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Emotional intelligence profiles and externalizing and internalizing symptoms in emerging adulthood

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Abstract

Introduction. In recent decades the relationship between emotional intelligence and mental health has been analyzed. One conception of emotional intelligence is as a trait, composed of three dimensions: attention, clarity and repair. On the other hand, mental health is commonly measured by the presence/absence of internalizing and externalizing symptoms.

Objective: In this study, the cluster analysis approach is used to determine the existence of different combination profiles of the three dimensions that make up the emotional intelligence construct, and to analyze possible differences in the symptomology reported by persons with different profiles of emotional intelligence.

Method: The sample consisted of 328 university students between the ages of 17 and 31 years (*M* = 20.86; *SD* = 2.22), that is, in the stage of emerging adulthood.

Results: Three differential profiles of emotional intelligence are obtained; these represent different combinations of attention, clarity and mood repair, and present significant differences in internalizing and externalizing symptomatology.

Conclusions: The utility of cluster analysis for determining the existence of different profiles in emotional intelligence has been demonstrated. The profile characterized by low levels of attention and higher scores in clarity and mood repair presents the lowest levels of internalizing and externalizing symptoms; by contrast, the profile that presents a higher level of attention and lower scores in clarity and repair is associated with the highest scores in internalizing and externalizing symptoms. A profile with high scores in all three dimensions of emotional intelligence occupies the intermediate position in terms of reported symptomology.

Keywords: emotional intelligence, internalizing/externalizing symptoms, mental health, emerging adulthood.

Resumen

Introducción: En las últimas décadas se ha analizado la relación entre la Inteligencia Emocional y la salud mental. Una de las formas en las que se concibe la inteligencia emocional es como un rasgo que se compone de tres dimensiones: atención, claridad y reparación. Por otra parte, una de las principales medidas de salud mental incluye la presencia/ausencia de síntomas tanto internalizantes como externalizantes.

Objective: En este estudio se utiliza el enfoque de análisis clúster para determinar la existencia de distintos perfiles al combinar las tres dimensiones que componen el constructo de inteligencia emocional y analizar las posibles diferencias en la sintomatología que informan las personas con los diferentes perfiles de inteligencia emocional.

Método: La muestra estaba compuesta por 328 estudiantes universitarios con edades comprendidas entre los 17 y 31 años (*M*=20,86; *DT*= 2,22) y que, por tanto, si sitúan en la etapa de la adultez emergente.

Resultados: Se obtienen tres perfiles diferenciales en inteligencia emocional que suponen distintas combinaciones de atención, claridad y reparación emocional y que presentan diferencias significativas en sintomatología internalizante/externalizante.

Conclusions: Se comprueba la utilidad del análisis clúster para determinar la existencia de distintos perfiles en inteligencia emocional. El perfil que se caracteriza por niveles mas bajos de atención y mas altos en claridad y reparación emocional presenta las menores puntuaciones en síntomas internalizantes y externalizantes, por el contrario, el perfil que presenta un mayor nivel de atención y menores niveles en claridad y reparación se asocia con las mayores puntuaciones en síntomas internalizantes y externalizantes. Una posición intermedia en cuanto a los síntomas manifestados la ocupa el perfil que se caracteriza por altas puntuaciones en las tres dimensiones de la inteligencia emocional.

Palabras clave: inteligencia emocional, síntomas externalizantes/internalizantes, salud mental, adultez emergente.

Introduction

Research in the past years has verified the relationship between Emotional Intelligence and mental health in both adolescents and adults. Several recent authors (Arnett, 2000), however, are affirming that the third decade of life is a period with characteristics that distinguish it from both adolescence and adulthood, proposing the term "emerging adulthood".

One of the main measures of mental health refers to the presence/absence of internalizing and externalizing symptoms. Hence, we find research studies that analyze the relationship between emotional intelligence and internalizing and externalizing problems; for example, the study by Siu (2009) in a sample of Chinese adolescents found an inverse relationship between measures of emotional intelligence and internalizing and externalizing behavior problems. There are even meta-analyses that examine the relationship between emotional intelligence and health; Martins, Ramalho, and Morin (2010) examined 80 studies involving 19,815 subjects between the ages of 15 and 53 years, and they reaffirmed the value of emotional intelligence as a predictor of mental and physical health.

