The Therapeutic Relationship and its Links to

Emotional Intelligence

By

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City University Declaration

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Section A: PREFACE

The primary purpose of this thesis was to assess whether emotional intelligence (EI) is distinctive and useful in understanding the therapeutic relationship. I investigated how qualified therapists view the concept of EI, focusing on the optimisation of EI skills and knowledge, with the aim of improving the therapeutic relationship. The primary focus was whether therapists who are skilful at regulating their own and others' emotions would be able to protect clients and themselves from the adverse effects of a range of emotional reactions and assist the processes and solutions for therapeutic intervention. The topic of EI and its links to the therapeutic relationship were inspired via my own academic and professional journey as a chartered counselling psychologist and my aspirations to examine the positive relevance of emotional intelligence as a part of training programmes in counselling psychology.

My primary interest in the area of counselling psychology is rooted in my personal experiences as a four-year-old refugee boy. During those years of my life, I experienced the chaos of war and the feelings of loss and hopelessness. Growing up in a refugee camp and having several times witnessed how people kept 'hope' as a way to manage their suffering prompted my curiosity about the importance of 'positive psychology'. I observed how the crucial determinant of suffering or stress response was not the war environment itself but rather the meaning that individuals attached to their experiences.

Throughout my postgraduate years and my clinical placement experiences, I was particularly inquisitive about the role of emotional perception, positive psychology and psychological resilience in the stress-mental health relationship. Due to my previous experience in EI and quantitative research (Poullis 1994, Poullis 2008, Sanchez-Ruiz, Mavroveli and Poullis, 2013), I became familiar with the concept of EI via a quantitative approach and felt that the concept of EI was limited in meaning within a quantitative discipline. During my counselling psychology training, I reflected on my quantitative

master's thesis on EI and vocational choices among university students, reminding me of a process in the therapeutic relationship. Throughout my postgraduate training I was contemplating how to open up the meaning of EI research in counselling psychology and I began to wonder whether I could devise a few simple questions to explore the overall research question of "how trainee counselling psychologist experience the concept of EI with their clients during therapy". I began with the research question "How does the therapist experience the therapeutic relationship emotionally and how does this link to emotional intelligence theory" (Poullis 2008), and then on the way I devised the methodology.

Being able to make sense of existential philosophy and carefully considering the epistemology and ontology that best suited me, I moved creatively to adopt an Interpretive Phenomenological Analysis (Moustakas 1994; Colaizzi 1980). The study provided good pilot research and illuminated how deep my data was and how engaging was my research topic. Moreover, it provided a deeper understanding and a new perspective on the issues of a research that is doable, bearable and that can produce some interesting results. In my current study I am using Grounded Theory (Strauss and Corbin 1998). Due to my previous experience with Interpretive Phenomenological Analysis (IPA), I was discouraged to use the IPA due to the resources available to me, thesis purpose, and IPA limitation of number of participants. I felt that the research question needed more participants to explore the topic and a pragmatic approach. As West (2011) outlines, choose a method that gets the job done efficiently, effectively and elegantly.

Introduction to the thesis

This thesis has three sections. Each section explores a different area that, in some way, is associated with the central theme of the therapeutic relationship. First is the phenomenological approach and investigation to study the perceptions and experiences of therapists, and gain their perspectives on the therapeutic encounter and its links to EI. The second part of the thesis focuses on the challenges of therapeutic work with a female client who suffered from childhood sexual abuse (CSA). The case is related to the practical applications of the therapeutic relationship and particular therapist behaviours and characteristics which are positively associated with quality alliances and the EI concept. The third part presents prior research related to the field of positive psychology and the relationships found among positive emotional /mental states, wellbeing and survival.

Section B: Research

The principle aims of this study were to investigate the role that emotional intelligence plays in therapy, the therapist's perspective of trait emotional intelligence in therapy, and the meaning of the therapeutic relationship from therapists' perspectives. This research was conducted because of a lack of research in this area. The literature review revealed some considerable gaps concerning the emotional experience of the therapeutic relationship and its link to emotional intelligence theory. Some contributions provided only a superficial assessment and analysis of this link, indicating the need to conduct research to analyse and determine the existence and importance of this relationship. Finally, a review of the literature on the therapeutic relationship, emotions, and intelligence traits, reinforced the significance of this research to the body of knowledge concerning EI and its possible relationship with the process of therapeutic relationship. The study explored the therapeutic experience and offered me the chance to participate and immerse myself in the research. That approach was very rewarding

because it included the study of EI and consciousness totally free of preconceptions, particularly those which stem from a natural science orientation. For this thesis, I chose grounded theory as it is a good design to use when a theory is not available for EI and its links to therapeutic relationship.

The grounded methodology chosen reminded me of a 'bottom up' inductive process, and the similarities in my own therapeutic practice. A snowball sampling method was used to locate relevant literature. These involved several different approaches including a citation network through a snowball sampling technique that starts with seed articles in Psychinfo, EBSCO, MEDLINE, Google Scholar and Social Research. The literature review supported the limitations of research in the field of qualitative research with regards to EI in psychotherapy counselling. Since little is known about the substantive area of emotional intelligence and its links to therapeutic relationship this is an attempt to gain this novel understanding. Having said all that, EI is extensively researched in other fields of educational, and business/ occupational psychology but surprisingly not in the field of counselling and psychotherapy. This is a very controversial and polemical issue both on theory and methodology. To be more explicit I have to choose how to undertake the role of the researcher in a qualitative way, which is problematic. This entails having to challenge the nuclear structures and schism of positivism versus constructivism paradigm and keep a balance of meaning in EI and therapeutic process. However, it was my strong belief that it would be remiss not to attempt an alternative perspective in understandings of EI within the therapeutic process and enrich the field of counselling and psychotherapy research. Grounded theory (Strauss & Corbin 1990) was deemed to be the right approach based on my previous phenomenological investigation on the therapeutic relationship and EI (Poullis 2008).

The intention of grounded theory is to move beyond the phenomenological meaning/description from individuals who have experienced the phenomenon and

discover a new theory (Strauss & Corbin 1998). The research question concerning "the therapeutic relationship and its links to EI" is best examined using a grounded theory approach to understand the therapists (as experts who have all experienced the process of therapeutic relationship) shared experiences of the phenomenon. Semi-structured face-to-face interviews were used with questions loosely informed by salient themes derived from both the literature and my previous experience. This method enabled me to position myself as other than an objective observer, as in quantitative research, to broaden the concepts and methods of modern science. By sifting out what is accurate and valid to study this systematic approach supports triangulation and the convergence of data (McLeod, 2003). The selection from among the range of qualitative research designs available was predetermined by the specific characteristics of the research being undertaken. On the surface, the study only presupposes that a specific research question had to be investigated, thus "EI and its links to therapeutic relationship". The key specifics of the given research are that, in the process of answering the research question and devising the methodology that best answers and explores the topic, the study provides a supposition emanating from my MA thesis.

The method chosen as the foundation for the study has admittedly many arguments against it, the key one being that its process is, in fact, in reverse to the traditional ones. Instead of providing a hypothesis to be proven, the aforementioned method demands that data should be collected prior to the thesis statement. On the one hand, such a method can be seen as counter-productive, since the large volume of qualitative data will produce a huge amount of factors, thus, the number of research outcomes can be immense. On the other hand, the use of grounded theory as the key research method to obtain the data is a more flexible approach and justifies the data analysis method chosen (i.e., research is doable, bearable and will generate interesting results) towards the issue. By using the principles of grounded theory as the key research

tool, one is capable of going beyond the issue, thus, locating the outward factors affecting the problem and designing a unique solution, which is clearly imperative in the case specified. Since the thesis incorporates the use of a case study (section C), and a critical review (section D), it already limits the research (section B). In particular section B is limited in the literature review and the analysis of complementary concepts or commonality of thought between EI and other counselling or psychotherapy paradigms. For example, therapeutical interest in empathy has been a main topic since its introduction by Freud. Both Rogers and Freud emphasize the importance of the capacity of empathy and therapeutic alliance.

Rogers in his inaugural work (1951) constructed his conception of individuation around the notion of empathic reflection before the concept of EI was noted by Salovey and Mayer (1990). Therefore, some of the options that lie beyond the exploration of a general review of the competencies of therapeutic relationship without an extensive review of all psychological paradigms in therapy, may be missed in the process. For example, in order to establish a pragmatic approach so that the research is doable, bearable and will yield some interesting results, one is most likely to omit previous psychological and therapeutical contributors. The study does not claim to provide an extensive review of commonalities of therapeutic thoughts between EI and other counselling/psychotherapy approaches and paradigms. The main purpose is to investigate the therapeutic relationships and its links to EI and the essential part of a therapy session as the role of the therapist's self and the integration of the therapist's emotional intelligence related skills.

Section C: Professional Practice Section

The purpose of this section is to depict the use of Cognitive Analytic Therapy (CAT) as a theoretical basis and treatment framework for clients who suffer from childhood sexual abuse (CSA). I chose to present this particular client because I encountered key therapeutic challenges that contributed to both my professional and personal learning. The case focuses on the collaborative, open relationship, the use of shared written material, and how the client and therapist worked toward a process of developing an understanding of unhelpful procedures and then exploring alternatives. This relationship was attained by paying close attention to the client's story, in particular the history of relationship patterns, using information provided by the psychotherapy file and from relevant psychometric measures, and most important of all, operationalising the space of the therapeutic relationship to identify dysfunctional procedures as revealed in the therapy itself.

The identification of dysfunctional procedures was achieved by highlighting examples of repeated relationship patterns that occurred in sessions and exploring their origins and consequences in an open way with the patient. The analysis of the case study also attempts to critically evaluate the limitations of CAT with constructive reflections on the therapeutic process and the particular case study in focus. I also found this section extremely challenging because it was very difficult to know how to write about clients: Is it a novel? Is it an allegory? Is it a true descriptive account? What is it? It's very difficult.

Section D: Critical Literature Review

The aim of this part of work is to present a link between positive mental states and mental/physical wellbeing. This present work also investigated the determining mechanisms, causes, and outcomes of positive emotional states and their individual implications as regards cognitive functions encompassing social thought process and social behaviour. The results of the review showed that there is indeed a link between positive mental states and mental/physical wellbeing. The topic of positive psychology emanated from my personal experience as a counselling psychologist and its importance in therapy (e.g., mood monitoring, relaxation training, mindfulness). I believe that positive emotions such as hope, joy, happiness and optimism all share a pleasant subjective feel and are the building blocks of unconditional love, congruence and authenticity. The awareness of how these positive emotions can provide a more complete understanding of the human experience and plays a major role in establishing a therapeutic alliance.

It has been shown that such cognitive modification reduces negatively biased and distorted perspectives on events. The findings presented in this section also strongly relate to the section on EI and show that EI is indeed an integral part of positive psychology. I was surprised to observe how EI and positive psychology overlap and share a positive and significant impact on performance, happiness, wellbeing, and the quest for a more meaningful life. It would be beneficial to consider the evidence in positive psychology and to develop programs to or to develop EI training programs for enhancing competencies and skills in counselling psychology. The review concludes and recommends the need for more studies to establish the application of positive emotional states in therapy to promote physical and mental wellbeing.

Personal reflections

The experience of researching and writing this thesis was a big learning curve itself. This project was largely a process of reflection, intuition, and research that provided a type of consciousness-raising by enhancing a process of self-knowledge and self-awareness. I reflect this process currently in my professional development and my therapeutic work. The journey through this thesis was, at times, enormously challenging and emotionally exhausting. At other times, I felt helpless and powerless to complete the thesis and felt extremely vulnerable. Thinking and supervision during these dark times provided an enormous relief and encouragement. I reflected a great deal on my own experience of positive psychology, positive thinking, and optimism, as well as on the reverse psychology of negative thinking, pessimism, and negative support. I questioned the applications of my experience in my clinical work and practice.

Moreover, during the writing stage of the thesis, I became aware from the interviews how words fail to capture and describe events such as the "now moments" described by Stern (1998) or intuition and emotional connection. However, perhaps the problem is that we cannot grasp 'now moments', intuition and emotional connection. It is having a feeling, a felt sense of what is going on in terms of a process. It is like two streams coming down and running together or like weaving in which the warp and the woof have been woven together. That is, if the therapist is not alive, he or she will not be able to help other people be alive. This awareness concerning trusting intuition and connectivity as part of a human energy that gives rise to patterns of meaning has broadened my clinical and professional perspective.

Section B: The Research

The Therapeutic Relationship and its Links to

Emotional Intelligence

Supervised by Dr Don Rawson and Dr Simon DuPlock

Abstract

The importance of emotional intelligence (EI) as a theoretical construct to understand human emotions has become quite prominent over the last two decades. However, the concept of EI has not been frequently applied to the therapeutic setting. This study investigated the role that EI plays in therapy, the therapist's perspective of trait EI in his or her work, and the meaning of the therapeutic relationship from therapists' perspectives. From interviewing 12 counselling psychologists and therapists, and analysing their responses using a grounded theory approach. The main themes that emerged from the data collected were empathetic balance, benevolent connection and mindfulness. Within these themes a number of findings were established. Most EI traits appear to be present within the therapy setting, albeit not in an overtly conscious way. There was also a sense that EI cannot adequately explain or describe the subtle yet very real emotional connection and empathy that the therapist and the client share and experience. From these findings, I present various recommendations for future research to explore the relevance of EI in the therapeutic setting. One suggestion is to explore the differences between ability and trait EI within the therapeutic relationship while another recommends development of appropriate EI teaching modules for psychotherapy training purposes.

Chapter One

1. Introduction

According to Picard, Vyzas, and Healey (2001), emotional intelligence (EI) is a fairly new construct in the mental health and social science literatures. It was not until the early 1990s that researchers, including Salovey and Mayer (1990), Goleman (1995a), Bar-On (1997), and Cooper and Sawaf (1997), de-emphasized the conventional, narrowed concept of intelligence that focused on performance, linguistic intelligence and other traditional academic skills and began to emphasize EI in the literature. For example, Salovey and Mayer (1990) argued that a person's degree of intelligence should include perceptual abilities , and understanding of, and ability to manage one's own and others' emotions. EI has generally been explored and investigated as a distinct entity from cognitive intelligence, but Goleman (1995b) proposed that it can help to predict many practical outcomes, such as degrees of happiness and success.

Petrides and Furnham (2001) reported that trait EI does influence affective responding beyond common personality traits (e.g., the Big Five) and thus, suggests it should be viewed as a discrete personality trait. These researchers also found that individuals with a high degree of trait EI were fast at identifying emotional expressions and experience healthy socio-psychological functioning; however, the results also suggested that high trait EI can intercede with a wide range of cognitions and evaluative estimations because of a general sensitivity to emotion-laden stimuli.

The therapeutic relationship is based on functional competencies of assessment and interventions in reflective practice. Intervention competency entails effective utilisation of the psychotherapy relationship to facilitate working alliance based on interpersonal connection and creating the qualities and conditions that can clear the path to emotional healing (Kaslow, Dunn and Smith 2008). Such relationship competencies involves interpersonal abilities, the management of feelings, and communication skills, all in the

interpersonal therapeutic context (Kaslow et al., 2008). The results of the study may provide support for exploring how EI informs the psychotherapy relationship and relates to the documented evidence of competencies and skills in the therapeutic relationship process. Given that little empirical research have explored this aim, this study addresses a gap in the literature, and may provide a foundation from which further research can be conducted upon, as well as build a framework for future, clear sighted therapeutic practice. The study may also show the validity and precision of the Trait Emotional Intelligence Questionnaire (TEIQue) – an instrument for the measurement of EI – with the therapist population, which could have clear implications for current counselling programs and therapy processes.

1.1. Prologue to the problem under investigation

This study aims to explore the role that EI plays within the therapeutic relationship. More specifically, this study investigates the way that particular emotional competencies (e.g., preceding, implicit memories, social developmental determinants, intrapersonal competencies, attributes, and skills) can assist the therapist in accurately perceiving, understanding, monitoring, and managing affective information in self and the client; and can assist how the therapist determines the processes and solutions for therapeutic intervention.

1.2. Statement of the problem

The results of the study may provide support for exploring how emotional intelligence informs the therapy process and relates to the documented evidence of competencies and skills in the therapeutic relationship process. Given that little empirical research have explored this research aim, this study addresses a gap in the literature, and may provide a foundation from which further research can be conducted, as well as build a framework for future, clear sighted therapeutic practice.

The study may also show the validity and precision of the Trait Emotional Intelligence Questionnaire (TEIQue) - an instrument for the measurement of emotional intelligence – with the therapist population, which could have clear implications for current counselling programs and therapy processes.

1.3. Significance of the research

There is a meagre amount of research on the concept of EI and its connection to the therapeutic relationship. This study addresses this gap and focuses on the therapists' perspectives on the place of intelligence in psychotherapy, and the role of emotions as a vital information process in therapist-client responses and relationship. This researcher assumes that when these aspects are considered, the role of EI will take primary emphasis in the therapeutic process.

1.4. Reflexive statement (Epistemological Standpoint)

As a Chartered Counselling Psychologist with experience in the National Health System and private clinical settings, As a Chartered Counselling Psychologist with experience in the National Health System and private clinical settings, I have encountered the process of therapy and EI in practice. My personal experience and previous research of EI would be impossible to incorporate as Glaser and Strauss (1967) suggest as they formed components of an intersubjective research experience. Epistemologically my stance is founded on inter-subjective phenomenological principles, placing emphasis on the value of participant and researcher subjectivity that can provide a meaningful investigation of human phenomena to this research (Luca, 2009).

I am also adopting Husserl's (1931b) 'bracketing' as a method to discourage the possibility of imposing meaning onto the results gained, and therefore, promote greater validity. My reflexive process also includes taking into account dimensions of therapeutic intervention, tacit knowledge, power, control and inequality.

I will be mindful of issues of gender, class, race, ethnicity, age and sexuality that may be impacting the process and relationship with study participants. As Hoffmann (2007) noted the researcher's negotiations with their participants can involve considerable emotional labour.

The objective of this research was to rich data that places an emphasis on the therapists' experiences, with an attempt at "letting the therapist speak", which gave major emphasis to language, meaning and description. In order to be critically reflexive, direct quotes from therapists were included in the analysis and findings sections of the study. This approach allowed the therapist participants to "speak" as the richness of their attitudes and opinions and the full meaning of their words were encouraged to emerge. This permitted a greater and more critically reflexive input from the therapists. The interviews, being open-ended in nature, ensured that the participant felt as though they were in control of the direction that the interview took. In addition, therapists were made aware prior to the interview that they were able to discuss anything concerning the subject of EI and the therapeutic relationship. This ensured that the researcher was not placing their own ideas of the outcomes of the interviews onto the participant; rather, the researcher enabled the conversation to unfold naturally.

