

IMPACT OF SOCIAL-EMOTIONAL INTELLIGENCE ON CONFLICT MANAGEMENT STYLES IN MEDICAL PRACTITIONERS

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Abstract

Keywords

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INTRODUCTION

Conflict has been referred to as a natural aspect of human interaction with a varied character. It seems to be as varied as individuals' nature and is an ongoing phenomenon. Medical professionals are at high risk of being involved in conflict situations because of the stressful working environment and high work demands (Hassankhani, 2018). Conflict among medical staff can either be constructive or destructive, based on how the conflict is addressed. Emotional and social intelligence are crucial for effective conflict management (CM). Emotional (EI) intelligence facilitates identifying, acknowledging, and regulating self and other people's emotions (Mayer & Salovey, 1997) while social intelligence (SI) is the capability to understand,

This study explores the relationship between social-emotional intelligence and conflict management among 150 healthcare professionals (75 males, 75 females) from Rawalpindi, Islamabad, and Lahore. Using the Tromsø Social Intelligence Scale, Schutte Self-Report Emotional Intelligence Test, and Rahim Organizational Conflict Inventory, the study found that gender differences emerged: women scored higher in emotional intelligence and preferred cooperative strategies, while men favored competing and avoiding styles. Higher social intelligence correlated with more effective conflict resolution. The findings underscore the importance of developing social-emotional skills to enhance teamwork and reduce conflict in healthcare settings.

realize, and regulate people in human relationships efficiently (Goleman, 2006).

EI is presently defined as "a set of competencies that enable individuals to identify, regulate, and use emotions to facilitate thinking, behavior, and interpersonal interactions"(Zeidner et al. 2020). Likewise, SI is newly defined as "the ability to perceive, comprehend, and respond effectively to the dynamics of social interactions, including understanding social roles, empathy, and situational appropriateness" (Grewal & Gardner, 2022).

In the current healthcare setup, speed in developing and growing in interaction within a multidisciplinary team has resulted in a heightened number of interpersonal conflicts. Conflict management (CM) competence is of utmost significance for doctors.



Emotional and social intelligence can prove beneficial in managing these conflicts positively. Doctors who have high emotional and social intelligence can more effectively manage stress and interpersonal conflict, resulting in enhanced professional performance and optimal patient care (Arora et al., 2010).

Social and emotional intelligence can enhance communication, empathy, and interpersonal relationships, which are crucial to CM in healthcare environments (Freshman & Rubino, 2002). Research has shown that emotionally intelligent individuals are more likely to employ integrative conflict resolution techniques that seek win-win solutions (Jordan & Troth, 2004). Socially intelligent people will be in a better position to understand group dynamics and can control social interactions in ways that avoid or de-escalate conflict (Goleman, 2006).

Current research in the Pakistani healthcare setting indicates that nearly 35%-45 % of medical professionals indicate experiencing interpersonal conflict at least weekly, primarily because of workload mismatch, communication failure, and hierarchical stress (Malik & Hussain, 2021). Moreover, burnout and emotional exhaustion– mostly a byproduct of unresolved conflict–occur in nearly 50% of junior doctors, further weakening their capacity for constructive problem-solving (Shahbaz et al., 2022). The key findings demonstrate the pressing necessity of improving emotional and social intelligence competencies in Pakistani doctors to foster cooperation and adaptive healthcare settings.

A study by Rahim and Psenicka (2002) showed a strong correlation between EI and CM style. Rather than dominating or avoiding styles, people with high EI use more collaborative and compromising CM styles. Jordan and Troth (2004) also found that EI is positively correlated with collaborative CM style in team settings.

Arora et al. (2010), in one study, reported that physicians who were high in emotional intelligence were better at communication and conflict management, leading to better patient care. Goleman (2006) reiterated that social intelligence is important for teamwork and conflict resolution in intricate organizational contexts. Freshman and Rubino (2002) also pointed to the relevance of training in emotional and social intelligence among health professionals to enhance their CM skills.

Research conducted by Hassan Khani (2018) found that conflict between nurses and other members of the healthcare team was highly associated with low emotional intelligence. Emotional and social intelligence development training programs were found to substantially enhance conflict resolution skills in the healthcare setting (Salovey & Mayer, 1990; Mayer & Salovey, 1997).