Emotional intelligence, however, can be conceptualized and measured in different ways. According to Davis and Humphrey (2012), the way that the emotional intelligence construct is measured influences its relationship to internalizing and externalizing problems. Emotional intelligence when conceived as a trait is more closely related to internalizing problems, while emotional intelligence as a skill primarily relates to externalizing problems. This idea of differential influence according to the measure used is also confirmed by Resurrección**,** Salguero, and Ruiz-Aranda (2014), who show that associations are greater in studies based on self-reports than in studies that use maximum performance measures.

The emotional intelligence construct as a trait is composed of different dimensions, namely, attention, clarity and mood repair. These three dimensions have been shown to present different relationships to measures of mental health. While the emotional attention dimension presents a negative relationship to mental health, the dimensions of clarity and mood repair show a positive relationship to mental health (Berking, Orth, Wupperman, Meier, & Caspar, 2008; Fernández-Berrocal, & Extremera, 2007; Wong, Oei, Ang, Lee, Ng, & Leng, 2007).

With regard to internalizing symptoms, emotional attention was found to be associated with greater emotional susceptibility, depression, anxiety and risk of suicide (Aradilla-Herrero, Tomás-Sábado, & Gómez-Benito, 2014; Gómez-Baya, Mendoza, Paino, & Gaspar de Matos, 2017; Resurrección et al.**,** 2014). Clarity and repair were negatively associated with depressive symptoms and anxiety (Gómez-Baya et al., 2017; Resurrección et al.**,** 2014).

Regarding externalizing symptoms, a negative relationship was found between emotional intelligence and aggression (Sancho, Salguero, & Fernández-Berrocal, 2014). Additionally, Coccaro, Zagaja, Chen, and Jacobson (2016) claim that low levels of repair and clarity and high levels of attention are positively associated with aggressivity and impulsivity.

This same idea is defended by Ciarrochi, Deane, and Anderson (2002), who feel that certain aspects of emotional intelligence may not be adequate, given that emotionally perceptive persons are more vulnerable to stress. On the other hand, according to Sánchez, Montañés, Latorre, and Férnandez-Berrocal (2006), persons with higher scores in perceived clarity and repair present better indices of mental health.

Thus, a profile of high emotional intelligence has been proposed as having moderate or low scores in attention and high scores in clarity and repair (Salovey, Bedell, Detweiler, & Mayer 1999). There is little research, however, to confirm the existence of this emotional profile, and its impact on individuals' mental health.

Consequently, instead of speaking of the global contruct of emotional intelligence, and given that the different dimensions of emotional intelligence do not behave the same, this study uses cluster analysis to analyze how the dimensions that make up emotional intelligence are grouped into differential patterns, and how these patterns relate to mental health. The technique of cluster analysis for determining different emotional intelligence profiles has been used in prior studies. For example, Gázquez, Pérez-Fuentes, Díaz-Herrero, García-Fernández, and Inglés (2015) used the cluster technique to determine whether there were different profiles combining the three dimensions of emotional intelligence as measured by the TMMS-24, and whether these profiles presented differences in the adolescents' social behavior. Although three groups were obtained initially, they ultimately adopted the option of four profiles of emotional intelligence. García-Linares, Carpio, Cerezo, and Casanova (2018) obtained three profiles by combining the three dimensions of emotional intelligence, and they confirmed

significant differences between the three profiles with regard to their parents' childraising practices. The study by Cabanach, Souto-Gestal, Gonzalez, and Corrás (2018) also identified three profiles of emotional regulation using the cluster analysis technique, and showed differences among physical therapy students in their strategies for coping with stress.

Objectives

Based on the foregoing, the present study seeks first to verify whether different profiles appear when combining the dimensions of emotional intelligence (perception, clarity and repair) in individuals within a particular transitional developmental stage of interest, that is, the stage of emerging adulthood. The second aim is to determine whether differences are seen in the internalizing and externalizing symptoms reported by the participants included in the different emotional intelligence profiles, in order to perceive the capacity of the different profiles for maintaining mental health.

Method

Participants

Participating in the study were 325 students from the first, second and third year of different undergraduate degree programs offered at the University of Jaen. Of the total sample, 33.1% of the students were enrolled in Primary Education, 25.5% in Psychology, 17.3% in Social Education, 12.1% in Electrical Industrial Engineering and 6.7% in Biology. Age of the participants was between 17 and 31 years (M=20.86 year, SD= 2.22). Distribution by gender was 108 (33.23%) male and 217 (66.77%) female. As for the distribution of gender by age, no significant differences were found, with $\chi^2 = 17.98$; $p = .158$.