In order to examine this subject, and the various issues that it concerns, this researcher decided to take a phenomenological (or interpretivist) stance when conducting this research. A phenomenological research approach does not primarily concern itself with researcher objectivity or absolutes, which can be difficult to manage under the best of circumstances. Instead, this researcher adopted the approach of Miles and Huberman (1998), whereby phenomenologists perceive that there can be more than one interpretation gleaned from the data collected. This stance recognizes that the interpretations gained may be influenced by researcher preconceptions or aims of the research, and further recognizes the influence of the specific cultural and historical period

in which the research is collated. The phenomenologist takes all of this into account when assessing collected data. This approach does enable flexibility in interpretation, however, and as Madill et al. (2000) claimed, "(the) reflexivity of the researcher, the attempt to approach the topic from differing perspectives, and the richness of the description produced" make up necessary elements of the research investigation in its entirety (p. 74).

This study adopts a grounded theory analytic approach in order to investigate the association among EI and the therapeutic relationship and processes. With the advent of this new associated tendency, it is envisioned that a new perspective will emerge that might be used in generating a new theory of development to inform therapist and counselling practising. Grounded theory is a leading option for researchers undertaking qualitative research, particularly when theory development is a desired outcome. Successfully described and used by Strauss and Corbin (1990, 1994), Glaser (1995), and Charmaz (2000), grounded theory is a systematic qualitative research methodology that focuses on developing theory from data in the course of carrying out a research study. Given the emergent nature of thematic analysis and patterns identified through the grounded theory approach, it is logical to assume certain methodological challenges, particularly with the confounding cognitive factor of attribution bias. However, it will be discussed later in chapter five how this issue will be addressed.

1.5. Aims and objectives

The principle aims of this study are to explore the role of EI in therapy, and investigate some of the overarching issues presented by Cadman and Brewer (2001), and Simpson and Keegan (2002). These researchers' results suggest that the emotional and cognitive dimensions should be accounted for in future training programmes for nursing and health care professionals. With therapists assisting the mental health care of their clients, EI seems to be a relevant concept to introduce into therapy training programs, but preliminary research is clearly needed first.

Thus, the central research question for this study is as follows:

How does the therapist's experience of the therapeutic relationship relate to EI theory? In order to address and answer this research question, various objectives must be addressed. These objectives include:

- Analyze what is meant by the term "emotional intelligence" and how it is measured, theorized and conceived;
- Explore the therapeutic relationship competences as documented in previous research and their associations with EI concept;
- Understand if and how therapists' degree of EI is used in the therapeutic setting;
- Evaluate the (TEIQue) and consider its relevance in the therapeutic process;
- Investigate the meaning of the therapeutic relationship as described by therapists and its links to existing therapeutic relationship competences as reported in the literature;
- And consider the relevance of the findings for developing a new theory and enhancing counseling and therapy programs.

In addressing these aims and objectives, it is hoped that a sound conclusion can be reached as to the role that EI plays, if any, in the therapy process and the therapeutic relationship.

Chapter Two

2. Introduction

In order to better understand EI and its role in the therapeutic process and relationship, an investigation of the current research and theories surrounding EI and its relation to psychotherapy literature in the twenty-first century are needed. This chapter is comprised of a literature review of various sources, such as scholarly books and journal articles, in order to gain a greater understanding of the published works and comments regarding the association of EI in the therapeutic realm. The review will firstly describe the ongoing debates surrounding EI and its relationship to other intelligences. It is an attempt to examine emotions, cognitions, and the structure of emotional competencies and intelligence. The analysis will consider the notion of overlapping theories with EI and emotional experiences and a relevant discussion about the complexities surrounding a network of multiple intelligence and consciousness multiple intelligence. In addition, we will begin our discussion with the methodology of literature review including the way that the vast body of literature was delimited.

2.1. Review methods

The review's purpose was to develop a coherent sense of current clinical practices to guide a larger study analysis by examining current publications in the field and investigating existing evidence concerning emotional intelligence (EI) and the therapeutic relationship (Dixon-Woods, Cavers, Agarwal, Annandale Harvey et al., 2006). The study is a professional doctoral in counselling psychology thesis that examines how EI might facilitate changes in practice within the context of the therapeutic relationship through practical application of therapeutic interventions. Literature searching was a dynamic and iterative process with a systematic review methodology (Pawson, Greenhalgh, Harvey, & Walshe 2005), focusing on the research question but not a specific hypothesis.

It treated the question as compass rather than anchor (Eakin & Mykhalovskiy 2003), with open possibilities until the end of the review. A snowball sampling method facilitated locating relevant literature (Pawson, Greenhalgh, Harvey, Walshe 2005).

The literature search included highly structured search strategies across a range of electronic databases, including searching websites' core seed-reference chaining. It involved systematic keyword searches in EBSCO Host, which hosts almost 3,000 journals; Medline, which indexes more than 5,500 journal titles; and PsychINFO, which indexes more than 2,450 journals. For the seed search, I used Google Scholar. Keywords included *"emotional intelligence and psychotherapy"*, *"psychotherapy"*, *"counselling and emotional intelligence"*, *"counselling psychology" and "therapeutic relationship"*, *"mindfulness therapy, "mindedness psychotherapy"*, *"therapeutic relationship and competencies"*, *"emotional intelligence and therapists training"*, *"therapeutic relationship"*, and *"emotional intelligence"*. However, searching generated links to thousands of papers, and trying to review all of them would exceed the capacity and resources for this study. To focus and make the review more manageable, purposive sampling was initially applied (Dixon-Woods, Cavers et al., 2006).

Nonetheless, the number of papers included in the synthesis still needed to be limited for practical reasons. To manage the number of sources and achieve a balanced literature review, inclusion criteria were based on the five steps realist perspective of Pawson (2006). The process was intended to capture only the essentials: Step 1: Identify the review question; Step 2: Search for primary studies; Step 3: Appraise the quality, relevance, rigour, and trustworthiness of the data; Step 4: Extract the data; Step 5: Question theory integrity, rival theories, transferability, and practical applications of data. A critical reflexive approach was also adopted to establish good seed articles and books by considering whether the authors were widely cited and how many years of face validity sources had.

The keywords were used to navigate the field and establish a sense of open codes (Glaser and Strauss 1967). Having identified the seminal key authors in the field via open coding, I was able to generate a larger perspective for creating a representative citation network. I could then observe how good seed articles should be widely cited. Next, I moved to another type of axial coding by using a citation network through a snowball sampling technique that starts with seed articles. For example, at the first level, articles that cite the seed article were collected; then at the second level, categories, subcategories, and themes were established. This technique resulted in an open process generating a selective network of articles relevant to the seed articles. The process provided insights into the broad context of the research instead of the narrow set of publications returned in keyword searches (illustrated in Appendix 1b).

The review begins by outlining the ongoing debates about EI and its relationship to other intelligences. It then addresses the structure of emotional competencies and concepts of intelligence. Finally, it moves to a discussion about a guiding framework to encompass the contributions of EI in mental health.

2.2. Literature review

In their definition of Emotional Intelligence, Salovey and Mayer (1990, p.189) specified three elements: "the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions**."** The first element, accurate appraising of emotion in oneself and others, involves both verbal (language) and nonverbal (facial expressions, body language) communications as a core transitional element through which emotions are appraised and expressed.

Clearly, by the early 1990s, a long tradition of research on non-cognitive factors in helping people to be successful both in work and in life in general. It would be simplistic to reduce EI to Salovey and Mayer's work in the 1990's since this orientation

has a long tradition of overlapping concepts. For example, Husserl's (1931) long-standing philosophical position on intersubjectivity and his advocacy of the combining of body and consciousness into one natural unity or "mutual understanding" led to the eventual emergence of a new set of constructs, such as the concept of EI (Mayer and Salovey 1990) and metalizing theory (Fonagy, Gergely & Target 2007). EI also arose from Spearman's (1927) non-cognitive aspects of intelligence, Thorndike's (1920) social intelligence work, and Gardner's (1983) development of the twin concepts of intrapersonal and interpersonal intelligence. In addition, the construct of EI is akin to the Intersubjective Systems Theory (Stolorow & Atwood, 2002), but is also similar to a long-standing philosophical position on the phenomenology of intersubjectivity (Husserl, 1931). According to (Stolorow & Atwood, 2002), intersubjectivity is more akin to the idea of being in the place where the other is rather than a shared or mutual understanding.

Regarding this point, Rogers (1957) conceptualised empathy as the ability to capture "the client's private world as if it were your own, but without ever losing the 'as-if' quality" (p. 99). Expanding the concept of intersubjectivity (Fonagy, Gergely, & Target, 2007) have generated a theoretical framework around the concept of mentalizing ability with several clinical implications in psychotherapy (e.g., Allen & Fonagy, 2006; Fonagy & Bateman, 2012). Mentalizing is described as an "imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, goals, and reasons)" (Fonagy, Gergely & Target 2007, p. 288).

Contrary to traditional psychological theories founded on the often implicit "Myth of the Isolated Mind" (Stolorow & Atwood, 2002, p. 7), the *Intersubjective Systems Theory* aims to transcend the subject-object dichotomy and seeks to describe the fundamentally affective and pre-reflective nature of the therapeutic situation (Atwood & Stolorow, 1984). The patient experiences The therapist is experienced by the patient as

someone who reacts to his true self, his true feelings and erstwhile forbidden thoughts in a different way to the pathogenic parent. The researchers also pointed out that "intellectual insight alone is not sufficient" (Atwood & Stolorow, 1984, p. 68). As Stein and Lambert (1995) proffered, the significance of research into the therapeutic relationship and its processes, and investigating how this research can build on the therapist's trained skills and attributes are of critical importance. Researchers agree that the therapeutic relationship is among the most important factors influencing therapeutic outcomes (Smith & Glass, 1977; Horvath & Bedi, 2002; Cooper, 2004; Luborsky, Singer & Luborsky, 1975; Norcross, 2002; Shapiro, 1985).

Stern (1985) emphasized that a majority of the transformation that takes place in a therapeutic relationship originates from the implicit knowledge emerging inside the therapeutic relationship between clients and therapists. Stern claimed that the patient's awareness of implicit memories is inter-subjectively shared within the process of the therapeutic relationship and that is an effective apparatus for therapeutic transformation. Accompanied by an emotionally available therapist, such memories may be re-experienced and understood. In fact, Bar-On (1997) and Martinez-Pons (1997) reported that substantiating implicit memories (e.g., instinctual capacities drawn from subconscious experience) requires a particular type of context mirroring to some extent the one prevailing when the memory was originally acquired. When the context and the subject are reconnected, within the therapeutic relationship, the memory emerges spontaneously.

Emotional experiences and reactions affect both mental and physical health (Herbert & Choen, 1993). Negative emotional states are, for example, related to unhealthy patterns of physiological functioning, and conversely positive emotional states are related to healthier response patterns from both the immune system and cardiovascular activity (Booth-Kewley & Friedman, 1987). Neuro-developmental research indicates that

human's initial experiences can transform neural pathways and structures that determine how one reacts to future events. According to Damasio (1999) and Stern (1985), the patterns are basically emotional (e.g., evaluations concerning harms or benefits) and serve to regulate behaviour at a subconscious level, referring to an individual's primary or core self that develops during early stages of human life.

Martinez-Pons (1997) noted how mental health problems s are viewed as implicit memories which are manifested as symptoms under stress, and making them explicit is difficult as they lack an interpersonal context which may foster inculcation into the autobiography of the self. Such implicit memories stay dissociated from the conscious self. It is the therapeutic relationship that enables the re-enactment of the memories inter-subjectively and later facilitates their introduction into the autobiographical self.

Notwithstanding the aforementioned work, it was Salovey and Mayer (1990), who initiated a research programme, with the goal of developing an EI model and a valid measure for EI. The paper "Emotional Intelligence," published in the *Imagination, Cognition, and Personality* (Salovey & Mayer 1990), has been cited widely and across various disciplines, as it initiated a line of research by postulating an EI model and offering a valid instrument of measurement. This recognition of the broader context of EI holds critical implications for defining intelligence as emotional learning, as a theory of mind, as a research method and perhaps as a training device in psychotherapy. The therapeutic relationship shares obvious similarities and overlap with Salovey's and Mayer's concept of Emotional Intelligence. Although these researchers were by no means the first to make social intelligence a crucial construct in the field of psychology, it was their advocacy of the idea that EI was a fundamental ability for greater problem-solving in an individual's emotional life that began to gain traction.

2.3. What is emotional intelligence?

EI pertains to the social and psychological cohesion between individuals, such as relationship understanding (Gallagher, Jaeger, & Paulo, 2010). Mayer, Salovey, and Caruso (2000) described EI as "an ability to appraise oneself and others' emotions, an ability to regulate one's own emotions, and an ability to use emotions to solve problems" (p. 396). In addition to this ability definition or framework of EI, there are some researchers who incorporate many non-intelligence qualities and personality traits into their definition of EI. Goleman (1995) defined EI as "the abilities which include self-control, zeal and persistence, and the ability to motivate oneself" (p. xii). Bar-On (1997) described EI as "an array of noncognitive capabilities, competencies, and skills that influence one's ability to succeed in coping with environmental demands and pressures" (p. 14). A more recent framework brought forth by Petrides and Furnham (2003) describes EI as "a constellation of emotion-related self-perceptions and dispositions, assessed through self-report" (p. 40).

2.4. Conceptions of intelligence

By the 1950s, the area of intelligence was divided into two distinct traditions - the intelligence tradition and the social psychological tradition. The intelligence tradition had an interest in the ability of person perception and the social psychological tradition was focused on the social determinants of a person perception (Roberts et al., 2001). The former camp believes that the domain of human cognitive ability can be thoroughly defined utilising leading psychometric tools. For example, Jensen (1998) and Caroll (1993) employed scholarly computational, genetic, and neuroscientific models to support their argument that general intelligence is the foremost predictor of educational, occupational, and overall life success. On the other hand, in the second camp, many researchers, like Mayer, Salovey, and Caruso (2000); Stankov (2000); and Robert, Pallier, and Goff (1999), reported that there remains a lot work to carry out in order to fully

understand   individual differences in human cognitive abilities. These social psychological researchers then began new discussions around the constructs of EI, implicit knowledge, and meta-cognitive processing (Gardner, 1983).

2.4.1. Multiple intelligences

Gardner (1983) played a major role in promoting EI theory. The author's influential theory of multiple intelligences includes personal intelligences, which can be dichotomized into intrapersonal intelligence and interpersonal intelligence. Intrapersonal intelligence is defined as the capacity to access "one's own feelings and one's range of affects or emotions: the capacity instantly to effect discrimination among these feelings and to label them, to enmesh them in symbolic codes, to draw upon them as a means of understanding and guiding one's behaviour" (Gardner, 1983, p. 239). Whereas interpersonal intelligence is defined as "the ability to notice and make distinctions among other individuals and, in particular, among their moods, temperaments, motivations, and intentions" (Gardner 1983, p. 239). The latter intelligence encompasses the "…capacity to place one's self into the skin of specific other individuals" (Gardner, 1983, p. 250).

2.4.2. Post-Cognitivism

Alternative approaches in the cognitive science field and intelligence have opened avenues of investigation to new approaches that challenged the mainstream classical paradigm, referred to as computationalism (Fodor, 2000). Understood in computational terms perception became passive, and was in distinct contradiction to the natural interaction between environment and action. As disappointment with cognitivism grew, a new era of post-cognitivism and intersubjectivity emerged. The new approaches argued against the mechanistic explanations of the mind as Stolorow, Atwood and Orange (2002) advocated, that human beings are by nature relational. Damasio (1994, 1999) was also positioned against classic cognitivism (which maintains a Cartesian disembodiment of mind) in support of these new paradigms. He argued for the connection between the body,

individual structures in the brain and aspects of the mind including will, consciousness, self-awareness and emotion. Similarly, the embodied cognitive approach, drawn from the work of Merleau-Ponty (1962), focuses attention on the sensory and motor systems rather than thinking, reasoning or memory per se. Carlos Cornejo (2008) supported the definition of meaning as a phenomenologically experienced construal. Consequently, Cornejo (2008) postulated, intersubjectivity is the space when we are being in the world with others - an open-ended, a presentational construct that is continually evolving, with deep roots in our bodies and our tacit knowledge and is far from a theoretical representation.

2.5. Emotions and intelligence traits

An analysis of the literature by Griffin and Mascolo (1998) reported the lack of expert consensus on the question of what is an emotion. The authors then categorized emotion theories into biological, cognitive, structural-developmental, functionalist, and socio-cultural perspectives. They assert that biological theories describe emotions as "innate, neuromuscular processes and for cognitivists, emotions are the coming together of thoughts, external incentives and feeling tones" (pp. 6-11). The structural-developmental theory is based on the idea of emotions as subjective reactions to an important event, marked by experiential, physiological, and overt behavioural changes.

The work of Damasio (1994, 2000, 2003, 2010) presents empirical evidence of intra-subjective and inter-subjective experiences. Damasio (1994) explored the neural connections linking the cognitive and emotional parts of the human brain. This pioneering work revealed the brain's neural imaging and studies on the development of consciousness illustrate the interconnectedness of thought and emotion (Damasio 1994, 2000, 2003). This scholar made it clear that emotions are imperative to the elevated levels of characteristic human intelligence, diverging from the notions of Descartes's (1641, cited in Almog 2002), dualist separation of mind and body, or rationality and emotion.

Damasio (1994) made the convincing argument that emotions do not obstruct or impair rational thinking, but are rather vital to rationality, anchoring it to a long-standing philosophical position of intersubjectivity and arguably much of the literature on empathy and theory of mind. Damasio (1994, 1999) also researched the process of reasoning in people possessing neurological damage to their emotional systems, such as damage to the ventro-medial segment of the pre-frontal cortex. He discovered that such people may be capable of performing to a high degree on most intelligence tests, but they express or reveal gross deficiencies in their abilities in planning, judgement, and social suitability. These defects are a direct result of their inability to react emotionally to the content of their respective thoughts. For example, these individuals were not able to feel the emotion of fear when thinking about a violent person.

Another significant contribution of Damasio was the notion of a 'somatic marker' mechanism, which is fundamental to the structure of human consciousness. This mechanism is the system through which cognitive affective somatic states connected with previous decision outcomes are applied to inform future decision making. Damasio (1999) raised the importance of emotions in decision making and highlighted that decision is not the result of a cognitive calculation but a product of good or bad emotional reactions to past experiences. Representations of the external environment interact with cognitive conceptions of the internal environment, as perceptions are in a constant interaction with emotions. This awareness of inner states enables humans to use somatic states (i.e., emotions) to mark and therefore, evaluate external perceptual data.

