Association between emotional intelligence and mental health of clinical teachers in health sciences .

Asociación entre inteligencia emocional y salud mental de docentes clínicos en ciencias de la salud.

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Summary

Objective: This study aimed to analyze the level of emotional intelligence—in its dimensions of attention, clarity, and emotional repair—and its association with mental health in faculty members with a clinical training role in university programs in the health field. **Methods:** A descriptive, cross-sectional study was conducted using validated self-report instruments (TMMS-24 and GHQ-30) in clinical faculty members from health science programs. Levels of mental health and emotional intelligence were assessed and compared according to the work context (public or private sector). **Results:** The results showed high performance in emotional clarity (68.5%) and emotional repair (73.98%), and low performance in emotional attention (43.47%). The majority of participants (84.83%) presented high levels of emotional well-being, with better results in the private sector (90%) compared to the public sector (81.39%). However, self-perception of mental health was higher in the public sector (76.67%) than in the private sector (58.14%), which shows a divergence between subjective perception and GHQ results. Significant associations were found between GHQ scores and self-perception of mental health (r = .33; p < .01) and between the GHQ and the emotional repair dimension (r = .26; p = .02). **Conclusion:** Emotional intelligence, especially the capacity for emotional repair, appears to play a protective role against alterations in the mental health of clinical educators. Low levels of emotional attention reinforce the need for institutional strategies to strengthen this competency. These findings highlight the importance of jointly addressing emotional and mental health aspects in those who train future health professionals.

Keywords: Emotional intelligence, Mental health, Clinical teaching, Health sciences education, Professional practice.

Resumen

Objetivo: El estudio tuvo como objetivo analizar el nivel de inteligencia emocional—en sus dimensiones de atención, claridad y reparación emocional—y su asociación con la salud mental en docentes con rol clínico formativo en carreras universitarias del área de la salud. **Métodos:** Se realizó

un estudio descriptivo de corte transversal, utilizando instrumentos validados de autorreporte (TMMS-24 y GHQ-30) en docentes clínicos de programas de ciencias de la salud. Se evaluaron y compararon los niveles de salud mental e inteligencia emocional según el contexto laboral (sector público o privado). **Resultados:** Los resultados mostraron un alto rendimiento en claridad emocional (68,5%) y reparación emocional (73,98%), y un bajo rendimiento en atención emocional (43,47%). La mayoría de los participantes (84,83%) presentó altos niveles de bienestar emocional, con mejores resultados en el sector privado (90%) frente al público (81,39%). Sin embargo, la autopercepción de salud mental fue superior en el sector público (76,67%) que en el privado (58,14%), lo que evidencia una divergencia entre percepción subjetiva y resultados del GHQ. Se encontraron asociaciones significativas entre los puntajes del GHQ y la autopercepción de salud mental (r = .33; p < .01 y entre el GHQ y la dimensión reparación emocional (r = .26; p = .02). **Conclusión:** La inteligencia emocional, especialmente la capacidad de reparación emocional, parece desempeñar un rol protector frente a alteraciones en la salud mental de los docentes clínicos. Los bajos niveles en atención emocional refuerzan la necesidad de estrategias institucionales que fortalezcan esta competencia. Estos hallazgos resaltan la importancia de abordar conjuntamente los aspectos emocionales y de salud mental en quienes forman a futuros profesionales de la salud.

Palabras clave: Inteligencia emocional, Salud mental, Docencia clínica, Educación en ciencias de la salud, Práctica profesional.

1. Introduction

In recent years, the World Health Organization (WHO) has reinforced the need to build resilient health systems (1) that allow the population to have universal coverage, which in turn must consider health security as one of its pillars (2), and in this way, have the capacity to absorb and manage the impacts of health emergencies (3), since the COVID-19 pandemic revealed a series of gaps in the capacities of health systems globally to provide safe, equitable and timely health care (4). It is in this context, where the strengthening of health human resources, both in quality and quantity of professionals, is considered an essential aspect for the development and implementation of this need (1), which must be addressed comprehensively, considering both the professional component of knowledge (cognitive edge), as well as the moral and motivational capacities of health workers (2). This strengthening of human resources would not only have a favorable impact on providing a quality service in the short term in the face of a health emergency (5), but could also have a future impact due to the clinical training role that some health professionals hold as a complementary activity to their care role, and which directly affects the capacities and skills of new health science professionals, given the understanding of the care-teaching role as a key amalgam for the professionalization and accompaniment of the teaching process (6-7).

