

The role of emotional intelligence in geriatric care: a critical and interpretative review

Abstract

The population ageing and the increasing complexity of care provided to elderly people have reinforced the need for relational and socio-emotional skills in geriatric practice. In this context, emotional intelligence is particularly relevant, as it favors the perception, understanding and regulation of emotions in situations marked by fragility, chronic disease, dementia and loss of autonomy. The present article critically analyses recent literature on the importance of emotional intelligence in geriatrics, with a focus on older people, formal and informal caregivers and multidisciplinary teams. The revisited evidence suggests that higher levels of emotional intelligence are associated with more effective communication, greater empathy, better adaptation to the emotional demands of care, and a reduction in caregiver burden and burnout. Furthermore, emotional intelligence is a potentially decisive resource for promoting more humane, ethical, and responsive institutional environments, thereby contributing to the overall quality of care provided. Despite its relevance, this domain remains underexplored in gerontological research, particularly regarding assessment and intervention. It is concluded that emotional intelligence should be recognized as a central competence in geriatrics, with direct implications for training, clinical practice and the sustainability of care systems.

Keywords: emotional intelligence, geriatrics, older people, caregiver, emotional regulation, quality of care

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Abbreviations: INE, instituto nacional de estatística/national institute of statistics; EI, emotional intelligence; MSCEIT, mayer-salovey-caruso emotional intelligence test; EQ-I, emotional quotient inventory; TEIQue, trait emotional intelligence questionnaire; CINAHL, cumulative index to nursing and allied health literature; EEG, electroencephalogram; PPG, photoplethysmography

Introduction

Population ageing is one of the most significant sociodemographic transformations of the twenty-first century and has major implications for health systems and social support structures. The United Nations projected that the proportion of people aged 65 years or more would increase worldwide from about 10% to 16% of the total population by 2050.¹ In Europe, this trend is particularly pronounced, with several countries reporting a high proportion of older adults and increasing pressure on health systems and social protection.² In Portugal, demographic ageing continued to intensify in 2023, with an ageing index of 188.1 older people per 100 young people, reflecting a structural shift with direct implications for health service organization.³

This demographic context has created new demands for geriatrics as a medical specialty and interdisciplinary field of intervention. Inouye et al. (2007)⁴ highlighted the clinical, research, and policy relevance of geriatric syndromes such as frailty and delirium, while⁵ emphasized the complexity of care in geriatric models. These realities show that geriatric care requires not only technical competence, but also emotional sensitivity, communication skills, and the ability to respond to highly vulnerable situations.

Emotional intelligence (EI) is particularly relevant in this context. Salovey and Mayer (1990)⁶ defined EI as the ability to monitor one's own feelings and those of others, discriminate among them, and use this information to guide thinking and action. Goleman (1995)⁷ later

broadened the concept by incorporating self-awareness, self-regulation, motivation, empathy, and social skills, dimensions that are especially pertinent in interpersonal care settings. From this perspective, EI is not only a psychological construct, but also a practical competence with direct relevance for healthcare relationships.

Over the following decades, EI became the subject of growing interest across various professional fields, particularly in healthcare. Research conducted in the fields of nursing, medicine and health professions in general has demonstrated that higher levels of EI are associated with greater job satisfaction, lower burnout, better communication with patients and better health outcomes.^{8,9} Louwen et al. (2023)¹⁰ showed that personality traits, behaviour styles, and EI are important characteristics in health professionals, while¹¹ demonstrated that EI training can improve outcomes across the healthcare workforce. Taken together, these studies suggest that EI has relevance not only for individual practice, but also for team performance and institutional climate.

Despite this broader evidence, EI remains underexplored in geriatric care specifically. Cé and Goedert (2025)¹² and¹³ both suggest that EI is linked to healthy ageing and to psychological, social, and physical well-being in later life. However, the literature still offers limited systematic and critical analysis of how EI operates across the different actors involved in geriatric care, particularly older adults, caregivers, and multidisciplinary teams.

The relevance of EI in geriatric settings lies in the relational nature of care for older people. Andrade et al. (2019)¹⁴ showed that emotional intelligence in older Portuguese adults is associated with emotional adaptation in later life. Bernabéu-Álvarez and Costa (2024)¹⁵ reported that emotional intelligence is associated with lower burden and greater perceived social support among family caregivers. In addition, the care environment itself requires emotionally competent communication, especially in situations involving dementia, loss of

autonomy, or end-of-life care. These findings support the view that EI functions as a key resource for both individual adaptation and the quality of care delivery.

