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Examining Emotional Intelligence Strategies of Human Resource Administrators for Women's Leadership in Healthcare

Selenda Johnson
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Walden University

College of Management and Human Potential

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Selenda Johnson

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Walden University
2025

Abstract

Examining Emotional Intelligence Strategies of Human Resource Administrators for
Women's Leadership in Healthcare

by

Selenda Johnson

MBA, Keller University, 2003

BS, University of South Carolina, 2000

Research Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Business Administration

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December 2025

Abstract

Gender-based distinctions between leaders create differences in leadership methods that reshape their choices and teamwork approaches. Human Resource Administrators are concerned with how the lack of organizational support for Emotional Intelligence (EI) in female leaders influences them to leave, potentially leading to increased organizational costs. Grounded in Emotional Intelligence theory, the purpose of this qualitative pragmatic study was to explore EI strategies used by healthcare administrators in the Southeastern United States to increase female leadership retention in their organizations. The participants were 6 HR administrators with at least 2 years of experience from healthcare organizations who successfully implemented EI strategies to reduce female leader turnover. Data were collected using semistructured interviews and reviewing public organizational reports. Through thematic analysis, three themes were identified: (a) emotional intelligence as a core competency, (b) training programs for emotional intelligence, and (c) identification of challenges and obstacles in implementing emotional intelligence strategies. A key recommendation is for HR administrators to integrate EI assessment tools into recruitment and leadership development processes. The implications for positive social change include the potential for HR administrators to foster more effective strategies, to retain valuable female leaders and supporting the quality for patients.

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Section 1: Foundation of the Project

Background of the Problem

Emotional intelligence (EI) has emerged as an essential leadership skill across various organizations (Chatzidimitriou et al., 2025; Devi & Banerjee, 2024; Lambert, 2021). EI refers to the ability of a leader to understand their emotions and those of others and has been reported as an integral factor in determining leadership success (Görgens-Ekermans & Roux, 2021). Leaders who are in a position to nurture their EI skills improve their ability to create a positive work environment, build strong relationships with their team, and lead their organization effectively in meeting its objectives (Hanchinalkar, 2024). This qualitative pragmatic project focused on exploring EI strategies that healthcare administrators in the Southeastern region of the United States used to increase women's leadership retention in their organizations.

The broad recognition identifies EI as fundamental for organizational leadership since leaders need it to manage emotions while improving teamwork and reaching their goals (Consten, 2023; Duncan, 2022; Pyke, 2022). EI serves two essential organizational functions by establishing strong leadership practices while creating the correct organizational values, leading to better staff satisfaction. Even though EI functions as a critical aspect at work, it demonstrates different skill levels based on the leader's gender. Women lead best in social responsibility with empathy and relationship-building skills, although men excel at innovation and strategic thinking abilities (Esteves et al., 2024; Ramos-Luna & Oliver, 2024). Gender-based distinctions between leaders create differences in leadership methods that reshape their choices and teamwork approaches.

Most human resource (HR) administrators neglect EI variations when evaluating prospective candidates by continuing to assess conventional intelligence traits (Al Thawabie, 2024; Pyke, 2022). Organizations miss leadership opportunities when they ignore women with high EI abilities, thus creating more employee departure issues (Dennett & Dedonno, 2024; Maldonado & Márquez, 2023). Effective HR leader strategies to reduce employee turnover often involve managing and resolving conflicts, fostering open communication, and promoting work-life balance. In these areas, EI plays a significant role (Lomas, 2024). Improving retention requires HR leaders to widen their evaluation of EI competencies in leader success frameworks. Specifically, studies have shown that targeted EI training programs can improve employee performance, interpersonal skills, and job satisfaction, which are critical factors in reducing turnover (Laing-Hall, 2023).

HR leaders should adopt EI assessment tools during recruitment and leadership training, especially for healthcare organizations (Kitsios et al., 2022; Pillay-Naidoo & Nel, 2022). Implementing EI assessment tools during recruitment and leadership training, as suggested by Pillay-Naidoo and Nel (2022) and Kitsios et al. (2022), is further supported by findings indicating that such assessments can help identify candidates with the potential to enhance team performance and navigate emotionally challenging situations effectively (Coronado-Maldonado & Benítez-Márquez, 2023; Lomas, 2024). Failure to implement these assessments means healthcare organizations will pass up leaders who can boost employee engagement and operational success. The healthcare field lacks EI research, even though its role in leadership maintenance and team

achievements suggests such studies are necessary. Resolving this research deficiency will improve the workforce and enhance recruitment methods, employee connection, and company success rates.

Business Problem Focus and Project Purpose

The specific business problem is that some HR administrators within the healthcare industry in the southeastern region of the United States lack the EI strategies needed to increase the retention of female employees. Therefore, this proposed qualitative pragmatic inquiry aimed to explore EI strategies used by healthcare administrators in the Southeastern United States to increase women's leadership retention in their organizations.

A deliberate analysis of HR strategies for female leadership retention emerged through the EI constructs established by Salovey and Mayer (1990) because they excluded alternative EI models from the project, including the EI Model from Goleman (1995) and the emotional and social intelligence (ESI) model from Bar-On (1997). The chosen theoretical framework established a consistent approach to evaluate the strategic application of EI through HR decision-making, thus showing how administrators utilized EI for sustainable leadership.

Healthcare administrators in the Southeastern United States utilized specific EI strategies to improve women's leadership retention in their facilities. The project selected six HR managers who made leadership decisions and implemented workforce retention strategies through purposive sampling. The primary data collection method was semistructured interviews accompanied by public healthcare reports, industry statistics,

and relevant organizational documents such as HR policies and EI training materials. The data sources adhered to research protocols approved by the Institutional Review Board (IRB) to establish both ethical standards and methodological strength. This research fulfilled its purpose by supplying actionable information about leadership retention frameworks that supported HR administrators in developing workplace inclusion strategies and aided organizational leadership development.

Research Question

What EI strategies do healthcare HR administrators use to improve female leadership retention?

Assumptions and Limitations

Assumptions

This section identifies the assumptions, limitations, and delimitations of the project. An assumption is a self-evident truth that has not been verified (Ross, 2024). Limitations refer to potential weaknesses of the research (Liu et al., 2022). According to Coker (2022), delimitations include aspects that limit the scope of the project and serve to define the boundaries of research. The research adopted primary assumptions connected to the Monitoring, Evaluation, Accountability, and Learning (MEAL) framework. Social science investigations base their designs on fundamental unverified truths, also called assumptions (Wonda, 2024). These assumptions directly impact the entire data collection process, the interpretive phase, and the establishment of methodological rigor, according to Hennink et al. (2022). The research adopted an evaluation basis demonstrating that EI instruments could adequately measure and function systematically within healthcare

personnel management. EI evaluation as a workplace force and staff maintenance influencer could be measured through this assumption. The project recognized EI as a trainable competency that enabled accountable HR strategy planning and execution. The project presupposed that implementing EI into HR management structures would supply ongoing analytics that would help enhance workforce health and update policies (Hsu et al., 2022).

Second, the epistemological assumption of the project was that HR administrators possessed relevant and valid knowledge about the emotional experiences and retention issues faced by female leaders. As such, I assumed that these HR administrators would provide insightful, credible perspectives on the complex relationship between EI strategies and female leadership retention. This assumption was founded on the belief that HR practitioners' lived experiences and professional insights constituted legitimate knowledge that scholars could systematically explore and analyze to understand the phenomenon under project (Duncan, 2022).

Third, in terms of methodology, I presumed that qualitative pragmatic inquiry was an appropriate research approach that would help uncover various strategies employed by HR administrators. In line with the extant literature by Creswell (2021), I assumed that conducting in-depth interviews could capture rich, contextual data that quantitative methods might overlook. Besides, I assumed that HR administrators who participated in the project would provide honest, reflective responses about their EI approaches when engaging female leaders in the healthcare industry. Also, despite proposing purposive sampling to recruit participants, the underlying assumption was that the selected sample

would represent a sufficiently diverse sample of HR administrators in the Southeastern United States healthcare industry.

Lastly, I assumed that, in line with the findings from the extant literature, EI played a substantial role in women's leadership retention (Consten, 2023; Pyke, 2022; Waidler, 2022). The assumption was based on the belief that emotional support, self-awareness, managing emotions, and understanding others' needs mitigated workplace stereotypes and biases likely to result in high turnover rates among women leaders (Singh et al., 2023; Xie et al., 2021). As such, the assumption was that barriers to retaining women leaders were not just systematic or structural but also influenced by EI practices within an organization. Thus, it was assumed that by identifying and understanding these EI strategies, HR managers could develop better retention measures and reduce turnover costs.

Limitations

Limitations refer to potential shortcomings that can impact the outcomes and deductions made from research (Tracy, 2024). The project had potential limitations that should be acknowledged since they could affect the interpretation of the findings. First, the project was geographically limited to the Southeastern United States. Such a limitation presents a notable constraint regarding the transferability of findings to other healthcare settings outside this region (Mpofu, 2025). Such a regional focus potentially excludes diverse EI strategies and perspectives in different geographical and HR organizational settings.

Second, the pragmatic inquiry was limited to the qualitative nature of subjective findings. Interview responses introduced inherent limitations regarding the lack of quantitative measurement and statistical representativeness. Since I relied on personal responses, the research was vulnerable to potential biases in participant self-reporting, considering that living experiences varied from person to person (Creswell, 2021). Social desirability bias could also result as participants prioritized sharing favorable or idealized versions of their EI strategies while underreporting unfavorable approaches. Using a small sample, a significant characteristic of qualitative studies (Hennink et al., 2022), could also affect the ability to draw broad and definitive conclusions about EI practices across the healthcare industry, further affecting the transferability of the findings.

Third, the project has some methodological limitations. Objectively measuring and interpreting EI strategies through interview responses was difficult. Obtained responses were primarily limited to the subjective experiences of each participant (Walker et al., 2024), which hindered the consistent development of reliable measurement protocols. The project findings were also likely limited by participants' self-awareness, understanding of EI and its importance to female leadership, and willingness to share candid insights about the topic during the interview sessions. Such issues might result in a partially obscured or incomplete understanding of actual EI strategies HR administrators employ in their organizational practices.

