


Developing Capabilities From the Scope of Emotional Intelligence as Part of the Soft Skills Needed in the Long-Term Care Sector: Presentation of Pilot Study and Training Methodology

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Abstract

The article presents the results of the preliminary survey and pilot application of the methodological toolkit for the improvement of certain competencies, which are part of the soft skills of professionals in the long-term care sector in Bulgaria. Based on the survey the authors define 2 target competencies, namely conflict management and empathic interaction. These skills are considered a part of the scope of emotional intelligence and its constituent dimensions and authors use Daniel Goleman's ability-based model as a base for their conceptual frame and theoretical explanations. In order to present their thesis, the authors perform a soft skill analysis of the long-term care sector; define the construct emotional intelligence and justify their choice of a theoretical model for the subsequent survey. On this basis, they develop a training design for the development of these skills and present the results achieved through its pilot application. The study includes 62 participants randomly divided into a test and control groups. The level of targeted skills is measured (before and after) and the authors report a significant increase in those skills (empathic interaction, net effect 1.87; conflict management, net effect 1.75). In conclusion, the authors open a discussion on the importance of emotional management as an essential part of any profession related to health care and underline its importance for the quality of caregiving services.

Keywords

long-term care, competence model, soft skills, emotional intelligence, empathy, conflict management, developing professional abilities/skills

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Introduction

One of the most apparent challenges in the long-term care sector is the provision of trained staff who can deliver quality customer care services. To date, the training of professionals in the sector has been focused almost entirely on hard skills, those competencies used in patient care, which are specific to the practice and are rooted in science such as medicine and gerontology. These skills are vital to improving the health and physical performance of patients, but insufficient in terms of an improvement in quality of life and patient/relative satisfaction.¹ In actual fact, the poor quality of service in this sector is not so much due to a lack of hard skills, but more often to a deficiency in the development of soft skills. Indeed, it is difficult to define or

measure the human faculties we call soft skills, which caregiving professionals must enhance in order to interact with patients and their loved ones. The enrichment of soft skills will go a long way to achieving the “caregiving environment” which we are familiar with from the specialized literature. The need for soft skills is considerably more than merely giving information about health status or explaining medical procedure. Soft skills include the ability of

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professionals to be patient, to manage conflicts, to show empathy, and so on. But the truth is that these skills are either not studied, or at best remain in the periphery of the training that prepares specialists to work with patients. The increasing awareness of the need for such skills provokes a number of authors to search for answers within the popular concept of emotional intelligence. To date, we are witnessing more and more efforts to relate certain skills of emotional intelligence to patient satisfaction,² physical and psychological well-being,³ and last but not least the level of work performance of health care professionals.⁴ From our perspective, advancement in soft skills will yield the most when we focus on skills directly related to emotionality which are part of the scope of Emotional Intelligence. In this article, we represent our point of view that they are the ones that play a key role in building a caregiver-patient relationship.

Main Soft Competencies in the Sector of Long-Term Care

In order to define the competencies that comprise the soft skills matrix of professionals in the long-term care sector, we conducted research and analyzed different sources of information.⁵⁻⁷

According to this studies the long-term caregivers are able to provide the highest level of care when they have the soft skills needed to cooperate effectively with the patient, his or her relatives, and other health care professionals (attending physician, general practitioner, rehabilitator, social worker, etc). These skills are vital for the recovery of patients in physiological and social terms. And as much as there is agreement about the role and importance of soft skills in patient care, there are quite different opinions as to what the main competencies are.

According to a list of nursing competencies presented by Zhi-Xue Zhang, the main soft skills vary from interpersonal understanding and commitment to information gathering and self-control, to responsiveness and critical thinking.⁸

Other authors add empathy to the list, as they claim that patients increasingly define the ability to “put ourselves in others’ shoes” as a leading factor in patient care, both in domestic and institutional settings.⁹⁻¹¹

A third group of authors focuses on the importance of conflict management and stress management skills and underline the importance of those skill for maintaining relationships with the patient and his family.¹²⁻¹⁴