Accordingly, this article critically examines recent literature on the role of emotional intelligence in geriatric care, focusing on three interconnected axes: the older person, the formal or informal caregiver, and the care team/institution. As a critical and interpretative review, it aims to identify emerging trends, gaps, and practical implications for geriatric training, practice, and organizational sustainability.

Theoretical framework and review methodology

Accordingly, the following subsection presents the main models of emotional intelligence.

Main models of emotional intelligence

EI has been conceptualized from different theoretical perspectives, which differ mainly in how they define the construct and in the methods they privilege for its assessment. The literature commonly distinguishes three main models: the ability model, the mixed model, and the trait model.¹⁶

The ability model, developed by Mayer and Salovey (1997),¹⁷ is the most rigorous from a psychometric perspective. In this model, EI is defined as the ability to perceive, use, understand, and manage emotions in a hierarchical structure of four branches, ranging from emotional perception to the management of emotions in interpersonal contexts. Assessment is carried out through maximum-performance tests, and the MSCEIT remains the most widely used and validated instrument in this tradition.¹⁸

The mixed model, initially associated with⁷ and later developed by,¹⁹ integrates cognitive abilities and personality traits. This approach includes dimensions such as emotional self-awareness, assertiveness, empathy, stress tolerance, and general happiness. Bar-On (1997)¹⁹ developed the EQ-i as a self-report instrument for use in clinical and organizational contexts, and later work has noted both its practical value and its conceptual overlap with personality constructs.^{20,21}

The trait model, developed by,²¹ conceptualizes EI as a set of affective dispositions and perceived competencies assessed through self-report. Unlike the ability model, it does not attempt to measure EI as a cognitive aptitude, but rather as a constellation of beliefs about one's own emotional functioning. The TEIQue is the reference instrument in this model and has shown incremental validity in predicting health outcomes, well-being, and professional performance.

Despite these conceptual and methodological differences, the literature converges on the view that EI is a relevant psychological resource for emotional regulation, interpersonal relationships, and adaptation to stressful situations.^{16,22} In healthcare settings, this convergence is especially important because the practical value of EI often lies less in the theoretical model adopted than in its contribution to effective communication, empathy, and resilient professional functioning.

Articulation between emotional intelligence and ageing and geriatric care

The relationship between EI and ageing has attracted growing interest, although research in this area remains relatively limited when compared with studies focused on younger populations. Recent evidence suggests that, unlike other cognitive abilities that tend to

decline with age, emotional regulation and emotion perception may remain stable or even improve throughout the ageing process, a pattern partly explained by socioemotional selectivity theory.^{23–25} This theory proposes that, as the perceived time horizon shortens, older adults direct their emotional resources towards meaningful relationships and experiences, supporting more adaptive regulation.

In geriatric care, EI is relevant in two complementary ways: in the older person, as a resource for adapting to ageing-related losses; and in the caregiver, formal or informal, as an essential competence for providing quality care [26]. Care in geriatrics is inherently asymmetrical and emotionally demanding, often marked by vulnerability, functional decline and progressive dependence. In this context, the ability to recognize and manage emotions, both one's own and those of others, is central to therapeutic interaction and to the well-being of everyone involved, in line with person-centred geriatric care, effective communication and patient and family involvement.²⁷

The literature also suggests that EI is associated with important organizational variables in institutional geriatric settings, particularly team climate, leadership styles, and institutional culture. Teams with higher levels of EI tend to communicate more effectively, manage interpersonal conflicts better and promote more humanized and person-centred care.^{28,29}

General criteria of the critical and interpretative review

Review design

The present article adopts a critical and interpretative literature review methodology, in accordance with recent approaches to qualitative and integrative synthesis applied to healthcare and gerontology.^{30,31} This approach follows the tradition of narrative and integrative reviews in social and health sciences, which privilege in-depth and contextualized understanding of the phenomenon under analysis, in contrast to the exhaustive and statistical procedures typical of systematic reviews and meta-analyses.¹⁴

Search strategy

The bibliographic search was conducted in PubMed, PsycINFO, CINAHL, and Scopus databases, using combinations of descriptors such as emotional intelligence, geriatric care, elderly, caregiver, burnout, dementia, empathy, and multidisciplinary team. Articles published between 2003 and 2025 in English, Portuguese, or Spanish, with full-text access, were prioritized. Complementarily, theoretical reference works, book chapters, and documents from international organizations relevant to the theme were included.