It is in this formative role where the modeling of future professionals raises the need to address the different types of knowledge, such as cognitive knowledge (8) , investigative knowledge (9), ethical and reflective knowledge, practical or procedural knowledge, and social or relational knowledge (10), which include communication skills (11-12) and soft skills also called non-cognitive or socio-emotional skills (14), a concept that we will use in this research. The latter represent one of the greatest challenges in the training of health professionals, as they are essential for comprehensive care focused on the user and their context (13).

From this perspective, clinical teachers take on the responsibility of incorporating technical resources that enable the development of their teaching skills and, in turn, enhance metadidactic learning, becoming professional role models for their students (15), impacting both the acquisition of knowledge and the interpersonal skills so necessary in the training process (16). However, to achieve these requirements, the clinical teacher must have the ability to attend to, understand and regulate

their own emotions, along with understanding those of others, aspects that are framed within the concept of emotional intelligence (17). Indeed, emotional intelligence considers the capacities that allow for having strategies for coping, adaptation, adoption and consolidation of socio-emotional skills, which are considered fundamental for the improvement of personal and work relationships (18). In turn, these capabilities foster a climate of trust in the context of the teacher-student relationship, encouraging students to request feedback on their academic work, along with encouraging them to dedicate time and effort to improve their future performance (18).

Additionally, greater emotional intelligence would favor better performance in the clinical teaching role of the health professional, given that this type of intelligence is recognized as a mechanism that contributes to the prevention and control of alterations in people's mental health, particularly highlighting its contribution in the management of anxiety and depression (19, 20). This situation becomes relevant in the face of the sustained increase in mental health problems that health professionals have presented, a product of the work and emotional overload conditioned by the COVID-19 pandemic, causing a reduction in their work performance and motivation (16), negatively affecting emotional self-perception, with the consequent implication in the quality of professional care and service (20-21).

Given the relevance of the level of emotional intelligence and mental health of health professionals for the correct fulfillment of the teaching-care role, and the impact that this would have on the training process of future health workers, adding the fact that, to our knowledge, in Chile there are no studies that report the behavior and relationship of these variables in health professionals with a teaching-care role. The main objective of this research is to analyze the level of emotional intelligence in its processes of perception (emotional attention), comprehension (emotional clarity) and regulation of emotions (emotional repair) and its association with the presence of depression and anxiety in teachers with a clinical training role in health careers.

2. Methods

2.1 Type of study, location and study sample

Prospective, observational, cross-sectional study. A total of 73 clinical instructors training students in health science programs (kinesiology, occupational therapy, nutrition, nursing, and speech therapy) from public and private health centers at the Universidad de Playa Ancha (Chile) participated in our study. They represented 40% of the total population of 182 professional practice instructors. The sample size was estimated using Fisher's z transformation, implemented using G*Power 3.1. For this estimate, the parameters of the size of the clinical faculty population, an alpha of .05 (two-tailed) and a statistical power of .80 were considered, along with an *r* of .33 based on the results obtained by Fernández-Martínez et al., (22), who analyzed the relationship between emotional intelligence and mental health, through the use of the self-report Emotional Metacognition Trait Scale tests and the Goldberg General Health Questionnaire in university students. The number of faculty from the public and private health sectors was 43 and 30 participants, respectively, which was established based on the proportion of clinical faculty belonging to each health sector, with 59% for the public area and 41% for the private area. Participants had to meet the following inclusion criteria: a) Carry out clinical and formative teaching activities in the professional practice curricular activity for eleventh and twelfth semester students of the undergraduate degree curriculum for the Faculty of Health Sciences of the Universidad de Playa Ancha de Valparaíso during the years 2022 and 2023, b) Present a work seniority of at least one year in the clinical center where they fulfilled the teaching-care role, and c) Signing of informed consent. The exclusion criteria considered were: a) Having presented absenteeism from work for more than 3 months in total in the years 2022 and 2023.

