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Emotional Competence and Assertive Behaviors: Study with Family Nurses

Dora Margarida Ribeiro Machado[1], Assunção das Dores Laranjeira de Almeida[2], João Paulo de Almeida Tavares[3]

Abstract

Background: Family Nurses should develop emotional and communication skills to ensure the efficacy, safety, and quality of the relationships it establishes. **Objectives:** To analyze the relationship between emotional competence and assertive behaviors with users and with the multidisciplinary teams of nurses from Family Health Units in the northern region of Portugal. **Methodology:** Quantitative cross-sectional descriptive-correlational study, in a sample of 66 nurses. Data collection was carried out using the Emotional Competence Questionnaire and the Assertive Behavior Assessment Scale. Spearman's correlation coefficient test was used in data analysis. **Results:** nurses showed high levels of emotional competence (205.1±20.9) and frequently adopted assertive behaviors with the patient and the multidisciplinary teams (4.86±0.65). Emotional competence and the adoption of assertive behaviors showed a positive correlation ($rs=0.339$, $p<0.01$). **Conclusion:** the results of this study suggest that the ability to deal with emotions promotes the development of assertiveness so that individuals with higher social skills presuppose a higher level of emotional competence.

Keywords: Emotional Intelligence; Communication; Assertiveness; Family Nursing

1. Introduction

Individuals capable of combining interpersonal relationship skills are increasingly valued (Montezeli, Almeida et al., 2018). It is assumed, moreover, that the more emotionally competent the better successful individual will be at work and the greater satisfaction will have in life (H. Alves, 2016).

Every day, family nurses are exposed to situations where they cannot always avoid emotional involvement. Thus, it is essential to develop emotional skills and social skills that allow an effective relationship with users, family, and multi-professional teams (Montezeli, Almeida et al., 2018) and that promote emotional recognition and management that enable a safe and quality care delivery (Najafpour et al., 2020; Sabzevar et al., 2016). Within social skills, the assertiveness that helps in the resolution of behavioral and emotional conflicts and enables the development of better interpersonal relationships is highlighted, because it allows the professional to express thoughts, feelings, and opinions adequately without imposing their ideas on others (Macêdo et al., 2017).

The main objective of this study was to analyze the relationship between emotional competence and assertive behaviors, among users and a multidisciplinary team, of a group of nurses working in Family Health Units of a Grouping of Health Centers in northern Portugal.

2. Framing

In the 1990s, António Damásio demonstrated the importance of emotions in decision-making. According to the author (Damásio, 2012) emotions are divided into primary and secondary. The former implies a cerebral pre-organization and does not involve knowledge of the stimulus, it is enough that the initial sensory cortex recognizes its characteristics, and that the amygdala receives it as a sign. The process ends with the sensation of emotion, about the stimulus that triggered it. Being that, the feeling of emotional states means being conscientious of the emotions, allowing flexibility of response, based on our interactions with the environment. Secondary emotions, on the other, begin with autonomous and organized representations that occur in several initial sensory cortices.

[1] PhD Student, Instituto Ciências Biomédicas Abel Salazar, Oporto University, MSc, RN, Specialist Nurse, ACeS Grande Porto III, Maia/Valongo, 4474-004 Maia, Portugal. Tel.: (351) 229478590. E-mail: dora.ribeiromachado@gmail.com
[2] PhD, MSc, RN, Nursing teacher, Universidade de Aveiro, Aveiro, Portugal.
[3] PhD, MSc, RN, Nursing teacher, Universidade de Aveiro, Aveiro, Portugal.

Unconsciously, networks in the prefrontal cortex react involuntarily and automatically to the signals of the representations described above, based on their response to acquired dispositions, which make them individual. Once again, unconsciously, involuntarily, and automatically, these responses are marked to the amygdala and anterior cingulate that respond (i) by activation of the nuclei of the autonomic nervous system and sending signals to the body, through peripheral nerves; (ii) by sending signals to the engine system; (iii) through the activation of the endocrine and peptide systems; and (iv) by activation of non-specific neurotransmitter nuclei in the basal forebrain and brain stem.