Analytical corpus

The analytical corpus of this review is organized around three main thematic axes, corresponding to the subsections of the central chapter: EI in the older person, in the caregiver, and in the care team/institution. From a theoretical perspective, the review privileges the Mayer and Salovey ability model as the primary conceptual reference, while also considering the mixed and trait models whenever they are explicitly mobilized in the literature.

Delimitation of the theoretical and analytical corpus

The analytical corpus of this review is organized around three main thematic axes, corresponding to the subsections of the central chapter: EI in the older person, in the caregiver, and in the care team/institution. This tripartite structure allows a differentiated analysis of

the contexts and actors involved in geriatric care, recognizing that EI operates in distinct, though interconnected, ways across these levels.

From a theoretical perspective, the review privileges the Mayer and Salovey ability model¹⁷ as the primary conceptual reference, given its stronger empirical support and construct validity. Contributions from the mixed and trait models are also considered whenever they are explicitly mobilized in the literature. The analysis is further enriched by complementary theories, namely socioemotional selectivity theory, the caregiver stress and coping model, and care humanization models.

Emotional intelligence in geriatrics

The integration of EI in the field of geriatrics constitutes a particularly relevant analytical axis, insofar as it allows for a deeper understanding of the emotional dynamics that traverse ageing, care and institutional relationships. This study proposes an articulated analysis of EI at three interdependent levels: the older person, the caregiver and the care team/institution. This multi-systemic approach recognizes that the emotional experience in the geriatric context is not isolated, but emerges from the continuous interaction between subjects, practices and organizational contexts.

In the older person — emotional intelligence as a resource for adaptation, emotional regulation and well-being

Ageing is often accompanied by biological, psychological, and social transitions that imply losses but also opportunities for emotional development and adjustment across the life course. In this context, EI functions as an important adaptation resource, enabling older adults to cope with chronic disease, loss of autonomy, social isolation, and proximity to death.

The literature suggests that emotional regulation remains relatively preserved with advancing age and may even improve in some domains. Carstensen et al. (2003, 2020)³² proposed socioemotional selectivity theory, which argues that older adults prioritize emotionally meaningful experiences and therefore tend to use more adaptive regulatory strategies. This may translate into a greater orientation toward positive information, more selective investment in relationships, and more effective management of emotionally challenging situations.

Empirical studies reinforce this perspective. Cachioni et al. (2017)³³ found that participation in learning and social interaction contexts in later life is associated with higher subjective and psychological well-being, including greater life satisfaction, predominance of positive affects, and better psychological adjustment. Similarly, [13] reported a positive relationship between EI and psychological, social, and physical well-being, suggesting that emotional competencies contribute to quality of life in ageing and may support more favorable adaptation to later-life transitions.

EI in older adults is also reflected in the ability to interpret and give meaning to emotionally significant experiences. This competence can transform adverse situations into opportunities for personal growth, supporting a more coherent life narrative and a stronger sense of continuity in ageing. In this sense, EI can be understood as a mechanism of psychological integration that favors healthy ageing.¹² Andrade et al. (2019)¹⁴ further showed associations between different dimensions of EI and indicators of psychological adjustment in older Portuguese adults, reinforcing its protective role in late-life adaptation.

EI is also relevant for communication and relationships in later life. Higher levels of EI are associated with better emotional

expression, active listening, and conflict management, which are especially important in the context of social isolation and declining functional or psychological well-being.^{12,34} In dementia care, person-centred approaches highlight the importance of empathy, emotional validation, and non-verbal communication in responding to the needs of the person with dementia.³⁵ Butcher et al. (2025)³⁶ further emphasize EI as a resource for sustaining humanized care practices in dementia settings and for maintaining a more responsive relational climate.

Finally, new approaches have explored EI assessment through digital technologies and physiological signals, such as electroencephalogram and Photoplethysmography. Sánchez-Cifo et al. (2023)³⁷ highlight the potential of these methods for more objective and continuous assessment of emotional competencies, opening the way to more personalized interventions in geriatric contexts and to more precise monitoring of emotional adaptation in later life.

In the caregiver — emotional intelligence, empathy, burnout and quality of care provision

Care for older people, especially in contexts of dependence and chronic disease, is an emotionally demanding activity and is often associated with high levels of stress and burden. In this scenario, EI emerges as a crucial competence for the quality of care provision and for the caregiver's well-being.