Incidental sampling was used for the study sample, such that the degree programs and classrooms were selected according to their availability.

Instruments

We used the Trait Meta-Mood Scale-24 as adapted by Fernández-Berrocal, Extremera and Ramos (2004), given that this version has shown adequate psychometric properties, similar to those of the original scale (Gázquez, et al., 2015). Moreover, this scale was recently validated in a Spanish-speaking population (Gómez-Nuñez, Torregrosa, Inglés, Lagos San Martín, Sanmartín, Vient, & García-Fernandez, 2018). The questionnaire is composed of 24

items. Participants were asked to evaluate the degree to which they agreed with each of the items on a five-point Likert scale, ranging from *Totally disagree (1)* to *Totally agree (5)*. The scale comprises three subfactors: attention to one's own feelings, emotional clarity and mood repair. Fernández-Berrocal et al. (2004) found internal consistency of .90 for Attention, .90 for Clarity and .86 for Repair; very similar internal consistency data were found in the present study (.90 for Attention, .88 for Clarity and .84 for Repair).

Adult Self-Report (ASR, Achenbach & Rescolar, 2003). The ASR is a parallel version of the YSR (Achebanch & Rescorla, 2001), created for assessing adults between the ages of 18 and 59. It is a self-report instrument that measures the adaptive and psychopathological capacity of adults. The ASR contains 126 items, of which 74 items, the items used in this study, refer to internalizing symptoms and externalizing symptoms. Internalizing symptoms are reflected in the subscales of anxiety-depression (n=18) *e.g. "I cry a lot"*, withdrawal (n=9) *e.g. "I don't get along well with others"* and somatization (n=12) *e.g. "I feel dizzy"*. Externalizing symptoms include aggressive behavior (n=15) *e.g. "I argue a lot"*, attention seeking (n=6) *e.g. "I try to attract attention"* and disobedient behavior (n=14) *e.g. "I steal things"* (Achenbach & Rescorla, 2003). The answer format requires the participate to make a judgement on the degree to which each statement corresponds to his or her behavior during the past six months, with three response options: 0= the statement is untrue of me or does not apply to me, 1= the statement applies to me sometimes , 2= the statement very often applies to me. This study only analyzed the subscales that measured internalizing and externalizing symptoms; their alpha was .83 and .79, respectively (Estévez, Oliva, & Parra, 2012). The internal consistency data obtained in this study were somewhat lower, with alpha values of .65 for the scale measuring the presence of internalizing symptoms and .61 for the scale measuring externalizing symptoms.

Procedure

The tests were applied during a single hour-long session, held during regular class hours for the different degree programs (primary education, psychology, engineering and biology), with both the professor and the researchers present. The students' collaboration was requested, and they were assured that questionnaire responses were entirely voluntary and confidential.

Results

Initially, in order to verify the existence of different emotional intelligence profiles by combining the three variables that make up this construct, we performed cluster analysis (K-means), using as criterion the scores obtained on the three dimensions of emotional intelligence assessed by the TMMS-24: perceiving one's emotions (attention), understanding emotions (clarity) and regulating emotions (mood repair). The criterion for choosing the number of clusters was to maximize intergroup differences. In addition to this criterion, we also took into account theoretical viability and the psychological significance of each of the groups represented by the different profiles of emotional intelligence. Through this procedure, a three-profile solution was determined, considering it the most adequate option from the point of view of its theoretical interpretation, given that the differentiating role of the attention and emotion regulation dimensions stood out. Therefore, three differentiated profiles were obtained (Figure 1).

As can be seen, there was one group of students that presented high levels of attention, clarity and repair (group 3), a second group characterized also by high levels of clarity and repair, but low in emotional attention (group 2), and a third group where attention was moderate but clarity and repair were low (group 1).

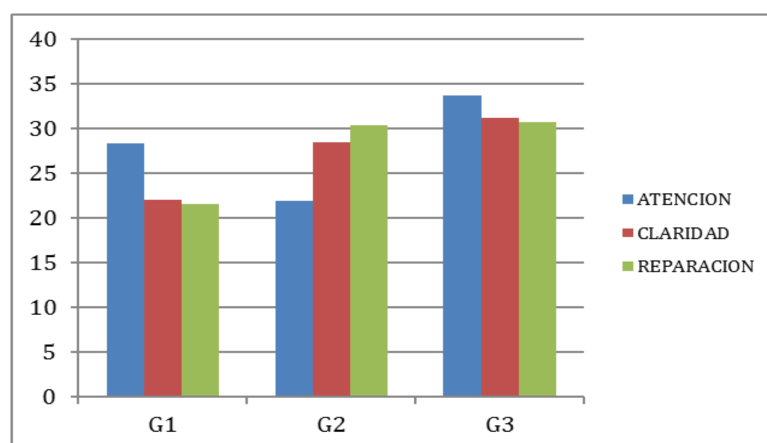

Figure 1. *Emotional intelligence profiles.*

[Key. *Atención*: Attention; *Claridad:* Clarity; *Reparación:* Repair]