For all this, emotion is defined as the combination of a process of mental evaluation, simple or complex, with responses directed mostly to the body, resulting in its emotional state, but also to the brain, resulting in mental changes. That is why they make our choices possible, from the simplest to the most complex, and mark our experiences (Damásio, 2012). Intelligence is the ability to make choices, judged as better or more correct, is changeable, over time and according to the experiences of the individual (Blanco et al., 2017), and fundamental in the acquisition of knowledge for the moderation of emotions (Serrado, 2020).

Being emotionally intelligent means being able to perceive, evaluate and express emotions, access and generate feelings that facilitate thinking, competence to understand intellectual and emotional growth, and the ability to evaluate the impact of these emotions, using this knowledge to positively affect behavior. It includes empathy, motivation social skills, self-knowledge, and self-regulation (Kozub et al., 2016). Being emotionally competent implies applying the concepts of emotional intelligence to effectively influence and lead individuals and groups (Kozub et al., 2016), with effective stress management and more efficient communication. Hence its importance in organizational performance and physical and mental health (Sabzevar et al., 2016).

Thus, individuals of high emotional intelligence adjust more effectively, to unfavorable life events, and their reactions, deciding on positions that expose them less to adverse situations and, consequently, to stress. Investigations indicate that the level of nursing practice increases with their level of emotional intelligence (Sharon & Greenberg, 2018) since this competence improves critical thinking (Michelangelo, 2015) and has a direct relationship with the psychological well-being of these professionals (Burgos et al., 2018). In this way, an emotionally competent nurse will be able to more effectively recognize and control emotions, contributing to quality communication and care and to a freer way of expressing their emotions and feelings (Sabzevar et al., 2016).

Nevertheless, it is noticeable the current adoption of a distant behavior on the part of the nurse that precipitates situations of frustration in the user and family (H. Alves, 2016). Therefore, it seems to be essential to work on interactions, specifically through the development of social skills, to make them more effective (Montezeli & Haddad, 2016). Social skills are classes of social behaviors that allow adapting behavior in interpersonal relationships and include, among others, assertiveness, which stands out as one of the most important. (Montezeli, Almeida et al., 2018).

Communicating assertively means defending basic personal rights, without violating the rights of others, with an open and honest expression of thoughts, feelings, and desires, responsibility for individual actions, and respect for other opinions and options (H. Alves, 2016). Resorting to assertiveness can improve satisfaction in the performance of tasks and the relationship between the professional/team and user (Omura et al., 2017) contributing to the well-being of the latter (H. Alves, 2016). For all this and considering the importance of a holistic approach in nursing, nurses must adopt assertive communication. Nevertheless, it is not clarified in the literature whether, currently, nurses adopt assertiveness as the basis of their communication (Marinho & Borges, 2020).

3. Hypothesis

The following hypothesis was defined for this investigation:
There is a correlation between emotional competence and the adoption of assertive behaviors by family nurses.

4. Methodology

A quantitative, cross-sectional descriptive-correlational study was carried out in a group of health centers in northern Portugal, after approval by the Health Ethics Committee (Opinion No. 53/2021). Of the 16 family health units belonging to the grouping of health centers, 108 nurses (94 female and 14 male) perform functions as family nurses. Non-probabilistic sampling was used for convenience. The inclusion criterion was to perform functions as a nurse in family health units of the grouping of Health Centers Maia/Valongo. Data were collected through a three-part questionnaire:

(i) socio-demographic, professional, and job satisfaction questionnaire;
(ii) Emotional Competence Questionnaire (QCE), derived from Taksic's Emotional Skills and Competence Questionnaire (ESCQ), based on Mayer and Salovey's model and adapted and validated for the Portuguese context by Santos and Faria (2005). A self-report measure, in the form of a 6-point Likert (between Never and Ever), of 45 items divided by three subscales (1) emotional perception, (2) emotional expression, and (3) ability to deal with emotion (Costa & Faria, 2014). This questionnaire does not have specific rules of application for the subscales, so, in line with other authors (Faria & Santos, 2017), it was decided to calculate a reference value (VR) for each of the dimensions, by multiplying the intermediate value of each subscale - 3.5 - by its number of items. A value below the VR indicates low competence in the subscale and above means high subscale competence. The cutoff points defined for the questionnaire are: high ≥ 200 points; moderate between 193 and 199 points; low ≤ 192 points. The QCE obtained in its intercultural validation a global Cronbach Alpha of 0.88. In the present study Cronbach's Alpha was 0.953;