After a detailed analysis of the aforementioned and other literary sources, we found that the list of soft skills is very long. This made it practically difficult to apply it as a starting point for improvement initiatives targeting a specific set of behaviors—the ones that influence the patient’s psychological sense of care the most. Thus emerged the need, before moving on to the development of soft skills,

to conduct an initial study to identify those competencies that are perceived as most important for consumers in Bulgaria. The logic behind that was that by narrowing the scope of these abilities and bringing them down to a few, we would be able to customize the methodology through which those few key skills could be developed with priority. In order to execute that, we created a questionnaire consisting of 12 questions, asking to prioritize the importance of different soft skills (Appendix 1). Before using it with a group of 64 randomly chosen patients, we conducted 2 rounds of validation (feasibility). The first round with a group of health care professionals and the second one with patients and family members. Although the purpose of the questionnaire was not to generate accurate statistics on patients’ attitudes, the results from it helped us navigate and select those two competencies that were identified by them as the most significant.

The survey results show that there are 2 skills of primary significance. First, the ability to de-escalate conflicts, and Second, empathy and compassion. These 2 competencies are strongly related to emotional intelligence and as a key finding of the survey, they formed the goal of the following training activities. A goal that was redirected from learning soft skills, as it was initially planned, toward an increase of emotional intelligence and its constituent dimensions.

Emotional Intelligence: Definition of the Concept, Justification of a Conceptual Model

Perhaps few people know that the words emotional and intelligence first appeared together as a collocation in a scholarly text as long ago as 1964. Then Michael Beldoch¹⁵ used the collocation to describe the ability of people to communicate their own emotions. Despite being a little-known reality today, most people are at least aware of the fact that there is such a concept. Daniel Goleman, who published his book *Emotional Intelligence*¹⁶ in 1996, is largely responsible for raising public awareness.

With this seminal work, he was the precursor for the wave of publications and studies which followed, focusing on intelligent emotion, its essence, scope, and application in different spheres of human life.

Since then, there can barely be a specialist working in any aspect of science related to human behavior who is not familiar with the term emotional intelligence.

However, in order to refine what we mean by emotional intelligence, and also to avoid the ambiguity resulting from the numerous models conceptualizing the construct, we should make the effort in this article to formulate a theoretical model and provide a definition.

After examining the numerous models that have attempted a theory of emotional intelligence, we have chosen the model created by Daniel Goleman (the ability-based model). Of the foremost reasons for our choice was the conceptual framework

created by the author, who views emotional intelligence as a constellation of different abilities, similar to the way in which competency models are an interconnection of certain skills. This is not the case for other theoretical models in which the characteristics of emotional intelligence are regarded as personal traits, that is, as persistent personal characteristics of the individual.¹⁷ Moreover, the arrangement of these abilities in the theoretical framework presented by Goleman corresponded to a great extent with the soft skills constituting the competence model of long-term care used in the Republic of Bulgaria. These skills are presented as parts of relatively independent domains, which is not the case in other theoretical models, and in a number of abilities are organized hierarchically.¹⁸ Finally, as the most important factor in choosing the ability based model, we should highlight the findings made after analyzing the result from the survey and the soft skill areas that are identified as the most important for the patients.

In terms of defining the term we have dealt with the definition given by Goleman, which states that emotional intelligence is *The capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships.*¹⁹

The Goleman model presents emotional intelligence as a constellation of different abilities that are divided into 2 major domains. The first is the domain of *personal skills* (how we manage ourselves). This largely consists of 3 dimensions: self-awareness; self-regulation; motivation. According to Goleman, these abilities are associated with the way the individual manages and masters his own emotions.

The second domain, which is more important in the context of our goals and tasks, is that of *social skills* (how we manage our relationships). Social skills can be analyzed by observing the manner in which individuals interact on an emotional level with others. As we know this is the essence of relationship management. This domain includes

1. Empathy, which is examined by several different aspects covering both the affective and the cognitive part of the skill
2. Social skills, that include the ability to build relationships, influence communication, and perhaps most important, conflict management and conflict resolution.²⁰

When creating his model of emotional intelligence, Goleman emphasizes that for each profession especially those which engage with people, the abilities listed at 1 and 2 are of the utmost importance. The manifestation of these abilities and their application to the social environment creates an atmosphere of understanding, cooperation, collaboration, and in our case, a supportive relationship between patient and provider in long-term care.²¹

