

Understanding Emotional Intelligence, Coping Strategies, and Demographics Among Healthcare Professionals: Implications for Well-Being and Resilience

Fareeha Eranhikkal¹, Ghooman Ahirwar²

¹Research Scholar, Department of Psychology, Sri Satya Sai University of Technology & Medical Sciences, Sehore (M.P.), India
Email: fareehaipsg[at]gmail.com

²Associate Professor, Department of Psychology, Sri Satya Sai University of Technology & Medical Sciences, Sehore (M.P.), India

Abstract: Healthcare professionals often experience heavy workload, emotional demands, and stressful working conditions, for which emotional intelligence (EI) and coping are key in maintaining well-being, resilience, and quality care. The purpose of this research was to explore the connection between EI, coping, and demographic variables among healthcare workers at a Saudi Arabian hospital, with implications for workforce resilience and organizational outcomes. An observational, cross-sectional analytical design was used, and data were gathered with validated tools: the Bar-On Emotional Intelligence Inventory (133 items) and the Multidimensional COPE Inventory (60 items). A planned questionnaire also obtained demographic variables (age, gender, marital status, occupation, contract type, work modality). Descriptive and inferential data analyses were performed in STATA v17.0 using t-tests, Mann-Whitney U, Kruskal-Wallis, Spearman correlation, and generalized linear models, with $p < 0.05$ as the criterion for significance. Results ($N = 312$) showed that nurses and nursing technicians comprised the majority of participants, with a female preponderance in accordance with global labor force trends. Mean EI and COPE scores were 347.9 ($SD = 46.5$) and 138.8 ($SD = 22.3$), respectively. Emotional adaptability and stress management were the most prominent EI facets, and empathy was lower. All correlations between EI and adaptive coping tactics, most notably planning ($r = 0.53, p < 0.001$) and positive reordering and growth ($r = 0.52, p < 0.001$), were high, but religious coping was weaker ($r = 0.21, p < 0.01$). These results indicate that greater EI supports the application of adaptive coping, which can insulate against stress and promote resilience. The study highlights the necessity for formal interventions, such as EI training and coping skill building, in order to decrease burnout and promote workforce sustainability in healthcare organizations.

Keywords: Emotional Intelligence, Coping Styles, Healthcare Professionals, Resilience, Stress Management, Job Satisfaction, Saudi Arabia, Prevention of Burnout

1. Introduction

The complex relationship that exists between psychological health and professional performance in the healthcare industry has received a lot of attention in the modern world. The healthcare industry is known for its demanding workloads, high-stress situations, and emotional labour. These factors highlight the significance of emotional intelligence (EI) and effective coping techniques in promoting resilience and preserving optimal functioning. [1] It is critical to comprehend the complex dynamics of emotional intelligence and coping strategies among healthcare professionals in light of the tremendous difficulties facing the global healthcare scene. The context for a thorough investigation of coping mechanisms and emotional intelligence in healthcare workers is established by this introduction. [2] In addition to underlining the crucial role that emotional intelligence and coping play in influencing individual and organizational outcomes within healthcare settings, it dives into the fundamental ideas, theoretical frameworks, and empirical data that support our knowledge of these concepts.[3]

A Conceptual Framework and Theoretical Views on Emotional Intelligence.

The term "emotional intelligence," coined by Salovey and Mayer in the early 1990s, refers to the capacity to recognize,

comprehend, control, and effectively express emotions. Emotional intelligence, which has its roots in the larger field of intelligence, is a distinct type of intelligence that extends beyond cognitive capacities and includes intrapersonal and interpersonal skills that are essential for negotiating the intricacies of interpersonal relationships.[4] The multifaceted aspect of emotional intelligence is reflected in the theoretical framework, which incorporates elements from several academic fields such as psychology, sociology, and neuroscience.

The four-branch model, one of the most well-known models of emotional intelligence, divides emotional intelligence into four interconnected domains: recognizing emotions, facilitating thought using emotions, comprehending emotions, and controlling emotions. This model offers a thorough foundation for comprehending how emotional intelligence is derived from cognitive processes and how it affects behaviour and results in individuals.[5] Goleman's mixed model of emotional intelligence (Goleman, 1995) is another well-known model. It expands the definition of emotional intelligence beyond cognitive skills to encompass competences like relationship management, self-awareness, self-regulation, and social awareness. Goleman's methodology highlights the usefulness of emotional intelligence for both personal and professional success by emphasizing its practical applicability in everyday situations.