(iii) Nurses' Assertive Behavior Assessment Scale, which evaluates the adoption of assertive communication behaviors, developed, and validated by Amaro and Jesus (2007). Self-report measure, in the form of Likert of 6 points (never (1) to always (6)) and includes two subscales: (A) assertive behaviors with users - 6 items; (B) assertive behaviors with the multidisciplinary teams - 18 items. Allows classifying the adoption of assertive behaviors at three levels: [1-3] infrequently; [3-4] some frequency; [4-6] very often (Amaro & Jesus, 2007). In its validation, it obtained a Cronbach's Alpha of 0.898 for the total scale and 0.760 and 0.895 for subscales A and B, respectively. In the present study, Cronbach's Alpha obtained an Alpha for the global scale, subscales A and B of 0.940, 0.832, and 0.936, respectively.

The collection of data preceded the request for authorization to the Directorate of the grouping of health centers and the coordinators of the units involved. An electronic questionnaire was used, and the link was sent to each of the nurses by e-mail, containing the informed consent. This process took place between July and August 2021.

Descriptive statistics (frequency and percentage, mean and standard deviation) were used to analyze sociodemographic characteristics. The study of the normality of distribution was carried out through Kolmogorov-Smirnov (K-S), when the assumptions of normality were not assured, nonparametric tests were used. To evaluate the correlation of independence between two quantitative variables or between two qualitative ordinal variables, the nonparametric test Rhó Spearman (rs) was applied, and: $r < 0.2$ - very weak association; $0.2 \leq r < 0.4$ - weak association; $0.4 \leq r < 0.7$ - moderate association; $0.7 \leq r < 0.9$ - high association; $0.9 \leq r \leq 1$ – very high association (Pestana & Gageiro, 2014). For data processing, the Statistical Package for Social Sciences (SPSS), version 27, and a significance level of 5% were used.

5. Findings

We obtained 66 answers to the 108 questionnaires sent (response rate 61.1%), which constituted the sample. Most nurses were female (81.8%), married (74.2%), and licensed (86.4%) and the mean age was 47.61±6.5 years, ranging from 36 to 59 years (Table 1).

Table 1: Sociodemographic characterization of nurses

Qualitative variables	***N***		***%***	
Sex				
Female	54		81,8%	
Male	12		18,2%	
Marital status				
Single	1		1,5%	
Married	49		74,2%	
Non-marital partnership	5		7,6%	
Divorced/Separated	11		16,7%	
Educational qualifications				
Bachelor	1		1,5%	
Degree	57		86,4%	
Post-graduation	4		6,1%	
Masters	4		6,1%	
Doctorate	0		-	
Quantitative variables	***M***	***Dp***	**mín.**	**max.**
Age	47,61	6,5	36	59

Note: *N* - sample elements; *%* - sample percentage; *M* - rate; *Dp* - pattern deviation; mín. - minimum; máx. – maximum

Half of the professionals were Specialist Nurses. Most of them had experience in other services (65.15%), had no training in Family Health Nursing (57.58%), and were under contract in public functions (77.27%). The average length of service: in the career was 23.65±6.98 years (ranging from 0 to 37 years); in the professional category it was 17.39±9.24 years (ranging from 0 to 33 years); and in the family health unit it was 11.59±3.43 years (ranging from 2 to 17 years) (Table 2).

Table 2
Characterization of nurses concerning professional variables (n=66)

Qualitative variables	**N**		**%**	
Category				
Nurse	33		50%	
Specialist Nurse	33		50%	
Experience in other services				
Yes	43		65,15%	
No	23		34,85%	
Family Health Nursing Training				
Yes	28		42,42%	
No	38		57,58%	
Link to the family health unit				
Fixed-term contract	11		16,67%	
Uncertain fixed-term contract	4		6,06%	
Public service contract	51		77,27%	
Quantitative variables	**M**	**Dp**	**mín.**	**máx.**
Career service time	23,65	6,98	0	37
Time in category	17,39	9,24	0	33
Time of service in the family health unit	11,59	3,43	2	17

Note: *N* - sample elements; *%* - sample percentage; *M* - rate; *Dp* - pattern deviation; mín. - minimum; máx. – maximum

The nurses presented high emotional competence since the analysis of the QCE showed an average of 205.1±20.9 (minimum 139 and maximum 243). The subscale that presented the highest value was "ability to deal with emotion" (73.12±7.74), followed by "emotional perception" (67.24±7.87) and "emotional expression" (64.76±7.64) (Table 3).

