Assessing the Relationship Between Emotional Intelligence and Patient Advocacy in Clinical Nursing Practice

Lara Fisher, Tanner McCoy, Aubrey Logan

1 Introduction

The intersection of emotional intelligence and patient advocacy represents a critical yet underexplored domain in nursing science. While emotional intelligence has gained recognition as an essential competency for healthcare professionals, and patient advocacy remains a cornerstone of nursing ethics, the precise mechanisms through which emotional capabilities enable effective advocacy behaviors remain poorly understood. Traditional approaches have often treated emotional intelligence as a monolithic construct, overlooking the specific emotional competencies that may be most relevant to advocacy situations in clinical environments. This study addresses this gap by examining the relationship between multidimensional emotional intelligence and various forms of patient advocacy, with particular attention to the contextual factors that moderate this relationship.

Patient advocacy in nursing practice encompasses a spectrum of behaviors ranging from communicating patient preferences to challenging institutional barriers that compromise care quality. The emotional demands of advocacy are substantial, requiring nurses to navigate complex interpersonal dynamics, manage their own emotional responses, and perceive subtle emotional cues from patients, families, and colleagues. Despite the intuitive connection

between emotional capabilities and advocacy effectiveness, empirical evidence delineating this relationship has been limited by methodological constraints, including reliance on self-report measures and insufficient attention to situational variability.

Our research introduces several novel contributions to this domain. First, we developed and validated the Situational Emotional Intelligence Assessment (SEIA), a context-specific tool that measures emotional intelligence competencies in scenarios relevant to nursing practice. Second, we employed a mixed-methods design that combines quantitative assessment with qualitative observation, allowing for triangulation of findings and richer interpretation of the emotional-advocacy connection. Third, we applied network analysis techniques to identify the most central emotional intelligence components in advocacy networks, moving beyond traditional correlation-based approaches.

The primary research questions guiding this investigation are: How do specific dimensions of emotional intelligence correlate with different types of patient advocacy behaviors? What emotional intelligence competencies are most predictive of effective advocacy in challenging clinical situations? How do contextual factors, such as unit culture and patient acuity, moderate the relationship between emotional intelligence and advocacy? And what emotional navigation strategies do nurses employ when advocating in ethically complex situations?

2 Methodology

2.1 Participants and Setting

We employed a prospective observational design with embedded qualitative components, recruiting 247 registered nurses from three healthcare systems in the northeastern United States. Participants represented diverse clinical specialties including medical-surgical units (32%), critical care (28%), emergency departments (21%), and specialty areas such as oncology and pediatrics (19%). Inclusion criteria required at least one year of clinical experience and current employment in direct patient care. The sample demonstrated a mean age of

34.7 years (SD = 8.9) and an average of 7.3 years of nursing experience (SD = 6.1).

2.2 Measures and Instruments

We utilized multiple assessment tools to capture the multidimensional nature of both emotional intelligence and patient advocacy. The Emotional Intelligence Appraisal® was administered to measure global emotional intelligence across four domains: self-awareness, self-management, social awareness, and relationship management. Additionally, we developed and validated the Situational Emotional Intelligence Assessment (SEIA), which presents nurses with clinical vignettes involving ethical dilemmas, communication challenges, and interprofessional conflicts, then assesses their emotional responses and proposed actions.

Patient advocacy was measured through the Patient Advocacy Engagement Scale, which assesses frequency and comfort with various advocacy behaviors, and the Advocacy Behavior Observation Checklist, used by trained observers during clinical rotations. The observational component included 480 hours of direct clinical observation across various shifts and patient acuity levels, with observers documenting specific advocacy incidents, emotional displays, and contextual factors.

2.3 Procedures

Data collection occurred over a six-month period, beginning with the administration of emotional intelligence assessments during scheduled education sessions. Participants then completed the SEIA electronically within two weeks of the initial assessment. The observational phase followed, with each nurse being observed for approximately two hours during typical clinical duties. Observers used standardized protocols to document advocacy behaviors and emotional interactions, noting both verbal and non-verbal cues.

Following the observational period, semi-structured interviews were conducted with a purposive sample of 35 nurses selected to represent varying levels of emotional intelligence and advocacy frequency. These interviews explored nurses' perceptions of the emotional

demands of advocacy, strategies for emotional regulation during challenging situations, and organizational factors that either supported or hindered their advocacy efforts.

2.4 Data Analysis

Quantitative data analysis employed both correlation and regression techniques to examine relationships between emotional intelligence dimensions and advocacy behaviors. Network analysis was applied to identify the most central emotional intelligence components within advocacy behavior networks. Qualitative data from observations and interviews underwent thematic analysis using a constant comparative approach, with particular attention to emotional navigation strategies and contextual influences.

3 Results

3.1 Quantitative Findings

Our analysis revealed significant correlations between specific emotional intelligence domains and advocacy behaviors. Emotional regulation demonstrated the strongest association with advocacy frequency (r = .42, p ¡ .001), particularly in situations involving conflict with physicians or institutional protocols. Empathy showed moderate correlations with patient-centered advocacy behaviors (r = .38, p ¡ .001), while social awareness was more strongly associated with advocacy directed toward family members (r = .35, p ¡ .001).

The network analysis identified emotional regulation as the most central node in the advocacy network, with strong connections to multiple advocacy behaviors. This suggests that the ability to manage one's own emotional responses serves as a foundational competency that enables various forms of advocacy. Interestingly, global emotional intelligence scores were less predictive of advocacy behaviors than specific competency combinations, supporting our hypothesis that advocacy relies on particular emotional capabilities rather than general emotional intelligence.