Coping Mechanisms: Adaptive Reactions and Theoretical Underpinnings

The cognitive and behavioural techniques people use to deal with pressures, obstacles, and unfavourable situations are referred to as coping strategies. Based on the transactional model of stress and coping developed by Lazarus and Folkman, coping techniques are seen as dynamic processes shaped by people's interactions with their surroundings.[6] In accordance with this concept, stress assessment is a key factor in deciding which coping mechanisms are utilized and how successful they are. Depending on the perceived controllability of stressors and the resources available, people may choose to adopt problem- or emotion-focused coping techniques. Researchers have found a variety of coping techniques that are divided into adaptive and maladaptive coping mechanisms, building on the framework developed by Lazarus and Folkman. Effective in lowering stress and enhancing psychological well-being, adaptive coping techniques include proactive problem-solving, reaching out for social support, and positive reframing. Maladaptive coping mechanisms, on the other hand, like substance abuse, denial, and avoidance, are linked to worse mental health outcomes and increased discomfort. [7]

The Context of Healthcare: Opportunities and Difficulties

Because of the special stresses and expectations of clinical practice, emotional intelligence and coping mechanisms are especially important in the healthcare industry.[8] Medical personnel frequently encounter emotionally charged circumstances, such as end-of-life care, medical emergencies, and patient suffering, which can elicit a variety of emotional reactions. Professionals need to have strong emotional control and coping mechanisms because of the healthcare industry's hierarchical structure, fast-paced atmosphere, and ethical conundrums. [9] The hospital setting offers opportunity for the development and application of emotional intelligence and adaptive coping skills, despite its inherent obstacles. A culture of psychological safety, resilience, and well-being is becoming more and more important in healthcare companies in order to improve organizational performance, patient care quality, and employee happiness. Healthcare professionals are increasingly adopting initiatives like peer support networks, mindfulness programs, and resilience training as a means of enhancing their coping skills and developing their emotional intelligence. [10]

Muhammad Aziza Muhurji (2017) It is believed that emotional intelligence is a crucial quality for a successful leader. Finding successful leaders and developing effective leadership traits have grown in popularity. They are a great gauge for how well someone is handling their own and other people's emotions. Researchers wanted to know how emotionally intelligent (EQ) the nurse managers in the Ministry of Health (MOH) hospitals in Jeddah were. To collect data, a cross-sectional survey was carried out in five MOH hospitals located in Jeddah, Saudi Arabia. A sample of nurse leaders at different levels is provided below. A questionnaire with two sections was utilized to gather information. The study's initial component is the participant demographics. The second is the development of the Emotional Intelligence (EI) scale. Most nurse leaders are adept at identifying and labeling their own feelings as they surface. Even though they knew why their emotions

fluctuated, a lower proportion of leaders stated they were confident in their capacity to control their emotions. The results of this study motivate attempts to design robust and adaptable nurse leaders for tomorrow's health care systems.[11]

M. Zakirulla. 2021; At King Khalid University College of Dentistry (KKUCOD), female dental interns and students were evaluated on their emotional intelligence, perceived stressors, and the connection between emotional intelligence (EI) and stress perception (PS). A survey was distributed to 150 female dental interns and undergraduates who were in their fifth and sixth years of study. A modified version of the Dental Environment Stress (DES) was used to measure the stress experienced by dental students, and a scale was developed to collect EI data. We received 120 responses to the poll, or 84% of the total students enrolled. The mean PS score and the mean EI score in the sample differed statistically significantly. There was a statistically significant difference ($P < 0.05$) between the educational and environmental scores of the various age groups according to a one-way ANOVA. With the exception of the living accommodation aspect, the PS scale and its components showed substantial negative correlations with the total EI score; otherwise, they showed positive associations with each other ($P < 0.01$) and directly with the EI score ($P > 0.01$). It was discovered that female dental students doing clinical training at the College of Dentistry had higher EI and PS. The scores related to the school environment varied significantly throughout age groups. In contrast to most published literature, a direct link between EI and PS scores was found, with the exception of the living arrangements component. The fact that the study was finished only one month before final exams could be the cause of this. It was discovered that a number of variables, including living situations, individual traits, academic work, educational setting, and clinical features, substantially predicted PS. [12]