In referring to emotions as intelligence, Lazarus (1994) followed the same line as Damasio (1994) who suggested that emotions and intelligence go hand in hand. The scholar asserted that emotions are elicited based on an individual's subjective evaluation or interpretation of key situations or events. In particular, an emotion is a subjective mental state with complex reactions that engages both our mind and body. It is aroused

by an appraisal of the personal significance or meaning of what is happening in that encounter. The meaning that a person attributes to a stimulus is an important factor in determining his or her reaction. Lazarus (1994) theorized that attributions are influenced by learning and previous experience; as a result, emotions are influenced by hereditary temperament, early experiences (e.g., attachment), and cognitive appraisal.

In his work "The Nature of Sympathy," Scheler (1954) argued that emotions have been understood by philosophers as merely "subjective" and therefore, promoted a "cognitive" view that emotions could be construed as a source of knowledge. Scheler rejected the Cartesian analysis of emotion in terms of sensation (i.e., a human is not considered to be both mind and body but solely mind). They are, to use Descartes' words (1641 cited in Scheler 1954), thinking things (*res cogitans*). Instead Scheler transcended the conventional distinction between reason and emotion by asserting that rationality encompasses, and does not oppose, our emotional judgment of our environment.

The work of Scheler (1954) influenced another scholar, Heidegger, who occupies an important place in the history of existential phenomenology but also one that is complicated and problematic. There is a very interesting discussion of moods in "Being and Time" (1962). Heidegger never acknowledged or coined the term emotions and did not properly distinguish moods from emotions, but instead wrote that moods open us up to being. These moods are not mere psychological feelings but modes of being-in-the-world. He opposed the Cartesian framework and emphasised the concept that existing-in-the-world is a unitary occurrence. A human, rather than being a Cartesian subject distinct from the world, is instead an entity whose being is defined by its very involvement in the world. Humans and the world reveal themselves as one, a unified phenomenon. Heidegger's idea of the unitary phenomenon is a breakthrough of some importance in helping us understand emotional experience. Heidegger further explained that moods neither come from the outside nor the inside; rather moods arise out of being-in-the-

world. He acknowledged that moods are not just subjective feelings, as Scheler (1954) postulated, but are a direct apprehension of the world.

Radford (2002) discussed emotions as subjective inner phenomena that can be discovered via a process of self-awareness or introspection. Comprehending and explaining emotions consists of a process of self-exploration carried out via a mixture of dialogue; a process appearing quite similar to therapy. The concept of intersubjectivity as the core element of consciousness has a number of consequences for cognitive theory.

2.5.1. Structure of emotional experience

Solomon (2003) made the convincing argument that emotions are rational, purposive and have a structure. Emotions are unitary phenomena which defy adequate analysis using subject/object, internal/external, or other dualistic distinctions. Solomon proposed that emotions are not feelings but rather are judgments. In fact, he theorized emotions consist of a web of constitutive judgments through which things appear in a particular way. These judgments are not intentional states. Thus, an emotion is not an internal, psychological state reaching out to an external and distinct intentional object. Rather emotions are structures through which we experience the world. They do not connect with but instead constitute their objects.

Solomon's (1984) definition of emotions as a system of judgement, prevents the concept from evolving into an explanation for everything and thereby, nothing. In this way, Solomon turned to phenomenology, noting, "An emotion, as a system of judgments, is not merely a set of beliefs about the world, but rather an active way of structuring our experience, a way of experiencing something" (p. 54). Solomon regularly appeals to the works of Heidegger and Sartre, all of who drew attention to the practical and/or embodied nature of world experience. Emotional experience, Solomon (2003) claimed, deals with our ways of engaging the world and generates the questions for a phenomenology of emotions, describing how we are doing rather than knowing what we are emotional about.

In referring to emotions as a value judgement, Clore (1994) noted that emotions are the form in which one experiences automised value judgments. Similarly, Fonagy et al. (2002) noted the infants capacity (by as much as 18 months) to understand beliefs, and concluded that "[t]his discrepancy in the developmental timetable suggest that separate mechanisms for interpersonal understanding concerning emotions and belief states should be considered" (p. 137). Peikoff (1991) asserted that emotions entail an automatic process of unconsciously held knowledge and values. Akin to Mayer, Salovey and Caruso (2000) notion that the interaction between emotion and cognition is an integral part of EI.

2.5.2. Emotions and consciousness

The importance of a synchronous response to emotions as a state of mind was made by Ekman and Davidson (1994). These researchers expounded the possibility of having an emotion without be consciously aware, and that an emotion may be seen as a state of mind which takes up a larger portion of consciousness and other psychological processes. Emotions reflect implicit memories; retained beliefs about relations with situations, objects, or people; and one's unconscious appraisal on the basis of one's values. Each emotion represents a particular kind of value judgment. For example, joy is the outcome of achievement, while fear is the instinctual reaction to a threat. Damasio (1994) similarly recognized and offered deep reassurance to those who support the complementarity in intellectual development of emotion and cognition. Damasio noted that emotion and feeling, "provide the bridge between rational and non-rational processes, between cortical and subcortical structures" (1994, p. 128).

2.5.3. Conceptions of emotion and emotional intelligence

Mayer, Salovey and Caruso (2000) reported emotions have evolved in order to signal and respond to the relationship between the individual and the environment, including the place one imagines oneself to inhabit within the environment. For example, fear rises as a response to danger. There is no specific course of time or duration that

emotions follow, like there is for motivational components (e.g., thirst, which rises until it is quenched). Rather, emotions respond to the environment, and can instigate behavioural responses, such as fighting or fleeing (in response to fear). They are therefore, much more flexible than motivations. Motives interact with emotion when frustrated needs result in increased aggression or anger, whereas emotion interacts with cognition when positive emotions result in an individual thinking positively. In continuing this review, it is important to consider the role of emotions and cognitions and the contributions of Salovey and Mayer (1990) with regards to the concept of EI, which arose from non-cognitive aspects of intelligence proposed by Spearman (1927) and Gardner (1983).

2.5.4. Emotions and Cognitions

Evidence suggesting that the interplay between cognition and emotion could be fundamental to our ability to regulate emotions adaptively is growing (Dennis, 2006). Emotion and cognition are acknowledged to be closely integrated in emotion regulation (Gross, 1998) but despite this some studies still treat cognition and emotion as antithetical (e.g., Zajonc, 1980) and not an integral part of the thought process (Bower, 1981; Gray, 2004; Lewis, 2005). LeDoux (1996) examined the onset of emotion and proposed that the amygdala can elicit emotions before information has reached the cortex. However, Storbeck and Clore (2006) argued that the amygdala, and emotion generally, does not function independently of cognitive and perceptual processes.

Neuroimaging research by Gray (2004) found that different cognitive control functions or specific emotional states can influence each other in selective ways, such as working memory. Research on the affective regulation of perception (Bruner, 1957) found that instead of being a passive registration of reality, perception reflected internal expectations and motivations as a component of the adaptive process. Witt, Proffitt, and Epstein (2004) suggested that perception of our physical environment is influenced by

internal factors including emotion.

Cognition and emotion processes are starting to be seen as complementary and not antagonistic. Supporting evidence for this comes from research on decision making and memory by Damasio, Tranel and Damasio (1991). These researchers found that patients with lesions to neural networks have an inability to use affective feedback, which has deeply negative consequences for decision-making and judgement. In another pioneer study Phelps and Sharot (2008) found that emotions support both a subjective sense of recollection and memory accuracy.

2.6. Summary

For a long time, theorists and researchers attempted to clarify the obscure nature of emotions and intelligence. The concept of EI develops the understanding of human cognitive abilities by proposing that both emotional and social factors can influence intelligent behaviour (Mayer, Salovey & Caruso, 2000a). Many debates have occurred over whether EI actually exists, at all or as a form of intelligence (Mayer & Salovey, 1993; Davies, Stankov & Roberts, 1998; Roberts et al., 2001). To sum up, it is clear the meaning of *intelligence* has ceded its prominent role in the mechanistic explanation of the structure of psychometric intelligence (Caroll 1993). Thus, the conceptualization of intelligence lies at a crossroads; this divergence may be because the construct addresses a complex and multifaceted phenomenon experienced from a wide variety of approaches. Emotions are perhaps rational and with a purpose (Solomon 2003).

Alternative approaches to cognition are clearly required for cognitive science. There is a need to reconceptualize with a focus on action and intentionality as a principle of ordering between sensing subjects and objects. Moreover, researchers need to address the intersubjective nature of complex cognitive phenomena and their implication for all individual and social behaviours. The literature on EI is focused on understanding the dimensions of cognitive as opposed to affective regulation of perception. From this

perspective, EI serves as a label for a large variety of emotional and intellectual competencies that develop from early childhood into adulthood. A number of overlapping theories, such as intersubjectivity and mentalization, consider the same characteristics as EI. EI represents a multifaceted phenomenon that should be analyzed and investigated in terms of its clinical applications and practicalities empirically.

Chapter Three

3. Emotional intelligence

The last two decades, has seen a growing body of research appear supporting the contribution of emotional intelligence with a variety of better outcomes to health professional practice (Mayer , Robert & Barsade (2008). In this chapter, we explore the three broad perspectives on EI, the ability model (Mayer, Salovey, & Caruso 2000), the Mixed Model (Bar-On, 1997, Goleman, 1995) and the trait EI (Petrides & Furnham 2000). Furthermore, we lack a consistent model of emotional intelligence as none has emerged from the body of research already undertaken. The review will outline the current debates within the different streams of emotional intelligence research and then move to a discussion about how emotional intelligence should be measured, and its clinical applications and evidence. However, prior to exploring in detail, it is first useful to reflect on the origins of EI theory and recognise the context within which the concept was developed.

3.1. Early perspectives and competing theories of emotional intelligence

For some researchers EI is most appropriately viewed as a separate category of mental abilities. A number of authors in the field of EI have termed this set of mental abilities as EI (Mayer & Salovey, 1997; Mayer, Salovey and Caruso 2008; Mayer, DiPaolo, & Salovey 1990). Mayer, Salovey and Caruso (2008) asserted that EI is how people differ in their capacity and ability to undertake sophisticated information processing concerning emotions and emotion-relevant stimuli, and to utilise this information to guide thinking and behaviour. In the second camp, researchers view EI as an eclectic mix of positive traits, such as empathy, relationship skills, self-motivation, social competence, adaptability, assertiveness, happiness, self-esteem, and optimism (Austin, Saklofske, & Mastoras, 2010; Bar-On, 1997; Petrides & Furnham, 2001).

Goleman was perhaps the most influential researcher in regards to launching research on EI. His seminal work (1995) allowed researchers to expand EI from a clearly definied singular psychological entity – a mental ability to process emotion – to a wider range of personal qualities. Goleman's (1995a) development of an alternative notion of EI led to Bar-On's (1997) definition of EI as a mix of emotion-based competencies, personality traits and dispositions. This early model was followed by a number of alternative conceptions, quickly converted into systematized instruments for measuring individual variances in this construct (Bar-On, 1997; Mayer & Salovey, 1997; Shutte et al., 1998; Goleman, 2000; Mayer, Salovey & Caruso, 2000; Petrides & Furnham, 2001; Tapia, 2001). Mayer, Salovey and Caruso (2008) noted that there are various models that have been proposed to explain or conceptualize EI.

Three broad perspectives on EI can be detected in the literature. Mayer, Salovey, and Caruso (2000) provide the ability model, focusing solely on mental abilities. Secondly, there is the mixed model that combines emotional abilities with a range of dispositions and personality traits (e.g., Bar-On, 1997). Third is the trait approach that operationalizes EI as a personality trait and not as a measure of intelligence (Petrides & Furnham, 2001). Table 1 below lists the major EI models and their main definitions.

Model	Source	Definition
Ability EI	Mayer & Salovey (1997)	Defines EI as the capacity to perceive and convey emotion, assimilate emotion in thought, use understanding and reasoning with emotion, and regulate emotion in the self and others
Trait EI	(Petrides, Pita, & Kokkinaki, 2007).	The formal definition of trait emotional intelligence describes it as a constellation of emotional self-perceptions located at the lower levels of personality hierarchies (Petrides, Pita, & Kokkinaki, 2007).
Mixed Model EI	Goleman (1995)	EI as the ability to recognize one's own feelings and those of others, to monitor ourselves, and to manage emotions in ourselves and in our relationships' (Goleman 1995, p. 317)
Mixed Model EI	Bar-On	EI as an emotional and social facilitator which influences intelligent behaviour (Bar-On 2007)

Table 1a: Three Main Models of Emotional Intelligence (EI)

3.1.1. Ability EI model.

Salovey and Mayer (1990) followed Gardner's earlier work on non-cognitive aspects of intelligence, initiating a research programme aimed at developing an EI model and an EI scale of measurement. These researchers identified three components of EI: an ability to appraise one's own and others' emotions, an ability to regulate one's own emotions, and the ability to utilise emotions for problem solving. Since Salovey and Mayer's (1990) conceptualisation of EI, the construct has received considerable attention in the scientific literature. A number of competing EI models have also been proposed, offering theoretical frameworks tp conceptualise and measure the construct (e.g., Mayer & Salovey, 1997; Bar-On, 1997; Goleman, 1995, 1998, 2001).

Mayer and Salovey (1997) reported that their earlier (1990) model was inadequate because it did not consider mechanisms related to thinking about feelings. Their later model (1997) proposes four dimensions of EI: (1) perceiving, appraising and expressing of emotion, (2) emotional facilitation of thought, (3) understanding, analysing, and deploying emotional knowledge, (4) and lastly, reflective regulation of emotions in order to stimulate further intellectual and emotional growth (see Figure 1).
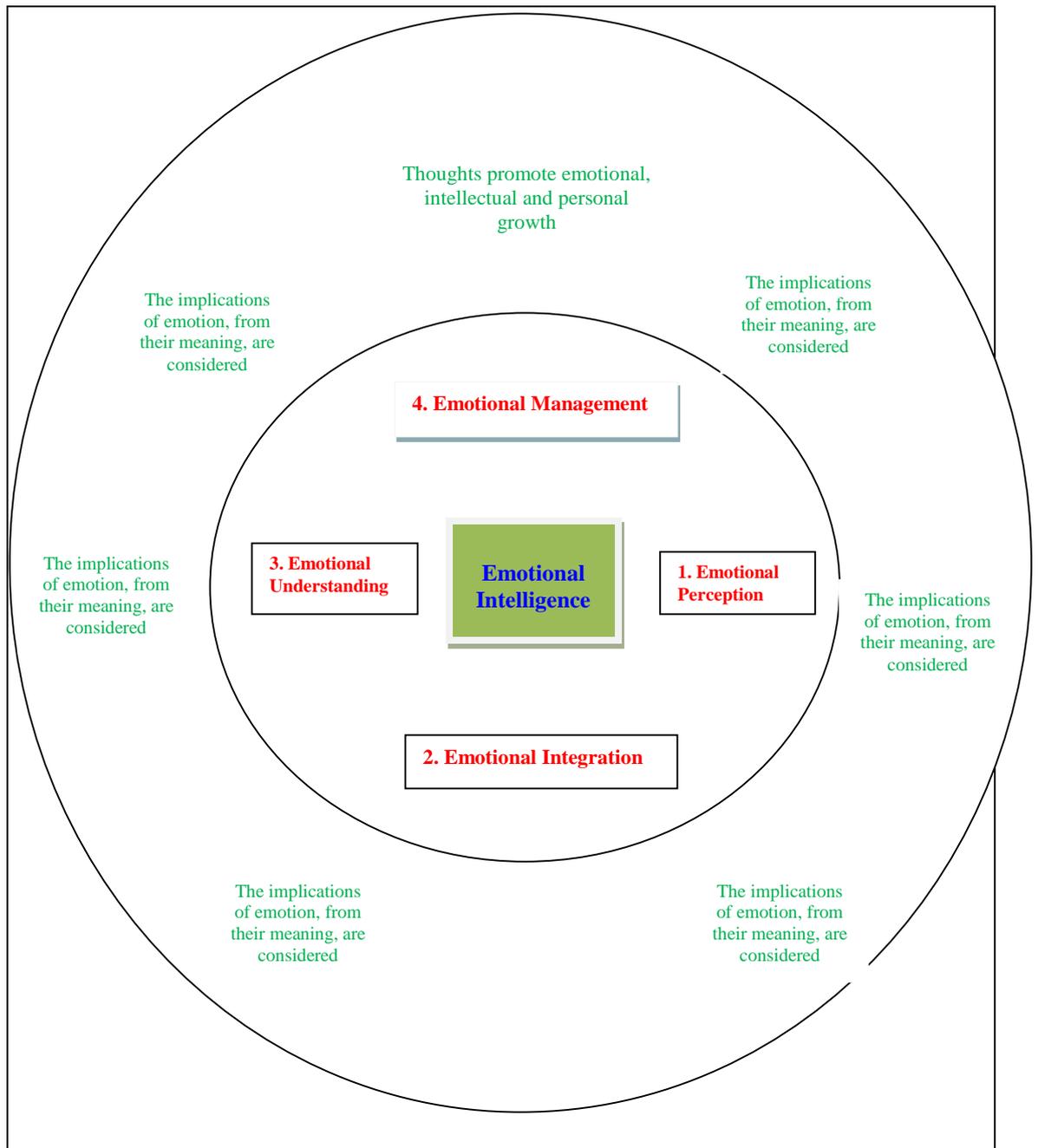
Figure 1 Mayer and Salovey (1997) Four Branch Model of Emotional Intelligence

3.1.2. Mixed Model

There are two main mixed models that have been particularly important and influential: Goleman (1995) and Bar-On's (1997). Both of these EI mixed models share a common similarity: in general terms, EI, is the capacity for recognizing and regulating both our own emotions and those of others.

According to Goleman (1995), EI consists of five factors (or competencies): self-awareness (knowing one's emotions), self-regulation (managing emotions) , Self-

motivation (motivating oneself) , empathy (recognizing emotions in others), and social skills (handling relationships). The research also put forward an emotional competence framework in which each broad area consists of certain specific competencies. The first three components are intrapersonal, that is, within the individual, and the second two are interpersonal, between people. Goleman's model is a developmental one with each succeeding factor building on the skills developed in the previous factor or competency.

The theoretical EI model established by Bar-On (1997) includes factors related to personality rather than cognitive abilities and does not address the cognitive characteristics that are typical of the traditional definition of the intelligence construct. As a result, Bar-On's concept of EI is similar in many respects to Goleman's; both authors advocate EI as a complex interaction of cognition, meta-cognition, personality, mood and emotions, which are applied to both intrapersonal and interpersonal situations. Bar-On characterizes EI as "…an array of non-cognitive capabilities, competencies, and skills that influence one's ability to succeed in coping with environmental demands and pressures" (1997, p.14).