Design and Conduct of the Training Intercession

In order to develop the aforementioned soft skills, an intercession methodology concerning design and training has been developed. A total of 62 participants, all of whom employed as long-term caregivers in nonhospital settings, were included in the pilot testing of the methodology. They were selected on the basis of 2 main criteria. The first, to have more than 12 months of experience as a caregiver, and the second, to actively care for a patient during the period the training program was conducted. None of these individuals were aware of the content of the questionnaire used in the initial survey, and none participated in the validation process. The goal of the intercession was to develop the 2 soft skills of the caregiver competency model, which, according to the patients, had been deemed most important. As has already been made clear, these areas are empathy and conflict management. The methodology includes assessing the level of these skills by the use of score cards to be completed by the patients. This is done before and after the training, the purpose being to ascertain if there has been any change in caregiver behavior with the patient. Before the evaluation cards were put into use, they had to be validated for feasibility on two levels, the first with experts, the second with service users (patients and relatives) (Appendix 2).

In order to increase the validity of the measured data and to follow a scientifically grounded experimental design, the participants were divided into 2 groups by randomization. One test group was composed of 32 participants, the other a control group composed of 30 participants. Participants in both groups were evaluated twice over a 50-day period, the first being *before* the test group had completed the interactive training modules, the second *after* it had completed the training. The control group completed neither the training nor any other activity. In order to avoid "data contamination" when filling out the evaluation cards, patients were told that the purpose of the cards was to measure service quality, this being a recent innovation of the company, which would happen on regular basis in the future. The patients were not told that the caregivers are taking part in a soft skills training program. If this information is shared, patients are more likely to be influenced by phenomena such as social agreeableness or even "placebo effect," and this can affect the assessment shown on the evaluation cards. The training design we implemented was built on the basis of 2 half-day modules at 3.5 astronomical hours each. Modules were conducted through a 7-day period, over 2 consecutive weeks. In order to increase efficiency, taking into account the high interactivity of the sessions, each training group consisted of 16 randomly selected participants. The training included a number of role-plays, discussions, small group tasks, and activities with fellow learners.

Table 1. Comparison between test and control groups.

Soft Skills	Control Group (No Training)			Test Group (Trained)			Net Effect
	Average Before	Average After	Dead Weight	Average Before	Average After	Gross Effect	
Total	2.06	2.1	0.04	2.12	3.97		1.81
Conflict management	2.1	2.12	0.02	2.16	3.93		1.75
Empathy	2.01	2.07	0.06	2.08	4.02		1.87

The sessions were conducted by 2 facilitators, one of whom was FEPTO²² certified and who moderated role-playing, group sharing, and auto reflection processes. Each of the modules focused on developing one or other of the skills, the first module targeting empathy, and the second module the ability to manage conflict. A detailed presentation of the sessions conducted in both modules, as well as a brief description of the activities used in them, can be found in Appendix 3.

Analysis

After completing the surveys, the data were processed by SPSS, which enabled a calculation of the difference in the quality of the service provided before and after the training. The Wilcoxon test revealed that the change in the test group (trained subjects) was statistically significant in all indicators, and the change in the control group was not statistically significant (Appendix 4). In order to obtain an overall assessment of the training, we have calculated and clarified the possible effects: gross effect; deadweight effect and finally a net effect.

The results of the scores for those who completed the training were used to establish the gross effect (GE). They were evaluated prior to the training and 25 days after its completion. The gross effect expresses the difference in behaviors of the caregivers included in the test group before and after the training.

The deadweight loss effect (DW) was measured on the basis of the results of the scores of the so-called "deadweight loss" (DW) of the control group. The idea is that because of some other factors (experience, salary increase, etc) they may also practice an improved set of behaviors, regardless that they did not participate in the training. Calculation of DW shows the extent to which some external factors have affected the targeted soft skills.

After a complete assessment of the aforementioned effects, the so-called net effect can be derived. The net effect was obtained by subtracting the DW effect from the GE and is an expression of the effect that is obtained as a result only from the training program.

The following results were obtained from the study: Total for all 12 questions covering the 2 soft skills, the

average score in the control group at the first measurement is 2.06 and in the second measurement 2.10. For the test group, the first measurement is 2.16, and 25 days after completing the training is 3.97. The results show that in those who underwent training, the manifestation of these skills and the quality of the service improved significantly (2.16 before and 3.97 after) while in the control group it remained almost unchanged (2.06 before and 2.10 after). The calculated GE of the training is 1.85; the effect of deadweight" is 0.04 and the net effect is 1.81.