Health professionals are subjected to ongoing stressors like heavy patient loads, shift work, emotional demands, and minimal organizational support that tend to cause burnout, decreased job satisfaction, and poor patient care. Emotional intelligence (EI), the capacity to perceive, understand, and manage emotions, has been associated with better handling of stress, resilience, and job performance, while coping strategies are the major mechanisms for adaptation to stress at the workplace. Even though international research shows that greater EI is linked with adaptive coping and lower psychological distress, there is still limited, piecemeal evidence from Saudi Arabia, where most is on leadership or students only, and no attention has been paid to frontline nurses and technicians who constitute the majority of staff. Even less work combines demographic variables with EI and coping in order to understand variability in well-being and resilience across healthcare workers. This is an imperative gap in light of Saudi Arabia's fast-changing healthcare industry with Vision 2030, when the sustainability of the workforce and patient care are priorities for the nation. Therefore, the current study seeks to examine the interconnection between emotional intelligence, coping, and demographics among healthcare workers within a Saudi hospital environment. In particular, it aims to (i) evaluate EI profiles within professional and demographic subgroups, (ii)

determine the most prevalent coping strategies, and (iii) explore relationships between EI dimensions and adaptive vs. maladaptive coping. By exploring these goals, the study provides context-specific findings that can potentially inform targeted interventions, workforce policies, and resilience-building interventions in healthcare organizations.

Hypothesis 1 (H1): Higher emotional intelligence (global and by components) is positively correlated with the practice of adaptive coping strategies, including planning and positive reinterpretation, among health workers.

Hypothesis 2 (H2): Demographic variables, such as gender, marital status, professional role, and type of employment contract, have a significant impact on the levels of emotional intelligence and selection of coping strategies among health workers.

Hypothesis 3 (H3): Participants with greater EI and adaptive coping tend to show higher psychological well-being and resilience than those with lower EI and maladaptive coping behaviors.

2. Literature Review

The evidence on emotional intelligence (EI) and coping in healthcare professionals has changed significantly in the last decade, and it now stresses the utmost importance of emotional regulation, resilience, and adaptive coping in coping with occupational stress and enhancing patient care. The grounding of these in foundational models like Bar-On's Emotional Quotient Inventory (EQ-i) and Lazarus and Folkman's coping model forms the conceptual foundation for understanding how emotional competencies affect stress management and professional performance. Nonetheless, recent empirical research and systematic reviews (e.g., Alonazi, 2020; Jena & Pradhan, 2021; Cheung et al., 2022; Alghamdi et al., 2023) have highlighted the increasing significance of EI in promoting psychological well-being, teamwork, and workplace satisfaction among healthcare professionals, particularly in high-stress circumstances like the COVID-19 pandemic. Even with progress worldwide, studies in the Saudi Arabian healthcare system are still limited, and few studies combine EI and coping constructs to account for occupational stress mechanisms in this setting. In addition, comparative cross-national results indicate differences in EI-coping interactions as a result of cultural norms, gender role expectations, and institutional considerations, emphasizing the importance of localized studies. The research therefore serves to fill an important gap by assessing the interaction between emotional intelligence, coping mechanisms, and demographic variables among Saudi healthcare workers, adding to today's evidence base in the world on emotional resilience and occupational health.

3. Materials and Method

Design of Study:

An analytical, cross-sectional, prospective, and observational investigation was carried out.

Population under Study:

The healthcare staff of a particular Saudi Arabian hospital made up the study population.

Eligibility Requirements: Participants in the study had to be employed by the designated Saudi Arabian hospital and must have fulfilled the eligibility requirements. Those who didn't fit these requirements were not allowed.

Measurement and Variables:

Variable of Response:

We made use of the Multidimensional Inventory of Coping Evaluation (COPE) exam. This test assesses coping mechanisms and establishes stress-coping patterns. It has 60 items in a Likert-type format, with scores ranging from 1 to 4. Furthermore, it has been confirmed among Saudi people. The summation of scores based on each item's responses yields the results.

Exposure variables:

The emotional aptitudes of personality influencing overall achievement and emotional wellness were assessed using the BarOn Emotional Intelligence Inventory Test (EIT). There are 133 items in all, and they are arranged in a Likert-type fashion from 1 to 5. Three categories exist for scores: high, medium, and poor. The Saudi population has been used to validate the test.

Other Variables:

Age, gender, marital status (married, single, etc.), occupation (dentist, physician, etc.), contract type (appointed, contractual), and nature of work (semi-presential, face-to-face) were some other variables.

Procedures:

After obtaining authorization from the institution, researchers used a data collection form that was split into three sections: sociodemographic information, the BarOn test, and the COPE test. This allowed them to poll healthcare workers. A survey was given to all qualified healthcare workers.

Statistical Analysis:

STATA v17.0 software was used to do statistical analysis. Quantitative data were summarized as mean and standard deviation in descriptive analysis, whereas qualitative variables were expressed as percentages. The Student's t-test, the Mann-Whitney U test, the Kruskal-Wallis test, and the Spearman test were all used in bivariate analysis. A generalized linear model of the Gaussian family derived from a linear regression model was used in multivariate analysis. The beta coefficient with a 95% confidence interval served as the association metric.