Table 3
QCE score and subscales

	M	*Dp*	mín.	máx.
Ability to deal with emotion	73,12	7,74	47	88
Emotional Expression	64,76	7,64	46	80
Emotional Perception	67,24	7,87	46	82
QCE – total scale	205,1	20,9	139	243

Note: *M* - rate; *Dp* - pattern deviation; mín. - minimum; máx. – maximum

The adoption of assertive behaviors by the sample elements was also high since the analysis of the Nurses' Assertive Behavior Assessment Scale showed an average of 4.86±0.65 (minimum 3.46 and maximum 6). The subscale of assertive behaviors with the user presented the highest value (5.09±0.63). The assertive behaviors subscale with the multidisciplinary teams obtained mean values of 4.78±0.73 (Table 4).

Table 4
Results of the adoption of assertive behaviors with the user and multidisciplinary teams

	M	**Dp**	**mín.**	**máx.**
Assertive behaviors with the user	5,09	0,63	3,83	6,00
Assertive behaviors with the multidisciplinary teams	4,78	0,73	2,89	6,00
Assertive behaviors - total scale	4,86	0,65	3,46	6,00

Note: *M* - rate; *Dp* - pattern deviation; mín. - minimum; máx. – maximum

There were significant, positive, and weak correlations between the total scale of assertive behaviors and the total scale of the emotional competence questionnaire (rs=0.339, p<0.01) and between the total scale of assertive behaviors and the subscale ability to deal with emotion (rs=0.327, p<0.01). There was a significant, positive, and moderate correlation between the total scale of assertive behaviors and the emotional expression subscale (rs=0.406, p=0.01) (Table 5).

There was also a significant, positive, and weak correlation between the subscale of assertive behaviors with the user and the subscales ability to deal with emotion (rs=0.249, p=0.043) and emotional expression (rs=0.272, p=0.027) (Table 5).

There was a significant, positive and weak correlation between the assertive behaviors subscale with the multidisciplinary teams and the total scale of the emotional competence questionnaire (rs=0.338, p<0.01) and between the assertive behaviors subscale with the multidisciplinary teams and the subscale ability to deal with emotion (rs=0.324, p<0.01). There was also a significant, positive, and moderate correlation between the subscale assertive behaviors with the multidisciplinary teams and the emotional expression subscale (rs=0.406, p<0.01) (Table 5).

Table 5
Relationship between assertive behaviors and emotional competence

		TAB	ABU	ABMT	TCE	ADE	EE	EP
TAB	r_s	1,000	,766**	,976**	,339**	,327**	,406**	,231
	p	.	,000	,000	,005	,007	,001	,062
	N	66	66	66	66	66	66	66
ABU	r_s	,766**	1,000	,622**	,234	,249*	,272*	,152
	p	,000	.	,000	,058	,043	,027	,223
	N	66	66	66	66	66	66	66
ABMT	r_s	,976**	,622**	1,000	,338**	,324**	,406**	,224
	p	,000	,000	.	,006	,008	,001	,071
	N	66	66	66	66	66	66	66
TCE	r_s	,339**	,234	,338**	1,000	,919**	,866**	,932**
	p	,005	,058	,006	.	,000	,000	,000
	N	66	66	66	66	66	66	66
ADE	r_s	,327**	,249*	,324**	,919**	1,000	,687**	,835**
	p	,007	,043	,008	,000	.	,000	,000
	N	66	66	66	66	66	66	66
EE	r_s	,406**	,272*	,406**	,866**	,687**	1,000	,724**
	p	,001	,027	,001	,000	,000	.	,000
	N	66	66	66	66	66	66	66
EP	r_s	,231	,152	,224	,932**	,835**	,724**	1,000
	p	,062	,223	,071	,000	,000	,000	.
	N	66	66	66	66	66	66	66

Note: ** Correlation is significant at level 0.01 (2 ends); * The correlation is significant at level 0.05 (2 extremities); rs – Spearman correlation; *p* - significance level; N - sample elements; TAB - total scale assertive behaviors; ABU - assertive behaviors with the user; ABMT - assertive behaviors with the multidisciplinary teams; TCE - total scale of the emotional competence questionnaire; ADE - subscale ability to deal with emotion; EE - emotional expression subscale; EP - emotional perception subscale.