2.2 Measuring instruments

2.2.1 Emotional intelligence

Perceived emotional intelligence was assessed using the self-report Trait Emotional Metacognition Scale (TMMS 24), an instrument that studies the factors of Perception, Understanding and Regulation, using 24 items with a Likert scale, with a score range from 1 to 5, considering score 1: "do not agree at all", score 2: "somewhat agree", score 3: "quite a bit agree", score 4: "strongly agree", score 5: "totally agree" (23). This instrument has been applied to university professors, showing internal consistency, according to its dimensions of attention ($\alpha = 0.90$), clarity ($\alpha = 0.90$) and repair ($\alpha = 0.86$) (24).

2.2.2 Mental Health

Mental health was assessed using the Goldberg self-report questionnaire (General Health Questionnaire, GHQ) (25-26). This tool studies the dimensions of Anxiety and Depression, through the application of 12 items on a Likert scale, with a score range from 0 to 3, where a higher score ("3") corresponds to a greater affectation in the mental health component. The questionnaire has been used in previous studies both in health professionals (27-28) and in higher education teachers (29-30), whose validation has been presented in previous research (31-32), showing a reliability of .89 (33). Additionally, self-perception of mental health is collected by asking participants to answer the question "What is your perception of mental health?", with the response options: "Good", "Regular" and "Poor".

2.3 Procedures

Initially, the University's clinical faculty members were convened for an informational meeting, where the study's objectives and procedural details were described. Informed consent was then provided to the professionals interested in participating. After signing the informed consent form, personal information was collected from each participant, including their email address and mobile phone number. Participants were informed that the instruments would be sent to their email addresses using an online form to facilitate the testing process in a private and relaxed environment. Participants were advised to allow a minimum of 40 minutes to complete the assessment instruments. Data collection was operationalized by recording responses in an Excel spreadsheet for subsequent statistical analysis.

2.4 Data analysis

Statistical analysis was performed using STATA, version 17 (Stata Corp LP, College Station, Texas, USA). The mean and 95% confidence interval were used to describe variables with a normal distribution, while absolute, relative, and cumulative frequency analysis was used to describe qualitative variables. The Mann-Whitney U test was used for comparisons between groups; while Kendall's tau test was used for associations between variables. An alpha of .05 was used.

2.5 Ethical considerations

The instruments and procedures of the study followed the guidelines of the Declaration of Helsinki for medical research on human subjects (34), and were previously reviewed and approved by the Bioethics Committee of the Universidad de Playa Ancha in Valparaíso, Chile (ID 55/2022), safeguarding the ethical principles of biomedical research.

3. Results

The demographic characteristics of clinical care teachers are shown in Table 1, highlighting a mean age difference of 3.69 years between the public and private sectors, and 3.11 years in terms of professional experience, with higher values for the public sector. Regarding gender, female clinical teachers represented the largest number of participants across all groups, with a prevalence of 79.1%, 80.0%, and 79.45% in the public and private sectors, and the total group, respectively.

Table 1. Demographic characteristics of clinical care teachers.

	Public health system n = 43, (women = 34)			Private health system n = 30, (women = 24)			Total group n = 73, (women = 58)		
	IC (95%)			IC (95%)			IC (95%)		
	Mean	Sup.	Inf.	Mean	Sup.	Inf.	Mean	Sup.	Inf.
Age (years)	37.19	40.41	33.96	33.50	36.18	30.82	35.67	37.86	33.48
Professional practice (years)	11.83	15.04	8.61	8.72	11.53	5.91	10.55	12.75	8.35

n: number of participants; CI: confidence interval; Sup: upper; Inf: lower .

Table 2 presents an analysis of the mental health and emotional intelligence status of clinical care teachers according to their healthcare system. No significant differences were observed in the dimensions of the variables studied according to the clinical teachers' work context. However, favorable differences were noted for professionals from the private healthcare system compared to the public system in those categories of the dimensions that guide greater well-being. This included self-perception of mental health (18.53%) and the GHQ (8.61%), as well as emotional intelligence in the dimensions of understanding and regulation, with values of 10.7% and 14.42%, respectively. Among the total group, 73.98% reported excellent or adequate "Repair," 68.5% reported the same for "Understanding," and 65.75% reported "Good" for "Self-perception of mental health." Meanwhile, in the "Attention" item, it is highlighted that the majority of participants obtained the result in the "Little" category, with 49.32%.