Fourth, another limitation of this project stemmed from contextual and temporal issues related to EI. Scholars observe that EI is a dynamic and evolving construct influenced by societal expectations, various leadership styles, and organizational cultures

(Esteves et al., 2024; Ramos-Luna & Oliver, 2024). An autocratic leader may perceive EI strategies differently from leaders practicing transformative, transformational, or servant leadership styles (Bakker et al., 2023; Sojer et al., 2024). Therefore, the snapshot findings of this cross-sectional project represented perceptions about EI limited to a specific moment in time. As a result, these findings might have become obsolete as HR managers in healthcare organizations continuously adapt varied EI strategies to their female leadership development and retention. Women's leadership also experienced different emotional aspects of EI across different personal, professional, and demographic backgrounds, further constraining the applicability of this project's findings.

Transition

Section 1 provided the foundation for the research by establishing the business problem, purpose statement, research question, and conceptual framework. A literature review extensively defined EI strategies and their application in female leadership retention within healthcare. According to Salovey and Mayer's (1990) EI model, the project examined some of the most critical EI components, including emotional awareness, regulation, and management, and their impact on leadership effectiveness. The review also highlighted challenges female leaders encounter, including limited career development opportunities, workplace discrimination, and poor HR support. It stressed the contribution of HR administrators in developing emotionally intelligent leadership. The part also touched on EI strategies and their role in organizational success, staff engagement, and inclusive leadership building. The project aims to address prevailing

gaps by providing evidence-based, workable EI practices that HR administrators can implement to improve leadership retention.

Section 2 consists of reviews of the professional and academic literature. Section 3 presents project outcomes by explaining critical themes and positioning them within the conceptual framework and the literature. Section 4 will provide conclusions, recommendations, and inferences to HR administrators, research direction for future EI retention policy research, and the overall conclusion.

Section 2: The Literature Review

A Review of Professional and Academic Literature

This qualitative pragmatic inquiry research project aimed to explore effective EI strategies of HR administrators for women's leadership in healthcare. I reviewed academic and professional literature to provide sound justification for my analysis of the effective EI strategies in healthcare. The conceptual framework of this project aligned with the phenomenon of EI strategies in healthcare HR management, with a primary interest in understanding female leadership retention in the Southeastern United States. Scholars observe that EI represents a vital construct that bridges individual emotional capabilities with strategic workforce management. This was specifically integral in high-stress healthcare environments where retaining talented female leaders is key to organizational and societal success (Abdallah & Mostafa, 2021; Majeed & Jamshed, 2021). Salovey and Mayer's (1990) EI theory and its four constructs were used to explore and understand the identified business problem.

Conceptual Framework

EI Theory

Various theories on EI exist alongside its association with women's leadership capabilities. Salovey and Mayer's (1990) EI theory and Goleman's (1995) EI model are accompanied by Bar-On's (1997) ESI model and Petrides and Furnham's (2001) trait EI theory. Scientific research began with Salovey and Mayer (1990), who defined EI as the complete framework to detect emotions and comprehend, manage, and utilize emotions effectively. The leadership connection Goleman made between EI and success through

self-awareness and self-regulation has not been confirmed by empirical research and omits gender-specific analysis. Bar-On introduced EI as a framework that merges social and emotional competencies with stress management and adaptability, while his conceptualization exists primarily in the domain of traits rather than abilities. Petrides and Furnham maintained that EI functions as a fundamental personality trait that does not follow a skill-based developmental pattern, thus reducing its utility in HR training initiatives (Sambol et al., 2022). The research by Gerhardt et al. (2025) demonstrated that EI strengthens leadership and keeps employees safe while showing that women can connect with others through EI skills. The research used Salovey and Mayer's theoretical framework because it provided an organized structure to evaluate HR strategies supporting women's leadership retention.

Bar-On's ESI model (1997) has also been used to assess EI and organizational leadership. However, the ESI model focuses on broad social competencies and personal traits, including emotional self-awareness, self-regard, social responsibility, and interpersonal relationships. The ESI model does not focus on cognitive aspects such as problem-solving. Moreover, critics argue that ESI lacks clear constructs and its measurement remains elusive in organizational contexts (Gerhardt et al., 2025). These findings indicate that the ESI model generally focuses on generic social skills and personal attributes, lacking contextual issues relevant to female leadership dynamics in the healthcare sector.

Trait EI theory by Petrides and Furnham (2001) has also been used in EI research. Trait EI theory postulates that EI is a personality trait embedded in individuals' personal

expression, regulation, and emotion perception. When applied to this project, the trait theory has limitations, as it lacked rigor and cognitive-based measurement focused on emotional processing skills. Petrides and Furnham's trait EI theory also lacked focus on broad dispositional traits, such as failure to explore impulse control, stress management, adaptability, and interpersonal relationships.

Considering the potential shortcomings of the theories by Goleman's (1995) EI model, Bar-On's ESI model (1997), and Petrides and Furnham's (2001) trait EI theory, there was a need to consider an alternative framework for this project. Specifically, the EI theory developed by Salovey and Mayer (1990) was practically appropriate and comprehensive in understanding EI strategies in women's leadership. The EI theory is a comprehensive cognitive-based model that defines EI as the individual's ability to perceive, use, understand, and manage personal emotions and those of others around them (Salovey & Mayer, 1990). The rationale for using Salovey and Mayer's EI theory was informed by four aspects: being a cognitive-based framework, offering specific components, aligning with healthcare research, and offering gender-specific characteristics.

Being a cognitive-based framework, Salovey and Mayer's (1990) EI theory focuses on emotional processing, a set of mental skills with measurable dimensions in EI. Specific model components include emotion perception (accurate identification of emotions), emotion facilitation in thinking, understanding emotions, and emotional management. Regarding research alignment, Salovey and Mayer's EI theory offered operationalizable constructs and helped assess employee retention using emotional

competency assessment. Gender-specific relevance of the EI theory ensured researchers could explore emotional skills in female leadership by moving beyond generalized trait-based approaches.

Salovey and Mayer's (1990) EI theory's practical relevance in this project aligned with its focus on emotional abilities, high-stress settings, and addressing interpersonal relationships in necessary healthcare settings. EI theory also emphasizes concentration on development, including learnable skills, and gives a framework for training programs (Dasborough et al., 2022), making it suitable for HR implementation. Besides, EI theory has a clear framework with substantial research support through years of extensive validation studies, giving it a robust theoretical foundation and continued empirical support in the extant literature (Bru-Luna et al., 2021; Majeed & Jamshed, 2021).

EI theory emerged from emotion and intelligence research traditions (Singh et al., 2022). This theory was initially defined as the "ability to monitor and discriminate emotions to guide thinking and actions" (Ding et al., 2024, p. 142). In elaboration, EI theory relates to a leader's ability to accurately identify, express, interpret, and control personal feelings and those of others or their followers (Dasborough et al., 2022). Over time, the theory has been refined to include four components related to emotional abilities: emotional awareness, emotional facilitation, emotional regulation, and emotional management (Salovey & Mayer, 1990). As applied to this project, the theory offered a framework to identify essential EI strategies HR administrators could use for women leaders to increase retention while reducing turnover costs in the healthcare industry.

Emotional awareness relates to individuals' ability to identify and understand their emotions and those of others (Salovey & Mayer, 1990). Scholars hold that emotional awareness entails identifying emotional signals via verbal cues, body language, and facial expressions (Duan et al., 2023). A leader should be able to distinguish between false and genuine emotional expressions and relate how they impact their behavior and those of others in workplace settings (Dasborough et al., 2022). A cross-sectional study by Görgens-Ekermans and Roux (2021) that included 267 employees and 85 leaders found that emotional awareness helps understand self and others' emotions. However, the researchers cautioned that objectively measuring emotional perception is still problematic. Besides, Duan et al. (2023) observed that the accuracy of measuring emotional awareness is often affected by cultural variations in emotional expression.

Emotional facilitation is using emotions to improve decision-making and cognitive processes. The concept entails comprehending how emotions stimulate creativity, prioritize attention, and guide thinking (Salovey & Mayer, 1990). A review of 35 publications on EI theory by Bru-Luna et al. (2021) found that through emotional facilitation, leaders used emotional states to improve their problem-solving abilities. Also, leaders used this facilitation to understand how emotional states influenced judgment and perspective-taking in different leadership circumstances. Majeed and Jamshed (2021) reported that emotional facilitation enabled nurse leaders to link emotions to cognitive processes, thereby improving decision-making. However, Majeed and Jamshed noted that feelings and thoughts have a complex relationship, while individual differences in emotional processing broadly impacted outcomes.

Emotional regulation is attributed to a person's ability to control and manage emotional responses suitably, irrespective of circumstances. The component relates to individual understanding of how to promote positive emotions while moderating or mitigating negative ones (Salovey & Mayer, 1990). Abdallah and Mostafa (2021) observed that emotional regulation included maintaining balanced emotions when under pressure, developing coping strategies, being empathetic, developing distress tolerance, and viewing challenges as opportunities. However, Xie et al. (2021) argued that emotional regulation assumed universality in individuals' ability to regulate emotions. Therefore, EI theory often fails to account for physiological differences.

Emotional management regards the individual's ability to influence others' emotions and build suitable relationships through emotional understanding (Salovey & Mayer, 1990). In line with this concept, leaders used emotional knowledge to create positive teamwork, address conflicts, and motivate others to become successful. Lambert (2021) noted that among leaders in the healthcare industry, the concept included creating strategies that ensured a supportive work environment, better team collaboration, and solid interpersonal connections at the workplace. However, Lambert found that emotional management varied across ethnic or cultural settings, making it challenging to implement consistently.

Concerning the identified business problem, EI theory aligns with the problem statement by focusing on skills such as identifying, interpreting, expressing, and controlling emotions (Dasborough et al., 2022). These skills are essential for HR administrators in healthcare to develop effective leadership strategies for women (Duan

et al., 2023). Hampel et al. (2024), Hanchinalkar et al. (2024), and Hsu et al. (2022) validated the EI framework and its applicability in organizational leadership practices. A qualitative study by Hanchinalkar et al. found that emotional awareness helped leaders recognize their own and others' emotions. A case study by Hampel et al. reported that using emotions facilitated effective decision-making, as EI leaders used emotional knowledge when problem-solving. In a meta-analysis of 45 past studies, Hsu et al. noted that emotional regulation improved how leaders controlled personal emotions while adapting to workplace challenges effectively, thereby formulating suitable stress management techniques. Hanchinalkar et al. also found that leaders with high EI adequately managed their emotions, which is essential in influencing team dynamics, building positive relationships, and embracing diverse conflict resolution strategies.