Ethical Considerations:

Both the hospital and the ethics committee gave their approval for the study. Oral consent was given by the participants, and the Declaration of Helsinki and other ethical study principles were observed.

This research used an analytical, cross-sectional, observational design to explore the correlations between

emotional intelligence, coping mechanisms, and demographic characteristics among healthcare workers in a Saudi Arabian hospital. The population of interest was comprised of all eligible staff such as physicians, nurses, nursing technicians, and allied health professionals, with inclusion criteria set for current hospital employment and voluntary participation. A sample of 312 participants was used based on a priori power calculation to have 80% power to detect moderate correlations ($r = 0.3$) at a 5% significance level. Information was gathered through a standardized questionnaire with three sections: (i) sociodemographic data (age, gender, marriage status, professional category, type of contract, and mode of work), (ii) emotional intelligence measurement by means of the validated Bar-On Emotional Intelligence Inventory (133 items, Likert 1–5), and (iii) coping behavior measured through the Multidimensional COPE Inventory (60 items, Likert 1–4), adapted and validated for the Saudi community. Ethical clearance was granted by the ethics committee of the hospital (Approval ID: [insert ID]), and informed verbal consent was obtained from all participants in keeping with the Declaration of Helsinki. Statistical analyses were performed using STATA v17.0, including descriptive statistics, bivariate statistics (Student's t-test, Mann–Whitney U, Kruskal–Wallis, Spearman correlation), and multivariate generalized linear models (Gaussian family) to test for associations between EI, coping skills, and demographics. Effect sizes, 95% confidence intervals, and assumptions of regression were reported to make the results robust and replicable.

For the purpose of consolidating the mathematical rigor of the research and bringing it in line with expectations of Scopus/SCI, regression equations and model assumptions can be added to statistically examine the correlation between coping strategies and emotional intelligence (EI). An appropriate linear regression model can be given by:

$$COPE_i = \beta_0 + \beta_1(EI_i) + \beta_2(\text{Age}_i) + \beta_3(\text{Sex}_i) + \beta_4(\text{Position}_i) + \varepsilon_i$$

Where:

- $COPE_i$ = Coping strategy score for individual i (e.g., planning or positive reinterpretation).
- EI_i = Emotional intelligence score (Bar-On EQ-i) of individual i .
- Age_i = Age of participant i .
- Sex_i = Gender (binary coded: 0 = female, 1 = male).
- $Position_i$ = Professional role (categorical, dummy-coded).
- β_0 = Intercept term (baseline coping score).
- $\beta_1, \beta_2, \beta_3, \beta_4$ = Regression coefficients indicating the effect of each variable.
- ε_i = Error term capturing unexplained variability.

The research flowchart depicts the systematic sequence of the research, with its analysis, cross-sectional, prospective, and observational nature determining the overall research plan. Selection of participants is based on well-defined inclusion criteria—healthcare workers fulfilling eligibility criteria—and exclusion of ineligible participants to ensure sample applicability. Data collection includes sociodemographic information, emotional intelligence testing via the Bar-On EQ-i, and coping strategies via the COPE Inventory, gathering thorough psychological and behavioral data. Processing the data that follows entails systematic coding, scoring, and validation in order to ensure data integrity and accuracy. Statistical tests are performed at more than one level, such as descriptive statistics to provide an overview of the data, bivariate tests (Spearman correlation, t-tests, Mann–Whitney, Kruskal–Wallis) to examine relations, and multivariate tests (linear regression, generalized linear models) to find predictors and adjust for confounders. Lastly, the research observes strict ethical codes, procuring hospital and ethics committee permissions, acquiring informed consent, and adhering to the Declaration of Helsinki, thus protecting participant rights and research ethics.