Table 2. Mental health (GHQ and self-perception) and emotional intelligence in clinical care teachers according to the health care system.

Variables	Categories	Public health system n = 43 (women = 34)			Private health system n = 30 (women = 24)			Difference between Private and Public FR (%)			Total group n = 73 (women = 58)		
		FA (n)	FR (%)	FAc (%)	FA (n)	FR (%)	FAc (%)	Diff (%)	W	p	FA (n)	FR (%)	FAc (%)
Emotional intelligence **TMMS 24**	Attention												
	Appropriate	18	41.86	41.86	13	43.33	43.33	- 1.47			31	42.47	42.47
	Bit	20	46.51	88.37	16	53.33	96.67	- 6.82	684.50	.63	36	49.32	91.79
	Too much	5	11.63	100.0	1	3.33	100.0	830			6	8.21	100.0
	Clarity												
	Excellent	4	9.30	9.30	6	20.00	20.00	- 10.70			10	13.70	13.70
	Adequate	28	65.12	74.42	12	40.00	60.00	25.12	612.00	.68	40	54.80	68.50
	Must improve	11	25.58	100.0	12	40.00	100.0	- 14.42			23	31.50	100.0
	Repair												
	Excellent	11	25.58	25.58	6	20.00	20.00	5.58			17	23.29	23.29
	Adequate	20	46.51	72.09	17	56.67	76.67	- 10.16	641.00	.97	37	50.69	73.98
	Must improve	12	27.91	100.0	7	23.33	100.0	4.58			19	26.02	100.0
Mental Health	GHQ Emotional Symptoms												
	Emotional well-being	35	81.39	81.39	27	90.00	90.00	- 8.61			62	84.93	84.93
	Slight elevation	4	9.30	90.69	2	6.67	96.67	- 5.98	704.00	.29	6	8.22	93.15
	Moderate elevation	1	2.33	93.02	1	3.33	100.0	- 1.00			2	2.74	95.89
	Significant elevation	3	6.98	100.0	0	0	100.0	6.98			3	4.11	100.0
	Autoper.: What is your perception of your mental health? Good	25	58.14	58.14	23	76.67	76.67	- 18.53			48	65.75	65.75
	Regular	17	39.54	97.68	7	23.33	100.0	16.21	522.00	.10	24	32.88	98.63
	Bad	1	2.33	100.0	0	0	100.0	2.33			1	1.37	100.0

TMMS-24, Self-Report Trait Emotional Metacognition Scale; GHQ, Goldberg General Health Questionnaire; n, number of cases; FA, absolute frequency; Fr, relative frequency; FaC, cumulative frequency; Diff, absolute frequency difference; W, Mann-Whitney U test; p, statistical significance; Autoper, self-perception.

The association between mental health, determined by the GHQ, and the self-perception of mental health and emotional intelligence of clinical care teachers is shown in Table 3 and Figure 1, which show significant direct relationships between the mental health of the GHQ with the self-perception of mental health (Kendal Tau-b = .33; $p < .01$) and the repair dimension of the TMMS-24 test (Kendal Tau-b = .26; $p = .02$). Regarding the association between self-perception of mental health and the dimensions of emotional intelligence, no statistically significant values were observed (Table 4).

Table 3. Association between mental health determined by the GHQ and self-perception of mental health and emotional intelligence in clinical care teachers.

| Variables | Dimension | Categories | Goldberg Mental Health Test Emotional Symptoms | | | | Tau-b | Z | p |
			Welfare n (%)	Slight elevation n (%)	Moderate elevation n (%)	Significant elevation n (%)			
Self-perceived mental health	What is your perception of your mental health?	Good	45 (61.64)	2 (2.74)	1 (1.37)	0 (0.0)	.33	2.87	< .01*
		Regular	16 (21.92)	4 (5.48)	1 (1.37)	3 (4,11)			
		Bad	1 (1.37)	0 (0.0)	0 (0.0)	0 (0.0)			
Emotional Intelligence TMMS-24	Attention	Adequate	26 (35.62)	3 (4.11)	1 (1.37)	1 (1.37)	-.02	-0.02	.88
		Little	31 (42.47)	2 (2.74)	1 (1.37)	2 (2.74)			
		Too much	5 (6.85)	1 (1.37)	0 (0.0)	0 (0.0)			
	Clarity	Excellent	8 (10.96)	2 (2.74)	0 (0.0)	0 (0.0)	.02	0.14	.89
		Adequate	35 (47.95)	2 (2.74)	1 (1.37)	2 (2.74)			
		Must improve	19 (26.03)	2 (2.74)	1 (1.37)	1 (1.37)			
	Repair	Excellent	16 (21.92)	1 (1.37)	0 (0.0)	0 (0.0)	.26	2.39	.02*
		Adequate	33 (45.21)	4 (5.48)	0 (0.0)	0 (0.0)			
		Must improve	13 (17.81)	1 (1.37)	2 (2.74)	3 (4,11)			