While Hsu et al. (2022) and Salovey and Mayer (1990) advocated the model's applicability in organizations, Hanchinalkar et al. (2024) and Hampel et al. (2024) contended that the EI model oversimplified complex emotional processes in leadership. Despite this concern, the model retained a robust theoretical foundation based on interviews and secondary data from past studies. However, there is a need for more empirical validation using primary data collected through surveys, focus groups, and field observations in healthcare settings. Such an approach will be vital in addressing the knowledge gap attributed to limited healthcare-specific applications of the EI framework, especially in the Southeastern region of the United States. Exploring the four components of EI (emotional awareness, facilitation, regulation, and management) will help to directly address the lack of EI strategies in women's leadership, potentially offering

solutions to increase retention of female employees in the healthcare industry and reduce organizational turnover costs.

When considering the research purpose, EI theory supports this project by providing a framework to explore and understand the EI strategies used by healthcare administrators. In this dissertation, the four elements of EI will offer a structured approach to investigate how EI is utilized and developed in women's leadership roles within healthcare organizations in the Southeastern United States. Regarding emotional awareness, the theory will help identify systems HR administrators can develop to identify and recognize women leaders' emotional cues, such as safe spaces and regular surveys for women to express workplace challenges (Görgens-Ekermans & Roux, 2021).

Emotional facilitation may help assess how HR administrators can use emotional data to create policies that support positive emotional engagement, develop leadership programs, and inform decision-making processes and individual innovation. Examples of successful EI training strategies identified in practice included workshops focused on self-awareness through reflection, training in self-assessment skills like journaling, coaching programs targeting EI, and the use of simulations and role-playing to practice emotional management in high-stress situations (Laing-Hall, 2023). Emotional regulation may help HR focus on the root causes of women leaders' emotional challenges to develop targeted interventions and tailored mentorship programs. In emotional management, the EI theory will help understand the support systems HR administrators should implement through executive coaching. Some of these systems can include

wellness programs, flexible work schedules, and stress management and emotion regulation interventions.

Salovey and Mayer developed EI theory in 1990, conceptualizing EI as social intelligence. That is, the researchers postulated that EI entailed the ability of an individual to monitor not only their emotions but also the feelings of others. Such an understanding helped individuals discriminate their emotions and those of others, using the captured information to evaluate and guide thinking and subsequent actions (Salovey & Mayer, 1990). As applied to this project, the decision to use EI theory was informed by its comprehensive framework to understand the project problem. The theory provides four conceptual lenses to understand interpersonal dynamics and HR leadership support mechanisms that influence female employee retention.

The four components of the EI theory include emotional awareness, emotional facilitation, emotional regulation, and emotional management (Salovey & Mayer, 1990). Based on this theoretical model, it becomes possible to investigate how EI is emerging and utilized by female employees in the healthcare industry. Perception of emotions relates to the individual capacity to recognize and interpret emotional signals of self and others accurately (Hsu et al., 2022). When considering the need to retain women leaders and reduce turnover costs in healthcare, perceiving emotions is crucial for HR administrators to address the emotional needs of female leaders. When administrators develop keen perceptual skills, they effectively identify delicate emotional cues that hinder the retention of female leaders, such as job dissatisfaction, workplace stress, and work-life balance (Duan et al., 2023). Failing to address emotional barriers like

defensiveness, resentment, and inadequacy increases the risk of high turnover costs and low retention of female leaders (Dasborough et al., 2022).

The second concept of the EI theory relates to the emotional facilitation of thinking. Under this component, the focus regards leaders' ability to integrate emotions into their cognitive processes to improve problem-solving and decision-making (Salovey & Mayer, 1990). In healthcare organizations that experienced the problem of retaining female leaders, emotional facilitation was critical in enabling leaders to create adaptive strategies that responded to unique challenges women encountered in their leadership roles. Hanchinalkar et al. (2024) found that when HR administrators could leverage emotions as informative signals, they designed more responsive and empathetic interventions for leadership development. As a result, HR administrators developed decision-making frameworks that acknowledged and addressed the emotional challenges that women leaders experienced.

Understanding emotions is related to the third component of the EI theory. According to Salovey and Mayer (1990), understanding emotions entails comprehending the complex meanings that others' emotions convey and how they evolve. In this project, the concept is related to developing a clear comprehension of the emotional path female leaders experience in their careers. Appreciating how the emotions of female leaders evolved enabled HR administrators to create dedicated support systems that recognized diverse emotional issues. Majeed and Jamshed (2021) found that some of the common emotional challenges that could be addressed included gender-related barriers to career advancement, managing work-life balance, and navigating workplace dynamics,

including stereotypes and gender bias. A detailed comprehension of diverse emotional landscapes ensured that the healthcare sector developed tailored retention strategies that aligned with the lived experiences of women leaders.

The fourth component of the EI theory relates to managing emotions. The ability to manage emotions refers to leaders' competency in regulating and navigating emotional responses effectively (Hsu et al., 2022). Such emotional reactions included managing personal emotions and those of others they interacted with. In the healthcare sector, this concept denotes that when considering female leaders, emotional management helped create a resilient and supportive workplace environment for employees (Hampel et al., 2024). HR administrators who effectively managed emotions created relevant interventions to assist female leaders in developing emotional regulation skills and supportive communication channels. The HR leaders also built organizational cultures that validated and supported EI in women's leadership. Abdallah and Mostafa (2021) noted that understanding emotions was likely to transform emotional management from a passive recognition to an active tool for professional development. As a result, Lambert (2021) argued that this vastly reduced turnover by creating more emotionally responsive and intelligent workplace ecosystems.

In line with the four concepts under the EI theory, its primary conceptual proposition included the recognition that EI could be learned and developed as a leadership skill set. Hampel et al. (2024) observed that EI directly impacted leadership performance, organizational effectiveness, employee engagement, job satisfaction, and retention. Majeed and Jamshed (2021) found that leaders with high EI effectively

understood, perceived, used, and managed diverse emotions in different professional contexts. Such leaders, therefore, could navigate and manage emotions in complex workplaces such as the healthcare industry, which was characterized by high-stress environments and complex interpersonal interactions.

The conceptual framework established logical connections between EI strategies and women's leadership retention in various ways. First, the EI theory helped explore how HR administrators' EI capabilities could directly influence the creation of supportive organizational environments. Second, using EI theory helped assess the potential relationship between emotionally intelligent leadership practices and female employees' perception of job satisfaction, managerial support, and commitment to their current organization. EI theory aligns with the problem statement by focusing on skills such as identifying, interpreting, expressing, and controlling emotions (Dasborough et al., 2022). These skills were critical for HR administrators in healthcare to develop effective leadership strategies for women (Duan et al., 2023). Exploring the four components of EI (i.e., emotional awareness, facilitation, regulation, and management) helped directly address the lack of EI strategies in women's leadership, potentially offering solutions to increase retention of female employees in the healthcare industry and reduce organizational turnover costs.

This project's research approach aligned with the theoretical framework using a qualitative pragmatic inquiry design. Pragmatic inquiry allowed me to explore various lived experiences (see Bru-Luna et al., 2021) with female leaders and EI strategies employed by HR administrators. The formulated research question was proposed to

directly evaluate the project problem and aligned with the theoretical propositions that sought to identify precise EI strategies that contributed to increased retention of female leaders in healthcare organizations (Dasborough et al., 2022). The development of the interview questions, as the primary instrument of the project, was intended to help me generate rich, contextual data that could be analyzed through the lens of EI theory. Thus, focusing on HR administrators' experiences, perceptions, and strategies they implemented, the research uncovered essential insights into how EI could be operationalized to support women's leadership retention.

The theoretical framework by Salovey and Mayer (1990) extended beyond individual emotional capabilities to address broader organizational dynamics. In the process, I recognized that EI was not merely a personal trait but a strategic approach to HR management (see Majeed & Jamshed, 2021). Hanchinalkar et al. (2024) found that the EI framework emphasized the interconnected nature of interpersonal relations, emotional understanding, and organizational success in healthcare contexts where diversity and inclusive leadership were critical to maintaining a competitive workplace environment. When integrating the EI theory and the human resources of the Southeastern U.S. healthcare sector, I aimed to provide a comprehensive approach to understanding the main factors that influenced female leadership retention. In this dissertation, the four elements of EI provided a structured approach to investigate how EI was utilized and developed in women's leadership roles within healthcare organizations in the Southeastern United States.

The research was delimited to Salovey and Mayer's (1990) EI framework as its primary analytic model, excluding alternative EI frameworks, including Bar-On's (1997) ESI model and Goleman's (1995) EI model. The selected research approach provided healthcare organizations a unified method to evaluate how HR administrators developed strategies to retain female leaders. The qualitative pragmatic inquiry research design required theoretical backing from Salovey and Mayer's framework to explore narrative-based experiences of EI practices.

To compose the literature review, I accessed both academic databases and websites. I used the following databases and search engines: ProQuest, Google Scholar, and Walden Libraries. Terms used during database searches included *emotional intelligence, leadership styles, women, leaders, success, strategies, healthcare, and retention in healthcare*.

This literature review consists of references from 122 journal articles, of which over 119 (98%) are peer-reviewed sources. Of the total sources used in the project, 97% were published between 2019 and 2024, with 3% having publication dates over 5 years old (see Table 1).

Table 1*Number and Percentage of Sources Used*

Source type	No. of total sources (%)	No. of peer-reviewed sources (%)	No. of sources < 5 years old (%)	No. of sources > 5 years old (%)
Journal articles	119 (98)	116 (97)	116 (99)	3 (60)
Books	3 (2)	3 (3)	1 (1)	2 (4)
Total no. (%)	122 (100)	119 (100)	117 (97)	5 (3)

Literature Review Organization

The literature review takes the format of the business problem, conceptual framework, and research question. It begins by providing an overview of the theoretical models of EI, how it emerged, and its measures and applications in leadership. Section two discusses EI and its effectiveness on leadership during decision-making, conflict resolution, and employee management. Section three examines gender, healthcare leadership issues, biases, careers, and HR interventions. Section four addresses HR's role in preventing leadership turnover through mentorship, EI training skills, and workplace diversity. The final section identifies literature gaps and proposes research avenues for improving EI applications to leadership development.