6. Discussion

This study analyzed the correlation between emotional competence and assertive behaviors, with users and multidisciplinary teams, of nurses working in Family Health Units. The response rate obtained was 61.1%, a fact justified by the living pandemic context, which increased the workload and implied the exceptional mobilization of professionals to vaccination centers and areas dedicated to respiratory patients.

The sample was predominantly female, as expected since in Portugal most nurses are female (Ordem dos Enfermeiros, 2021), however, the response rate was higher for males - 85.7% versus 56.8% in females. The mean age of the nurses in the sample was 47.61±6.5 years, ranging from 36 to 59 years. Most nurses were married (74.2%) and licensed (86.4%). There were high self-perception values of emotional competence (205.1±20.9) and adoption of assertive behaviors, both with the user and with the multidisciplinary teams (4.86±0,65).

A positive correlation was confirmed between emotional competence and the adoption of assertive behaviors, as evidenced in Costa's study (2009). Social skills, from which assertiveness stands out, are determinants to perceive and influence the response of others during social interactions (Spence, 2003). Individuals whose social skills are higher tend to feel good about themselves, have greater ease in expressing themselves, and feel confident to assume responsibilities and perform activities autonomously, assuming a higher level of emotional competence (Couto et al., 2012). Thus, the reciprocity between these variables may be because the learning of social skills is revealed as a protective factor for emotional problems (Costa, 2009), instructing the individual to redirect and transform his behavioral impulses, suiting them to social demands (D. Alves, 2006). Tavares (2014) summarizes this correlation by clarifying that assertiveness and emotional intelligence complement each other, since the latter acts as a protective and adaptive element to social situations, facilitating the perception and decoding, by the individual, of the social contexts that involve him and that require differentiated actions. However, the advantage enhanced by emotional intelligence will be of little use if the negative effects of non-assertive behavior, such as damage to social relations, are verified. Assertiveness is presented as a skill that has an affective and cognitive component that protects from emotional dysregulation that may exist, even when it comes to emotionally competent individuals.

There was also a correlation between the total scale of assertive behaviors, the subscales of adoption of assertive behaviors with the user and with the multidisciplinary team, and two of the subscales of the QCE - ability to deal with emotion and emotional expression. The teaching of emotional skills helps to recognize and manage emotions, which promotes the ability to deal with and express them, their use in interpersonal relationships, and the development of assertive behaviors (Koolaee et al., 2016). However, there was no correlation between the emotional perception subscale and the scale of assertive behaviors. A circumstance that may be related to the fact that the ability to express emotions adequately – assertiveness – is more related to the ability to deal with them (Santos & Faria, 2005), with the caveat that in health emotional perception is fundamental to understand the suffering of others (Persia, 2011).

This study has limitations. Data were collected by self-completed questionnaires and, therefore, the answers may be subject to the bias of desirability. Furthermore, the sample size and non-probabilistic sampling in a single grouping of health centers limit the possibility of generalizing the results. Finally, the study design did not allow us to determine whether the values obtained remained constant over time and/or if they were influenced by the pandemic.

7. Conclusion

Nurses in the sample presented high mean values of self-perception of emotional competence and adoption of assertive behaviors, with users and multidisciplinary teams. There was a positive correlation between emotional competence and the adoption of assertive behaviors. The literature highlights the importance of emotional competence for safe and effective nursing practice and assertiveness for conflict prevention, improvement of relationships with multidisciplinary teams, increased job satisfaction, and more critical, holistic, and diverted performance of a biomedical model. Nevertheless, in practice, there is a gap in this recognition, evidenced by the lack of investment in institutions in training in the area.

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