3.1.3. Trait Model

The third EI perspective is the trait approach, developed by Petrides and Furnham (2000), which suggests EI is more appropriately explored within the framework of personality (trait EI), rather than cognitive intelligence. A focal research challenge of ability EI was its problematic operationalization due to the subjectivity variable and complexities of emotional experience (Matthews, Zeidner, & Roberts, 2007). The development of EI as a personality trait results in a framework or model that is found to be exclusive of the classification of human cognitive ability (Day & Carroll, 2008). The trait EI label is a reflection of the existence in the literature of differing notions described as "emotional intelligence" or "EQ" and which are usually used to describe mixes of personality traits, including self-control, empathy, emotional expression, and

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adaptability. Petrides, Pita, and Kokkinaki (2007) suggested that the construct can alternatively be labelled as an emotional self-efficacy trait, found at the lower levels of personality hierarchies. In their study, the researchers found that trait EI was distinct to other personality traits like Eysenckian "Giant Three" and "Big-Five" and did lie at the lower levels of personality hierarchies, as the trait EI factor was oblique, instead of orthogonal to these other constructs. It is important to acknowledge that correlations between measures of trait EI and ability EI are nearly always low, in support of explicitly distinguishing between them (Brannick, Wahi, Arce, & Johnson, 2009).

3.2. EI measurements for ability and trait EI models and the conceptual overlap with the therapeutic relationship

3.2.1. Ability EI and therapeutic relationship competencies

There have been many different measures in order to hypothesize, conceptualize, and test EI (Mayer, Roberts & Barsade, 2008). Given that this model of EI claims that it is a kind of intelligence, the MSCEIT is modelled on ability-based IQ tests, assessing an individual's personal abilities on each of the four-fold branches of EI competencies. In this way, it calculates an individual score for each competency together with a combined score. Kaplowitz et al. (2011) observed parallels between different factors within the ability EI model with at least four salient competencies in the psychotherapy literature: psychological mindedness (Faber & Golden, 1997); empathy (Rogers, 1980); affect regulation (Schore, 2003); and reflective functioning (Fonagy & Target, 1999; Karlsson & Kermott, 2006).

After outlining the four branches to the MSCEIT measurement of EI (refer to appendix 2), it is important to have some critical understanding of how this scale has proven resilience under research scrutiny, before exploring remits for using other EI measures. The constructs of the MSCEIT have been criticised as being invalid and confounded by Mayer, Salovey, Caruso, & Sitarenios, 2003) own research data in the

conceptualisation of EI, which has taken several different concepts for such an abstractly diverse topic (Matthews, 2002). Taking into account that some of the items of the MSCEIT are designed to elicit emotional states in participants, it raises a question on how ecologically valid the conditions are during the test to ensure the responses are natural and representative of real-life scenarios. The questions that pertain to a participant's ability to decipher another individual's feelings across different situations may have ecological validity through written and visual imagery. This is because certain emotions are conveyed through verbal and visual content in real life, which may result in valid responses.

For example, a study was conducted to investigate whether people who had a tendency to accurately decipher emotional content through EI measures could demonstrate this in a situation involving real people experiencing dispositional states. Geher, Warner, and Brown (2001) used a sample comprising of 40 undergraduate student participants, half of which were selected based on the lowest EI scores, and half based on the highest EI scores from the MSCEIT measurement. The students then observed video recordings of other undergraduates who were filmed describing their thoughts about certain issues. It was found that those participants who previously scored the highest on EI demonstrated the most accurate estimations about the emotional states of the individuals video recorded, compared to the 20 students who scored the lowest on EI (Geher, Warner, and Brown, 2001). These results suggest that the MSCEIT items measure EI in a way that can be generalised to competency-based situations that require the responses to be more qualitatively engaged.

On the other hand, there has been controversy regarding the reliability of the MSCEIT. This controversy is grounded in the fundamental issue that it is rather difficult to ensure a scientifically objective measure for such an abstract and changeable trait of human behaviour, even though its manifestations can be seen with varied consistency

(Matthews, 2002). With these limitations in mind, and in order to determine a proper EI measure for the proposed study, I will next discuss a trait EI assessment tool in terms of its relationship to the therapeutic approach, and its reliability and validity properties.

As a therapist and someone in their own therapy the question on how ecologically valid is an ability EI measurement is raised. The burgeoning role of "therapist" through meaning-making with my clients has presented me with a reflectively minded stance about helping the client to make sense of their own experience rather than making sense of experiences for them. Of equal importance is the therapeutic process, where it provides a respectful space for the client to explore their inner narratives and deepen their inner life. That exploratory process and the honouring of that exploratory process are exactly the means by which the client becomes psychologically minded (Farber and Golden 1997). The therapist's role is to help contain experience and help the client find more effective ways for processing, reframing, and accepting potent early feelings and wounds. The role of a therapist is to view the client as capable in finding their own understanding and solutions by pointing out in a variety of ways what it means to be thinking about thinking and to articulate what it feels like to be thinking and feeling. Consequently, the client can develop his way of feeling and can become more mindful as a feeling person.

Alexander and French (1946) accentuated that insight and interpretation in therapy was not enough and that therapists should provide clients with an experience rather than an explanation. The journey to that new emotional experience via empathy (Rogers 1980), psychological mindedness (Farber and Golden 1997), affect regulation (Gross 2007; Larsen & Prizmic 2004; Schore 2003) and a transpersonal relationship (Clarkson 2002) is actually the "royal road" toward helping the client develop a richer and more differentiated internal life.

Operationalizing ability EI is problematic due to the subjectivity of emotional experience and thus, EI defies artificial objectification in attempts to make it suitable

for IQ-style testing. Consequently, it may be dauntingly difficult to measure EI through an ability EI theoretical lens (Zeidner, Matthews & Roberts, 2009).

3.2.2. Trait EI and therapeutic relationship competencies

One of the most psychometrically-sound instruments to measure trait EI is the Trait Emotional Intelligence Questionnaire (TEIQue; Petrides 2009). The Trait Emotional Intelligence Questionnaire (TEIQue) is organized and comprised of 15 subscales under four headings: well-being, self-control, emotionality, and sociability. Various studies conducted by Mikolajczak, Luminet, Leroy and Roy (2007) have shown the results of this test to be normally distributed and reliable. Thus, the TEIQue is considered to be a useful, reliable test to use in order to discern an individual's emotional intelligence.

Trait EI avoids such empirical limitations as ability EI since is investigates an individual's perceptions of their personal emotional abilities. Trait EI theory, however, operationalizes on the basis that emotional experience is inherently subjective. Therefore, I chose a trait EI measurement to examine the aim of this study and investigate qualitatively the concept of trait EI with experienced therapists.

This section addresses the psychotherapy research suggestions for improving the effectiveness of psychotherapists' competences and the trait EI (TEIQue) as a possible mediator of psychotherapy processes and outcomes. There is a conceptual overlap between "big ideas" and different dimensions of the trait EI branches as depicted in Table 1b. Contemporary ideas for psychotherapy training based on the extant research findings from the Vanderbilt II Project (Strupp 1993; Binder 2004) propose a useful means of structuring psychotherapy training and skill development is to focus on a limited number of "big ideas" (Futh, Vinca, Gates, et al., 2007, p. 384). Firstly consideration is given to the concept of therapeutic responsiveness, described in TEIQue (Petrides & Furnham 2001) as the branch of emotionality and the prominent factor of empathy (Rogers 1980).

According to Stiles and Shapiro (1994), therapeutic responsiveness occurs when

therapists recognise, pay attention to, and are empathically responsive to clients' emotional needs as they emerge implicitly or explicitly in the therapeutic space. The concept overlaps with empathic attunement (Cozolino 2010; Rogers 1980). The development of therapeutic responsiveness denotes two interrelated metacognitive skills: mindfulness and pattern recognition through experiential practice. Pattern recognition considerably overlaps with the self-control branch of TEIQue (Petrides & Furnham, 2001).

Pattern recognition requires the skills for discerning and responding effectively to critical events; such skills are akin to the affect regulation strategies to respond to emotional states in one's self and others (Shore 2003). The objective of affect regulation is the attainment of subjective well-being through an increase in positive affect and a decrease in negative affect (Larsen & Prizmic, 2004). For instance, Safran and Muran (2000) describe the experience of an emotional disconnection between patient and therapist creating a negative shift or break in the alliance (i.e., how ruptures and their repair affect clinical change; Safran, Muran, & Samstag, 1994; Safran & Muran 2000). Thus, therapists must become attuned to these relational themes and interpersonal patterns that people constantly repeat and respond effectively to these interpersonal markers (Safran and Muran 2000). Therapists' rupture-resolution processes (i.e., corrective emotional experiences; Alexander & French, 1946), involve attending to the rupture marker, exploring the rupture experience pathway, and avoiding confrontational communication or behaviour and withdrawal.

Another important metacognitive skill in conjunction with pattern recognition is the therapist's mindfulness (Safran & Muran 2001). Mindfulness is one of the common factors in different psychotherapy orientations (Dunn, Callahan, & Swift, 2013; Martin, 1997). In this respect, Bishop et al. (2004) argues that mindfulness firstly requires the self-regulation of attention by allowing focus of mental events on the present moment.

Secondly, is the adoption of a certain orientation towards the experiencing of the present moment, this orientation involves curiosity, openness, and acceptance. Mindfulness can be seen as enhancing the capacity to empathise with self and others (Fauth, Vinca, Gates, & Boles 2007). These concepts overlap with psychological mindedness (PM), which emerged from psychodynamic thinking (Taylor, Bagby & Parker 1989; Appelbaum, 1973) and in the TEIQue branch of self-control (e.g., emotional regulation, impulsiveness, emotion management, stress management, adaptability). These conceptual overlaps between TEIQue and interpersonal skills indicate a number of potential avenues for training to develop self-awareness (Roessler 2011) and behavioural change during an intervention. However, a deep-rooted issue remains as to the clinical and practical application of TEIQue because the development of therapeutic responsiveness denotes experiential practice and experiential learning, not psychometric testing.

Psychotherapy Training Focus on "Big Ideas" (Fauth et al.2007)	Prominent Competencies in Therapy-Overlap	Branch	Branches of Trait EI
Therapeutic Responsiveness	Empathy	Emotionality	Emotion perception (self and others) Emotion expression Relationships Empathy
Pattern recognition and Mindfulness	Affect Regulations & Psychological Mindedness	Self-control	Emotion regulation Stress management Impulsiveness (low)

Table 1(b): TEIQue indicates; Therapeutic responsiveness

3.3. Emotional intelligence and clinical evidence

EI examined across all three models (trait, mixed and ability) has been both theoretically and empirically linked to many psychological constructs that play a large role in the therapeutic relationship and setting. A meta-analysis examining the relationship between trait EI and health revealed that higher EI was associated with improved physical and mental health (Schutte et al., 2007). Trait EI has been especially related to various emotion-related variables, including alexithymia, optimism, and mood (Petrides, Pérez-González, & Furnham, 2007). It has also been related to adaptive coping to depressive affect and effective decision-making (Sevdalis, Petrides, & Harvey, 2007). In challenging and demanding environments, trait EI has an influence on the selection and control of strategies for coping used within the immediate situation (Matthews & Zeidner, 2000).

There are a variety of other benefits found with trait EI, including life satisfaction and success, social network size, loneliness (Saklofske, Austin, & Minski, 2003), depression and mental health (Dawda & Hart 2000; Taylor 2001), psychological distress, (Slaski & Cartwright, 2002) and psychopathology (Malterer, Glass, & Newman, 2008). Various studies like those of Bar-On (1997) and Martinez-Pons (1997) have been specifically focused on the role that EI plays in the prediction of life satisfaction, and found that those people with a higher EI were more likely to have greater outcomes. Bar-On (1997) also provided evidence that EQ-I total scores have a positive relation to emotional health measures, and a negative relation to psychopathology and neuroticism measures.

In two recent meta-analyses (Martins, Ramalho, & Morin, 2010; Schutte, Malouff, Thorsteinsson, Bhullar, & Rooke, 2007), there appears to be evidence that, irrespective of gender, the higher the perceived trait EI, the better the mental health. In a recent study by Salami (2011), trait EI had significant correlations with psychological well-being in adolescents. The study points out the moderate relationship between EI with neuroticism,

extraversion, and psychological well-being. The study implies that EI gives a boost to the positive effects of extraversion while limiting the negative effects of high neuroticism to produce greater overall well-being. The importance of EI and mental health most recently was investigated by Bhochhibhoya, Branscum, and Taylor (2014). The authors explored the relationship among physical activity, EI, and mental health in a sample of university undergraduate students through a trait EI measure (i.e., the Schutte Self-Report Emotional Intelligence Test). EI was a significant predictor of physical activity and mental health among college students. There is also some evidence emerging recently that a depressed youth might also be experiencing difficulty regulating negative affect (Shabani et al., 2010). Specifically, it seems that they may possess a more restricted set of strategies for regulating affect, use less effective strategies, or fail to use strategies within their repertoire. Trait EI scores have been positively correlated with emotional stability and negatively correlated with neuroticism and psychopathology (Dawda & Hart, 2000). Trait EI has been found negatively correlated with depression in studies by Dawda and Hart (2000) and Schutte et al. (1998), and psychological distress in research by Slaski and Cartwright (2002).

David (2005) demonstrated that the higher a person's EI, the lower their psychiatric distress including, less problems with concentration and less frequent headaches. Other reports, like those of Lizeretti, Oberst, Chamarro, and Farriols (2006) indicated that those diagnosed with dysthymia have lower EI scores than other psychiatric groups. Subsequently, there has been considerable evidence reported by Schneider, Lyons, and Williams (2005) that a higher degree of EI does appear to promote better attention to physical and mental processes relevant to clinical outcomes. For example, people higher in some EI skills can detect variations in their own heartbeat more accurately -a physiological response related to emotion. Malterer et al. (2008) found that people with

primary psychopathy are less likely to both respond to emotion cues and have less ability to revise their mood states after experiencing emotions.

Sanchez-Ruiz, Mavroveli and Poullis (2013) investigated the interrelationships among general cognitive ability, academic performance, personality traits, and trait EI. Additionally, the study sought to explore the variances across university majors in trait EI profiles. Trait EI was found to predict academic performance beyond cognitive ability and establish personality traits. Differences across university majors in terms of trait EI scores were reported. In particular, psychology students scored higher on trait EI than business and management, computer science, and electrical engineering students.

3.4. Repurposing emotional intelligence in psychotherapy

Though out the literature, there are both conceptual and empirical grounds to relate EI to various concepts in counselling and psychotherapy practising. In 1936, Rosenzwigs published an article in the *American Journal of Orthopsychiatry*, suggesting that some potent implicit common factors are more important than the methods to have success in therapy. Years later, Heine (1953) supported Rosenzwigs observations and also concluded that the characteristics of the therapist are more important than the approach and techniques in obtaining a successful therapeutic outcome. Much later, Luborsky et al. (1986) reported findings from four major studies on outcomes, demonstrating how a therapist's personal competencies make a greater contribution to therapeutic outcomes than the treatment modality.

EI appears to be one of these personal competencies of a successful therapist, but the construct has been referred to various names throughout the literature, such as Alexander's and French's (1946) notion of "corrective emotional experience", as well as throughout Carl Rogers work in "Client-Centered Therapy" (1951), "On Becoming a Person" (1961), and "A Way of Being" (1980). A number of other studies demonstrated that therapists' relational skills – a component of EI - can mediate the therapeutic process

and outcomes (Lambert, 1986; Orlinsky & Howard, 1980; Rogers, 1957; Truax and Carkuff, 1967; Grencavage and Norcross, 1990; Norcross, 2002; Ackerman & Hilsenroth, 2003; Hersoug et al., 2001; Mallinckrodt & Nelson, 1991). Stupp (1986) suggested that a therapist's skillset needs to consist of an ability to create a particular interpersonal context, and within that context, to facilitate certain kinds of learning in order to be successful with clients.

Without psychotherapy research, we can have no clear perspective of how people differ in their relational and emotional competencies or in their regulation of emotions. It may be that EI encompasses a new psychological terrain that could add to therapists' understanding of their own and others differences in emotion. Such knowledge can aid with helping patients adapt to threats and opportunities.

Psychotherapists, counsellors, and general mental health workers face an enormous challenge with complex realities in their professional practice. EI may help as it has been found to be a significant contributor to health professionals' knowledge and practice (Jaeger 2003; Hen & Goroshit, 2011; Jahangard et al., 2012; Rieck & Callahan, 2013). However, despite its potential relevance for counselling and psychotherapy practice, there has been little investigation and few research papers about its application in therapeutic settings, or in professional development courses and counselling psychology educational programs (Poullis, 2003; Hen & Goroshit, 2011; Rieck & Callahan, 2013). Despite the association and overlaps between the EI model and psychotherapy models, in particular on interpersonal and affective competencies (Ikiz, 2009), there has been only one study to date by Kaplowitz, Safran and Muran (2011) that explores empirically how therapist EI impacts treatment (Rieck & Callahan, 2013).

Psychotherapy researchers are increasingly in agreement that caring in mental health is complex and needs therapists who are competent of developing relational skills (Safran and Muran, 2000), establishing meaningful relationships (Skovholt and Jennings,

2004), and discovering the active emotional learning competencies of therapeutic change. Equally important is preparing therapists to participate in therapeutic relatedness under a great deal of severe emotional stress with specific problems and behaviours from their clients (e.g., depression, anxiety, delusions, aggressions, resistance, suicide, self-harm, mistrust). Norcross (2000) emphasized the importance of the "hazards of psychological practice" (p. 710).

In a broader context, the true effectiveness of a psychological treatment lies in developing and testing a successful psychotherapy training program (Hilsenroth, Defife, Blagys, & Ackerman, 2006). The components of professional psychology competencies have been a prominent theme throughout therapist/psychologist training and professional education (Spruill et al., 2004). The emotional stress on a therapist can cause the experiences of burnout when they must deal regularly with feelings of anger, pity, fear, irritation and impatience. Given such stress, therapists could negatively impact other therapeutic relationships and treatment outcomes (Akerjordet & Severinsson, 2004; Megens & van Meijel, 2006).

According to Hochschild (1983), to prevent burnout or negative outcomes in the therapeutic process, therapists need to regulate their emotional expressions in a way beneficial to the situation, the patient or both. Martin, Garske and Davis (2000) also noted that a competent therapist must receive training in building relationship skills. Rogers advocated for interpersonal abilities, such as empathy and congruence, in the therapeutic relationship. Rydon (2005) demonstrated the underlying complexities of therapeutic engagement and identified the need for interpersonal constructs of resilience and hardiness, self-awareness and openness, Hurley and Rankin (2008) advocated that in order to therapeutically engage with someone, cognitive intelligence is not sufficient, as this process demands the need for communication, authenticity and genuineness that are the building blocks of mindfulness and empathy.