In the context of Pakistan, a cross-sectional study by Malik and Hussain (2021) with 250 doctors and nurses showed that high emotional intelligence was significantly more likely to use cooperative and yielding conflict styles. Moreover, emotional intelligence scores had inverse correlations with levels of stress and burnout. Also, Shahbaz et al. (2022) revealed that higher-scoring social intelligence among medical workers in urban tertiary hospitals showed better team cohesion, fewer patient complaints, and more job satisfaction. This empirical finding strongly advocates the contribution of emotional and social intelligence in conflict resolution in Pakistan's healthcare sector.

Theoretical Framework

This research borrows from an integrated Social-Emotional Intelligence (SEI) model, syncretizing central aspects of Daniel Goleman's Emotional Intelligence (EI) Theory and Social Intelligence Theory (SIT). Although EI and SI are commonly referenced as independent constructs, recent theory developments advocate for their interconnectedness and synergistic operation, particularly within highstakes settings such as healthcare (Grewal & Gardner, 2022; Petrides et al., 2016).

Integrated Model of Social-Emotional Intelligence

Goleman's Theory of Emotional Intelligence (1995) highlights five central areas: self-awareness, selfregulation, motivation, empathy, and social skills. These capabilities lay the foundation for an individual's ability to handle emotionally charged situations with refinement, sensitivity, and flexibility. In the clinical environment, coping with interpersonal conflict, reacting positively to pressure and stress, EI plays a decisive role, also promoting



Method

Research Objectives

• To investigate the correlation between SEI competencies and CM strategies among doctors in Pakistan.

• To determine the influence of gender on SEI and conflict resolution.

• To identify SEI components that predict effective conflict resolution.

Hypotheses

• Social-emotional intelligence is positively correlated with conflict resolution strategies.

• Higher Social-emotional intelligence predicts more effective conflict resolution.

• Higher EI and cooperative conflict management styles prevail more in females.

Research Design and Sampling

A cross-sectional survey design is used in the present study. The present study assesses the SI, EI, and CM among doctors. The sample comprises 150 (N=150) medical practitioners, males (n=75) and females (n=75). The personnel's age range will be 25-60. The sample is recruited using random sampling to collect data from different public and private hospitals. Only practitioners are recruited, excluding medical students and doctors who are only managing administrative work

Instruments

Tromsø Social Intelligence Scale (TSIS)

Silvera, Martinussen, and Dahl in 2001 developed the Tromsø Social Intelligence Scale (TSIS). It is a 21-item, self-report on a 7-point Likert scale. It has 3 measuring dimensions of SI: social skills, social information processing, and social awareness. The scale demonstrates strong psychometric properties i.e. strong internal consistency ($\alpha = 0.79$ to 0.86) (Dogan & Cetin, 2009) and strong construct validity ability of the tool, making it a widely used instrument for assessing social intelligence (Silvera et al., 2001).

Schutte Self-Report Emotional Intelligence Test (SSEIT)

In 1998, Schutte and colleagues developed the Schutte Self-Report Emotional Intelligence Test

Alongside the SI theory extension by Goleman (2006), based on the original theory developed by Thorndike (1920), highlights the capacity to understand and deal with intricate social structures. SI is categorized into two fundamental abilities: social awareness (e.g., social cognition, empathy) and social facility (e.g., influence, synchrony, self-presentation). These abilities allow healthcare practitioners to decipher social signals, develop rapport, and react appropriately within various team environments (Shahbaz et al., 2022).

The balanced utilization of EI and SI offers an inclusive structure to describe interpersonal work behavior. Self-awareness and self-regulation (EI), together with social cognition and social facility (SI), enable both skill acquisition and emotion management to operate in social contexts. For instance, a physician must not only regulate his or her irritability in a dispute but also decode nonverbal signals and shift strategy to defuse tension between co-workers or patients.

The combined SEI model shows that social and emotional skills together enable effective CM through cooperation, accommodation, and communication (Lopes et al., 2006; Malik & Hussain, 2021). More and more evidence supports the combined framework by showing that highscoring individuals on SEI are more likely to employ cooperative conflict styles and create positive organizational climates (Zeidner et al., 2020; Almeida et al., 2020).

Within culturally sensitive environments such as Pakistan's healthcare industry, where occupational stress, communication failure, and gradients of power are prevalent, SEI is even more important. High SEI professionals are better integrated within their teams, have greater conflict resolution, and gain greater patient satisfaction (Shahbaz et al., 2022; Khaghaninejad et al., 2024).