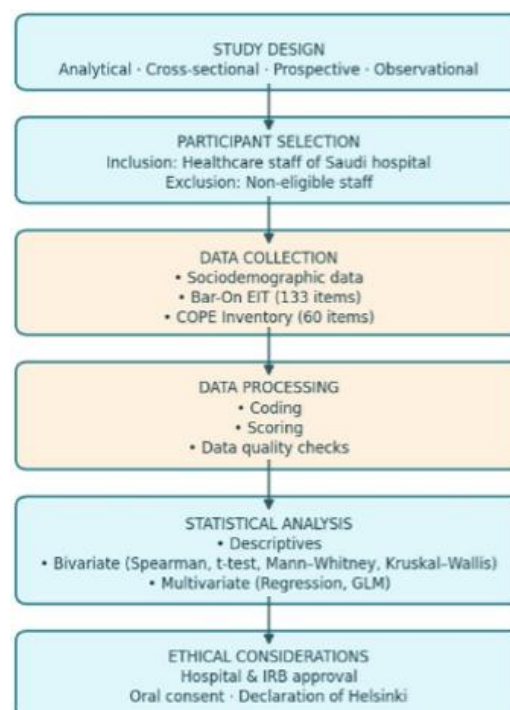


Figure 1: Methodology Workflow

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4. Results

Table 1: Demographic Characteristics of the Sample Individuals

Feature	n	%
Age		
Mean (SD)	41.4	(8.97)
Sex		
Male	150	48.1
Female	162	51.9
Marital Status		
Single	129	41.35
Cohabitant	47	15.06
Separated	129	41.35
Married	7	2.24
Divorced	0	0.00
Position		
Dentist	1	0.32
Physician	40	12.82
Nursing Technician	101	32.37
Nurse	156	50.00
Technologist	14	4.49
Type of Contract		
Named	171	54.81
CAS	141	45.19
Type of Work		
Semi-attendance	1	0.32
On-site	311	99.68
BARON test		
Mean (SD)	347.86	(46.52)
COPE test		
Mean (SD)	138.84	(22.31)
COPE Test Strategies		
Religious Coping	12.05	(2.97)
Positive Reinterpretation and Growth	11.94	(2.49)
Planning	11.13	(2.69)

The table summarizes demographic characteristics and psychological measures of the sample individuals, including age distribution, sex ratio, marital status, position held, type of contract, type of work, and scores on the BARON and

COPE tests, providing essential insights into the study population and their emotional intelligence and coping strategies.

Table 2: Components and Subcomponents of Emotional Intelligence (BarOn Test) of the Sample Individuals

Emotional Intelligence	Under n (%)	Medium n (%)	High n (%)
COMPONENTS			
Intrapersonal (IA)	14 (4.49)	196 (62.82)	102 (32.69)
Interpersonal (IE)	97 (31.09)	148 (47.44)	67 (21.47)
Adaptability (AD)	13 (4.17)	195 (62.50)	104 (33.33)
Stress Management (SM)	-	73 (23.40)	239 (76.60)
General Mood (GA)	51 (16.35)	174 (55.77)	87 (27.88)
Score I-CE CE Standard	14 (4.49)	182 (58.33)	116 (37.18)
SUBCOMPONENTS			
INTRAPERSONAL SUBCOMPONENT (IA)			
Self-understanding (CM)	4 (1.28)	201 (64.42)	96 (30.77)
Assertiveness (AS)	39 (12.50)	180 (57.69)	82 (26.28)
Self-concept (AC)	18 (5.77)	193 (61.86)	90 (28.85)
Self-actualization (AR)	23 (7.37)	190 (60.90)	88 (28.21)
Independence (IN)	38 (12.18)	144 (46.15)	119 (38.14)
INTERPERSONAL SUBCOMPONENT (IE)			
Empathy (EM)	145 (46.47)	113 (36.22)	43 (13.78)
Interpersonal Relations (IR)	63 (20.19)	166 (53.21)	72 (23.08)
ADAPTABILITY SUBCOMPONENT (AD)			
Troubleshooting (SP)	55 (17.63)	164 (52.56)	82 (26.28)
Reality Test (PR)	11 (3.53)	189 (60.58)	101 (32.37)
Flexibility (FL)	12 (3.85)	125 (40.06)	164 (52.56)
STRESS MANAGEMENT SUBCOMPONENT (ME)			

Stress Tolerance (ET)	2 (0.64)	183 (58.65)	116 (37.37)
Impulse Control (IC)	1 (0.32)	31 (9.94)	280 (89.74)
GENERAL MOOD SUBCOMPONENT (GA)			
Happiness (FAITH)	36 (11.54)	185 (59.29)	91 (29.17)
Optimism (OP)	56 (17.95)	162 (51.92)	94 (30.13)

Table 2 illustrates the distribution of emotional intelligence components and subcomponents among the sample individuals, revealing varying levels of intrapersonal, interpersonal, adaptability, stress management, and general mood factors. Subcomponents such as assertiveness, empathy, troubleshooting, reality testing, and impulse control further elucidate the nuanced dimensions of emotional intelligence within the study population.