TMMS-24, Self-Report Trait Emotional Metacognition Scale; n, number of cases; Mod., moderate; sign., significant; p, statistical significance; *:, p value less than .05; Intell., intelligence; Autoper., self-perception; Tau-b, Kendall's Tau-b test.

Table 4. Association between mental health determined by self-perception of mental health and emotional intelligence in clinical care teachers.

| Variables | Self-perception: What is your perception of your mental health? | | | | Tau-b Kendall | Z | p |
	Dimension	Categories	Good n (%)	Regular n (%)	Bad n (%)			
Emotional Intelligence TMMS-24	Attention	Adequate	19 (26.03)	11 (15.07)	1 (1.37)	-.08	-0.70	.49
		Little	25 (34.25)	11 (15.07)	0 (0.0)			
		Too much	4 (5.48)	2 (2.74)	0 (0.0)			
	Clarity	Excellent	5 (6.85)	4 (5.48)	1 (1.37)	.07	0.63	.53
		Adequate	31 (42.47)	9 (12.33)	0 (0.0)			
		Must improve	12 (16.44)	11 (15.07)	0 (0.0)			
	Repair	Excellent	4 (5.48)	3 (4.11)	0 (0.0)	.16	1.46	.14
		Adequate	23 (31.51)	13 (17.81)	1 (1.37)			
		Must improve	11 (15.07)	8 (10.96)	0 (0.0)			

TMMS-24, Self-Report Trait Emotional Metacognition Scale; n, number of cases; p, statistical significance.
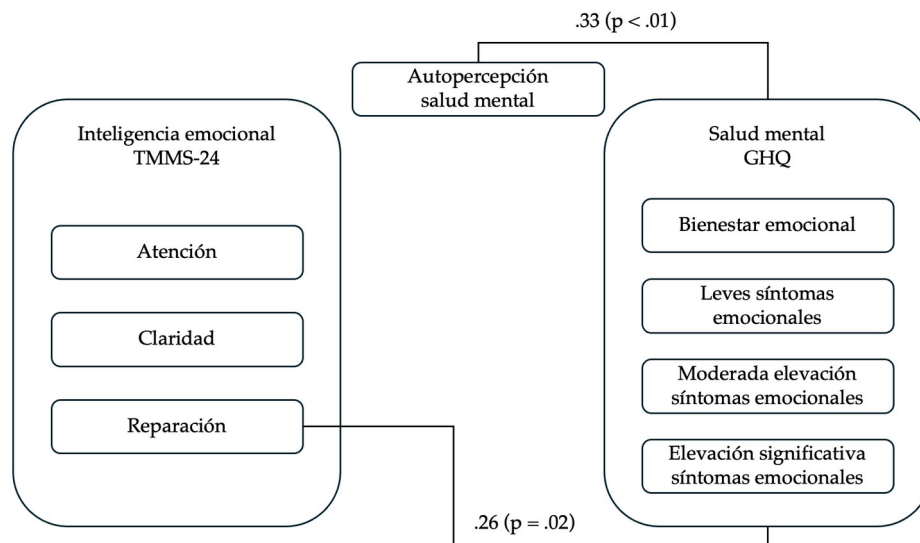
Figure 1. Association between mental health estimated by the GHQ , self-perception of mental health and emotional intelligence in clinical teachers with a training role in health sciences.