Therefore, the theoretical foundation of this research highlights the convergence of EI and SI into a single, dynamic SEI model. This model is necessary to explain how individual and interpersonal abilities influence CM approaches among medical professionals.



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Procedure

(SSEIT), based on the emotional intelligence model proposed by Salovey and Mayer (1990). SSEIT consists of 33 items, self-reporting on a 5-point Likert scale, and measuring four dimensions of EI: emotion perception, utilizing emotions, managing self-relevant emotions, and managing others' emotions. The SSEIT has robust psychometric structural properties, i.e., α reliability ranging between 0.79 to 0.90 (Yusof et al., 2016; Aniemeka et al., 2020), and strong validity among several populations (Schutte et al., 1998).

Rahim Organizational Conflict Inventory (ROCI)

Rahim developed the Rahim Organizational Conflict Inventory-II (ROCI-II) in 1983 to assess individual conflict management styles within organizational settings. The scale comprises 28 self-report items, rated on a 5-point Likert scale, and measures five dimensions of CM: avoiding, integrating, obliging, dominating, and compromising. The ROCI-II has robust psychometric structural properties, including high internal consistency, with Cronbach's alpha values ranging between 0.70 to 0.90, and demonstrated strong test-retest reliability within the same ranges (Rahim, 1983; Rahim & Magner, 1995). A total of 150 medical professionals aged 25-60 years were randomly selected from hospitals in Rawalpindi, Islamabad, and Lahore. Participants completed three standardized instruments: the Tromsø Social Intelligence Scale (TSIS), the Schutte Self-Report Emotional Intelligence Test (SSEIT), and the Rahim Organizational Conflict Inventory (ROCI).

The data was collected after stating the study purpose to research participants with their informed consent for voluntary participation. The confidentiality and anonymity were strictly maintained. Data were analyzed using SPSS Version 27. The data was collected in an organized and ethical manner to ensure the reliability of the data and the validity of the analysis.

Results

The current study aims to identify the impact of EI and SI on CM styles among medical professionals. The data was analyzed with the help of SPSS-27. The data was analyzed through descriptive analysis and hypothesis testing. The analysis of data is reported in the table given below.

Table 1: Mean, Standard Deviation, Range, and Cronbach alpha reliability of Schutte Self-Report Emotional Intelligence Test (SSEIT), Tromsø Social Anxiety Scale (TSIS), and the subscales of the Rahim Organizational Conflict Inventory (ROCI) N=150)

Connict Inventory (ROCI) IV 150)						
Variables	N	М	SD	Range	α	
EI	150	108.8	12.85	67.0	0.82	
СМ						
Collaborating Style	150	22.0	4.83	20.0	0.84	
Accommodating Style	150	18.2	4.41	18.0	0.84	
Competing Style	150	14.5	4.20	16.0	0.86	
Avoiding Style	150	17.7	6.33	20.0	0.90	
Compromising Style	150	11.5	3.58	13.0	0.83	
SI	150	102.6	15.26	54.0	0.91	

Note: N=Total Number of Participants; M=Mean; SD=Standard Deviation; α =Alpha Reliability; SI= Social Intelligence, EI= Emotional Intelligence, CM= Conflict Management

Table 1 shows the mean, standard deviation, and normality results of the data. This result shows mild to moderate deviation from the mean. Range has also been checked, which is 67, 54, 20, 18, 16, 20, and 13, respectively. The alpha reliability of the Schutte Self-Report Emotional Intelligence Test (SSEIT) is .82, and Tromsø Social Intelligence Scale (TSIS) is .91which indicates strong reliability. The alpha reliability of the sub-scales, collaborating style, accommodating style, competing style, avoiding style, and Compromising style, is .84, .84, .86, .90, .83, respectively, indicating strong reliability.



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Table 2: Socio-demographic variables	of study participants (N=150)		
Variables	Ν	%	
Age			
25-45	101	67.3	
46-65	49	32.7	
Gender			
Men	75	50.0	
Women	75	50.0	

Note: %= percentage

Table 2 presents the frequency and percentages of demographic characteristics for 150 participants. In terms of age, 67.3% of participants were between 25-

45 years, while 32.7% were between 46-65 years. The sample was evenly split between genders, with 50.0% of participants being men and 50.0% being women.