The literature shows that higher levels of EI are associated with better psychological functioning in professional contexts, including lower occupational stress, greater job satisfaction, and stronger adaptive capacity in care settings, particularly among healthcare professionals.^{8,9} Evidence also suggests that EI training interventions can improve emotional competencies and contribute to psychological well-being, with moderate positive effects in organizational and healthcare contexts.^{38,39} More recent research deepens this understanding by showing that EI can act as a mediator in situations of high emotional demand. Ibrahim et al. (2025)⁴⁰ found that EI reduces the impact of anxiety and role ambiguity in nurses working in critical geriatric contexts, promoting greater functional clarity and better performance.

Burnout is one of the main risks associated with geriatric care.⁴¹ EI has been identified as a protective factor in this context, allowing caregivers to recognize early signs of emotional exhaustion and mobilize self-regulation strategies. In this sense, EI contributes to reducing psychological wear and promoting professional resilience in contexts of high emotional demand.^{9,38}

Empathy, as a central component of EI, plays a particularly relevant role in caring for older people.^{8,42} However, recent literature emphasizes the importance of distinguishing between emotional empathy and cognitive empathy.⁴³ While excessive emotional empathy may be associated with higher levels of emotional wear in healthcare professionals,⁴¹ cognitive empathy, associated with higher levels of EI, allows a more structured and functional understanding of the older person's needs, favoring more adaptive care practices.^{42,43}

In the context of palliative care,⁴³ highlight that EI plays a significant role in managing end-of-life emotions, contributing to more effective communication with families and more ethically sensitive decision-making processes. This competence is especially important in settings where the emotional dimension of care is particularly intense.

In the case of informal caregivers,¹⁵ show that higher levels of EI are associated with lower burden and greater perceived social support. In this context, interventions focused on developing emotional

competencies appear promising for promoting psychological well-being and adaptation to the caregiver role.

EI also influences the relational quality of care. Caregivers with higher levels of EI tend to establish more empathetic and collaborative relationships with older people, thereby promoting better care behaviors and higher-quality care provision, particularly in dementia contexts.^{8,26} Thus, EI is a fundamental resource for caregivers, supporting both the quality of care provision and the protection of their own emotional balance and professional resilience.^{38,41}

In the team/institution — communication, relational climate and humanization of care

The organizational dimension of EI has gained prominence in the literature, particularly in geriatric contexts where care is provided by multidisciplinary teams. In this context, EI plays a central role in communication, relational climate, and the humanization of care.

Côté (2014)²⁸ highlights that EI is associated with organizational functioning, promoting more effective communication, greater team cohesion, and stronger collective efficacy. McNabney et al. (2022)⁵ emphasize that the quality of interactions between healthcare professionals is an important element in geriatric care models, influencing both the quality and safety of care provision.

Communication, as a fundamental competence, is closely linked to EI and favors a more empathetic and person-centred approach toward the older person and their family.^{8,28} The literature suggests that teams with higher levels of EI show more effective communication patterns, better conflict management, and a stronger orientation toward collaborative care environments.^{9,10}

Evidence also indicates that team relational climate is influenced by EI. Environments characterized by trust, respect, and mutual

support are associated with lower levels of occupational stress and greater professional satisfaction.^{38,41} By contrast, contexts marked by dysfunctional communication and low emotional competence are associated with reduced care quality and emotional well-being, as well as higher levels of occupational stress.^{5,44}

Leadership also plays a relevant role in consolidating positive relational environments. Prezerakos (2018)⁹ indicates that leaders with high EI tend to promote psychologically safe environments, reinforcing effective communication patterns and contributing to better team performance and motivation.

Recent evidence points to the role of EI in the humanization of care, especially in end-of-life contexts. Su et al. (2025)⁴³ indicate that teams with greater emotional competence are associated with better management of high-emotional-load situations, favoring more transparent communication and more ethically careful decision-making.

Additionally,¹¹ highlight the importance of continuous EI training as a strategy for improving organizational climate and the quality of care. This perspective is reinforced by evidence suggesting that integrating EI into institutional practices, such as emotional supervision and continuous competency development, promotes more adaptive work environments.^{10,38}

In summary, EI is a relevant element of geriatric organizations, influencing communication, relational climate, and the humanization of care, and is essential for the quality and sustainability of health systems. Table 1 provides a concise synthesis of the review’s three analytical axes, highlighting the main challenges, the role of EI, and the practical implications across each context.