The capacity to develop these skills could be facilitated by one's degree of EI or EI training (Salovey et al., 2008). Some researchers (Hurley, 2008; Akerjordei & Severinson, 2007) have explored EI with mental health nurses and found that the construct is essential to developing professional competence and being effective in the mental health setting. Harley and Rankin (2008) concluded that to practically incorporate EI into educative practice within the therapeutic relationship, the tasks should foster enquiry-based learning activities grounded not on content and knowledge but on the experiences to emotionally engage with learners on an interpersonal level of self-awareness and empathy. It seems clear that EI abilities are implicitly related with the development of relationship/interpersonal skills and are affiliated with therapeutic relationship competencies.

EI has the potential to improve training and clinical outcomes, but even more important is the utilization of existing EI measurement tools by repurposing them for inservice therapists. Because EI and emotional competencies are complex and multifaceted, assessment should also be multidimensional with experiential teaching modes (Hens & Goroshit, 2011). EI can become an efficient way of overcoming the gradual accumulation of clinical exposure to therapists. On reflection of my own experience, I endorse Danielsen and Cawley's (2007) assertion that both compassion and integrity, and subsequently EI, cannot be taught in a traditional manner.

Through the practicum experience, there is a requirement to develop new experiential methods (Hens & Goroshit, 2011) and for accessing, evaluating, and applying scientific knowledge (Bieschke, Fouad, Collins & Halonen, 2004). Hatcher and Lassiter (2007) in their introduction to the "Practicum competencies outline" emphasized the development of baseline competencies in psychology training; these include: interpersonal skills (e.g., listening, empathy, and openness), cognitive skills (e.g., flexibility, critical thinking, intellectual curiosity, problem solving), affective skills (e.g.,

resilience, tolerate ambiguity and uncertainty), personality/attitudes (e.g., the desire to help others, openness to new ideas, integrity, honesty, personal courage), expressive skills (e.g., ability to communicate accurately one's ideas or feelings both verbally and nonverbally), reflective skills (e.g., ability to examine and consider one's own motives attitudes, behaviour, and their effect on others) and personal skills (e.g., personal organization, hygiene).

Given the relevancy of EI to baseline competencies, encompassing EI experiential activities in the current therapy environment, such as self-exploration, empathy, emotional learning, role playing and resilience, could improve therapists' degree of EI and thus, the therapeutic relationship and intended outcomes. One approach is the modelling technique, which has been introduced for health professionals to teach compassion, integrity and EI to medical students (Danielsen & Cawley, 2007; Cooke et al., 2006). Modelling is based on a cognitive psychology notion in which concepts are best learned and put into action when they are taught, practised and assessed in the context in which they will be used (Cooke et al., 2006).

After a critical review of EI teaching models, Hens and Goroshit (2011) concluded that the best way of teaching EI, emotional competencies, and interpersonal skills is by adopting a constructivist approach. The researchers indicate that the needed constructivist learning environment should first provide health care professionals an active process to construct meaning around their own experience, rather than teach, practice and assess EI competencies. Second, the method should engage participants in a process of assimilating and accommodating new information in their cognitive framework, and in so doing foster thereby fostering significant learning and profound understanding. Last, the approach establishes a community of learners that constitutes both instructors and students, whereas students are encouraged to recess emotional events by identifying, understanding, regulating and utilizing emotions (Mayer et al., (2000).

Following the development of a social work course that incorporates such a constructivist EI approach, Hen and Goroshit (2011) explored its effect on a students' degree of EI and empathy. Using Schutte's Self Report Emotional Intelligence Test (1998) to measure EI and the Interpersonal Reactivity Index (Davis, 1988) to measure empathy, they found an increase in EI scores from the beginning to the end of the course for advanced-year students but not for first-year students, suggesting such a constructivist approach may only be helpful for advanced students with experience to reflect upon. Further empirical research is needed in counselling psychology to examine whether an experiential EI course could enhance students' emotional competencies and degree of EI, especially for advanced students.

In the first study to explore ability EI with psychotherapy, Kaplowitz, Safran and Muran (2011) explored whether therapists' degree of EI served as a potential mediator of the therapeutic process and its outcomes. The sample comprised 23 therapist-patient dyads. The outcome metrics included a series of self-reported therapist and patient rated inventories, administered at four time points (intake-after the fourth session, midphase, termination and three months follow-up). The researchers found moderate initial evidence supporting the hypothesis that a therapist's emotional skills have a positive influence on treatment efficacy. The findings revealed that higher overall therapist EI led to a reduction in therapist-rated complaints and patient interpersonal problems. Moreover, a higher the therapist's score on emotion-management abilities (a subcomponent/branch of EI measurement) resulted in a lower patient drop-out rate and a greater improvement in patient-rated symptomology. Despite the sample deficiencies of the study, the findings suggest that EI can holds promise as a mediator and practical tool in psychotherapy.

3.5. Summary

To conclude, there are three main EI models: mental ability models, mixed models, and the trait EI model. The mental ability models of Salovey and Mayer (1990), Mayer and Salovey (1997), and Mayer, Salovey, and Caruso (2000) emphasize the role of emotions themselves and the interactions they have with thought. Further, the mixed models of Bar-On (1997) and Goleman (1995a) indicate that both mental abilities and a multitude of other individual characteristics— including states of consciousness (and flow), motivation, and social activity—come together as a singular entity to create EI. The trait EI model, however, as developed by Petrides et al. (2007), focuses on the self-perceptions of individuals with respect to their emotional self-efficacy and self-perceived ability to determine their EI. All these models have their benefits and limitations, as well as accompanying measurements.

The therapeutic relationship would appear to be related to Salovey and Mayer's (1990) definition of EI as encompassing awareness, understanding, and emotional management of one's self and others. Interestingly, Safran and Muran (2000), in their review of contemporary relational theory, emphasize one of the important variables of therapist competencies is the capacity to properly perceive, process, understand, and respond appropriately to the relational dynamics in the therapeutic relationship. The therapeutic encounter strongly emphasizes relational dynamics, interpersonal and affective skills between the therapist and client, and the relationship between client and therapist. The TEIQue emotionality branch overlaps with therapeutic responsiveness, and the self-control branch corresponds with pattern recognition and mindfulness. The central concern is the experiential application of TEIQue in counselling and psychotherapy learning programs. Ironically, it may undermine one of the original reasons for introducing trait EI, to enhance the competence and quality of outcomes of therapist interventions.

Chapter Four

4. The therapeutic relationship

This chapter, through many perspectives, addresses therapeutic relationship and rapport, most notably through trust, collaboration, communication, therapist empathy, and mutual respect. This section summarizes this study's contributions to contemporary understanding of therapeutic relationships and EI conceptual overlaps and delineates several barriers to developing therapeutic relationships. In "The Dynamics of Transference," Freud (1912 as cited in Strachey, 1958) discussed the importance of the analyst having a supportive attitude and sympathetic understanding toward the client to facilitate a connection with the healthy part of the client's self to form a positive attachment.

Freud accentuated the therapist's supportive attitude would unconsciously connect the therapist with the "images of people by whom he was accustomed to be treated by affection" (pp. 139-140). Researchers since have posited the idea that the therapist-client relationship is the most significant influence on the efficacy of therapy and its therapy (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1986; Burns & Nolen-Hoeksema, 1992; Ackerman & Hilsenroth, 2003; Norcross, 2002; Cooper, 2004).

However, there is a piece of the puzzle missing in terms of explaining the successful client-therapist relationship. It is only logical that researcher Lambert (1983) would state that the consistent failure to identify differences in the efficacy of the various forms of psychotherapy and the therapy nonspecific factors, along with a significant unexplained measure of variance, promotes the attention of research to be placed on the determinants of a positive therapeutic relationship.

The notion of common factors in counselling was first framed by Saul Rosenzweig (1936). This author observed that factors common to all schools of psychotherapy are responsible for facilitating change. More than three decades later, Frank (1971) suggested six therapeutic factors: an emotionally charged, intense relationship; a therapeutic rationale explaining how the client is experiencing distress; providing new information on the sources of the client's issues; developing the client's expectations of help based on the personal qualities of the therapist; providing the experience of success; and facilitating of emotional arousal.

Zetzel (1956) described the therapeutic alliance as a rational, conscious, collaborative agreement between therapist and client. A positive working alliance between therapist and client was advocated by Greenberg and Safran (1987) both to cultivate the conditions necessary for a client feel free to raise and explore any inner feelings and to facilitate a safe space for behavioural experimentation. Empirical research on the therapeutic relationship in general and the therapeutic alliance in particular have been advancing (Horvath, 2005). Some studies have indicated that the therapeutic alliance is significantly important in virtually all types of therapy, irrespective of the particular approach used (Horvath & Bedi, 2002; Luborsky, Singer, & Luborsky, 1975; Martin et al., 2000; Shapiro, 1985; Smith and Glass, 1977). Knox (2001) described how the therapeutic relationship generates change via the recovery of autobiographical memories. Furthermore, at the early stage of treatment the therapeutic alliance is especially predictive of outcomes, according to research evidence (Luborsky, Singer, & Luborsky, 1975; Martin et al., 2000; Shapiro, 1985).

This alliance has been considered both an intrapersonal and an interpersonal process (Horvath, 2005). Hendry and Strupp (1994) further supported the inter- and intrapersonal argument by documenting how elements of therapists' and clients' internalized self (introject) have unconscious interaction, and this interaction affects the

quality of the therapeutic alliance. In sum, both intra- and interpersonal processes make a contribution toward a positive therapeutic alliance.

Recommendations for potential methods to examine the therapeutic relationship were presented by Horvath and Bedi (2002) including greater consideration of the micro-level at the expense of the macro-level identifying the intrapersonal variables and qualities of therapists, which may influence their interpersonal relationships in therapy as well as outcomes. Suggesting that without these inter and intrapersonal skills or abilities, a therapist might not be successful. A number of studies on therapist characteristics in the context of the development of a positive alliance support the importance of these characteristics to the therapeutic relationship. Research conducted by Perraud, Delaney, Carlson-Sabelli, Johnson, Shephard, and Paun (2006) focused on particular psychotherapy skills necessary for a positive therapeutic alliance. These researchers formulated four domains of competence in which these skills could be located: Therapist contributions to the therapeutic alliance, skills and techniques to increase positive reception of empathic overtures, goal consensus and collaboration skills, and skills related to development of self-awareness and management of countertransference (pp. 221–223).

4.1. The therapeutic relationship and its links to EI

There have been studies investigating the possible positive relation between EI and the therapeutic relationship, however, only a limited handful of EI components or competencies have been explored to determine this link. Poullis (2007) conducted a phenomenological investigation to explore which EI competencies mediate and have an influence on the therapeutic relationship. The researcher found five themes that emerged from the qualitative thematic analysis: the therapist's subtle competencies, substantial attributes and skills, experience, extraneous variables, and the interaction process. The therapeutic relationship and the constructs of EI models share a number of core overlaps in relational skills, however, it will be a challenge to establish a clinical applications on

the levels of inter-subjectivity within a therapeutic experience, as well as the transpersonal elements so eloquently outlined by (Clarkson, 1990, 1995).

Clearly the notion that the complex relationship between the therapist and the client has a profound effect on the therapeutic journey has been the subject of much research and debate for quite some time, as has the ways in which the quality of the therapy-client relationship affect client outcomes. The ways in which emotions may impact the therapeutic relationship and the significance of EI within therapy could also be critical areas for current and future therapists. Thus, these are issues that are areas of acute importance for practitioners and trainee therapists in the twenty-first century. An increasing body of research into the therapeutic alliance has a focus on the exploration of the relationship between the alliance and therapeutic outcomes across a range of helping contexts, including therapist training and experience different types of treatments, diverse populations, and gender effects. Also noteworthy is whether the alliance is a curative component of therapy in itself or whether the process and quality of the relationship generates the interpersonal context for further therapeutic components.

In referring to self-management and coping to emotional stress, Salovey (2001) stated that the introduction of these EI skills may have a positive impact in dealing with the therapist's perception, expression, and regulation of moods and emotions. This is particularly evident with the issue faced by newly qualified social workers, as there is an ever-increasing disparity between the taught theoretical models of solving mental health problems and the emotional stress. Therefore, in order to further explore the link between EI and the therapeutic relationship, it is important to identify how certain components of EI affect professional competence in the applied psychodynamic setting.

The social work profession has been the subject of much research concerning the extent to which empathetic awareness – a trait of EI – and intuition influence the interaction with clients who are socially/psychologically vulnerable, oppressed and living

in low economically developed communities (National Association for Social Workers, 1999). While governmental agencies have recognised the need for interventions to accommodate the culturally diverse systems that underpin behaviour to ensure responsiveness and compliance, it is evident that new academically prepared social workers may need better preparation in diversity.

The social work profession may be a promising starting ground for exploring the association between EI and the clinical therapeutic relationship, primarily because it incorporates similar psychosocial and interpersonal dynamics evident in a traditional counselling context (Eborall & Garmeston, 2001). The self-management and coping of emotional stress mentioned earlier in reference to Salovey (2001) are prominent in the emotional demands and stress that accompany the client assignments of social work. Stress in recent qualified social workers is considerably high, which is evident in the high rates of psychosocial distress found in participants sampled by a study conducted by Kinman and Grant (2011).

Even though research has indicated that emotional awareness of oneself and of others in a therapeutic setting help to improve the efficacy of the therapist to patient relationship and intervention outcome (Gant, 2007), it has been found that students generally have the notion that it is not professional to express or share their personal emotional reactions to client cases, even to their own supervisors in the practicing field (Rajan-Rankin, 2013). This is similar to how social workers' perceive empathy or empathetic awareness; it is viewed as a positive trait, however, it can be used to skew the accuracy of trained judgement and consequently lead to empathetic distress (Grant, 2013).

Contemporary researchers have concurred with Salovey's (2001) self-management idea of coping with emotional stress in order to meet the demands of the dispositions of a patient/client. Laming (2009) argued that social workers need to develop

emotional resilience in order to persevere through the challenges faced between the patient. It has also been suggested that in order for a social worker's or therapist's internal emotional management to yield a more effective intervention for the client, it is important to also exercise accurate empathetic awareness (Morrison, 2007). After all, inadequacies and irreversible situations transpire when performance difficulties occur in the context of social workers and therapists who lack self-awareness and consideration of patients' subjective feelings (Morrison, 2007). The Social Work Task Force (2009) also agreed that the need for developing and exercising empathetic awareness, emotional resilience, and intuitive skills, are integral for the success of social workers to deliver effective interventions for their patients. Grant and Kinman (2013) conducted a qualitative study investigating which inter- and intra-personal values predict emotional resilience in student social workers, testing variables such as EI, multi-dimensional measures of empathy and reflection, social competence, and coping mechanisms. They found that emotional resilience is a complex multi-faceted construct that encapsulates many values, and should be viewed as a generalised conceptual term within the therapy/intervention context.

Grant and Kinman also found that student social workers need to develop competencies that coincide with Salovey and Grewel's (2005) MSCEIT measurement of EI, particularly when self-regulation and awareness of emotional states underpins resilience in order to improve their wellbeing and practice. It was also found in the study that students in social work, who are learning about therapeutic interventions and how to deal with patients, need to be supported to develop emotional literacy and undergo training to foster reflective ability and to better understand the multifaceted characteristic of empathy. Grant and Kinman made several inferences from the qualitative data they analyzed from their study, with one of the prominent findings being that self-reflection and empathetic awareness via a quantitative analysis were correlated with higher scores

on emotional resilience and more effective professional competence in the social intervention practice. This provides credence to the notion that stronger resilience in the face of patient conflict and reception of emotional turmoil, paired with heightened accurate empathetic awareness, both provide vital performance metrics for therapeutic relationships with successful outcomes (Wilks & Spivey, 2010).

Grant, Kinman, and Baker (2013) conducted another study to explore EI as an application for improving social work education curriculums, particularly to address the reviewed research findings pointing to enhanced therapist resilience and patient intervention success outcomes. Quantitative survey data was collected online from thirty five university student respondents, followed by a follow-up qualitative telephone interview. The researchers found that 92% of respondents perceived emotional resilience and EI to be of high necessity for social workers who are managing projects for patients complying with therapeutic interventions, and 95% of respondents believe that hiring social workers should include emotional resilience as a key competence criterion for practicing in the field. Respondents were asked whether they view reflective writing as an important part of the curriculum for enhancing their empathetic awareness and intuition from acquired knowledge, which resulted in a majority supported verdict. However, coping strategies and mentoring had the least contribution to the design and execution of education curriculums. As a result, the researchers concluded that a revision to the current social work education curriculum, consisting of the development of EI competencies through mentoring applications that help prepare newly qualified students on how to cope with emotional stresses during patient interaction in the field, is clearly needed.

As suggested from prior studies, an emotional component in psychodynamic therapy and social work education is important for fostering resilience and empathetic awareness. The methods used by schools to help students enhance their professional

identity and transferable EI competencies in the patient interaction context may be a strategy to counter the disparity between theoretical limitations and real work scenarios. Without such a focus, there could be a gap in practical competence when the newly qualified social worker is presented with a problematic situation that has mild similarities with the intervention models studied during schooling. Challenging the generalisation of theoretical applications to the field has been a long standing issue, which is understandable considering the complexity of human social behaviour, particularly with latent traits such as emotional states, coupled with culture influencing the variance in behaviour across therapeutic practice fields, namely, substance abuse, mental health, and child welfare. With such dynamics, it raises a question of how significant the role of EI is when solving social and psychological issues, particularly in growing poly-ethnic societies where social aid needs more tailoring to different belief systems for what constitutes favourable interventions. To answer this inquiry, recent research has explored the benefits of self-assessment and personal development methods used in social work education programs, examining how the enhancement of self-management and empathetic awareness has implications to the therapeutic relationship. This also coincides with studies analysing the link between increased intuition and empathetic awareness, and how this strengthens a newly qualified worker's ability to apply theory in solving untrained situations during stressful patient interaction scenarios (Curtis, Moriarty, & Netten, 2009).

The conception of the "reflective practitioner" was coined by Schon (1983), referring to a practitioner who adopts the use of self-reflection as a way of reviewing prior experiences and acquiring knowledge in order to learn from the reflection. Self-reflection is a means to enhancing EI and professional intuition by knowing when certain components of acquired knowledge serve as useful solutions to circumstances that carry a need for empathetic awareness, which without it, experiences may cloud the quality of

judgement in the mind of a newly qualified therapist or social worker (Mann, Gordon, & MacLeod, 2009). The emergence and use of self-reflection for monitoring personal development and empathetic awareness in social work is an increasingly encouraged practice in contemporary training and therapy practices (Anghel, Hicks, & Amas, 2010). The positive outcomes of using self-reflection, particularly in terms of increasing intuition and professional EI competence, are growing.