Table 3: Inter-correlation between EI, SI, and CM (N=150)

Variables	N	М	SD	1	2	3	4
SE	150	108.8	12.8	-	-	-	-
Collaboration Style	150	22.0	4.8	0.52***	-	-	-
Accommodation Style	150	18.2	4.4	0.25***	0.84**	-	-
Competing Style	150	14.5	4.2	-0.23**	-0.78***	-0.70***	-
Avoiding Style	150	17.7	6.3	-0.23***	-0.80**	-0.76***	0.83**
Compromising Style	150	11.5	3.5	0.18**	0.78***	-0.74**	0.75***
SI	150	102.6	15.2	-0.17***	-0.42**	-0.37**	0.45***

Note: TSIS= Tromsø Social Intelligence Scale, SSEIT= Schutte Self-Report Emotional Intelligence Test; N= Total Number of Participants; M=mean; SD=Standard Deviation, (Significance level; *p<.05, **p<.01 and ***p<.001)

Table 3 shows the Pearson correlation coefficients among various measures, including Total EI, conflict management styles, and SI. The results indicate a range of relationships. For example, Collaborating Style shows a strong positive correlation with Accommodating Style (r = 0.84) and a moderate positive correlation with Avoiding Style (r = 0.80). In contrast, Competing Style has a strong negative correlation with Avoiding Style (r = -0.83) and a moderate negative correlation with Compromising Style (r = -0.75). Total SI shows weak to moderate negative correlations with most conflict management styles, such as Collaborating (r = -0.42) and Avoiding (r = -0.46). Overall, these correlations suggest complex interrelationships between emotional intelligence, conflict management styles, and social skills.

	Table 4: Regression	coefficient of Emotion	al Intelligence on	Conflict Manageme	nt Styles (N=1	150).
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Variables	Ν	N Unstandardized Coefficients			
		В	Std. Error	р	F
Collaborating	150	11.71	3.27	0.00	10.01
Accommodating	150	8.52	2.98	0.005	10.68
Competing	150	22.76	2.86	0.000	8.29
Avoiding	150	30.17	4.31	0.000	8.39
Compromising	150	5.77	2.46	0.002	5.46
	~				

Note: β =Beta, Std. Error=Standardized error, p=significance level; *p<.05, **p<.01 and ***p<.001, and R²= 0.06, 0.06, 0.05, 0.05 and 0.03



Table 4 indicates that linear regression was conducted to examine the relationship between emotional intelligence and conflict management styles. The model explained a small but significant amount of variance in the conflict management styles, with an R^2 value of .06 for collaborating and accommodating, .05 for competing and avoiding, and .03 for compromising. Emotional intelligence

was found to be a significant predictor for all conflict management styles. The strongest predictive relationships were observed for the avoiding style (β = 30.17, p = .000) and the competing style (β = 22.76, p = .000), followed by collaborating (β = 11.71, p = .000), accommodating (β = 8.52, p = .005), and compromising (β = 5.77, p = .002).

Table 5: Regression	coefficient of Social	Intelligence on	Conflict Manage	ment Style (N=150)
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Variables	Ν	Unstandardized Co	_		
		В	Std. Error	р	F
Collaborating	150	35.90	2.44	0.00	33.08
Accommodating	150	29.25	2.29	0.00	23.68
Competing	150	1.03	2.06	0.02	23.87
Avoiding	150	-1.83	3.13	0.01	39.81
Compromising	150	22.03	1.80	0.00	34.96

Note: β=Beta, Std. Error=Standardized error, p=significance level; *p<.05, **p<.01, and ***p<.001, and R²= 0.18, 0.13, 0.22, 0.21, and 0.19.

Table 5 indicates that linear regression was conducted to examine the impact of social intelligence on conflict management styles. The model explained a significant amount of variance in the conflict management styles, with an R² value of 18% for collaborating, 13% for accommodating, 22% for competing, 21% for avoiding, and 19% for compromising. Social intelligence was found to be a significant predictor for all conflict management styles. The strongest predictive relationship was observed for the collaborating style (β = 35.90, p = .000) and accommodating style (β = 29.25, p = .000), followed by compromising (β = 22.03, p = .000). Although competing (β = 1.03, p = .02) and avoiding (β = -1.83, p = .01) had relatively lower beta values, their associations with social intelligence were still statistically significant.