In order to determine whether the three groups were significantly differentiated between themselves, a corresponding analysis of variance was performed, and significant differences were found (Table 1). The multiple post-hoc comparisons indicated significant differences between the three groups in all factors relating to emotional intelligence, except for groups 2 and 3 who did not differ significantly in the “repair” factor.

Table 1. *Differences among the three profiles of the dimensions of emotional intelligence*

		M	SD	F	η^2
ATTENTION	Group 1	28.2842	5.93343	188.002**	0.53
	Group 2	21.8454	4.20649		
	Group 3	33.6466	3.57855		
CLARITY	Group 1	22.0632	4.59141	105.071**	0.39
	Group 2	28.4021	4.99929		
	Group 3	31.2406	4.66475		
REPAIR	Group 1	21.5474	4.04172	125.220**	0.43
	Group 2	30.3814	4.64005		
	Group 3	30.6767	5.08496		

*p< .05, **p< .01

An ANOVA was also conducted in order to verify whether there were differences in the appearance of internalizing and externalizing symptoms according to the emotional intelligence profile of the participants (see Table 2), and the existence of such differences in both internalizing and externalizing symptomology was demonstrated.

Table 2. *Differences in general internalizing and externalizing symptomology in the three profiles of emotional intelligence*

		M	SD	F	η^2
INTERNALIZING PROBLEMS	Group 1	23.6737	10.22559	31.968**	0.16
	Group 2	14.1753	7.53604		
	Group 3	17.3083	7.53696		
EXTERNALIZING PROBLEMS	Group 1	14.9263	7.98435	9.687**	0.05
	Group 2	10.3918	6.39426		
	Group 3	12.3835	7.05361		

*p< .05, **p< .01

The multiple comparisons carried out *a posteriori* using Scheffé's test showed that there were differences among the three groups with regard to the presence of internalizing and externalizing symptomology. Specifically, differences in internalizing problems were significant between groups 1 and 2 (p<.01) and 3 (p<.01), and between groups 2 and 3 (p<.05). In the case of externalizing problems, differences were only significant between groups 1 and 2 (p<.01). As seen in Table 2, group 1 was found to present a greater measure of both internalizing and externalizing problems, while group 2 reported the least amount of both types of problems.

Afterward, to further examine any relationships between emotional intelligence profiles and the presence of specific internalizing problems, an analysis of variance was conducted using specific internalization symptoms as dependent variables. Results from the analysis showed significant differences between the three types of emotional intelligence profiles in reference to participants' manifestation of anxiety, withdrawal and somatization.

As for differences in specific externalizing symptomology according to emotional intelligence profile, the results of the analysis of variance showed significant between-group differences only in the appearance of aggressive behavior (Table 3).

Table 3. *Differences in specific internalizing and externalizing symptomology in the three profiles of emotional intelligence*

		M	SD	F	η^2
ANXIETY	Group 1	14.9053	5.99658	38.037**	0.19
	Group 2	8.6495	4.33263		
	Group 3	10.9398	4.75420		
WITHDRAWAL	Group 1	4.7368	3.40279	12.842**	0.07
	Group 2	2.93381	2.33102		
	Group 3	3.1880	2.36819		
SOMATIZATION	Group 1	4.03316	3.21384	6.307**	0.04
	Group 2	2.5876	2.53210		
	Group 3	3.1805	2.74920		
AGGRESSIVE BEHAVIOR	Group 1	8.3789	4.96408	15.011**	0.08
	Group 2	5.0000	3.64863		
	Group 3	6.3083	4.25900		
DISOBEDIENT BEHAVIOR	Group 1	3.9474	3.17694	1.224	0.00
	Group 2	3.2784	2.90740		
	Group 3	3.6466	2.86091		
ATTENTION SEEKING	Group 1	2.6000	1.71601	2.117	0.00
	Group 2	2.1134	1.56042		
	Group 3	2.4286	1.71131		

*p<0.05, **p<0.01

Finally, *a posteriori* comparisons between each of the groups were calculated through the Scheffé test in order to determine which group pairings showed differences in specific internalizing or externalizing symptomology. Significant differences were found between groups 1 and 2 (p<.01), 1 and 3 (p<.01) and 2 and 3 (p<.01) in the manifestation of anxiety. In withdrawal, differences were significant between groups 1 and 2 (p<.01) and between 1 and 3 (p<.01), while in somatization, the only differences were between groups 1 and 2 (p<.01).