We identified a notable 'advocacy threshold' effect, whereby nurses scoring above the 75th percentile on emotional regulation and empathy measures demonstrated qualitatively different advocacy patterns. These high-advocacy nurses were 3.2 times more likely to challenge physician orders they perceived as problematic (95% CI: 1.8-5.7) and 2.7 times more likely to persist in advocacy efforts after initial resistance (95% CI: 1.5-4.9).

3.2 Qualitative Insights

The observational and interview data provided rich context for understanding how emotional intelligence facilitates advocacy. High-advocacy nurses employed sophisticated emotional navigation strategies, including strategic empathy displays to build rapport before delivering challenging messages, emotional framing to make advocacy concerns more palatable to colleagues, and emotional boundary-setting to maintain professional resilience.

Contextual factors emerged as significant moderators of the emotional intelligence-advocacy relationship. Unit culture particularly influenced advocacy expression, with psychologically safe environments enabling more direct advocacy approaches. Patient acuity also affected emotional demands, with critical care situations requiring more rapid emotional processing and regulation.

Nurses described advocacy as an emotionally labor-intensive practice that often involved managing competing emotional demands—balancing patient distress with professional composure, navigating hierarchical power dynamics while maintaining collaborative relationships, and containing their own emotional reactions while responding appropriately to others' emotions.

3.3 Integrated Findings

The mixed-methods approach allowed for integration of quantitative patterns with qualitative mechanisms. For instance, the quantitative finding that emotional regulation strongly predicts advocacy was explained qualitatively through nurses' descriptions of using emo-

tional regulation techniques to maintain composure during difficult conversations, to choose strategically appropriate moments for advocacy, and to recover from unsuccessful advocacy attempts without becoming discouraged.

Similarly, the network analysis finding regarding the centrality of emotional regulation was reflected in interview data highlighting how the ability to manage one's own emotions created cognitive and emotional resources that could then be directed toward perceiving patient needs and planning advocacy approaches.

4 Conclusion

This research makes several original contributions to understanding the relationship between emotional intelligence and patient advocacy in nursing practice. By moving beyond global emotional intelligence assessments to examine specific emotional competencies in context, we have identified the particular capabilities that most strongly enable advocacy behaviors. The development and validation of the Situational Emotional Intelligence Assessment provides a novel tool for measuring emotional intelligence in clinically relevant scenarios, addressing limitations of generic emotional intelligence instruments.

The identification of an 'advocacy threshold' associated with high emotional regulation and empathy scores suggests potential targets for educational interventions and competency development. Rather than aiming for general emotional intelligence improvement, nursing education and professional development programs might focus specifically on cultivating the emotional capabilities most directly linked to effective advocacy.

Our findings also highlight the importance of organizational context in either facilitating or constraining the translation of emotional intelligence into advocacy behaviors. Healthcare institutions seeking to enhance patient advocacy should consider not only individual nurse development but also the creation of environments that support emotional expression and psychological safety.

The network analysis approach represents a methodological innovation in nursing research, revealing the interconnected nature of emotional competencies and advocacy behaviors. This approach moves beyond linear relationships to model the complex systems through which emotional capabilities enable professional practices.

Several limitations warrant consideration. The observational nature of the study limits causal inferences, and the sample, while diverse, was drawn from a specific geographic region. Future research might employ longitudinal designs to examine how emotional intelligence and advocacy develop over time, or experimental approaches to test targeted interventions for enhancing specific emotional competencies.

In conclusion, this study demonstrates that the relationship between emotional intelligence and patient advocacy is neither simple nor uniform. Rather, specific emotional capabilities enable particular advocacy approaches in context-dependent ways. By elucidating these connections, we contribute to both theoretical understanding of nursing practice and practical approaches for enhancing patient-centered care through emotional capability development.

References

American Nurses Association. (2015). Code of ethics for nurses with interpretive statements. Nursesbooks.org.

Boyle, M. J., Williams, B., Burgess, S. (2017). Contemporary insights into the nature of emotional intelligence in nursing. Journal of Clinical Nursing, 26(23-24), 3911-3924.

Freshwater, D., Stickley, T. (2004). The heart of the art: Emotional intelligence in nurse education. Nursing Inquiry, 11(2), 91-98.

Goleman, D. (1995). Emotional intelligence: Why it can matter more than IQ. Bantam Books.

Hanks, R. G. (2007). Barriers to nursing advocacy: A concept analysis. Nursing Forum,

42(4), 171-177.

Mayer, J. D., Salovey, P., Caruso, D. R. (2004). Emotional intelligence: Theory, findings, and implications. Psychological Inquiry, 15(3), 197-215.

Numminen, O., Repo, H., Leino-Kilpi, H. (2017). Moral courage in nursing: A concept analysis. Nursing Ethics, 24(8), 878-891.

Schwarz, J. K. (2018). Patient advocacy: A concept analysis for nursing. Nursing Science Quarterly, 31(4), 354-361.

Vaartio, H., Leino-Kilpi, H., Salantera, S., Suominen, T. (2006). Nursing advocacy: How is it defined by patients and nurses, what does it involve and how is it experienced? Scandinavian Journal of Caring Sciences, 20(3), 282-292.

Watson, J. (2008). Nursing: The philosophy and science of caring (Rev. ed.). University Press of Colorado.