Personal reflection and its relation to psychodynamic therapy outcomes are addressed frequently in the literature. It is now concurred among researchers that enhancing self-awareness mutually raises a therapist's empathetic awareness among clinical settings as well as social work fields (Boud et al., 1985; Epstein & Hundert, 2002; Moon, 1999). Although students qualifying for social work do not have as much demand counselling psychologists do in providing empirical grounds of reflective practice for licensure, it is becoming increasingly important for maturing the awareness of patients' or therapists' emotional states in order for therapeutic relationships to be more responsive and successful (Negi, Bender, Furman, Fowler, & Prickett, 2010), and also part of their academic development (Catto, 2005). However, in order to ensure the efficacy of experiential knowledge that has emotional content, it is important to keep engaging with situations that coincide with what has been previously learned through adversity to avoid egocentrism and allowing for a more receptive awareness of a patient's feelings, especially when certain dispositions are difficult to articulate or express. Self-reflection provides an explicit way of integrating emotional awareness and theoretical knowledge into real world situations (Epstein, 1999). The early onset of this metacognitive process takes place during psychodynamic therapy and social intervention education, which may perhaps underpin the student's advancement into professional and EI competencies through the degree of self-awareness, thus engaging with out-of-classroom situations in a more intuitive manner through self-regulation (Bandura, 1986).

The reason why self-reflective methods are becoming a prominent part of training students to become qualified therapists and social workers is because schools acknowledge the need for students to be more mindful of empathetic awareness and stress coping mechanisms (Boud, 1999). This is to reverse the traditional pattern in therapist recruitment, where students tended to learn theory before they exposed themselves to emotionally demanding situations with direct patient contact. Laming (2009) argued that social work education should help students in growing their emotional perseverance, as well as the ability to reflect on what they have learned and experienced to ensure professional competence under real stressful work situations. In order to endure stress and emotional challenges during social work practice, students need to be more self-aware and develop coping mechanisms for professional etiquette (Howe, 2008; Laming, 2009). This would allow new restructured curriculums to support students in attaining a better grasp of tolerance and working with uncertainty (Stevens & Cox, 2008), as well as adequate coping mechanisms (Collins, 2008; Ferguson, 2005). A qualitative study on self-reflection in social work practice, conducted by Ruch (2000), found that it enhances empathetic awareness and increases insight into how a student's personal background affects academic development and future employment. The emotional values evident between the social worker and client are an interpersonal dynamic, requiring regulation that may be aided by the increased empathetic awareness and intuition from self-assessment and reflection exercises. The utilisation of self-reflection also refines the concept of "self" during a professional case, which grants the newly qualified social worker the EI competencies to moderate personal anxieties (Anghel, Deborah, & Hicks, 2010).

Prior research findings indicating that EI skills can be taught may provide a positive impact on the therapeutic relationship by infusing interventions across various areas of human functioning (Bar-On, 2006). Perhaps one route to better understand EI

and its links to therapeutic relationship, so as to examine its potency in therapy, is to study the views of experienced therapists to determine the development, maintenance, and negotiation of the therapeutic alliance. In this way, for example, therapists can share their experiences of how they first establish an effective alliance, the flow that the alliance tends to take during the process of therapy with both engaging and less responsive clients, how they manage or fail to manage the alliance and to balance these complex issues with different types of clients.

EI, as a construct and identifier of personal and social maturity, often helps therapists discern whether a certain individual may be suitable for psychotherapy. For this reason, Ciarrochi, Forgas and Mayer (2001) noted the importance of EI assessment as a tool that enables the therapist to identify the patient's ability to understand and express emotions. An important part of research remains as to what are the benefits and implications of EI on therapists' mental and emotional health, skills in the therapeutic relationship and professional development. A second area of research yet to be explored is in regards to whether the quality of a positive therapeutic alliance that is comprised of a therapist's inter- and intrapersonal skills can be reached through the construct of EI.

4.1.1. The role of emotional intelligence within therapy

As aforementioned, EI appears to play a key role in the therapeutic process. Matthews, Zeidner and Roberts (2004) reported:

> *"Psychologists have proposed that understanding the emotions of oneself and others is the key to a satisfying life. Those people who are self-aware and sensitive to others manage their affairs with wisdom and grace, even in adverse circumstances. On other hand, those who are 'emotionally illiterate' blunder their way through lives marked by misunderstandings, frustrations, and failed relationships. A scientific understanding of this EI can allow us to train our emotional skills so that we can live more fulfilling and productive lives." (p. 3)*

Levels and ability of EI, then, differs for each individual. The personal importance given to emotion management in today's society has grown over the past few decades. Thus, Matthews, Zeidner and Roberts (2004) suggested that it has become

clinically important to nurture people's personal EI so that they may have a greater awareness and control of their own emotions and of others, leading them to have happier, more fulfilled lives.

The knowledge and importance attached to EI over recent years has led to various new types or methods of therapy, such as Maree and Fernande's (2003) solution-focused therapy and Greenberg's (2004) emotion-focused therapy. Clinical psychology offers a multitude of therapeutic techniques for improving the management of emotions, including cognitive-behavioural therapies, occupational psychology, and even educational and school psychology. Not only does this indicate the importance of EI, but also suggests that many therapists, counsellors, and psychotherapy practitioners may have been improving their client's EI without realizing - especially given the rate of "emotional dysregulation" that clients of therapy harbour (Matthews, Zeidner & Roberts, 2004).

However, Matthews, Zeidner and Roberts (2004) point out that, despite its importance and its place among academic literature and theory, there is actually a paucity of studies that measure the practical utility of EI in various applied settings, such as clinical psychotherapy. EI is viewed as a prerequisite to therapy; according to Salovey (2001), those with a high degree of EI should be more likely to be amenable to treatment, and more successful in attaining their therapeutic goals, as well as experience greater coping. Yet the therapist's perception of EI, its components, and its place within the therapeutic relationship, has not yet been fully explored, and thus, provides an issue that is central to the concerns of this study.

Empathy, as a construct of EI, has been argued among researchers as the fundamental component of virtually all successful therapeutic relationships and in the primary care practice field (Mercer & Reynolds, 2002). The credibility of empathy playing a key role in therapeutic relationships as an expression of EI comes mostly from patient satisfaction feedback data, indicating the common perception of quality of care is

attributed to therapists' display of empathetic awareness (Mercer & Reynolds, 2002). Research has found a significant positive correlation between empathy and improved diagnostic accuracy. Empathy has been argued to be imperative to the growth of a successful therapeutic relationship. This is evident across several studies proving a positive correlation between empathy and the therapeutic relationship in the psychiatric field; findings demonstrated enhanced patient outcomes due to psychological and pharmacological interventions targeting individual empathy levels (Krupnick, Sotsky, & Elkin, 1996).

Contrary to the theoretical models and training students undergo to become qualified psychotherapists, it has been emerging from that the reciprocation and transferability of an empathetic relationship is more vital to the clinical outcome than the therapy itself (Orlinski, Grawe, & Parks, 1994). This is particularly evident across several examined cases of cognitive behavioural therapy, where the therapist's empathetic awareness and other EI competencies such as self-regulation of feelings, play a pivotal role in aiding trust and comfort in order for a patient's adequate recovery from issues, such as depression (Burns & Auerbach, 1996). Taking into account the correlation between a therapist's empathy level and success of the therapeutic relationship, it is important to explore this link further.

4.1.1.1. Empathy

Kohut (1982) eloquently demonstrated empathy as "a mode of observation attuned to the inner life of man" (p. 396). Storlow, Atwood and Brandchaft (1994) reported that the empathetic inquiry is to "investigate the meaning of affective responsiveness or its absence, for the patient" (p. 44). Tettegah and Anderson (2007) conceptualized empathy as a situation-specific cognitive affective state. Pizarro and Salovey (2002) formulated empathy as an integration between cognitive empathy and affective empathy. Duan and Hill (1996) define the cognitive empathy element as a

reference to the intellectual understanding of another's experience while the affective empathy refers to immediate experiencing of the emotions of another person. According to Ikiz (2009), the ability to comprehend the perspective of others within, rather than outside, entails an ability to self-perceive that in turn, enhances the development of an empathetic subjective frame of reference. Mercer and Reynolds (2002) argued that one of the most important elements of EI that therapists must use is that of empathy. This emphasis also prompts the question of whether empathy can be developed or is simply inherited and perhaps a by-product of being emotionally intelligent (Zeidner et al., 2002; Brackett et al., 2006).

Empathy is a complex multi-dimensional concept that has moral, cognitive, moral behavioural and emotive components. Mercer and Reynolds (2002) stated three abilities that clinical empathy should involve:

(a) Understanding the patient's situation, perspective, and feelings;

(b) Communicating that understanding and checking its accuracy;

(c) And acting on that understanding with the patient in a way that is therapeutically helpful.

Thus, the concept of EI becomes not only relevant, but integral, to the therapeutic relationship, as it contains within it all the components necessary to identify not only the feelings in others, but also in oneself, which is essential for the therapist and the client if they are to have successful emotional and personal lives. Furthermore, EI enables the therapist to aid the management of those aspects of the client that carry the potential for pre-reflective complicity with destructive tendencies (on the part of the client) within the therapeutic setting. This self-perception enables the therapists to identify and apprehend those emotions or feelings that the client experiences, which may be transferred to the client, enabling them to deal with these emotions, and transfer them back to the client in a therapeutically appropriate manner (Salovey, 2001).

4.1.1.2.The role of implicit memory

Earlier in the discussion it was noted that various researchers have traced the development of EI to a child's early years, given that neural pathways are altered by everyday events in order to help create ways of responding to everyday events (Damasio, 1999). Stein et al. (1993) expanded on this topic by noting that these patterns and ways of responding are primarily emotional, serving to (unconsciously) regulate behaviour and forming one's 'primary' or 'core' self that starts in early infancy. The importance of the implicit memory system in human functioning is of paramount importance. Tulving (1983) distinguished two memory systems in humans: explicit memory and implicit memory. Explicit memory recalls events and "…is concerned with unique, concrete personal experiences dated in the rememberer's past" (Tulving, 1983, p. 1). Implicit memory, on the other hand, is self-relevant, context specific, and concrete. Explicit and implicit memory, therefore, may differentiate between the two types of cognitive systems - rational and experiential. Epstein (1991) noted that the rational system is analytical, involving conscious appraisal processes that function via conscious control. The researcher also stated that the experiential system, however, is much more concrete and emotional, as well as being experienced passively, and is based on feelings from past experiences, as opposed to present judgements and appraisals.

Siegel (2001) found that the brains of infants are attuned to social information and that interpersonal relationships begin to develop due to repeated social interactions and experiences. The multiple, repeated social experiences are believed by researchers Beebe (1998), Lyons-Ruth (1999), and Siegel (2001) to become part of the natural makeup embodied in neuromotor pathways, which lead to relational knowing – implicit memories of how to behave with others. For example, Siegel (2001) claimed, "although we may never recall 'explicitly' what happened to us as infants, the experiences we had with our caregivers have a powerful and lasting impact on our implicit processes" (p. 74). Alan Schore (2000) dovetailed with others authors, such as Bowlby (1988), Damasio (1999),

and Siegel (2001), to describe how experiences involve our behaviours, emotions, and perceptions, together with our mental models of the work of both ourselves and of others. Our very earliest forms of learning of the world around us are encoded in the mind in these explicit memories which have a direct shaping function for our experiences in the here and now although they do so without leaving traces of where and when they first originated (Siegel, 2001).

Interestingly Schore (2000) advocated in his theory that an essential component of the regulatory implicit memory is the child's experiences and history of the contact and emotion that they have had with significant others. Communication with others is important in helping the scheme of a regulatory implicit relational memory to be developed. This is acquired by experiencing many of the common facets involved in relationships and forming an attachment, such as separation, reunion, or mutual availability issues. Of key relevance here, Panksepp (2001) concluded that the development of an infant's brain depends on their social experiences, as they learn to view their social environment as essentially friendly or essentially threatening. In this way, the regulatory implicit memory processes matures, and an unconscious, intuitive sense of one's ability to regulate emotional flow in relationship to others or alone is created in the brain. If an infant has a sense of security, there is a greater likelihood that they will have the capacity regulate their experiences of a range of both negative and emotions, as their social relational experience of these emotions was effectively resolved, in the past.

Daniel Stern (1985) similarly recognized the profound impact of being empathetically attuned on early learning, emotional development and socialisation. Stern described how the baby's brain becomes encoded with the mother's underlying affective response through her displays of empathic responsiveness. According to Stern (1985), this empathic attunement evokes, stimulates, validates and possibly develops the infant's

emotional and physical state. Stern's work outlines the development of 'intersubjective relatedness', which refers to the ability to experience one's self as a being separate from others but also dependent on others. Regulatory implicit memories, rather than simply being accurate records of single events, are the result of a group of early experiences according to Stern (1985) and Epstein (1991). Generalisations such as these result in an unconscious predisposition to behave in certain ways, or feel certain emotions, dependent on the situation. The role of the subconscious is revealed in the works of Siegel (2001), when he stated that one's EI is formed by monitoring and regulating the links between the self and others, and then changing the possibility of an emotional response prior to the emotion actually being experienced. This is a subconscious occurrence, and is generally unable to be explicitly accessed. Psychotherapy, as a process, among other goals, attempts to free and unpack these unconscious or implicit memories of emotionally heavy experiences.

4.1.1.3.Transference

Hence the basis for the unconscious patterns of behaviour, attitude and expectations often re-enacted in therapy is this implicit memory in which models of the world are constructed, models which program the patterns that an individual relates to a new experience. Implicit memory also gives us the capacity to see the aggregation of multiple real-life events and, furthermore, how the hopes or fears someone has at the time of the event can become incorporated into the memory of it (Knox, 2001). The end result of this process of internalization of multiple experiences was captured by Bowlby (1988, p. 129) as an "internal working model" or as internal maps organizing our perception of the world. An insecurely attached child will have internal working models of others as unreliable, dangerous, rejecting, or unpredictable and will bring this generalised expectation into transference. It is these internal working models that represent the clearest clinical examples of implicit memory and have profound implications for our

understanding of the therapeutic relationship and its process. Thus, it is easy to accept Knox's (2001) theory that implicit memory is the basis for the transference.

Transference describes the process within the therapeutic relationship wherein the client projects onto the therapist the feelings or ideas that are deriving from introjected figures, objects, and implicit memories in the client's past. When the transference is analyzed, with the help of the therapist, the unconscious patterns or suppressions may become conscious. If the therapist themselves projects back their own previous "wounds" or suppressions, this is known as countertransference (Martin et al., 2000). Jung (1958) posited that the processes of transference and countertransference is "…the crux, or at any rate the crucial experience, in any thoroughgoing analysis" (p. vii). Psychotherapy then, as described by Knox (2001), through the process of the quality of the therapeutic relationship, brings about a positive change by the recovery of autobiographical memories.

Sedgwick (1994) so vividly 'coloured' in his book the wounded healer and how the central unconscious connection between the therapist and the client (labelled as 'transference') enables a mutual attraction, understanding, respect, and a possibility for healing. Given that EI describes an individual's ability to appraise the emotions of the self and of others, and to regulate emotions in oneself, and to use emotions to solve problems (Salovey & Mayer, 1997), it is easy to see how the therapist within the therapeutic relationship is placed in a situation that requires these skills. The therapist recognizes unhelpful or negative emotions in the client, and understands if and how they may be transferred to the therapist themselves. The therapist must then react accordingly in order to help the client to become more self-aware about the feelings they are emitting, and to explore their cause.

4.1.1.4. Implicit procedural knowledge

Stern et al. (1998) suggested that one of the most important tools for use within the therapeutic setting is implicit procedural knowledge. This researcher asserted that much of the change that occurs with the client in the therapeutic relationship is due to the implicit knowledge that occurs and changes between the therapist and the client. The patient's awareness of implicit memories, Stern argues is intersubjectively shared within the therapy process, providing a potent mechanism for therapeutic change. An emotionally intelligent therapist can help these memories become re-experienced and understood.

As has already been noted by Siegel (2001), implicit memories cannot easily be accessed, but they have helped to shape the foundations of adult mental and emotional functioning. Psychological difficulties are therefore, implicit memories which can manifest as symptoms under stressful circumstances or situations. It is difficult to make them explicit as they lack an interpersonal context that could help the client to integrate the memory as a conscious part of oneself. However, as Stern et al. (1998) asserted, the therapeutic context enables these implicit memories to be re-enacted, as the therapeutic context is reconstituted to the context wherein the memory was acquired, and this enables the memories to be dealt with and explored, and then integrated into the autobiographical self.

4.1.1.5. Change

Continuing with the train of thought from Stern et al. (1998), an appropriate environment and an emotionally intelligent therapist can provide the best aid for clients that are experiencing negative emotional and/or psychological symptoms, and desire change. Throughout the therapeutic process, there are various moments of change, including an improvisational (Beebe & Stern, 1977; Gianino & Tronick, 1988; Stern, 1985; Stern et al., 1980), self-finding, and self-correcting process (Tronick, 2007), which

work towards a specified goal. Stern (2004) labelled these moments as "now moments," referring to brief sparks of interactions between therapist and client, a fertile source of growth and change for both client and therapist as well as the relationship between them. Until such flashes of interaction occur, Stern (2004) saw the therapeutic process as progressing somewhat randomly and spontaneously. When this happens, Stern et al. (1998) referred to this as a "moment of meeting," which facilitates change in the client. This is also akin to transference, as described above. The "open space," which Stern et al. (1998) insisted proceeds immediately after a moment of meeting, describes the brief pause for reflection from both the therapist and the client. The dynamic of the therapeutic relationship has changed, as has the status quo within the client and thus, a moment is required wherein the client (and the therapist) need time to reflect and adjust to this change.

4.1.1.6. The lived-body paradigm

The views of Merleau-Ponty (1962) are important for the phenomenology of emotions, mainly for advancing the theory from intentionality to motility, and creating a unique bodily perspective. Husserl's notion of intentionality ignores the significance of the embodied experience of emotions and focuses on the object of emotion and its relevance to the subject, and is only secondary to the "act" of intending (Solomon, 2003). The perspective of embodiment relevant to the therapeutic relationship is taken from the phenomenological movement and particularly from the phenomenology of perception and the work of Merleau-Ponty (1962). Merleau-Ponty (1962) asserted that the way therapists experience their bodies in relation to their clients can have an important role in interpreting and making sense in the therapeutic relationship.