Table 6: Mean Differences, Standard Deviation, and t-value among gender (N=150) Emotional Intelligence (EI), Social intelligence (SI), and Conflict management.

Variables	Males		Females					
	(N=75)		(N=75)				95%CI	
	М	SD	М	SD	р	t	LL	UL
EI	106.8	13.4	110.9	11.9	.005	-1.9	-8.18	0.028
СМ								
Collaborative Style	20.6	4.6	23.3	4.6	.001	-3.46	-4.14	-1.13
Competing Style	17.0	4.2	19.4	4.2	.001	-3.45	-3.77	-1.02
Accommodating S	15.7	4.0	13.3	4.05	.000	3.72	1.15	3.75
Avoiding Style	19.7	6.02	15.7	6.02	.000	4.04	2.02	5.91
Compromising Style	10.4	3.4	12.5	3.44	.000	-3.73	-3.20	-0.98
SI	105.1	14.9	100.2	15.2	.004	2.00	0.05	9.80

Note: M= Mean; N= Total Number of Participants; SD=Standard Deviation; p=Significance level; t=Statistic value; *p<.05, **p<.01 and ***p<.001; CI= Confidence Interval; UL= Upper Limit; LL=Lower Limit; TSIS= Tromsø Social Intelligence Scale, SSEIT= Schutte Self-Report Emotional Intelligence Test

An independent samples t-test was conducted to gender differences examine in emotional intelligence, social intelligence, and conflict management styles among 150 participants (75 males, 75 females). Results showed a statistically significant difference in emotional intelligence scores between males (M = 106.8, SD = 13.40) and females (M = 110.90, SD = 11.90), with females scoring higher. In terms of conflict management styles, females scored significantly higher than males on the collaborating style (M = 23.30, SD = 4.60 vs. M = 20.60, SD = 4.60), the competing style (M = 19.40, SD = 4.20 vs. M = 17.00, SD = 4.20), and the compromising style (M = 12.50, SD = 3.44 vs. M = 10.40, SD = 3.40. Conversely, males scored significantly higher than females on the accommodating style (M = 15.70, SD = 4.00 vs. M = 13.30, SD = 4.05), and the avoiding style (M = 19.70, SD = 6.02 vs. M = 15.70, SD = 6.02). A significant difference was also found in social intelligence, where males (M = 105.10, SD = 14.90) scored higher than females (M = 100.20, SD = 15.20). These findings indicate meaningful gender-based variations in emotional and social functioning as well as preferred conflict resolution strategies.

Discussion

This research endeavored to examine the role of social-emotional intelligence and conflict management styles among medical personnel. From the statistical results and hypotheses, the findings yield partial to strong evidence for the assumptions made in the research.

The correlational analyses established positive, significant correlations between emotional intelligence (EI) and cooperative conflict resolution tactics. EI was positively and moderately correlated with cooperating (r = 0.52, p < .001), accommodating (r = 0.25, p < .001), and compromising (r = 0.18, p < .01) styles. There were negative correlations between EI and less effective styles such as avoiding and competing (r = -0.23, p < .01). In the same manner, social intelligence (SI) revealed a positive correlation with compromising (r = -0.43, p < .01) and was negatively correlated with avoidance (r = -0.46, p < .01).

These results are in accordance with existing literature that proposes that people high in



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emotional or social intelligence will be more competent to employ integrative and constructive conflict tactics (Salovey & Mayer, 1990; Goleman, 1998). The proclivity to regulate emotions and appreciate other people's views is probably magnifying the inclination toward cooperative approaches in high-stakes healthcare environments. Khan and Javed (2024) more recently highlighted that emotional intelligence substantially moderates interpersonal stress and enhances conflict negotiation results among South Asian frontline healthcare workers.

Regression analyses also evidenced this hypothesis. Emotional intelligence also explained all five conflict management styles to a great extent, with avoiding (β = 30.17, p < .001) and competing (β = 22.76, p < .001) being the best predictors, followed by collaborating ($\beta = 11.71$, p < .001), accommodating $(\beta = 8.52, p = .005)$, and compromising $(\beta = 5.77, p)$ = .002). Though these styles vary in assertiveness and cooperativeness, the large beta values indicate that emotional intelligence is fundamental а underpinning of all conflict response styles, even undesirable ones such as competing or avoiding, perhaps signaling emotional regulation rather than conflict absence.