4. Discussion

The present study aims to analyze the level of emotional intelligence, in its processes of perception (emotional attention), comprehension (emotional clarity) and regulation of emotions (emotional repair) and its association with mental health in teachers with a training clinical role in health careers. The first results show that: (i) Clinical care teachers showed high performance in the dimensions of "Clarity" and "Repair", and low performance in the "Attention" dimension, while in mental health, the majority presented "Emotional well-being" and a "Good" self-perception of this variable, (ii) There were no statistically significant differences in mental health and emotional intelligence among clinical teachers according to the health system where they perform their clinical care role, (iii) Significant associations were found between mental health, determined by the GHQ, with self-perception of mental health and the "Repair" dimension of emotional intelligence.

In our cohort of clinical faculty, mental health was assessed using the GHQ and a single self-perception question ("What is your perception of mental health?"). In the GHQ, 84.83% of clinical faculty members reported high levels of emotional well-being, with a higher prevalence in the private sector (90%) than in the public sector (81.39%). When disaggregating cases with mental health disorders (18.61%), 8.22% presented mild disorders, 2.74% moderate disorders, and 4.11% significant disorders. Meanwhile, in the self-perception measure, 65.75% of clinical faculty members reported "good" mental health (76.67% in the public sector and 58.14% in the private sector). This discrepancy between instruments is significant, as self-perception was 19.08 percentage points lower than the GHQ overall, with a particularly marked difference in the private sector (-31.86%) and a smaller difference in the public sector (-4.72%). A reversal of the pattern was observed between the systems, with the GHQ favoring the private sector (90% vs. 81.39%), while self-perception favored the public sector (76.67% vs. 58.14%). Despite these differences, a direct and statistically significant association was observed between the two measures (r = .33, p < .01), suggesting that better self-perception tends to correspond with higher GHQ scores.

When comparing our results with the available literature, we did not identify any studies that specifically characterize mental health in clinical educators. However, patterns of psychological well-being/distress greater than those observed in our sample have been described in health professionals. Indeed, Magaña-Salazar et al. (35) evaluated 121 healthcare workers with the GHQ and reported mostly intermediate-level disturbances (79.3%), followed by mild disturbances (16.5%) and severe

disturbances (4.1%). Similarly, Roshani, Saboni, and Amjadian (36) reported that, among 163 healthcare providers assessed with the GHQ, 92.7% presented disturbances (54.6% moderate, 30.1% mild, and 11.7% severe). This discrepancy with our study is likely due, at least in part, to the timing of the studies, as both studies were conducted in 2020 and 2021, in the midst of the COVID-19 pandemic, while our research took place in the post-pandemic period. Furthermore, given the academic nature of our sample, comparison with university professors outside the health field suggests similar levels of mental health impairment (29). In this study, after evaluating 106 higher education academics using the GHQ-30, 37% showed signs of mental health impairment, a proportion that is higher than the values observed in our sample with the GHQ, but consistent with the estimate of "good perception" derived from the single self-perception question.

Regarding emotional intelligence, assessed using the TMMS-24, clinical educators showed a favorable profile in the "Repair" and "Clarity" dimensions, and a comparatively lower performance in the "Attention" dimension, a pattern consistent with research on health professionals assessed with the same instrument (37-39). In "Repair," 73.98% achieved "Excellent" or "Adequate" categories (with greater weight on "Adequate" at 50.69%). This performance was slightly higher in the public sector than in the private sector (76.67% vs. 72.09%; difference + 4.58%). These results align with those reported by Fernández et al. (38) in 247 health workers with 83% "Excellent/Adequate," and by Ordóñez-Rufat et al. (37) in 92 ICU nurses (77.17%) and by Mata Peón et al. (39) in 95 health workers (75.79%).

Unlike the pattern described in healthcare personnel, studies with university professors show heterogeneity. Muñoz et al. (40) reported that only 22% of professors obtained "Excellent/Adequate" results, in contrast to the 85.11% reported by Botey et al. (41) in 47 professors from the humanities and sciences, and the 96.6% reported by Fernández et al. (42) in university nursing professors. This variation in results suggests potential contextual and methodological variability (e.g., discipline, gender, job requirements, organizational climate, among others), which deserves to be addressed in future research.