The results obtained assessing the net effect of the 2 competencies viewed separately, also reveals interesting data (Table 1).

The average score of the 6 questions that measured the behavioral manifestations of conflict management skills for the control group are 2.10 at the beginning of the study and 2.12 at the second measurement. For the test group: at the beginning of the study (before finishing the training), the average score is 2.16, while after the training it was >3.93. The gross effect of the training is 1.78, the net effect is 1.75, and the deadweight effect is 0.02.

For questions related to the "empathy" competence, the control group's average score at the first measurement was 2.01 and the second 2.07. In the test group before the training it was 2.08 and afterward 4.02. The gross effect of the training is 1.93, the net effect is 1.87, and the "deadweight" effect is 0.06.

Ultimately based on these data and the concomitant analysis, we can claim that training has had a significant effect on the participants in the test group. Based on the net effect, indicating the extent to which the caregivers tend to exhibit empathy and conflict management in contact with patients, we can conclude that those 32 caregivers are practicing the targeted soft skills more often in their daily work. We can also add that they have most likely increased certain aspects of their emotional intelligence, which contributes to the easier behavioral manifestation of those skills and strengthens the relationship with the patient. These results can also be interpreted unambiguously as indication that caregivers, who have completed the training, offer a better quality of service compared with the period prior to training. The lack of change in behaviors exhibited by the control group provides further proof of this assertion.

Discussion

Nowadays, there is no doubt that many aspects of health care need to apply less “mechanistic,” less “directive” and more patient-centered approaches. In order to deal with that need, we have to determine which of the so-called “soft skills” are essential for creation of the caregiving environment. Different authors search for different methods to develop those skills of patient care professionals and the ways in which their training can be improved. In that continuous search, many researchers turn to the construct of emotional intelligence for answers.

Even though some good practices already exist, there is room for better methodological clearance regarding the training programs and methods that develop those skills.

As an example of that, 2 very respected bodies such as the World Health Organization (WHO) and the International Council of Nurses (ICN) jointly formulated a framework for nursing competencies²³ where they pay special attention to the soft skill domain called “personal attributes and attitudes” (ICN Framework of Disaster Nursing Competencies, p 34). They also add a training manual through which the nurses acquire additional skills to provide better quality services. The training program lists competencies related to emotional intelligence such as self-resilience and dealing with emotions but does not provide any methodological insights or hints on how to develop those skills in the process of formal training.

In that regard, the pilot study and the training methodology described in this article can contribute with some practical instruments and techniques. Furthermore, taking into consideration that the training design is based on patients’ evaluation of which soft skills need improvement, this makes it a practical tool, that can be used from specialists without specific background or certification. Despite all the criticisms that may arise in relation to the validity of the initial questionnaires or the usage of the scoring cards, or the size of the groups, the training methodology presented in this article provides a simple and easy to use training solution which can be used to increase the 2 soft skills related to emotional intelligence—and those are empathy and conflict management. We strongly believe that if we can manage to improve even only those 2 skills, the quality of the service provided by long-term care professionals will certainly improve together with patients’ satisfaction and that will have a positive effect on their recovery.

Conclusion

People who require long-term care services may not always be elderly, but they have certainly been experiencing long-term, even chronic, suffering. This makes them over emotional, insecure, irritable, and ultimately much more vulnerable than others. Very often, they have a significantly

greater sensitivity to what others are doing or talking about, because, unlike us, their world is reduced to only a small number of people—their loved ones and the specialists who take care of them. Problems that arise in their daily lives are sometimes rooted in health issues, sometimes in psychological pain and social exclusion, but in both cases, they need to be emotionally supported in order to boost the healing effect, or at least reduce their suffering.

Most of this support is provided through the manifestation of empathy, compassion, and nonconfrontation. Therefore, the soft skills that are recognized as core competencies, defining the quality of this particular service, are conflict management and empathy. The conclusion to be drawn is that if the caregivers are helped to develop these skills, their professionalism can only be improved and they will be able to provide not only medically precise and comprehensive care but also service that creates a much needed atmosphere of emotional support.

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Supplemental Material

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