EI has been widely accepted as a key to successful leadership, organizational effectiveness, and talent management, particularly in healthcare. EI encompasses self-awareness, self-regulation, motivation, empathy, and social skills, all applicable to leaders working in high-speed and high-stress environments. Emotionally intelligent leaders have been found to create more teamwork, greater employee engagement, and

improved decision-making. Beyond individual performance, emotionally intelligent leaders were better equipped to manage and resolve team conflicts, fostering a more positive and productive work environment that contributed to lower turnover rates (Lomas, 2024). Within healthcare organizations, HR managers were crucial in implementing EI strategies for female leadership retention, reducing workplace biases, and encouraging emotionally supportive leadership cultures. This literature review critically analyzed the intersection of EI and effective leadership, gendered leadership retention differences, HR intervention, and workplace culture to identify achievements and gaps in the field.

Görgens-Ekermans and Roux (2021) postulated that EI was important in transformational leadership because it helped leaders inspire and engage teams based on self-knowledge and emotional understanding. Saha et al. (2023) highlighted how EI improved adaptability and resilience in leadership, especially in the changing scenario of the future workforce. In HR practice, Coronado-Maldonado and Benítez-Márquez (2023) recognized the promise of EI to build high-performing teams where emotionally intelligent leaders created psychological safety and trust with employees. Such findings rendered EI a critical leadership skill, especially in healthcare management, where HR administrators faced intricate interpersonal relationships and high-stakes choices.

Although EI has been internationally recognized as a critical driver of leadership success, issues regarding gender in leadership have continued to persist in most industries, including healthcare. Mousa et al. (2021) systematically reviewed women's development in health leadership and proposed that the central organizational

interventions were prejudice training, mentoring programs, and leadership coaching. Smith and Sinkford (2022) also referred to gender equity in international health leadership. They found that institutional prejudice and organizational culture continued to be lingering issues that hampered the progression of women leaders. Their findings demonstrated that although EI could empower women leaders in addressing workplace concerns, system-based issues still required HR intervention for retaining leadership and ensuring long-term career growth.

Mey et al. (2021) explained the impact of emotionally intelligent leadership on staff retention and how HR administrators could implement EI strategies to reduce turnover and enhance job satisfaction. Their findings aligned with those of Dugué et al. (2021), who emphasized the importance of EI in nurse education and proposed its use in developing emotionally competent healthcare leaders. These works substantiated the importance of HR departments integrating EI-based leadership development programs, training, and coaching into their portfolios to establish a resilient and inclusive workforce.

A review of the extensive literature on EI showed that organizational leaders could use various strategies to increase the retention of female leaders and reduce turnover costs. Findings from past studies largely supported the theoretical components of emotional awareness, facilitation, regulation, and management proposed by Salovey and Mayer's (1990) EI theory. Strategies for HR administrators included developing emotional self-awareness, creating emotional facilitation processes, and promoting emotional regulation techniques. Other promising strategies involved creating emotional

management interventions, reforming workplace values, and facilitating relationship management using peer networking, mentorship, and professional counseling. These strategies could be integrated into HR administration practices to address the challenges of limited EI competencies, potentially resulting in high retention rates and cost reduction.

Despite the extant literature providing substantial information about strategies that healthcare HR administrators could use to address the problem of limited EI competencies, potential knowledge gaps remained. First, most studies were subjective, drawing their data from qualitative interviews, which limited their transferability to other settings. There was a need for further empirical evidence based on quantitative studies to validate the effectiveness of identified strategies when applied in healthcare settings. Second, there was a lack of standardized measurement tools for examining emotional regulation, facilitation, and management strategies (Bodrogi et al 2022). This created hurdles for cross-organizational evaluation and comparison of reliable strategies administrators could use to support EI among women leaders. Third, findings from the identified studies were primarily limited to management and business contexts, with few scholars examining the problem in its applicability to the Southeastern United States. There was a need to expand research on this understudied topic, focusing on this region of the United States and the healthcare sector. Lastly, most studies employed cross-sectional designs limited to a specific period. Undertaking longitudinal studies would help comprehend the long-term impacts of various EI strategies on reducing female leader turnover costs and increasing retention.

In line with the obtained findings, there were essential recommendations to address these limitations. First, scholars needed to conduct empirical studies focused on the healthcare industry. Collecting surveys, interviews, questionnaires, and quasi-experimental designs could empirically explore and test the efficacy of EI strategies in healthcare organizations. Such findings would complement the extant literature and current evidence base, contributing to the generalization of results. Second, another critical area was the development of validated questionnaires on self-awareness and emotional facilitation strategies to ensure the validity and reliability of findings across different healthcare facilities. Third, more research should focus on healthcare institutions in the Southeastern United States. Such an approach would contribute vital information relevant to HR administrators' local needs when reducing turnover costs among female leaders. The next chapter presents the research methods and strategies that will be used to collect relevant data to explore the formulated research problem and research question.

Transition

The literature review provided EI theories with critical analysis, gendered leadership issues, and HR interventions within the health field. Significant findings indicate that EI is central to successful leadership, and HR managers have no systematic EI plans to enable female leaders, leading to high turnover. The literature review also identified empirical research gaps toward EI's implementation in retaining health leaders, particularly in the Southeastern United States. These loopholes necessitate further research studies to examine how HR administrators employ EI strategies to improve female leadership retention. Section 3 will expound on the project design, including the

qualitative pragmatic inquiry process, participant selection, and data collection protocol.

It will also describe ethical concerns and project procedures for validity and reliability.

This systematically studied HR administrators' experiences and how to integrate effective EI-based retention strategies into healthcare settings.

Section 3: Research Methodology

The purpose of this qualitative pragmatic inquiry was to explore EI strategies that healthcare administrators in the Southeastern United States use to increase women's leadership retention in their organizations. In this section, I present findings from semistructured interviews with six healthcare administrators across the Southeast United States and review documents by the administrative leaders. Through research findings, I identified effective EI strategies administrators used to retain women leaders in their organizations. These findings may help administrators to apply more effective EI strategies to keep women leaders motivated and provide the support needed, thereby retaining female employees and reducing employee turnover within healthcare organizations.

Project Ethics

I collected data based on research ethics that constitute fundamental requirements for all studies, especially when research subjects are human beings. The researcher in qualitative research must adhere to ethical principles to defend participant rights and validate data while keeping a neutral scientific perspective throughout the investigation. Based on Eckstein (2021), the research maintains established ethical standards through confidentiality arrangements and obtaining informed consent and voluntary participant choices consistent with the principles detailed in *The Belmont Report* (1979).

Detailed informed consent documents, containing complete information about the project objectives, related procedures, potential risks, and withdrawal rights without penalty, were provided to all participants to preserve ethical standards. The collection of

participant names, professional positions, or workplace identifiers was avoided to ensure confidentiality. Instead, participants were assigned unique codes or pseudonyms. All data were kept confidential and restricted to me to prevent unauthorized access. The collected data were stored securely for 5 years to protect participants' rights, in compliance with ethical academic guidelines, before being permanently deleted. The final doctoral manuscript included the Walden IRB approval number. Throughout the project, I maintained transparency about the research project while actively minimizing bias and upholding institutional ethical boundaries. These measures enhanced the project's credibility, reinforced moral integrity, and safeguarded participants' welfare.

Nature of the Project

I took a qualitative pragmatic approach to project how HR administrators employ EI strategies to sustain female leadership within their organization. The practical inquiry research approach matches EI theory because it enables interviewing to explore EI processes within healthcare leadership contexts (Görgens-Ekermans & Roux, 2021). The constructivist approach of pragmatic inquiry allows research to explore how healthcare administrators deploy EI skills during their support and retention efforts for female leaders because it examines real-life leadership situations. The qualitative method works excellently to recognize leadership situations in their context since it uses detailed interview interactions to involve participants.

Population, Sampling, and Participants

The target population of this research was six healthcare HR professionals tasked with formulating, executing, and evaluating leadership retention strategies within health

institutions, hospitals, and clinics. These professionals significantly impacted workplace policy, recruitment strategies, and leadership development programs; therefore, they were well-placed to provide information on female leadership retention influenced by EI strategies. To ensure relevance, participants had to have at least 2 years' experience in HR leadership roles and be actively involved in hiring, training, or retaining female healthcare leaders. The inclusion criteria targeted participants with first-hand experience of EI activities initiated by HR, which allowed the project to develop hands-on, experience-based knowledge of how EI could be leveraged to sustain leadership retention in the long term.

Participants

The participants were sourced through professional HR networks, LinkedIn, healthcare leadership networks, industry conferences, and HR webinars to acquire access to experienced participants. Direct recruitment consisted of email solicitations, professional recommendations, and collaboration with healthcare institutions that had created HR leadership initiatives. Institutions were officially requested for approval to conduct research, a confidentiality protocol, and the optional participation requirement. In addition, I received approval (04-22-25-0976493) from the IRB before recruiting participants to ensure that ethical standards were met. I provided an informed consent form to all the participants, informing them of their rights, the procedure in the project, and their right to withdraw at any time without penalty.

Establishing a Working Relationship With Participants

I established a working relationship with participants through the following steps:

1. Expressly state the purpose of the project and how it relates to HR leadership and retaining female leadership.
2. Be open to confidentiality and anonymity protocols, such that responses by participants will be anonymous.
3. Make scheduling accommodations for interviews so that participants can choose the most convenient time on their calendars.
4. Utilize active listening and open discussion invitations during interviews, offering a safe environment to provide feedback.

The population included HR administrators with at least two years of work experience in the healthcare sector, such as hospitals, clinics, medical insurance companies, and pharmaceutical firms across the Southeastern region of the United States. Across several healthcare settings, six participants were randomly sampled to participate in the semistructured interview sessions. The data sources included HR administrators from various healthcare companies in the Southeastern United States.

I used purposive sampling as the non-probability sampling strategy to recruit participants with expert knowledge, thereby increasing the reliability of the project results. This research strategy helped achieve data saturation by reaching the point at which no further new information was obtained from additional participants (Walker et al., 2024). In this sampling approach, the researcher selected participants with direct subject knowledge, which Hennink et al. (2022) noted as particularly suitable for qualitative research. Creswell and Creswell (2022) established that six to 20 research participants provided adequate methodological rigor while achieving saturation. The

selected participants in this project were healthcare HR administrators actively working in the industry and HR managers from the Southeast United States. Evaluating data obtained from these participants enabled the identification of effective EI strategies for lowering employee turnover while enhancing female leadership retention rates. Section 3 extensively analyzed the research strategies and methods that guided this project.