Merleau-Ponty's (1962) work provides a new perspective for viewing the process of the therapeutic relationship as an intrinsically embodied experience. Shaw (2004) suggested that the therapist's body is a way of monitoring the psychotherapeutic process.

Field (1989) examined a number of somatic phenomena in his therapeutic practice, which he termed embodied countertransference. Samuel (1993) used the same term embodied countertransference, and further noted that the body is an organ of information, echoing Merleau-Ponty's view that our understanding of the life-world originates as an embodied experience. Rowan (1998) took Samuel's notion of the term embodied countertransference and put forward the concept of linking to describe a particular type of empathy and the embodied nature of the connection between therapist and client. Thus, the concept of linking gives the opportunity to see the therapeutic relationship as an embodied encounter.

The lived-body paradigm emphasises the notion that it is our perception of the world that is vital in knowledge acquisition, and that our understanding emanates from our bodily sensations. The notion is that the body is the means by which we engage with the world. As Merleau-Ponty (1962) stated, "The world is not an object such that I have in my possession the law of its making, it is a natural setting of, and field for, all my thoughts and my explicit perceptions" (p.186). The importance of his work is summed up in the following quotation: "It is through my body that I understand other people" (Merleau-Ponty, 1962, p.186). He further noted that an understanding of our life world starts as an embodied experience. Thus, he maintains that emotions are essentially bodily, but without ignoring the phenomenology of emotion and by encompassing a phenomenology of the body and bodily movement.

4.2. The characteristics of the therapist

A number of reliable studies have concluded that certain commonalities and qualities of therapists are important in the therapeutic relationship. Norcross (2002) listed 11 elements within the framework of therapeutic relationships: the alliance, cohesion, empathy, goal consensus and collaboration, positive regard, congruence, feedback, repair of alliance ruptures, self-disclosure, countertransference (management of) and relational

interpretation. Although there is evidence that many of these measures overlap (Bachelor & Horvath, 1999), there are also important differences among them (Horvath & Bedi, 2002). This ecumenical status of the alliance makes it much more complicated to distill clinically useful guidance and training for the therapist (Horvath, 2004).

Luborsky et al. (1986) cited findings from the data of four major outcome studies and showed how the personal competencies of the therapist contribute more significantly to therapeutic outcomes than the treatment modality. From his findings, Strupp (1980) argued that a major factor distinguishing poor outcome cases from effective ones was the therapist's difficulty in establishing a good therapeutic relationship with the client. Strupp (1980) inferred that such difficulties for the therapist might emanate from a negative interaction cycle in which the therapist responds to the client's hostility with counter hostility. Grencavage and Norcross (1990) carried out a review of 50 articles and books for an investigation on common reasons that lead to therapeutic change. The authors cited the attributes of the therapist as one of four causal factors leading to therapeutic change.

Ackerman and Hilsenroth (2003) found that the therapist's personal attributes, such as benevolence, dependability, responsiveness, and experience assists patients with holistically trusting their therapist to both empathize with and help them manage the issues that are behind needing therapy. The researchers noted that a kind relationship between the patient and therapist assists in creating a cordial, accommodating, and supportive therapeutic environment that could add to therapeutic change. Saunders (1999) reported that clients rated sessions highly when they had a feeling of being understood by their therapist, when their therapist expressed her/himself effectively, and when their therapist was truthfully dedicated to the therapy. Saunders concluded that a therapeutic relationship encompasses both commitment of personal energy and attendant variables. Orlinsky and Howard (1986) had first introduced this theme by describing three dimensions in the therapeutic relationship: commitment, empathy and acceptance.

4.3. Therapeutic relationship and emotional experience

The question of what factors determine our emotional experience is vital in understanding the role of the therapeutic relationship. The concept of cognitive factors (especially appraisals) is of fundamental importance in determining emotional experience and is emphasized in appraisal theory. Thus, emotion is generated in response to perceived, remembered, or imagined events, and by automatic or controlled processing. In his theoretical advances on what constitutes an emotional experience, Parkinson (1994) revealed how emotional experience depends on four separate factors: appraisal of some external situation, reaction of the body, facial expression, and action tendencies. More specifically, cognitive appraisal of the situation affects bodily reactions, facial expression, and action tendencies, but equally having a direct effect on emotional experience.

Winnicott's (1963) concept of holding is the notion that at the beginning of life, the infant is in a state of absolute dependency on mother or the caregiver. The word 'holding' for Winnicott, is "relocating the arena of psychic life from the internal world of the individual into the environment" (1960, p. 43). The holding process is providing an as near as perfect adaptation to the infant's needs as possible in order to foster a continuity of being in his/her internal world that aids in the process of integration. This represents a "psychosomatic existence that is lived out and bestowed with meaning in inter-human relationships, be it from the viewpoint of the self or that of the individual's relationship to the environment" (Fulgencio, 2007, p. 450). For example, Bowlby's (1969) notion of attachment, as well as Stern's (1985), indicate that attachment develops out of the interplay in the optimal infant-mother relationship in the first year of life.

Stern's (1985) work outlined the importance of parents' representations and the relational constellations of attachment. His work also offers a closer examination of conscious and unconscious factors in their interaction with infants, and the way in which early experiences of attachment form relationship templates or blueprints. Leiper and

Casares (2000) took this concept further by describing these memories of past attachment experience (secure and insecure), as instrumental in fostering behaviour in interpersonal encounters through life.

The essence of appraisal theory by Lazarus (1982), that was a precursor to the development of further appraisal theories (Barrett in press), inspired a bold notion that "appraisals start the emotion process, initiating the physiological, expressive, behavioural and other changes that comprise the resultant emotional state" (Roseman & Smith, 2001, p. 7). Another important theoretical approach in appraisal theory is Smith and Kirby's (2001) framework, which emphasizes the processes involved and underlying mechanisms in producing appraisals. Under their theory, a variety of appraisal processes take place in parallel but initially there is an associative processing that entails activation of memories. This process takes place instantly and automatically, but lacks flexibility. Second, there is a process of thinking and reasoning that is slower and more flexible. Last, there is a continuous appraisal and monitoring of information coming from the associative and thinking processing. Thus, emotional states and experiences are determined by a total process of information registered by the appraisal detector (Smith & Kirby, 2001). Beck and Clark (1988) assumed that appraisal processes and in particular cognitive biases (e.g., attentional, interpretive, explicit memory, and implicit memory) enhances the vulnerability in developing depressive or anxiety disorders.

Another theoretical approach as to what constitutes an emotional experience within the therapeutic relationship is Alexander and French's (1946) understanding of the "corrective emotional experience." These scholars asserted the importance of the emotional experience as therapeutic action by indicating:

> *If the therapist knows what kind of problem is emerging into consciousness he will find it simple to elicit such reactions deliberately. He may, for example praise a patient for therapeutic progress in order to bring out a latent guilt feeling about receiving the father's approval. Or he may express approval of a friend of the patients in order to bring out latent jealousy.* (p. 83)

Corrective in this aspect relates to providing patients with a positive experience that is in contrast to what patients have come to expect. In other words, therapists provide their clients with deliberate provocations and consciously choose to respond in ways that contrast with the previous patterns by which clients have been emotionally treated in the past. Alexander and French argued that insight, interpretation in therapy was not enough, and that therapists should provide clients with an experience rather than an explanation. Problems in therapy, according to Knight (2005), are understood as a result of the therapist and client using the professional relationship for re-enacting, rather than resolving, the same conflict that the client has been struggling with in other personal relationships despite the fact that neither is aware of the re-enactment.

4.3.1. Meta-cognition and reflective functioning

Research conducted by Main (1991) put forward the idea that a critical aspect of children's development is the ability to develop metacognitions. The author defined meta-cognitions as 'the thoughts about thoughts' (p. 68) and a way of how the child interacts with his parents and resolves contradictions and incongruity. For Bowlby (1998) a communicational context whereby the different parenting styles shaped attachment and the child's affective communicational styles could be a highly damaging process. It is the nature of the attachment children form that has so many long term developmental consequences (Bowlby, 1969). In relation to chaotic or inconsistent care-taking, or if the child experiences the parent as inconsistent, Main (1991) proposed that older children are less likely to be affected by problematic attachment experiences as they have a greater capacity to formulate meta-cognitions. For instance, with a parent saying, "You are a bad child," an older child can use reason to digest it and think, "I may be a bad person because Mum seems to think so, but she might be wrong, as many times I saw that." Conversely, a younger child finds it harder to resist the parent's perception.

Fonagy, Leigh, and Steele (1996) supported the concept in which a child's internal working model encompasses an ability to engage in meta-cognition. In addition, these researchers noted that the ability to think about others' internal thoughts and feelings is an underpinning element of attachment processes; therefore, attachment patterns and reflective functions are directly linked.. Main (1991) also noted that the mother's capacity for reflection on the child's internal state is vital. Consistent with this notion is Bion's (1962) influential concept of 'containment'—the idea that, in understanding the child, the mother tries to understand both what has caused the child anxiety and also what the anxiety feels like. Furthermore, mother's ability to withstand this is also communicated.

Bion (1962) has suggested that the container and contained were linked in a way that was beneficial and promoted growth in both the infant and mother . In particular, Bion (1970) emphasized the types of links further as "symbiotic" and "parasitic" and says, "By 'symbiotic' I understand a relationship in which one depends on another to mutual advantage. By 'parasitic' I mean to represent a relationship in which one depends on another to produce a third, which is destructive to all three" (p. 95). The integrated nature of coping and understanding of what the child is feeling aligns with theory of mind work (Baron-Cohen, Tager-Flusberg, & Cohen, 1993), which argues that *mindblindness* is the inability to understand others as having perceptions, thoughts, and intentions, and to recognise that these can be different than our own. Children with autism have much more difficulty in making this judgment (Baron-Cohen & Goodhart, 1994).

In summary, meta-cognition abilities and reflective functioning are vital for our ability to change. The conceptual approach in reflective functioning raised by Fonagy et al. (1991) has important implications on how we understand mental activities. These activities include being able to reflect on our own thought, see contradictions in our perspectives, contemplate alternative views, identify the origins of our memories and beliefs, hold the view that there are multiple ways to interpret events, be mindful when

we may have become stuck, and recognise how others can impact the way we perceive things.

4.4. The transpersonal relationship

In a pivotal book, *The Transpersonal Relationship in Psychotherapy,* Clarkson (2002) instigated a new perspective in the field of therapeutic relationships, transcendence, which is a spiritual human reality that had hitherto mainly been studied through motivational aspects, that is, the experiential process (Assagioli, 1991b; Maslow, 1993) and states of consciousness, that is, the perceptive content of reality (Grof, 2000).The spiritual meaning of existence comes through from self-actualization (Maslow, 1993), 'transcendent actualization' (Hamel, Leclerc, & Lefrancois, 2003), and 'ecological actualization' (Reason, 2002).

Transpersonal experiences are important because they can trigger engagement in life and deep questioning (Redfield, Murphy & Timbers, 2002), and this in turn can facilitate greater fulfilment of human potential. In addition to evoking existential questions, transpersonal experiences mean accessing an expanded view of self, others, and the world (Vaughan, 2002). Through transpersonal development humans can achieve an alternative conception of the self – beyond ego/identity (Rothberg, 2003) – that is linked to an ecological "field-like sense of self" (Fox, 1990, p. 69). Tarnas (2006, p. 491) reminds us that the intensenature of transpersonal experiences shows s that there are "many possible meanings, living within us in potential, moving through us, awaiting enactment"=.

Through transpersonal experiences human beings can evolve, what Loretta do Rozario (1997, p. 116) described as a "transcendent ecology of living." This is a viewpoint echoed by Clarkson (2002), who observed that there is a growing acknowledgement of the influences of healing qualities in therapeutic relationship that transcends the limits of our understanding. Clarkson (2002) asked the question "what is

the transpersonal?" grounding it in humans' quest for meaning and the existential task of "how to live in the face of death" (p. 3). Levin, cited in Zahi (2009), identified three main elements of the transpersonal discipline: the search for the meaning of life and life goals, belief in transcendental abilities for self-growth , and the development of inner personal resources..

Jung's work 'On the nature of the psyche' (cited in Hull, 1960, 2001) underpinned the appreciation of spiritual or transpersonal dimension as the most profound in human life. This implies much more than a traditional understanding of healing primarily in the sense of symptom reduction (although this may occur as a secondary benefit) in the therapy relationship. It opens the way to the acknowledgement of the fundamental meaning of the experience of otherness at all levels, which implies taking an I-Thou stance (Buber, 1958) toward the world. In other terms, it represents Buber's (1958) I-Thou relationship, which honours the simultaneous interconnectedness and separateness of the persons involved.

Palmer (1998) identified that *knowing* can occur through an "intuitive intelligence" (p. 173), which is then reflected through *being* via the different "qualities of consciousness" that are experienced. Vaughan (2002) characterized spiritual intelligence as "a capacity for a deep understanding of existential questions and insight into multiple levels of consciousness" (p. 19). Mayer (2000) enquired about the mental transformations necessary to think and tune in the spiritual sphere of human experiences. The difficulty with Mayer's (2000) enquiry is that spiritual/transpersonal experiences are not only about mental transformations, but they are also profound multisensory experiences that connect body, mind, and soul (Sommer, 2003). Orr (2001) argued that growth in EI contributes to spiritual development, as Hartsfield (2003) found a link between EI and spirituality.

Conversely, EI may be developed though mindfulness meditation, a practice aimed at the spiritual development of consciousness (Cherniss & Goleman, 2001).

Tischler, Biberman, and McKeage (2002) asserted that qualities, such as self-awareness, manifests in high EI and spiritually developed people. Among those qualities is the possibility that EI and spiritual intelligence (SI) share common factors (e.g., self-awareness). The authors also suggested a few models linking EI and spirituality, arguing that the links between EI and SI make it inappropriate to exclude either EI or SI from a review of newer forms of intelligence.

4.5. Professional development training, and supervision in therapy

Haynes, Corey, and Moulton (2003) interpreted clinical supervision as being a process under which continual observation and evaluation of the therapeutic process is conducted by an experienced, qualified professional who understands and is capable in the specific knowledge corpus and skills necessary for professional development. Brown and Miller (2002) highlighted the importance of intersubjective matrix through examination in the supervisory process.

The experiences of the supervisor support the therapist to observe parallel processes in the therapy and supervisory dyads. In intersubjective analysis, inspection of parallel processes in client-therapist and therapist-supervisor dyads is core to therapy supervision (Auerbach & Blatt, 2001). Client disclosures offer information on the therapist's functioning and reveal the client's transference issues as well as the countertransference responses of the clinician (Brown & Miller, 2002). Exploration of parallel processes identifies recurring patterns of behaviour that might reflect re-enactments of unresolved issues or themes that may inhibit the growth process (Brown & Miller, 2002). The work of Wheeler (1996) proposed a number of major criteria for supervision, such as reports of personal experience, theoretical essays, case studies, live recorded practical observations or role-playing, and the experiences of trainees regarding supervision.

Bernard and Goodyear (2004) have considered clinical supervision as an important way in which trainee therapists learn to become effective clinicians. Bambling, King, Rauer, Schweitzer, and Lambert (2006) investigated the effect of receiving a single supervisory session prior to beginning treatment and reported a significant effect on the working alliance in the first session, treatment retention and symptom reduction. Similarly Lyons and Woods (1991) reported a significant correlation between therapist training and experience with treatment effects that confirmed the importance of training and experience with an extensive rational-emotive therapy approach through a meta-analysis of 70 studies. In sum, there is a consensus across these studies supporting the importance of supervision in both hindering and facilitating therapists' work with clients (Lyons & Woods, 1991).

4.6. Emotion- Focused Therapy (EFT) and EI

It is clear from reviewing the extant literature that the primary emphasis in this thesis is on EI and the therapeutic relationship. It would be impractical for the purposes of the thesis and indeed counterproductive to insist that this review, on EI and therapeutic relationship, should encompass and integrate all psychotherapy approaches and treatment modalities. However, it is imperative to consider the conceptual overlap between EI and EFT as a useful corpus of knowledge and for any future research.

The following section briefly outlines some overlapping aspects shared by emotion-focused therapy (EFT) and EI and its potential integration in clinical training. EFT's roots are in the humanistic tradition and particularly in the research on emotions (Greenberg, 2011). In EFT the therapist focuses on painful and avoided emotions from the client (Timulak, 2014). Timulak and Pascual-Leone (2014) has commended how important the therapist's ability to attune with the client's subjective emotional processes and world of meaning is. The therapist's conveyance of empathy, calmness, connection, authenticity, security, and trust enables the client to transform the experience of past maladaptive

memories of emotions into a more positive re-experience within the therapeutic alliance (Spruil et al., 2004). A similar concept to the "corrective emotional experience'" of Alexander and French (1946). The therapist's attunement with the clients shared sense of emotional suffering, is crucial in the overall outcome of therapy (Kivlighan & Arthur 2000).

Taken together EFT experts (Paivio & Laurent 2001; Greenberg & Elliott 1997) have identified a set of specific interrelated functions of empathic responses. Firstly, the development of empathic response fosters an advance ability of awareness which assists clients to perceive, appraise and express the meaning of emotional experience. Secondly, the knowledge gained through empathic responses may function as an important foundation to manage emotions by moderating distress. For instance, a client's emotionally painful memory is re-experienced, the therapist attunes to the emerging narrative context via the appropriate empathic responses, which can alternate and transform an emotional experience (Timulak & Pascual-Leone, 2014).

Thirdly, when clients experience the therapist's empathic response interventions, it could help them to understand and analyse the meaning of feelings and to reflectively engage in their emotional experiences (Paivio, 2013). A related conceptualization of understanding mental states such as empathic response and emotional processing was offered under separate literature, based on the field of emotions and cognition as part of an individual's emotional intelligence (Mayer & Salovey, 1997). The Mayer and Salovey (1997) model of EI encompasses 4 relational competencies or "dimensions" between therapist and client: (1) the perceiving, appraising and expressing of emotion, (2) emotional facilitating of thinking, (3) understanding, analysing, and employment of emotional knowledge, (4) and lastly, reflective regulation of emotions in order to promote further intellectual and emotional growth.