Table 1 Summary of the main analytical axes and implications of emotional intelligence in geriatric care

Analytical axis	Main challenges	Role of EI	Practical implications
In the older person	Chronic illness, functional decline, loss of autonomy, social isolation, dementia, and proximity to death.	Supports emotional regulation, adaptation to ageing, and meaning-making in the face of later-life losses.	Promotes well-being, quality of life, and person-centred support in ageing contexts.
In the caregiver	Care burden, stress, burnout, emotional exhaustion, and role ambiguity.	Strengthens empathy, self-regulation, resilience and adaptive coping strategies.	Improves care quality, mitigates burnout, and supports training and intervention initiatives.
In the team/institution	Communication breakdowns, low cohesion, weak leadership, and adverse organizational climate.	Enhances communication, team cohesion, psychological safety, and the humanization of care.	Contributes to a healthier organizational climate, collaborative practice, and sustainable care delivery.

Source: Prepared by the authors based on the reviewed literature.

Discussion

The present review highlights EI as a central resource in geriatric care, with relevance at individual, relational, and organizational levels. Overall, the findings suggest that EI helps manage the emotional demands of ageing while supporting caregivers’ well-being and the quality of care. These results are consistent with established theoretical models [6,16] and with more recent applied perspectives in healthcare.^{10,38} This supports the view that EI should be understood not merely as an individual trait, but as a functional competency with systemic implications in complex care environments.

At the individual level, the evidence consistently shows that higher EI is associated with lower occupational stress, greater job satisfaction, and increased resilience, acting as a protective factor against burnout.^{9,41} Skills such as emotional regulation and cognitive

empathy appear particularly relevant for supporting balanced and adaptive care practices.^{42,43} These findings reinforce the importance of integrating emotional competencies into professional training in geriatrics, especially in contexts marked by sustained emotional demand.

At the organizational level, EI emerges as a determinant of communication quality, team dynamics, and overall effectiveness. Emotionally competent environments tend to foster collaboration, improve conflict management, and strengthen team cohesion, with direct implications for care quality and safety.^{5,28} Leadership also plays a critical role, as emotionally intelligent leaders are more likely to promote psychologically safe and motivating work environments.⁹ In addition, EI contributes to the humanization of care, particularly in high-demand settings such as palliative care.⁴³ Taken together, these

findings highlight the systemic role of EI in shaping organizational culture and broader service outcomes.

Despite these contributions, several gaps remain. The predominance of cross-sectional designs limits conclusions about causal relationships between EI and clinical or organizational outcomes. Furthermore, although EI training interventions show promise, their methodological heterogeneity constrains generalizability.^{11,39} Research on informal caregivers, particularly in European contexts, also remains limited despite their growing relevance.^{2,15}

From a practical perspective, the findings support the integration of EI into healthcare training programs and institutional policies. Approaches such as emotional supervision, reflective practice, and continuous professional development may contribute to more adaptive and sustainable work environments.^{11,38} In this sense, EI should be understood not only as an individual competence but also as a strategic organizational resource. Overall, the review suggests that EI may represent a foundational component in the delivery of effective and person-centred geriatric care.

This review has some limitations. The selection of studies was influenced by the availability of recent literature and specific care contexts, which may not fully represent the breadth of existing evidence. In addition, the conceptual diversity of EI is.^{21,34} Future research should prioritize longitudinal and experimental designs to better understand the impact of EI on geriatric care outcomes. Further studies across diverse cultural and healthcare contexts are also needed, particularly with informal caregivers and dementia care settings.

Conclusion

EI is a key component of contemporary geriatric care, with important implications for caregiver well-being, therapeutic relationships, and organizational effectiveness. The findings of this review support established theoretical models of EI as a multidimensional capacity for perceiving, regulating, and using emotions in adaptive ways, particularly in complex care contexts.

Overall, EI emerges as a critical and functional resource that underpins both individual and organizational functioning in geriatric settings. Its integration into professional training and organizational strategies appears essential for promoting more humanized, sustainable, and person-centred care for older adults. In this sense, EI should be recognized as a foundational element in the ongoing transformation of geriatric care toward more responsive and emotionally competent healthcare systems.

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Conflicts of interest

The authors report no potential conflicts of interest relevant to this article.

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