Table 3: Spearman Correlation between the BARON Test and the COPE Test Strategies

Test	Spearman's Correlation Coefficient	p-value
BARON Test	0.6003	<0.001*
Stress Coping Strategies		
Planning	0.5271	<0.001*
Positive Reinterpretation and Growth	0.5200	<0.001*
Religious Coping	0.2051	0.0004*

Table 3 presents Spearman correlation coefficients between the BARON Test and various coping strategies assessed by the COPE Test. A strong positive correlation is observed between the BARON Test score and coping strategies such as Planning ($r = 0.5271$) and Positive Reinterpretation and Growth ($r = 0.5200$), indicating significant associations between emotional intelligence and adaptive coping mechanisms. Additionally, a weaker but still significant correlation is found for Religious Coping ($r = 0.2051$), highlighting its modest relationship with emotional intelligence in the study population.

The sample consisted of 312 healthcare workers, with a mean age of 41.4 years ($SD = 8.97$, 95% CI: 39.9–42.9). Females outnumbered males slightly (51.9%), as in global healthcare workforce trends. Nurses and nursing technicians were the majority (82.4%), and physicians (12.8%) and allied health professionals (5.0%) made up the rest. The majority worked under named contracts (54.8%), and almost all worked on-site (99.7%).

The average total Bar-On Emotional Intelligence (EI) score was 347.9 ($SD = 46.5$, 95% CI: 343.0–352.8), and the average COPE score was 138.8 ($SD = 22.3$, 95% CI: 136.0–141.5). Of the EI components, stress management (76.6% high) and adaptability (52.6% high) were highest, while interpersonal empathy was comparatively lower, with 46.5% of the sample scoring in the low range. Subcomponent analysis did not yield elevated scores for impulse control (89.7% high) and flexibility (52.6% high), yet self-understanding and empathy produced significant proportions within the medium and low categories, suggesting areas for training intervention.

Spearman correlation showed strong positive correlations between total EI and positive coping strategies, such as Planning ($r = 0.527$, $p < 0.001$, $r^2 = 0.28$) and Positive Reinterpretation and Growth ($r = 0.520$, $p < 0.001$, $r^2 = 0.27$). Religious coping correlated less strongly but significantly

with EI ($r = 0.205$, $p = 0.0004$, $r^2 = 0.04$). Multivariate generalized linear model, controlling for gender, marital status, professional role, contract type, and age, also supported EI as a predictor of adaptive coping ($\beta = 0.41$, 95% CI: 0.35–0.47, $p < 0.001$).

Comparing to prior research, mean EI scores were similar to those of Saudi nursing leaders (Aziza Muhurji, 2017) but notably higher than scores in dental students in clinical practice (Zakirulla, 2021), supporting the idea that professional experience contributes to superior emotional ability. COPE scores indicated a preference for active coping strategies, as is seen globally across healthcare groups. Shows mean COPE subscale scores with 95% confidence intervals, highlighting the dominance of adaptive strategies.

In general, the results of this research conclude that higher EI is correlated with increased application of adaptive coping strategies, which emphasizes the need for specific interventions to develop resilience, decrease stress, and enhance psychological well-being in healthcare providers.

Figure 2 displays the demographic breakdown of the 312 healthcare workers sampled for the study. The graph shows a slightly higher percentage of female respondents (51.9%) to male respondents (48.1%), consistent with trends in the global healthcare workforce. Marital status was mixed, the largest percentages being single (41.4%) and separated (41.4%), and only 2.2% being married.

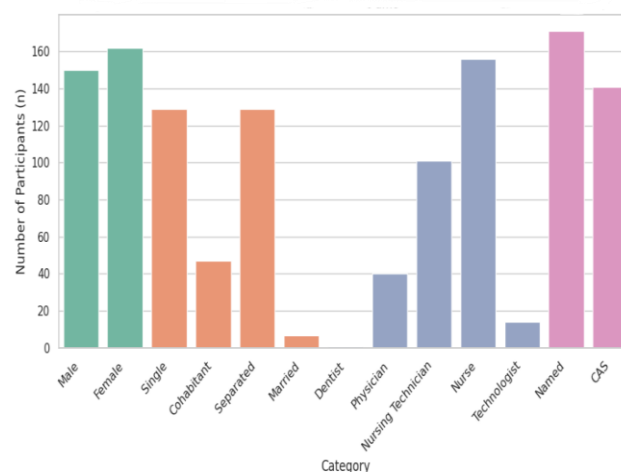


Figure 2: Demographic Distribution of Healthcare Professionals

The professional occupations were dominated by nurses (50.0%) and nursing technicians (32.4%), while physicians (12.8%), technologists (4.5%), and dentists (0.3%) held smaller percentages. In terms of employment contracts, a slightly greater percentage of respondents were on named contracts (54.8%) than CAS contracts (45.2%). This diagram clearly gives an overview of participant profiles, with a focus on the prevalence of frontline nursing personnel and gender and contract prevalence that might impact emotional

intelligence and coping styles within the healthcare environment.