Finally, concerning manifestation of aggressive behaviors, differences were found between group 1 and 2 (p<.01) and between 1 and 3 (p<.01).

Discussion and Conclusions

This study has analyzed relations between the different dimensions that make up emotional intelligence and the appearance of internalizing and externalizing problems in individuals in their period of emerging adulthood.

The relationship between emotional intelligence and adjustment problems in adolescents has been confirmed in recent research studies (Gugliandolo, Costa, Cuzzocrea, Larcan & Petrides, 2015) and in different cultural contexts (Cheung, Leung, Chung & Cheung, 2018). However, it has been demonstrated that not all dimensions that make up emotional intelligence, understood as a trait, present the same behavior. For this reason, it may be important to analyze the existence of different patterns of association between the dimensions that make up emotional intelligence, in order to determine their relationship to mental health in individuals who find themselves in the transitional period of emerging adulthood.

First of all, the results obtained here support the utility of a cluster analysis approach for examining the effects of the different dimensions that make up the construct of trait emotional intelligence. In this way, we consider not only the relationships between different dimensions that make up the construct of emotional intelligence, but rather the different combinations of these dimensions that constitute established profiles, thereby allowing a more accurate determination of the influence of emotional intelligence on individuals' mental health.

This study confirms the idea defended by Davis and Humphrey (2012), that trait emotional intelligence is more closely related to internalizing problems than to externalizing problems, given that the measuring instrument used here considers emotional intelligence as a trait.

Regarding internalizing symptoms, our results confirm other findings that higher scores in emotional attention and lower scores in clarity and repair are associated with higher levels of depressive symptoms and anxiety (Gómez-Baya et al. 2017).

Regarding externalizing symptoms, our results confirm other findings where aggression is associated with higher levels of attention and lower levels of repair (Coccaro et al. 2016).

This study demonstrates the existence of an emotional intelligence profile that consists of higher scores in attention accompanied by lower scores in clarity and repair; this profile presents negative effects for mental health. These negative effects may be explained, as indicated by Coccaro et al. (2016), in that persons with this profile maximize the effect of emotional experiences and maintain negative states of mind instead of alleviating them; moreover, such emotionally perceptive persons are more vulnerable to stress, as defended by Ciarrochi et al. (2002).

Our data also confirm the idea defended by Sánchez et al. (2006): that persons with higher scores in clarity and perceived repair present better indices of mental health. Specifically, our data demonstrated the existence of a profile composed of moderate or low scores in attention and high scores in clarity and repair; this profile was confirmed as beneficial for preserving individuals' mental health, since this group presented lower scores in both internalizing and externalizing symptoms.

The latter idea is also reaffirmed by the third emotional intelligence profile that we obtained: persons showing high scores in all three dimensions of attention, clarity and repair. The main difference between this profile and the previous one is precisely in its dimension of emotional attention, which is the highest of the three profiles. This profile might initially be interpreted as the most beneficial; however, it occupies an intermediate position among the three profiles in terms of internalizing symptoms and aggressive behavior.

These results show the clear utility of considering programs designed to foster emotional intelligence in adults, with special emphasis on the emotional attention dimension. As the data reveal, excessive attention and focus on one’s own emotional states may have harmful consequences and contribute to the appearance of both internalizing problems (anxiety, withdrawal, etc.) and externalizing problems (aggressive behavior). Therefore, strategies should be aimed at fostering an intermediate level of attention and a high level of discrimination and control of emotions.

The limitations of this study have to do with the sample used, formed exclusively of university students, and with the use of self-report measures. The fact that the sample considers only university students does not allow us to generalize the results to the entire population within the stage of emerging adulthood. Consequently, it would be profitable for future research studies to try to replicate these results, taking into account other types of samples with different origins, ages, cultural contexts and conditions of mental health. Regarding assessment using self-report measures, it would be profitable to also use information available through other means and agents, in order to ensure the objectivity of these measurements.

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