurement method rather than to the constructs the measures represent" (p. 879). Our research obtained responses on SI, EI and caring behavior from one source, namely nurses. Seeking responses from one source can potentially introduce error in the form of bias in our results (Conway & Lance, 2010). Therefore, we used Herman one-factor method to assess if common method bias is a cause of concern in our research. We loaded all the items (33 items of EI, 24 items of SI, and 24 items of caring behavior) on a common factor using Exploratory Factor Analysis and observed that the total variance explained was 18.4%. This is less than the maximum 50% suggested by Podsakoff et al. (2003) and therefore, we conclude that the effect due to common method bias is not significant.