Sampling Method and Rationale

Purposeful sampling was employed in this project. Purposeful sampling is an established qualitative research practice that ensures respondents have experience relevant to the subject of the project. This approach allowed me to select HR administrators with first-hand expertise in EI-based leadership retention approaches, ensuring that the data collected were rich, thoughtful, and directly aligned with the project research question. Six participants were recruited in total, as this number was sufficient to reach data saturation, where no new understanding or themes emerged from additional interviews. In past qualitative research, it has been argued that six interviews provide sufficient depth to identify patterns, themes, and best practices in HR leadership styles (Guest, Bunce, & Johnson, 2006). The sample size was also justified in line with qualitative research standards, prioritizing rich understanding over statistical representativeness.

Achieving Data Saturation

To ensure data saturation, I did the following:

1. Conduct ongoing coding, thematic analysis, and data examination following each interview to track emerging themes.

2. Employ follow-up questions to explore key findings further and further understand participants' perceptions.
3. Recruit additional participants to provide further insights continuously until saturation is reached.
4. Construct recurring themes periodically across multiple interviews to ensure repetition of reliability and consistency.

Data Collection Activities

As the researcher, I was the primary data collection instrument, and I conducted all interviews, collecting the raw data from participants. After obtaining IRB approval and informed consent from participants, I commenced the data collection process. The data collection instrument was anchored on semistructured interviews. The interview protocol (see Appendix) included 10 semistructured questions that guided the data collection process.

The formulated interview questions aligned with the four constructs of EI theory by Salovey and Mayer (1990) (i.e., perception of emotions, emotional facilitation of thinking, understanding emotions, and managing emotions). Interview Questions 1–2 assessed whether HR administrators understood what EI entailed and whether their organizations prioritized EI when hiring leaders. Interview Questions 3–6 aligned with the conceptual framework by evaluating how HR administrators perceived emotional needs, facilitation, understanding, and managing emotions among female leaders. Questions 7–10 explored HR's approach to emotional self-awareness, organizational

emotional climate, professional development issues, and potential barriers and enablers in the acquisition of EI strategies

Data Collection Technique

As previously stated, data collection was achieved through semistructured interviews. Due to geographical distance, I scheduled interviews with recruited participants at their convenience. The data collection included conducting online interviews and capturing data through audio recordings on Microsoft Teams and email exchanges. All interview questions were emailed to participants, who completed and returned them via email. Any clarification was obtained by contacting participants directly for unresolved questions. Audio-visual interviews were recorded using an audio recorder after participants verbally consented to having their responses recorded.

Each interview session lasted between 25 and 35 minutes. I followed the interview guide, asking each participant the same questions in the same manner. I encouraged richer, more detailed responses by asking probing questions such as “Can you explain further?” or “Can you give me an example?” After completing each interview, I thanked all interviewees for participating in the project.

I conducted member checking and transcript reviews to enhance the reliability and validity of the data collection process. Participants were informed that a copy of their transcribed interview would be made available for review to ensure nothing had been omitted, misstated, or misunderstood. Participants were advised that they would have 72 hours after receiving the transcript to request edits or changes; if no response was received within that period, I assumed the transcript to be accurate. Merriam and Tisdell

(2021) observed that sharing transcribed interviews with participants is an essential debriefing exercise that ensures objectivity and eliminates misinterpretation of facts that could result in biased findings. The verified raw data were then used for subsequent thematic analysis.

Interview Questions

Interview questions were used to collect relevant responses from participants to help answer the primary research question. The interview questions aligned with the four constructs of EI theory by Salovey and Mayer (1990; i.e., perception of emotions, emotional facilitation of thinking, understanding emotions, and managing emotions). Open-ended interview questions encouraged in-depth responses from HR administrators who participated in the project by fostering active listening and allowing for contextual and narrative explanations (Creswell & Creswell, 2022).

Interview Questions 1–2 assessed whether HR administrators understood what EI entailed and whether their organizations prioritized EI when hiring leaders. Interview Questions 3–6 aligned with the conceptual framework by evaluating how HR administrators perceived emotional needs, facilitation, understanding, and managing emotions among female leaders. Questions 7–10 explored HR’s approach to emotional self-awareness, organizational emotional climate, professional development issues, and potential barriers and enablers in acquiring EI strategies. The abridged interview protocol that was used is as follows:

1. How do you define emotional intelligence, and how does it impact leadership effectiveness in healthcare settings?

2. What emotional intelligence skills does your organization prioritize when hiring leaders, and how are they assessed?
3. Describe how you use emotional intelligence to support female leaders through professional challenges in your organization.
4. What specific strategies have you implemented to:
 - Create emotional self-awareness strategies.
 - To facilitate the emotions of female leaders.
 - To promote emotional regulation among female leaders in high-stress situations.
 - To enhance the emotional management of female leaders.
5. What organizational barriers prevent HR administrators from developing effective emotional intelligence strategies for women in leadership, and how do you overcome them?
6. How do female leaders in your organization navigate emotionally demanding situations, and how does HR support them?
7. What leadership training or professional development initiatives have been introduced to enhance emotional intelligence among female leaders?
8. How do HR strategies support female leaders in managing emotions effectively when interacting with teams and executives?
9. What organizational barriers prevent HR administrators from developing effective emotional intelligence strategies for women in leadership, and how can they be addressed?

10. What measurable impacts have emotional intelligence strategies had on leadership retention within your organization?

Data Organization and Analysis Techniques

The raw data was transcribed verbatim and recorded in a Microsoft Word file secured on a password-protected computer. The transcribed data were then exported to NVivo qualitative analysis software (Version 12) for thematic analysis. Dollah et al. (2021) observed that the NVivo tool helped researchers organize and analyze significant qualitative texts into appropriate codes and themes. Considering the characteristics of qualitative data, which often included detailed interview responses, NVivo eased the analysis process by reducing large quantities of captured information.

After exporting data into NVivo software, I applied the six-step thematic analysis process proposed by Pearson et al. (2025) to code and identify themes from the transcribed interviews. In Step 1, Pearson et al. recommended that the researcher peruse and familiarize themselves with the raw data. This step included highlighting initial notes and essential texts. Step 2 entailed coding data by creating nodes based on main sentences, keywords, or sentences. The project focused on the four constructs of EI theory by Salovey and Mayer (1990; i.e., perception of emotions, emotional facilitation of thinking, understanding emotions, and managing emotions). Step 3 included identifying patterns and grouping similar information based on the codes generated in Step 2. In Step 4, all relevant themes were assessed and matched with supporting insights from the interview excerpts using participants' direct responses and quotes. Step 5 included aligning and organizing identified themes and deleting or merging overlapping

ones to ensure they contributed to answering the project problem. Lastly, Step 6 entailed reporting findings by supporting themes using exact interview excerpts (Pearson et al., 2025). All hard and soft copies of data were stored in a secure filing box in my possession and will remain securely stored for 5 years following the project's completion.

Data Analysis

The current project addressed issues of validity and reliability in the research findings. In qualitative inquiry, validity was established by ensuring the credibility and transferability of findings, while reliability was achieved by ensuring their dependability and confirmability (Merriam & Tisdell, 2021). Lincoln and Guba (1986) proposed that the four elements of confirmability, dependability, transferability, and credibility are essential to ensuring that the findings of a qualitative project are credible, valid, and trustworthy. Applying these elements enabled me to draw meaningful and reliable conclusions that met scientific rigor and respected participants' contributions. Subsequent subsections elaborate on the processes used to ensure the trustworthiness of the qualitative findings, based on Lincoln and Guba's (1986) criteria.

Reliability and Validity

Operational Definitions

Emotional intelligence (EI): Social intelligence entails the individual's ability to monitor their emotions and those of others, distinguish among them, and apply obtained insights to guide thinking and desirable actions (Consten, 2023).

Healthcare industry: An economic sector that includes various interrelated organizations that provide medical services, including clinics, medical insurance, nursing

and home care, hospitals, and related medical support services (Majeed & Jamshed, 2021).

Human resource administrators: Professionals managing employee welfare, including recruitment, development, retention, task assignment, and remuneration strategies (Al Thawabie, 2024).

Leadership retention strategies: Interventions and measures developed to support, assist, and maintain organizational leadership talent (Pyke, 2022).

Retention: The ability of an organization to maintain employees in their current positions, mitigating voluntary resignations, and preserving unique business talent and knowledge.

Organizational support: Perceived and actual provision of assistance, materials, resources, and developmental opportunities to improve employee engagement and professional growth (Hsu et al., 2022).

Professional development: Activities and processes are in place to encourage continuous improvement of employees' skills, competence, and knowledge about their professional roles (Esteves et al., 2024).

Qualitative pragmatic inquiry: A research method based on qualitative design to understand complex phenomena using in-depth interviews to explore contextual insights, perspectives, and experiences of participants (Ramos-Luna & Oliver, 2024).

Southeastern United States: The geographic region includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.

Turnover costs: Resources are required to source and hire new employees, train them, and retain them in an organization (Maldonado & Márquez, 2023).

Women leadership: Women hold strategic positions and professional responsibilities in executive and management positions in organizations (Esteves et al., 2024).

Reliability

I ensured the findings are reliable through two main aspects of confirmability and dependability. Dependability was established via audit trails, member checking of data interpretation, transcript review, and elaborate data analysis procedures subsequent subsections detail how reliability was established in this project.

Dependability

Lincoln and Guba (1986) defined dependability as the extent to which the data collection methods and analysis procedures are reliable and well-documented. This project used several techniques to ensure dependability, including maintaining audit trails, conducting elaborate data analysis, and thoroughly documenting the pragmatic inquiry process. Through the use of audit trails, all findings were supported with full interview transcripts, excerpts, audio recordings, and transcribed data. Additional procedures, such as seeking participant clarification, clarifying responses, and engaging in critical reflection, helped achieve methodological triangulation (Braun & Clarke, 2023).

The methodology chapter presented detailed methods and procedures to demonstrate the comprehensive process used to obtain data, including the role of the

researcher, the sampling process, data collection, and data analysis. Identifying the knowledge gap, research question, problem statement, and research design also contributed to the dependability of the qualitative findings (Ertiö et al., 2024). Furthermore, peer debriefing and sharing the entire research journal with experts or project supervisors, followed by discussing feedback and making revisions before, during, and after project completion, enhanced the dependability of the findings.