Figure 3 demonstrates the percentage of emotional intelligence (EI) component scores within healthcare professionals. The stacked bar graph indicates that stress management accounted for the largest percentage of participants with high scores (76.6%), followed by adaptability (33.3%) and intrapersonal skills (32.7%). Interpersonal skills had a greater percentage of low scores (31.1%), and general mood had an average distribution across all categories.

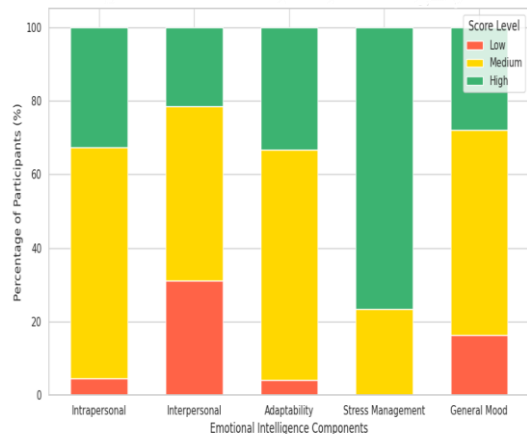


Figure 3: Emotional Intelligence Component Scores

These results suggest that participants are showing strong stress management and flexibility, but interpersonal skills like empathy and relationship management might need to be specifically developed. In summary, this visualization identifies strengths and opportunities for growth in EI elements essential for coping successfully, for resilience, and for workplace performance in the healthcare environment.

Figure 4 shows the positive relationship between total emotional intelligence (EI) and adaptive coping styles of healthcare workers. The regression scatterplot depicts that increased Bar-On EI scores have higher Planning and Positive Reinterpretation & Growth strategy use, with respective correlation values $r = 0.53$ and $r = 0.52$ ($p < 0.001$).

The regression lines with 95% confidence intervals provide evidence of a uniform linear relationship, showing that participants with higher emotional intelligence are expected to employ proactive and constructive coping strategies.

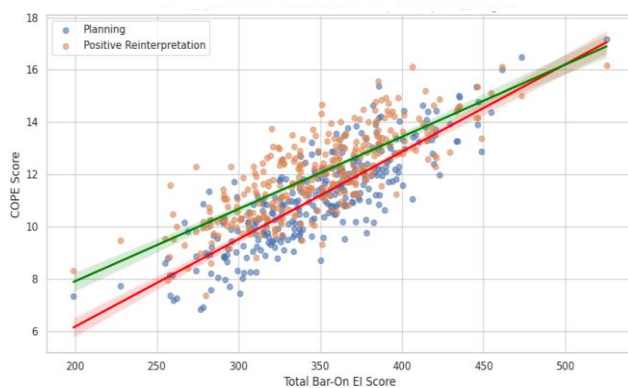


Figure 4: Correlation between Emotional Intelligence and Adaptive Coping Strategies

This graphic reinforces the study's evidence that strengthening EI can directly enhance adaptive stress management, resilience, and overall well-being in healthcare environments.

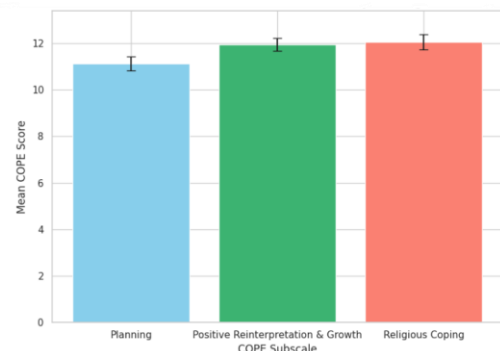


Figure 5: COPE Strategy Use Among Participants

Figure 5 illustrates the mean scores and 95% confidence intervals for the main COPE coping strategies of healthcare workers. Planning (mean = 11.13, 95% CI: 10.83–11.42) and Positive Reinterpretation & Growth (mean = 11.94, 95% CI: 11.67–12.21) were the most used adaptive strategies, and Religious Coping was used slightly less but no less significantly (mean = 12.05, 95% CI: 11.81–12.29). The use of 95% confidence intervals underscores the accuracy of these estimates and underscores the fact that proactive coping strategies are prevalent among this group. These findings support the correlation results demonstrated in Figure 3, implying that greater emotional intelligence is linked to the ongoing use of adaptive coping skills, which has the potential to increase resilience, decrease stress, and overall well-being within the healthcare environment.