Regarding the "Clarity" dimension, in our cohort, 68.5% achieved "Excellent/Adequate," a performance slightly lower than the range described for healthcare professionals (71.58% to 87.7%) (36-38). In the general university setting, the results are also disparate, with values of 23% (Muñoz et al., 40), 87.7% (Fernández et al., 42), and 78.72% (Botey et al., 41). Within our sample, public sector teachers outperformed their private sector peers by 14.42 percentage points, which could reflect differences in organizational culture, institutional support, or healthcare demands.

In contrast to the two previous dimensions, "Care" showed the lowest performance, with 43.47% in "Adequate," with minimal differences between sectors (41.86% public vs. 43.33%). This behavior is consistent with that observed in healthcare personnel (44.9%, 37; 46.67%, 36; 46.32%, 38) and non-clinical teachers (42.44%, 41). However, the literature again diverges, reporting 20% in "Adequate" in the study by Muñoz et al. (40), while Fernández et al. (42) reported 58.6% for the same category. This variability of results reinforces the need for comparative studies that delve deeper into the specificities provided by the discipline, the level of teaching-care load, and the psychosocial conditions of the work.

Regarding the relationship studied between mental health and dimensions of emotional intelligence, we observed a direct association between mental health measured by the GHQ and self-perception of mental health (r = .33; p < .01). Furthermore, the GHQ correlated significantly and positively with the "Repair" dimension of the TMMS-24 (r = .26; p = .02), suggesting that the ability to regulate emotional states is associated with better indicators of psychological well-being. However, in our literature review, we did not find previous studies that explain these relationships in populations

of clinical teachers, which gives an exploratory nature to our findings and opens a specific field of research.

In light of the implications our research provides for academic practice, our results support the need to delve deeper into the factors that regulate the mental health and emotional intelligence of professionals in teaching and care roles (43). In this context, identifying organizational conditions (workload, recognition, resources, etc.), as well as trainable emotional skills (e.g., repair strategies), can guide observation, support, and mentoring interventions that impact both the well-being of clinical faculty (44) and the professional modeling of students (43-46). Likewise, addressing the imbalance between overload and self-care could mitigate demotivation, dropout, and the migration of healthcare professionals to lower-wear positions (45) in a university context of increasing demand (8-9, 11-12, 46-49). In line with recommendations from the literature (1, 47), we consider it key that institutions move towards resilient organizational cultures, with informed dialogue on mental health and coping strategies at the community level.

Among the strengths of our study, we highlight: (i) the focus on an understudied population, but with a high impact on the training of new health science professionals; (ii) the inclusion of multiple healthcare professionals, both from the public and private sectors; and (iii) the combined use of the GHQ and TMMS-24 together with a self-perception measure, which allows for triangulation of indicators. Among the desirable improvements, we recommend expanding the sample to other institutions and regions of the country, and incorporating qualitative methods (open surveys, focus groups, observation) to contextualize and understand the mechanisms underlying the results obtained, facilitating the design of interventions tailored to specific contexts and the evaluation of the impact on the mental health and emotional skills of clinical faculty.

Finally, based on our work and with the intention of contributing to the consolidation of a line of applied research that links the well-being of clinical teachers with the quality of the training process in health sciences, and that in turn contributes to providing evidence to support the modification and/or generation of university policies that improve the management of healthcare teachers, we consider projecting future studies that: model the determinants of mental health and emotional intelligence in clinical teachers; design and implement emotional training programs integrated into academic well-being policies; and the development of studies with mixed designs that combine validated scales (GHQ, TMMS-24) with other contextual metrics and qualitative data, favoring the approach of multilevel analysis (individual, team, institution).

5. Conclusions

- This study highlights the importance of emotional intelligence and mental health as key factors in the performance and well-being of clinical educators in health sciences training.
- The dimensional profile of emotional intelligence shows strengths in "Clarity" and "Repair," along with persistent challenges in the "Attention" dimension. In terms of well-being, most participants enjoy good emotional well-being, with no significant differences between the public and private systems.
- Consistent with this, the significant associations between the "Repair" dimension of emotional intelligence and mental health with Goldberg's GHQ support the premise of a protective effect of emotional regulation against mental health disorders such as stress and burnout . This link aligns with evidence that strengthened emotional regulation capacities is a determining factor in promoting the personal and professional well-being of health sciences faculty.

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