Validity

The validity of the current findings will be achieved by ensuring the data is credible and transferable. Credibility will be established using a robust interview protocol, and transferability will be achieved via sampling sufficiency and thick description techniques. The subsections below elaborate on how I attained validity.

Credibility

In this project, credibility refers to how accurately the findings on EI strategies in women's leadership reflect the lived experiences of HR administrators in healthcare, thereby ensuring the internal validity of the results. Credibility was achieved by adopting a well-established data collection protocol during interview sessions, as discussed under the Data Collection Activities. I engaged deeply with participants during the process, allowing HR administrators ample time to share, evaluate, and document their stories about EI strategies in women's leadership. Member checking was also used to establish the credibility and authenticity of the final transcripts (Creswell, 2021). In addition, conducting narrative reviews ensured the authentic reflection of participants' stories,

reflections, and perspectives on relevant EI strategies for HR administrators in the healthcare industry.

Transferability

The concept of transferability denotes the level to which the findings of a qualitative project can be applied to diverse settings or different people (Lincoln & Guba, 1986). In HR practices, transferability was assessed regarding how the findings could inform policy, existing culture, business operations, and future practice. This also included the potential to apply the findings to other healthcare sectors outside the Southeastern United States, general business managers or administrators, and non-medical industries.

Transferability was achieved through thick description by detailing background data and establishing the research context. Thick description also ensured a detailed evaluation of the problem under project, allowing for comparisons of EI strategies in female leadership used by HR administrators in different healthcare facilities in the Southeastern United States. Such comprehensive detail ensured the findings were meaningful when applied to other contexts (Hanchinalkar, 2024). Through sampling sufficiency, I further ensured transferability by achieving data saturation and methodological rigor.

Confirmability

Trustworthiness of findings can also be established through confirmability, which relates to the ability of others to confirm or corroborate obtained research findings (Lincoln & Guba, 1986). Confirmability was achieved through elaborate thematic

analysis and coding using a well-defined data analysis process. Detailed coding ensured that main themes were exhaustively identified and aligned to the primary theoretical concepts. I provided detailed evidence from interviews using direct quotes and excerpts to support the identified themes and participants' lived experiences. Researcher reflexivity was also employed to maintain awareness and objectivity in how themes unfolded, thereby avoiding bias resulting from personal misperceptions (Creswell & Creswell, 2022). My positionality and reflective commentary ensured that important themes about EI strategies in women's leadership were elaborated based on HR administrators' experiences. The integrity of the findings was further scrutinized through in-depth methodological descriptions. Finally, acknowledging all shortcomings of the project, including assumptions, limitations, and delimitations, helped establish the confirmability of the research.

Data Saturation

In this project, using pragmatic qualitative inquiry ensured that HR administrators detailed their responses about EI strategies and elaborated on how these approaches impacted women's leadership in the healthcare industry. In the process, participants who participated in the project identified new topics, themes, or ideas about EI strategies in women's leadership that HR administrators used, which I might have overlooked or omitted during the project (see Hennink et al., 2022). Ensuring that interview sessions were engaging, active, and collaborative resulted in an in-depth evaluation of the problem under project. This led to a comprehensive assessment of essential EI strategies that should be implemented in the healthcare industry. Using qualitative pragmatic inquiry in

this project enabled me to collect sufficient, detailed information on the EI strategies HR administrators in the Southeastern region of the United States used to increase women's leadership retention in their organizations.

Transition and Summary

The research project methodology was key in elaborating methods and strategies used to collect relevant data to answer the formulated research question. Essential concepts discussed include the role of the researcher, project ethics, the nature of the project, the target population, sampling, and participants. Relevant data collection activities using online interviews and data organization and analysis have been discussed. Other important Issues of validity and reliability that have been discussed include elements of trustworthiness such as credibility, dependability, transferability, and confirmability. The following section presents an in-depth discussion of findings addressing the overarching research query. The section includes a presentation of collected data, analysis of outcomes, theme identification, relevance to professional practice, potential impacts on societal change, recommendations for future research, personal reflections, and conclusions.

Section 4: Findings and Conclusions

Presentation of the Findings

This qualitative pragmatic project aimed to explore the EI strategies that healthcare HR administrators used to facilitate the retention of female leaders. The overarching research question that guided the project was: What EI strategies did healthcare HR administrators use to facilitate the retention of female leaders? Semi-structured interviews were conducted with six HR administrators from the Southeastern United States healthcare organizations to address this question. Each participant was assigned an alphanumeric identifier (H1, H2, H3, H4, H5, and H6) to protect confidentiality. Data was then analyzed through thematic analysis using NVivo software, enabling systematic coding and identifying patterns within the participants' responses. Three broad themes from the study were identified that represent essential dimensions of how EI was perceived, used, and contested in the context of female leadership retention. These themes described the strategies and obstacles HR administrators encountered in implementing EI in leadership practices. The research findings were written in narrative style as required by the guidelines of Walden University. They were substantiated with direct quotes from participants to preserve the authenticity of their opinions.

Theme 1: Emotional Intelligence as a Core Competency

The first theme that emerged was the recognition of EI as an essential leadership competence. Participants repeatedly emphasized the importance of healthcare leadership, which encompasses understanding and managing emotions and building trust with teams. H1 said, "I understand emotional intelligence as having the ability to recognize and

manage our own emotions and understand what other people are feeling.” EI is essential for effective leadership in healthcare because it makes communication, collaboration, and patient care possible. H2 defined EI as the capability to use your emotions to work with others to achieve a better result; he added, “In healthcare, emotional intelligence results in better collaboration and decision making, both of which are key to providing high-quality care to patients.”

H3 also defined EI as “the ability to recognize and respond to our own emotions as well as those of other people,” adding that “in healthcare, strong emotional intelligence leads to improved teamwork and improved decision making.” H4 agreed with this perspective, stating that EI is our “cognitive and affective ability to understand and manage our emotions and the ability to understand and manage the emotions of others,” and that these leaders are “more people-oriented, appreciative of relationships, and capable of building trust.” H5 took it a step further, defining EI as “the ability to identify, manage, and generally evaluate emotion” and connecting it to crisis management: “It really helps leaders better connect with their teams and handle crises more effectively.” Lastly, H6 emphasized the importance of EI in organizations by saying, “Emotional intelligence is about the ability to understand and manage your own emotions, but also being able to understand the emotions of others.” Teamwork and engagement are crucial in healthcare, leading to improved patient care.

Participants reported that their organizations actively use EI assessment instruments when selecting leaders, especially female leaders. Methods: Peer interview, situational judgement tests, and behavioral interviews were used. According to

Participant H1, his organization looks at “key skills [such as] empathy, self-regulation, and social skills,” which are measured by “behavioral interviews and role plays.”

Participant H2 explained that they “focus on emotional awareness, resilience, and teamwork skills” and evaluate them by “using situational judgment tests and reference checks” to determine how applicants “responded to emotional challenges in the past.”

Participant H4 described “peer interviews, where candidates are asked to work in real team meetings and demonstrate emotional intelligence.” These alternative approaches intentionally focus on EI within the leadership selection process.

Relation to the Theoretical Framework and Literature

The findings of Theme 1 point to the assumption that EI can be purposely developed according to the structured training programs that strengthen the healthcare leadership pipelines and retention. Throughout interviews, respondents documented the growth in self-awareness, resilience, conflict management abilities, and other aspects in female leaders through workshops, mentorship, simulated learning, and reflective practices. As an illustration, H2 mentioned that her organization relied on journaling, stress management, and high-pressure simulations to equip leaders with emotionally challenging situations, and H3 mentioned mentorship as one of the methods to develop confidence and provide valuable tips on how to deal with professional problems. These findings demonstrate the concrete relationship between EI building and effective leadership, confirming that training interventions enhance personal capabilities, team performance, and organizational culture.

According to the EI theory (Salovey & Mayer, 1990) perspective, the findings reveal that four theory constructs were applied practically during training: emotional awareness, facilitation, regulation, and management. Findings showed that reflective workshops were seen to have resulted in greater awareness (H1) and mindfulness and journaling regulation (H6), and coaching programs were seen to have resulted in greater management of emotion when leading a team (H4). As mentioned in Chapter 2, EI is the capacity to observe and control one's own and other people's behavior (Ding et al., 2024). The descriptions of training interventions by participants provide information about the idea of training operationalizing these constructs, and the leaders can use them to maintain emotions, establish a free discussion, and develop inclusive workplaces that can directly affect retention and patient care outcomes.

These results also correspond with the social role theory, which emphasizes the importance of social expectations in leadership behavior. Women leaders are frequently expected to exhibit EI-based soft skills in the healthcare setting, such as empathy, bonding, and joint problem solving, which are also promoted through EI development training. According to Esteves et al. (2024) and Ramos-Luna and Oliver (2024), such gendered expectations may burden women leaders with additional emotional labour. H5 and H6 training programs can provide women with the tools to balance the pressure exerted by their communities and the pressure exerted on the organization's performance positively. Organizations can fulfill the demand to develop skills and the social role female leaders are expected to take by establishing mentorship, coaching, and peer support communities in leadership tracks.

Lastly, these findings support the literature on optimal practice business by suggesting the inclusion of EI training as a component of healthcare leadership training. Recently, Pillay Naidoo et al. (2022) showed that clinical teams experienced more relational trust and collaboration when they applied formal EI programs. Kitsios et al. (2022) proved that the EI organizational embeddedness boosts the innovation capability and the retention of long-term employees. This is also modifiable in the comments of the participants, with H1 noting that peer workshops were valuable in developing a culture of learning together. H5 also originated the concept that training women leaders in individualized empathy and conflict resolution helped them to deal with complex work cultures. These parallels also support the notion that EI training programs are not peripheral but central to successful and viable healthcare leadership practice.

Theme 2: Training Programs for Emotional Intelligence Growth

The second theme from the interviews was providing training and professional development programs to assist female leaders in developing EI abilities. Respondents re-emphasized that EI is learnable and can be deepened by intentional organizational investment in formal education, mentoring, and experiential learning. This theme proves that the administrators do not see EI as a heritable characteristic but a leadership competency that can be learned, reinforced, and measured over time.

H1 described how her organization built EI capacity through regular training workshops and reflective practices. She further added, “We do training workshops that are aimed at helping leaders to grow self-awareness by reflection. To manage stress, we welcome women to discuss their experiences during peer support groups.” These

workshops involved personal awareness and a culture of collective learning, where the female leaders could talk about approaching high-stress situations.