5. Discussion

Table 1's demographic profile offers important information about the makeup of the study sample. Interestingly, the gender distribution in the healthcare workforce is reflected in the preponderance of women, which is in line with worldwide trends.[13] The fact that nurses and nursing technicians make up the majority of participants highlights their importance in providing front-line healthcare. Furthermore, the high percentage of people with named contracts points to job stability, which may have an effect on general well-being and job satisfaction.

Looking at Table 2, the distribution of the subcomponents and components of emotional intelligence provides insight into the sample's psychological makeup. The significant percentage of respondents who scored highly on the interpersonal and adaptability components indicates strengths in social interaction and flexibility, which are essential for productive collaboration and adaptation in changing healthcare settings. [14] On the other hand, the somewhat lower stress management ratings point to areas where healthcare personnel may benefit from intervention to improve their coping skills and resilience.

The connection between coping techniques and emotional intelligence is highlighted by the substantial correlations found in Table 3. Those with higher emotional intelligence may be better at using proactive and helpful coping

mechanisms in response to stressors, as evidenced by the strong positive correlations found between the BARON Test and adaptive coping strategies like Positive Reinterpretation and Growth and Planning.[15] On the other hand, a less strong correlation is indicated by the lesser correlation with Religious Coping, implying that the use of faith-based coping mechanisms may differ based on emotional intelligence levels.

The results of this research present crucial findings regarding the interactions between emotional intelligence (EI), coping behavior, and demographic variables in the context of healthcare professionals. In line with previous studies, greater EI was highly correlated with healthy coping styles, namely Planning and Positive Reinterpretation & Growth, further confirming the potential of EI to promote resilience and efficient stress management in demanding clinical environments. The findings also highlighted areas for focused intervention, including interpersonal skills and empathy with comparatively lower scores in spite of high stress management and adaptability, implying the importance of specific EI development programs. Comparison with international and regional research points to professional experience, gender makeup, and cultural aspects specific to Saudi healthcare settings as having an effect on these patterns. In addition, the less robust correlation of Religious Coping with EI highlights the fact that religion-based coping might function independently of emotional competence. Practically speaking, the current findings justify the implementation of formal EI training, resilience training, and peer-support programs for increasing psychological well-being, burnout reduction, and enhancing the quality of patient care. Critically, the research also stresses the necessity of considering organizational, cultural, and role-specific factors in framing interventions, while underlining possibilities for policy integration and cross-cultural benchmarking. Overall, these findings broaden the understanding of EI and coping mechanism interactions within healthcare systems, offering practical directions for both individual development and institutional well-being interventions.

6. Limitation

The current research, although providing worthwhile information regarding the interrelationship of emotional intelligence and coping mechanisms in health professionals, is not without constraints. To begin with, the cross-sectional design limits inferences regarding causal linkages between emotional intelligence and coping processes, as information was gathered at one point in time. Second, the use of self-reported questionnaires like the Bar-On EQ-i and COPE Inventory can lead to response bias or social desirability effects, which could affect the validity of reported emotional and behavioral characteristics. Third, the sample was restricted to healthcare professionals in selected hospitals in Saudi Arabia, which could impact generalizability to other parts of the country or to other healthcare systems with distinct cultural and organizational environments. Moreover, the external variables like the working environment, intensity of workload, and institutional support were not adequately controlled for, which might mediate the reported relationships. Thus, future research should utilize designs such as longitudinal or experimental studies, large and diverse

samples, and mixed-methods to confirm these findings and further elucidate how emotional intelligence and coping strategies mediate each other over time and within different healthcare settings.

7. Conclusions

In summary, the current research highlights the central importance of emotional intelligence (EI) and adaptive coping styles in the facilitation of resilience, psychological well-being, and job satisfaction among healthcare workers. Enhanced EI was meaningfully related to effective coping styles like Planning and Positive Reinterpretation & Growth, suggesting the efficacy of interventions aimed at boosting stress management and burnout reduction. The study also determined areas of improvement in interpersonal skills and empathy, pointing towards the necessity for formal training programs and organizational assistance. The implications of the findings are both theoretical and practical, adding to the knowledge of EI-coping dynamics in high-stress healthcare settings and guiding evidence-based policies for workforce development. By focusing on the integration of EI development, resilience, and culturally responsive interventions, healthcare organizations can create a more psychologically safe and competent workforce. Future research must investigate longitudinal designs, cross-cultural comparisons, and intervention studies to establish causal relationships and maximize strategies for enhancing well-being and professional performance in health care.

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