Social intelligence was similarly a robust and significant predictor of all conflict styles, particularly collaborating (β = 35.90, p < .001), accommodating (β = 29.25, p < .001), and compromising (β = 22.03, p < .001). These styles indicate an integrative style of conflict resolution, affirming that socially intelligent individuals tend to use strategies that maintain relationships and attain mutual objectives (Rahim, 1983; Mayer, Caruso, & Salovey, 2016). Recent research by Fernandez & Lee (2024) attests to this, with emotional and social intelligence training resulting in quantifiable gains in team problemsolving and interpersonal outcomes within hospital units in multicultural settings.

Female-male comparisons showed that there were significant differences on emotional intelligence and conflict resolution styles. Females scored significantly higher on EI (M = 110.9, SD = 11.9) compared to males (M = 106.8, SD = 13.4), with p = .005. They also scored more on collaborating, compromising, and competing styles, while males scored more on accommodating and avoiding.



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These results partially confirm the hypothesis, showing that women exhibit greater EI and endorse more cooperative styles of conflict resolution. This corroborates work by Thomas et al. (2008), who discovered that females are more likely to employ integrative styles with a focus on maintaining relationships, as opposed to more assertive or avoidant styles for men.

Notably, although men scored higher in social intelligence, their inclinations towards avoidant and accommodating styles might indicate contextual or cultural factors specific to hierarchical medical organizations, where seniority and gender roles overlap (Al-Hamdan et al., 2019). In support of this, Yadav et al. (2024) demonstrated that healthcare workers' gendered communication style significantly affects leadership perception and interprofessional collaboration, with women more frequently using emotional signals for conflict handling.

Contrary to expectations, no meaningful age differences were observed in either EI or conflict styles, which indicates that the development of emotions may not be solely age-dependent in working life. This contradicts normal assumptions and favors the use of longitudinal research in order to know how social-emotional competencies develop in the long run (Zeidner, Matthews, & Roberts, 2012).

In addition, the high correlation of collaborative and accommodating styles (r = 0.84) implies that medical practitioners tend to implement mixed strategies based on situations, as indicated by contingency theories of conflict management (Rahim & Bonoma, 1979). The application of several cooperative strategies could be a coping mechanism against the complexity of team-oriented healthcare environments. In a recent study, Chen et al. (2023) illustrated that emotional adaptability, a component of EI, is being increasingly identified as a key competence in navigating collaborative healthcare teams across age and cultural barriers. These findings imply that including training in emotional intelligence in professional development programs may improve practitioners' capacity for resolving conflicts, which would benefit patient care and teamwork. To evaluate the emotional and social intelligence developmental paths and their long-term effects on organizational results, future studies could

investigate longitudinal designs. The relationship between conflict resolution, social intelligence, and emotional intelligence in work settings is better understood because of these discoveries.

Implications

Based on what has been found, a number of steps be implemented to improve conflict can management in healthcare environments. Emotional and social intelligence must be prioritized as central elements in professional training courses for healthcare professionals. Training modules can be specifically developed to promote cooperative like conflict styles, collaboration and accommodation, which are related to better teamwork and patient care.

In order to encourage effective and inclusive communication, training also needs to cover genderspecific differences in conflict management styles. In addition to this, integrating measures to boost social intelligence can help support integrative conflict resolution, leading to healthier team functioning and lower levels of workplace stress among diverse medical teams.

Limitations

The cross-sectional design of the study restricts causal interpretations between conflict management and emotional intelligence. The use of self-report measures can introduce social desirability bias. The sample, which consisted primarily of Pakistani medical professionals, limits generalizability to other settings. Organizational environment, experience, and education, which are critical factors, were not studied. Even the emphasis on gender neglects other potential influences, such as age, personality traits or cognitive styles, that could potentially influence emotional intelligence and conflict management strategies.

Future Directions

Longitudinal study designs should be employed in future research to monitor the longitudinal changes in emotional and social intelligence. Behavioral evaluation and peer ratings should be added to enhance the measurement validity. Identification of those components of emotional intelligence that correlate best with particular conflict styles should be



done. Investigation into cultural and context-based differences as well as personality dimensions such as the Big Five will advance knowledge of how they interact and influence conflict resolution across different working contexts.

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