Similarly, H2 indicated that her organization spends on experiential activities and simulated experiences to ground EI in practice. According to her, we have workshops where we learn emotional self-assessment tools, like journaling. Stress management techniques are also discussed, including deep breathing and dealing with emotions in simulated high-pressure situations. This fact highlights the importance of experiential training to equip women leaders with skills to handle emotions and respond efficiently in healthcare settings, which are typically characterized by crisis.

Mentorship was also determined to be another important training strategy. H3 demanded that new women be paired with older mentors, citing that we pair female leaders with more seasoned mentors, who can guide them on how to leverage their EI to deal with work-related problems. This mentoring not only provides them with confidence but also provides them with practical strategies that they can implement. The emphasis on mentoring demonstrates that learning EI continues beyond the formal workshops into relational and contextual coaching.

H4 and H5 were concerned about EI being part of wider leadership development programmes. H4 stated that her company seeks female leaders to participate in “coaching programs where emotional intelligence is the critical point,” which she said helps women “address challenges, use EI as a powerful tool for personal and team development.” H5 also continued this line of thinking and stated: “We have also introduced training programs that focus on building emotional intelligence skills such as empathy, active

listening, and conflict resolution, specifically for women leaders.” Such initiatives show that HR strategies now incorporate EI into leadership pipelines to groom women for senior positions.

Finally, H6 correlated training programs with measurable retention results. She said, “We have workshops around self-assessment and encourage peer mentoring. For emotional regulation, we teach skills like mindfulness and stress management. We also do simulations under high-pressure conditions for emotional management practice.” She concluded that these initiatives directly impacted higher retention rates among female leaders.

Given the emotional demands of healthcare, many programs included training in how to handle difficult situations. Participant H1 discussed the use of simulations to “practice emotional management in crisis,” a practice also described by Participants H2, H3, and H6, who emphasized role-play and scenario-based learning as tools to develop composure and decision-making under pressure. Such experiential methods enabled leaders to practice EI skills in high-stakes, real-life situations.

In addition to formal training, participants identified continued support structures needed to maintain EI development. Some of the strategies were weekly individual coaching (H1), developing safe spaces to talk about issues in the workplace (H3), attending leadership forums to share experiences (H5), and having open forums to learn with one another (H6). The results of such programs were confidence, resilience, and belonging, which participants attributed to leader retention (Laing-Hall, 2023; Lomas, 2024). Collectively, these results signify a holistic perspective that integrates skills

development with the continuous support mechanisms to institutionalize EI in leadership practice.

Relevance to the Theoretical Framework and Literature

The results of Theme 2 on training programs on the development of E) are consistent with EI theory (Salovey & Mayer, 1990), which suggests that EI is a cognitive and affective competence that can be trained through conscious and experiential learning. The participants highlighted that EI competences are strengthened through structured practices such as reflection, mentoring, and simulations. For instance, the H2 had women leaders prepare for emotionally challenging events by journaling, stress management exercises, and simulated training. In addition, H6 stated that mindfulness-based activities and workshops can be applied to develop emotional regulation and resilience skills. These findings are also consistent with Ding et al. (2024) in that they assumed that such skills as self-awareness, empathy, and self-regulation are not innate but can be developed through deliberate training interventions within the context of leadership.

The theme is also echoed in the social role theory, particularly how EI training is a reaction to the gendered demands of female medical leaders. As Esteves et al. (2024) and Ramos-Luna and Oliver (2024) note, women leaders are frequently expected to showcase superior relational and empathetic competencies and excel at strategic and operational work. The participants confirmed this dual demand. To illustrate, H3 described mentorship programs that enhance confidence and equip women with practical skills for dealing with professional failure. H4 concurred, emphasizing that coaching and peer forums contribute to effective female leaders to balance relational demands and

organizational performance. Such programs can be an excellent example of how EI training can empower women to manage emotional work more effectively and significantly impact leadership positions.

These outcomes further support and broaden business practice studies that suggest that EI training should be part of leadership pipelines, especially in healthcare contexts, where interpersonal effectiveness directly affects patient safety, quality of care, and workplace climate. According to Pillay Naidoo and Nel (2022), EI-based leadership development programmes may improve relational trust and team communication in a clinical setting, and Kitsios et al. (2022) showed that organizations with EI development as part of the professional pathway had better innovation climates and sustainable leadership retention. These participants' findings also coincide with the observations. H1, for instance, expressed that the workshops would aim to help them think about their own practice as leaders and provide peer support for sustainable leadership development.

By integrating EI development as an ongoing professional development approach, organizations not only embed the skills of female leaders in them but also build more resilient leadership cultures that can retain the talent in high-stress medical settings. These findings support the assertion that EI training is not an extrinsic but intrinsic element of good leadership practice and directly supports both the theoretical framework and the contemporary evidence of business performance in healthcare organizations.

Theme 3: Identification of Challenges and Obstacles in Implementing EI

Despite the established importance of EI and ongoing training activity, the interviewed HR administrators reported several challenges that prevent reliable,

organization-wide implementation. Barriers were often related to organizational culture, resource constraints, and gender dynamics, which influenced the interpretation and implementation of EI. Four aspects are discussed: organizational resistance to change, competing operational priorities, scarce resources available for EI development, and gender bias in leadership contexts.

A recurring theme expressed by several respondents was the view that EI is less important than technical competency. H1 stated, “One of our biggest challenges is that some people in the organization still see EI as less important than technical skills.” H2 echoed this view: “Some staff resist the idea that emotional intelligence is an important leadership skill, and see it as a ‘soft’ skill.” H5’s opinion was similar, noting, “Upper management does not fully appreciate the importance of emotional intelligence.” H6 added that they had encountered “skepticism about the relevance of emotional intelligence to leadership.” These statements indicate a cultural barrier that tends to delay the incorporation of EI into leadership development models.

Participants noted that one of the key challenges to adopting EI strategies in healthcare leadership was organizational skepticism that EI is a “soft skill” rather than a measurable competency, and they shared various ways of changing this perspective. H1 said, “We have success stories of leaders who have been successful because of their EI, and we are also integrating EI metrics into performance reviews to emphasize its importance.” Similarly, H2 stated that they overcame resistance by “providing data that shows the positive impact of EI on team performance”. In contrast, H3 indicated they needed to relate EI to outcomes, saying, “We try to relate improvement in EI to tangible

outcomes, such as staff retention and satisfaction”. H4 highlighted training as a tool for persuasion, pointing out that her team tries to “encourage certain EI training sessions and present evidence of its utility within leadership roles”. H5 supported this focus on evidence by sharing that “we integrate EI development into leadership pipelines and communicate its impact on creating a positive workplace culture.” Likewise, H6 noted that organizational narratives are used to create credibility, noting that they actively “integrate success stories from our organization into training sessions and strategic discussions”. Collectively, these perspectives illustrate a common understanding that overcoming resistance involves data and narrative: participants sought to establish EI’s legitimacy by integrating it into performance systems, demonstrating measurable results, and reinforcing its impact on workplace culture.

While it was difficult to quantify EI’s impact on retention directly, participants consistently associated EI with a more positive and collaborative work environment. H1 said, “Emotionally intelligent leaders can build a positive workplace culture that fosters trust and engagement.” H2 said there was a clear correlation between retention. H2 explained, “We have seen a significant correlation in retention rates in female leaders who have undergone emotional intelligence training, with a 25% reduction in turnover over the past year.” H3 also reinforced this point by linking EI with “staff retention and satisfaction.” H5 also mentioned that EI-based mentoring and conflict resolution support “helps female leaders manage their responsibilities effectively.” While participants agreed that retention gains may not always be directly quantifiable, they decided that EI

initiatives create a work environment that supports long-term leader engagement and performance.

Relation to the Theoretical Framework and Literature

Although the significance of EI was widely acknowledged, the findings also highlighted significant challenges and obstacles to its application in the real world of healthcare organizations. The fact that some leaders and employees perceived EI as less important than technical competence indicated a continued lack of recognition of its strategic importance. This barrier has been noted in previous studies. Studies showed that many HR administrators focused on traditional cognitive intelligence measures over EI competencies when assessing potential candidates, thus missing out on critical relational competencies (Al Thawabie, 2024; Pyke, 2022).

These findings could also be interpreted through the lens of social role theory. Resistance to EI often stemmed from traditional leadership norms that favored agentic, task-focused attributes over communal, relationship-oriented skills. Such norms placed female leaders who were more frequently expected to demonstrate heightened EI at a structural disadvantage. As Esteves et al. (2024) and Ramos-Luna and Oliver (2024) found, gender-based differences among leaders shaped leadership styles, influencing decision-making approaches and team dynamics. Participants' responses to these challenges, including providing empirical evidence, connecting EI to measurable performance outcomes, and sharing leader success stories, were consistent with organizational change management literature that suggests using evidence and narratives to integrate new practices into institutional culture.

Furthermore, participants' inability to directly measure the immediate influence of EI on retention indicated a methodological challenge often cited in the EI literature. As discussed in the literature, capturing the full effect of EI initiatives usually requires longitudinal analysis, given that many benefits, such as improved workplace climate, reduced conflict, and stronger interpersonal trust, are manifested indirectly over time. These insights underscore the need for cultural change and robust evaluation frameworks to strengthen the adoption and sustainability of EI practices in healthcare leadership.

Summary of Findings

The findings of the interviews with Southeastern United States healthcare HR administrators show a strong awareness of the pivotal role that EI plays in successful leadership, particularly that of women leaders. The organizations under the project intentionally implement a variety of training and support mechanisms to facilitate EI competencies. However, despite this, there are challenges, first and foremost, such as the attitude towards the importance of EI compared to technical skills and the ongoing necessity for quantifiable data to connect EI initiatives to retention rates and reduced turnover costs. The subsequent discussion will delve deeper into these findings in more detail, addressing their implications within the framework of current literature and the theoretical model of this research.

Business Contributions and Professional Practice Recommendations

The project discussed in this article makes several key contributions and recommendations for business and organizational leaders throughout the healthcare sector. Firstly, the consistent focus on EI as a key leadership skill by HR managers sets

the need to give it priority in talent management. Participants noted that their organizations increasingly evaluate EI through structured tools such as behavioral interviews and situational judgment tests to identify candidates who can regulate emotions and manage complex interpersonal relationships (H1, H2, H4). This aligns with the broader perception in the literature that EI is not merely an individual trait but a leadership skill that can enable sound working relationships and achievement of organizational goals (Gorgens-Ekermans & Roux, 2021; Hanchinalkar, 2024). The importance of the assessment of EI in recruitment is particularly relevant to female leaders, as they are usually subject to gendered leadership expectations. According to Esteves et al. (2024) and Ramos-Luna and Oliver (2024), women leaders are expected to be relational and empathetic leaders, balancing the requirements of operations. EI is a handy skill set. In response to contemporary scholarship, which has drawn attention to the possibility of bias in recruitment based on gendered presumptions (Al Thawabie 2024; Pyke 2022), explicit consideration of EI in recruitment also reduces bias by making evaluation criteria reliant on quantifiable skills instead of gendered assumptions. By embedding EI into hiring and promotion systems, organizations can foster leadership styles that enhance communication, strengthen team performance, and support the delivery of high-quality patient care.

Secondly, the extensive rollout of EI training and developmental programs across healthcare organizations included within this project shows a dedication towards developing these highly valued skills. Specifically, organizations are building programs, such as workshops, coaching, and mentoring, for female leaders to make themselves

more aware, regulate their emotions, and communicate well with others (H1, H2, H3, H4). Healthcare organizations can support this investment as these programs attain maturity, and should be prepared to produce and utilize these programs with as many suitable methodologies as feasible for the details of women leaders. Such training programs resonate with what the research suggests, that is, the belief in the adaptability of EI, which is among the key principles of EI literature (Dunsborough et al., 2022; Goleman, 1998), and is required to learn the skills of measuring the leaders under stressful conditions and complex interpersonal relationships (H1, H2). Organizations can create a climate for continuous EI development that empowers leaders to cope healthily with stress, solve disputes well, and form functioning teams, which leads to more employee satisfaction and retention and less turnover that comes from organizational tyrannies of lack of utilization of high EI women (Dennett & Dedonno, 2024; Maldonado & Márquez, 2023).

Finally, dealing with the listed obstacles to EI implementation is a priority. Business leaders must actively refute the belief that EI is secondary to technical competence. The project establishes that leaders and staff view EI as a “soft” skill, which can de-prioritize it in leadership development and organizational practice (H1, H2, H5, H6). The resistance can be addressed by presenting evidence-based evidence regarding the positive impact of EI on key organizational outcomes. For example, Participant H3 emphasized that it is imperative to link “improvements in EI with quantifiable results, such as staff retention and satisfaction.” At the same time, Participant H4 underlined the importance of presenting evidence demonstrating EI’s worth for leadership positions.

Adding EI measures to performance assessments and highlighting case studies of successful emotionally intelligent leaders can also bolster its usefulness and drive organization-level uptake. This practice is in line with the research's appeal for HR leaders to use EI assessment tools in recruitment and leadership development, particularly in healthcare organizations (Kitsios et al., 2022; Pillay-Naidoo & Nel, 2022), and will help organizations avoid losing opportunities for leaders who can drive staff engagement and operational success.

Implications for Social Change

The implications of the findings of this project for healthy social change in healthcare organizations and society generally are significant. As seen through healthcare facilities, EI in women leaders can be channeled and nurtured to make workplaces much more equitable and inclusive. Research shows that increasing EI could help women do their work better, look after social needs, and resist gender stereotyping and bias (Esteves et al., 2024; Ramos-Luna & Oliver, 2024). Empowering individuals to lead also enables diversity in decisions to improve patient-centered and culturally competent care. Empathy and reading people's feelings (Salovey & Mayer, 1990) may make EI helpful at any healthcare level in building relationships at the interpersonal level. This increase can contribute to good communication from the staff, working with other departments more, and a healthier, friendlier environment. The project also showed the importance of EI in HR managers to facilitate healthy workplace relationships, and it was used in communication, collaboration, and patient care (H1, H6). Such a culture could increase job satisfaction, reduce burnout among health professionals, and enhance well-being for

staff and patients. Moreover, emotionally intelligent leadership development can snowball effect on patient care. Empathic and self-aware leaders who can effectively manage others and their own emotions are likely to create a compassionate and empathic climate for patients and families. This may increase patient trust, patient experiences, and health outcomes. As per the project, EI enhances workplace performance by fostering positive workplace relationships, effective communication, and collaboration (Ding et al., 2024). With a focus on EI among health leaders, institutions can be included in a kinder and more efficient healthcare system, producing positive social change in their institutions and communities.

Recommendations for Future Research

While valuable, this project 's findings are framed by several limitations identified. Addressing these constraints is critical to strengthening the evidence base on EI and the retention of female leaders in healthcare. First, this project focuses on the Southeastern United States to address the geographic limitation. Future research should incorporate multi-regional and cross-cultural samples to assess whether the patterns observed are transferable to other healthcare contexts. Comparative studies could examine differences in EI perceptions, strategies, and leadership outcomes across varied organizational and cultural settings (Rodrigues et al., 2024). This broader approach would enhance external validity and test the applicability of findings beyond one region.

Second, quantitative or mixed-methods research should be conducted to overcome the qualitative-only design and reliance on self-reported perceptions. Large-scale surveys and statistical modelling could establish correlations between specific EI strategies and

measurable outcomes such as leadership retention rates, turnover costs, patient satisfaction, and organizational performance scores (Kark & Buengeler, 2024). Longitudinal studies could track these indicators over time, mitigating the limitation of this project 's cross-sectional "snapshot" design. Third, the methodological challenge of measuring EI objectively should be addressed by employing validated EI assessment tools (e.g., Mayer-Salovey-Caruso Emotional Intelligence Test, EQ-i 2.0) alongside qualitative interviews. This would reduce reliance on participant self-awareness and social desirability, and provide a more consistent, standardized measurement protocol. Triangulating HR administrator perspectives with the lived experiences of female leaders through in-depth interviews or reflective diaries would fill the gap left by this project 's reliance on third-party accounts (Carmeli et al., 2023; Day et al., 2021). Fourth, to address the contextual and temporal limitations, longitudinal research is recommended to examine the evolution of EI strategies over time and in response to shifting organizational cultures and leadership styles (Esteves et al., 2024; Sojer et al., 2024). Repeated measures could capture how leadership approaches adapt in changing healthcare environments and how these shifts influence retention.

Finally, future studies should explore innovative, technology-enabled EI development approaches such as virtual reality simulations, web-based training modules, and AI-driven EI assessments (Khalil & Ebner, 2022). Such interventions could be tested for scalability, cost-effectiveness, and sustainability in high-demand healthcare contexts. This would address the lack of data on innovative training delivery methods and provide pathways for sustained EI capacity building. By systematically linking each proposed

research direction to a corresponding limitation, geographic scope, methodological constraints, measurement challenges, and temporal context, these recommendations offer a structured roadmap for building a more robust, inclusive, and contextually relevant evidence base on EI and female leadership retention in healthcare.

Conclusion

The findings reveal the critical role of the EI strategies of HR administrators in determining the future of women in leadership in healthcare. In this scholarly examination, understanding effective EI strategies by healthcare leaders proved critical for enhancing the retention of female leaders in healthcare. The research discussed some specific practices and produced key EI competencies, empathy, social awareness, and relationship management as central to a culture of inclusive leadership. This stresses that HR professionals need to go beyond implementing policies and play a role in creating a culture that encourages the promotion of women to leadership positions. Being aware of and using these EI techniques means that healthcare organizations can cure such gender imbalances in leadership and draw on the rich diversity of talent and viewpoints brought to the table by female leaders. Among the implications of this research is that targeted training and organizational development recommendations toward developing EI among HR administrators are necessary. Finally, EI can be cultivated within HR functions in the healthcare sector, and this can ultimately enable positive social change by creating more equitable and efficient leadership systems in the healthcare sector that benefit the wider business and communities being served.

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Appendix: Interview Protocol

Action	Script
<p>Introduce the interview and set the stage—often over a meal or coffee.</p>	<p>“Hello, my name is Selenda Johnson, and I am a student at Walden University. Thank you for taking the time to participate in this research project. I appreciate the criticality you attach to the expected findings, and I hope to add to the literature that develops emotional intelligence strategies. I have been working on a degree for a Doctor of Business Administration for the past few years. In this project, I examine the Emotional Intelligence Strategies of Human Resource Administrators for Women Leadership in Healthcare.”</p> <p>“A few weeks ago, you agreed to sign an informed consent form. Do you have any questions for me or any matter that requires my attention? This interview is confidential, and your identity and that of your organization shall remain anonymous and represented by codes.”</p> <p>“I will collect data using semi-structured interview questions. The idea is to allow you to explain any strategies, events, and memories that answer the interview questions. During your narration, I may prompt you for further explanation and details.”</p> <p>“I will need to record your responses so I do not miss anything.”</p> <p>“Note that you may rescind your decision to participate in the research anytime.”</p>
<p>Ask Interview Questions to get in-depth responses. Listen for nonverbal cues. Paraphrase as needed.</p>	<ol style="list-style-type: none"> 1. How do you define emotional intelligence, and how does it impact leadership effectiveness in healthcare settings?

Action	Script
	<ol style="list-style-type: none"> 2. What emotional intelligence skills does your organization prioritize when hiring leaders, and how are they assessed? 3. Describe how you use emotional intelligence to support female leaders through professional challenges in your organization. 4. What specific strategies have you implemented to: <ol style="list-style-type: none"> a. Create emotional self-awareness strategies. b. To facilitate the emotions of female leaders. c. To promote emotional regulation among female leaders in high-stress situations. d. To enhance the emotional management of female leaders.
<p>Schedule a transcript review either by phone or email.</p>	<p>“In a few days, I will need your assistance in authenticating my understanding of your responses to the interview questions as part of the research process. You may adjust the script or add to your initial responses if needed. I will send the transcript by email, and we can discuss it by phone if you agree.” If I don’t receive a response in 3 days, I will assume no changes are required.</p>
<p>Introduce a member checking review and set the stage.</p>	<p>“Thank you for agreeing to meet me today to finalize what I heard from you during the interview and the meaning I have provided for each response.”</p>
<p>Wrap up the interview by thanking participants.</p>	<p>“Your contribution to this doctoral research has been most impressive, and I thank you very much for helping me to achieve the doctoral degree. I hope you will find the research findings beneficial to your organization and professional development.”</p>