Taken together the four dimensions of EI, an empathic response is to some extent a conceptual overlap with the first two branches of EI above, since an empathic response entails the ability to identify the other person's physical state, feelings and thoughts and to prioritize feelings as aids to judgement. The second function of managing emotions, refers to the third and fourth dimensions of EI as an ability to see relationships among feelings, thoughts and behaviours, then reflectively engage, monitor, and interpret an appropriate meaning. From the EFT perspective, Paivio (2013) advocates that any therapeutic change is a process of two main mechanisms, namely emotional processing and therapeutic relationship. The emotion theory posits that emotions are meaningful information such as beliefs, feelings, wishes, and bodily experiences (Paivio, 2013). The therapists need to trigger or emotionally activate their clients' painful memory via the appropriate empathic responses (Greenberg & Golman, 2007). Similarly, researchers have examined the potential value of EI in therapeutic settings (Kaplowitz, Safran & Muran, 2011; Poullis, 2007). Unfortunately the research examining EFT and its link to EI within therapeutic and clinical settings does not exist. Although Kaplowitz et al. (2011) elucidated the overlap between EI and therapist-relational abilities, the study findings of Rieck and Callahan (2013) adds to the need for more research by citing that better therapeutic outcomes can be encouraged when trainee clinicians score higher on both neuroticism and EI.

EFT perspective (Greenberg & Pascual-Leone, 2006) have emphasized emotional change processing, which encompass reflective strategies for self-awareness, understanding and regulating emotions and emotional states. Thus the primary focus is on emotions and how to experience a new level of emotions in order to re-experience and change dysfunctional emotional meaning. Despite all the importance of EFT experiential interventions and empathic response, there has not been any substantive discussion about the contribution of EI and the cognitive and affective processes as an interdependent

system (Hodgson & Wertheim, 2007). Within the understanding and investigation of emotions, the most prominent components are cognitive empathy and affective empathy (Pizarro & Salovey, 2002). According to Duan and Hill (1996) the affective component is rooted in the emotions of an individual at the "here and now" moments of experience, whilst the cognitive part originates in the intellectual understanding of such an experience. There is a fundamental assumption that these two parts of empathy, cognitive and affective, contribute to an interdependent system of cognitive-affective processes (Hodgson & Wertheim, 2007).

Psychological intervention in therapy is an ongoing goal for treatment and an adaptation of scientific therapeutic evidence in therapeutic approach and clinical practice (Hens & Goroshit, 2011; Spruil et al., 2004). There is a broad agreement amongst researchers in therapy that learning should encompass experiential, didactic and mentoring experiences. Training approaches requires emotional competencies (Hens & Goroshit, 2011) and an understanding of an ongoing process (Stein & Lambert, 1995) of maintaining an effective therapeutic alliance that depends largely upon the therapist's interpersonal and communication skills (Spruil et al., 2004).

4.7. Summary

This literature review succeeded in reviewing literature relevant to the therapeutic relationship and EI. After reviewing the various contributions from seminal researchers and theorists, such as Norcross (2002), Luborsky et al., (1986), Grencavage and Norcross (1990) is evidently that developing therapeutic common factors can facilitate a positive change in therapeutic alliance and outcomes. Previous work as depicted in the work of Goleman (1995), Bar-On (1997), Petrides and Furnham (2001), Petrides et al. (2007), Ciarocchi et al. (2000), and the numerous other theories developed in association with this research topic, accentuated that there are some considerable gaps in the current research literature concerning the therapists interpersonal competencies, common factors,

and the role of emotional intelligence within of the therapeutic relationship. Some contributions, such as Ciarocchi et al. (2000), provided only a superficial assessment and analysis of this link and its potential impact on the individual.

This review then underscores the significance of carrying out a research study aimed at analysing and determining the existence and importance of this relationship. Furthermore, the chapter covered reviews of research studies on the therapeutic relationship, emotions, and intelligence traits. These reinforced the significance of this research, concerning the therapeutic relationship on the basis of a deficiency of studies in this area. Finally, the author also recommends that any future direction in EI and therapeutic relationship, need to integrate evidence-based therapeutic approaches and particularly experiential therapy. EI and emotion-focused therapy (EFT) have certain similarities in that both use emotion as a primary source of information and construction of meaning. As Paivio (2013) evocatively suggests, "EFT posits the therapeutic relationship and emotional processing as the two primary mechanisms of change" (p. 342).

4.8. Limitations

One of the key problems with encompassing an overview of therapeutic approaches and commonalities in relation to EI is failing to consider all possible issues or research that could be related to this association. It is important to keep in mind that the aim of this study is on EI and its links to therapeutic relationship. The literature reviewed in this chapter, therefore, focuses on EI and the therapeutic relationship and not on therapeutic approaches such as emotion-focused therapy and commonalities with EI. While the literature review can be viewed as exhaustive, it is practically impossible to embrace every source of related research into the study. It should also be kept in mind that new studies may have emerged while the given paper is being written, which makes it hardly attainable to make the literature study fully complete.

Chapter Five

5. Methodology

This aim of this chapter is to discuss the methodology employed in this research and describe how it steered data collection, analysis and theory development. Different methods of data collection related to grounded theory are first discussed in order to explore the reasons for choosing particular methods over others. Following this, the details of the chosen research methods are provided, and the limitations and ethical considerations regarding this project are outlined. This research has been undertaken in order to understand the possible role that emotional intelligence (EI) plays in the therapeutic relationship. The chapter ends with an explication of the approach taken for analysing the empirical data.

5.1. An overview to grounded theory methodology

In their book *Discovery of Grounded Theory*, Glaser and Strauss (1967) accentuated that graduate students of social sciences at the time were generally being trained on a positivist paradigm to develop a hypothesis and follow a systematic process to gather evidence to prove, or disprove, that hypothesis. This framework, however, fails to recognise the multifaceted, complex nature of social life. Glaser and Strauss (1967) crafted a method that aims to bridge this gap between theory and research and in turn, improves social researchers' capacity for generating theory. Grounded theory is a methodology that rather than using data to test theory, uses it to develop theory on issues affecting people's lives in the social world (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1998). Charmaz (1983) argued that in developing theory through 'grounding' it in data, Glaser and Strauss managed to bridge the gap between theoretically 'uninformed' empirical research and empirically 'uninformed' theory. The main distinguishing feature of grounded theory when compared to other qualitative methods is

its systematic way of theory building, whereas the researcher does not begin with a hypothesis but looks within the emerging observations in data to generate theory (Morrow, 2005). Theory emerges in the course of the research process being a "product of continuous inter-play between analysis and data collection" (Goulding, 2002, p. 42). This process is of data collection is often characterised as inductive (Morse, 2001), in so far as the researcher does not hold preconceived ideas to support or reject. Particularly, Glaser and Strauss (1967) developed grounded theory as a method combining two distinct processes of data analysis. Firstly, all data is coded and systematically analysed seeking clarification of how valid a certain proposition is. Subsequently, the researcher then inspects the data properties of categories, using the facilitation of memos in tracking the inductive analysis and develops theoretical ideas via the method of constant comparison. The data analysis processes eventually progresses to into emergent theory because of its relevance "through the comparisons between their interpretations translated into codes and categories to generate concepts, categories, and their variations" (Strauss & Corbin, 1998, p. 52).

5.1.1. Different grounded theory approaches

Although Glaser and Strauss (1967) were offering guidelines for generating theory by challenging the then dominant position of positivism, the scholars were not dogmatic in their approach, on the contrary, they anticipated that other researchers would come forward with their own methodology, as they reported: "Our principal aim is to stimulate other theorists to codify and publish their own methods for generating theory" (p. 8). Despite their advocated claims of grounded theory as a pluralistic method, the two scholars went their separate ways and produced their own set of specifics to how a grounded theory was to be conducted and debated over whose version was more valid. In the end, the once combined grounded theory method has now become the Straussian or

the Glaserian models of grounded theory (Stern, 1994). The differences of these two

approached are depicted in Table 2.

'Glaserian'	'Straussian'
Starts from a state of general wonderment (a clear mind)	Researcher has a general idea of where to start
Theory emerges, uses neutral questions	Forces the theory, with structured questions
A conceptual theory is developed	Conceptual description (describing situations)
Theoretical sensitivity (being able to perceive variables and relationships) achieved through immersion in the data	Theoretical sensitivity derived from methods and tools
Theory is grounded in the data	The theory is interpreted by the researcher
The basis of the theory's credibility, or its verification is its being grounded in the data	The basis of the theory's credibility is the rigorous methodology
A basic social process is first identified	Basic social process(es) need to be identified
The researcher's role is passive, and exhibits disciplined restraint	The researcher's role is active
Data reveals the theory	Data is structured to reveal the theory
Less rigor is applied to the coding, a continual comparison of incident with incident, with neutral questions and where categories and properties evolve. Take Care is taken to not 'over-conceptualise', key points are identified	Greater rigor is applied to the coding and is defined by technique. Type of comparisons vary according to the precise technique used. Labels are devised contemporaneously. Codes are derived from "micro-analysis which consists of analysis data word-by-word"
Dual coding phases or types, simple (fracture the data then group it conceptually) and substantive (open or selective, producing categories and properties)	Three types of coding, open (identifying, naming, categorising and describing phenomena), axial (the process of relating codes to each other) and selective (identifying a core category and relating other categories to it)
Considered by some as the one and only 'true' Grounded Theory Methodology	Considered by some to be a form of qualitative data analysis (QDA)

Table 2: Comparisons of the two schools of Grounded Theory (adapted from Onions 2006)

More recently, the grounded theory method had been further developed by Kathy

Charmaz. In 2007, this researcher claimed that it is important to distinguish between a

social constructionist and objectivist approach to grounded theory, as it provides a

heuristic means by which grounded theory can be understood and enables the social

constructionist view of grounded theory to be further clarified. Charmaz (2000)

postulated that both Glaser's and Strauss and Corbin's approaches to grounded theory is

based on an assumption of an objective external reality and so actually takes a positivist and objectivist perspective.

Gaining an understanding of both constructivist and objectivist ideas of grounded theory enables researchers to clarify and discern their own assumptions and knowledge prior to the research. Constructionism therefore relates to: the reflexivity of the researcher; the relativity of the researcher's ideas, practice and research circumstances; and the way social constructions are viewed. Charmaz (2007) believed action to be a primary focus of social construction, as it cannot be separated from the context or from socially embedded and created situations and structures. Constructionists, therefore, ask the what and the how questions, and do so through studying "abstract understanding of empirical phenomena and contend that this understanding must be located in the studied specific circumstances of the research process" (Charmaz, 2007, p. 398).

On the other hand, objectivist grounded theory (as discussed and expounded by Glaser, 1998) has origins in mid-20th century positivism, and caters to the 'why' questions of research. Generalised explanations, predictions and recommendations are explored as answers to specific research phenomena and circumstances. Glaser (2002) firmly rejects constructivism, arguing that the approach is prone to 'descriptive capture' (which aims to accurately describe the data instead of transcending abstractions), and does not eliminate 'researcher bias' in the way it privileges of the researcher's active interpretive role.

Grounded theory is a method that, Charmaz (2007) argued, is fitting for a social constructionist research approach, as it not only asks the 'what' and 'how' of social constructions, but also asks 'why' questions, which characterize more positivistic research enquiries. It uses inductive methods where theory is grounded in qualitative data but this does not claim that the theory is beyond question; instead the theory comprises a series of integrated hypotheses. Instead of being the last work on the topic at hand it is

just one step closer to full understanding. Grounded theory is therefore both a research method, and a means by which data can be analyzed. It starts by utilizing various strategies and methods by which qualitative data can be both collected and analyzed in order to produce theories, enabling the complex 'why' questions to be brought in and answered using this method (Charmaz, 2007).

Objectivist grounded theory and social constructionist grounded theory are not paradigms that are mutually exclusive; rather, social constructionists can gain abstract understandings and views of specific phenomena and can then (in the vein of objectivist grounded theory) move towards a more general, conceptual understanding and application. In fact, Charmaz (2007, p. 400) argued that "the close attention that social constructionist grounded theorists give their research problems builds the foundations for generic statements that they qualify according to particular temporal, social and situational conditions." Thus, grounded theory, within the social constructionist paradigm, can be influenced by objectivist ideas so as to ensure that all bases are covered, and the who, what, how and why questions can all be answered, so as to provide a much rounder, deeper analysis of a phenomenon (Morse, 2001; Stern & Corbin, 2008). Charmaz (2006, p. 402), however, claimed that grounded theory strategies are just that: "strategies for creating and interrogating our data, not routes to knowing an objective external reality."

Grounded theory from the objectivist viewpoint assumes that a single reality can be discovered by a "passive, neutral observer...through value-free enquiry" (Charmaz, 2007, p. 402). Thus, if one makes assumptions about objectivity and neutrality in order to make the data collection, selection and analysis processes unproblematic and straightforward, they become givens, as opposed to constructions that take place and form during the research process itself. They also shape its outcomes, and a "naive empiricism results" (Charmaz, 2007, p. 402). Clarke (2006) concurred with this argument, stating

that objectivists claim that data are self-explicit and evident, and the possibility that the data are duplicated, limited, partial or missing is overlooked.

Glaser (2001) maintained that objectivists attempt to generalize via abstractions, which distinguishes and separates grounded theory from the conditions of the data collection and analysis processes. Yet, the more abstraction there is, the more the research is decontextualized (Charmaz, 2007, p. 402). Glaser (1978) reported that objectivists desire to ascertain generalizations in order to reach explanations and predictions, and that the whole and completed grounded theory aims for fit, work, relevance and modifiability. Glaser (2002) rightly indicated that ground theory is about a conceptualisation of latent patterns rather than explicit patterns. By contrast, Charmaz (2006, p. 403) stated that, from her perspective, "reality is multiple, processual, and constructed - but constructed under particular conditions."

Seeing the ambiguity surrounding grounded theory methods in the literature review, I felt more dejected than inspired and developed the view that the procedures were needlessly cumbersome. Whilst both objectivist and constructionist approaches are used in the implementation of grounded theory method, the former urges researchers to actively analyze their data. Constructionist approaches to grounded theory urge reflexivity and relativity when analyzing data, to better understand the researcher's position and impact on the data gathered, and to assess how the participants of the research construct their lives (Charmaz, 2006; 2007). Nevertheless, I reached a conclusion.

In this study, I adopt a pluralist approach to grounded theory, mainly supported on the ideas developed by Glaser and Strauss (1967) and the rudiments of a concept-indicator model as captured by both Glaser (1978) and Strauss (1987). In particular, I adhere to Glaser and Strauss (1967) guidelines to codify a method for generating theory and do not engage in a degree of intellectual submission, at the expense of research needs

and creativity. Indeed, Strauss (1987) advised researchers to adopt the principles of grounded theory, but at the same time, modify them in accordance with the non-bias requirements of one's own research. However, I am cognizant of the fact that the pluralistic character of grounded theory is not a license to researchers to do whatever they wish and then label it grounded theory. I believe that the pluralistic nature of the methodology allows flexibility on procedures and techniques but the principles of the approach are crucial. Strauss and Corbin (1998, p. 295) recommended to "stay within the general guidelines outlined in Basics of Qualitative Research and use the procedures and techniques flexibly according to the students' abilities and the realities of their studies."

5.1.2. Researcher context

Glaser and Strauss (1967) advised when conducting grounded theory to encompass the researcher's personal experience into the methodology process. More specifically, Birks and Mills (2011) emphasized the importance of the researcher to position him/herself and acknowledge one's own assumptions, experience and knowledge at the onset of the study.

As a result, I, as the current researcher, position myself as follows. I am a chartered counselling psychologist in private practice and the National Health Service (NHS) for ten years. I have a special interest in individual psychotherapy for adolescents and adults, especially in cognitive analytic therapy. This approach assists me with helping clients to explore their emotional discomfort and challenges in their lives. Based on my background, I believe I can provide a new perspective regarding the therapeutic relationship process and offer new clinical training possibilities. My previous research background (Poullis 2007; Maria, Mavroveli & Poullis, 2013) provides me with the opportunity to integrate my reflective practice experiences, thoughts, knowledge, and clinical challenges. The research I conducted enabled me to obtain Chartered status in

Counselling Psychology and a post-MA in counselling psychology, a Masters in Psychology of Education and a Masters in Counselling Psychology.

Corbin and Strauss (2008) noted that when a researcher relates and shares a similar culture as the interviewees, it will assist the process since it will be common elements to draw upon their own experiences. In this research study, my prior experience will serve as a benefit to the interviewees, but I cannot be free of values or prior knowledge and paradigmatic allegiances. I also believe that such prior knowledge can be used to review the literature and identify the existing gaps in knowledge, as well as provide a perspective and rationale for the research being proposed.

5.2. Rationale for adopting a grounded theory method

I chose a grounded theory approach because it is the most appropriate method for the current study and concepts of interest. Grounded theory is an effective investigative strategy to analyse EI and its link to therapeutic relationships since there is relatively little existing research exploring this connection, creating a paucity of knowledge (Payne, 2007; McCann & Clark, 2003a). This current research attempts to interpret therapists' trait EI and its link to the therapeutic relationship (i.e., interpersonal competencies) that could inform counselling psychology and therapeutic training programs. I chose to stay out of futile debates about subjectivity *versus* objectivity paradigm debates and I support Patton's (1990) notion and discussion on "empathetic neutrality" and the importance of a researcher being non-judgmental, and striving to report what is discovered in a balanced way.

On these grounds, I accept that knowledge is not static but dynamic, and is interpreted by both the researcher and participant in their dialogue. Thus, meaning is conveyed through dialogue and action in which encompasses the understanding and meaning of our experience. Subsequently, this study adopts Strauss and Corbin's (1990) notion of "evolved grounded theory," which emphasizes the co-construction of meaning

between researcher and participant and requires the researcher to employ the following: theoretical sensitivity, theoretical sampling, constant comparative methodology, coding, data verification, identifying core categories, memoing, diagramming and rigorous research (McCann & Clark, 2003b). Whereas credibility in quantitative research rests on its objectivity, for qualitative research, "the researcher is the instrument" (Patton, 2001, p. 14). Accepting the necessity of abstraction when conceptualizing theory, I have embraced the tension between Patton's (2002) notion of 'embracing-subjectivity' (i.e., a researcher together with the participant are active agents in the construction of meaning (Rennie, 1994)); and understanding participants constructions of meaning, including therapeutic practice preconceptions, context, culture, rapport, intentions, motivations, which are all subsumed under Lincoln and Cuba's (1986) criteria of 'authenticity'.

As a therapist and researcher, I am aware of allegiance-induced distortions and researcher allegiance, which can possibly contaminate data (Luborsky et al., 1999). In my role in practice and in research, I acknowledge the benefits of subjectivity and value the meaningful purpose and adoption of reflexivity to manage biases. Thus, a balance between the researcher and participant was achieved by engaging in a reflexive process, including "bracketing" biases in advance and using self-reflective journalism (Morrow, 2005) as well as having an external auditor to ensure trustworthiness (Hill et al., 2005).

On top of these processes, it is regularly suggested by several renowned grounded theorists to avoid a literature review at the beginning of a study in order to permit categories to emerge unprompted from the empirical data during analysis (Stern, 2007; Glaser, 1998). For postmodern epistemology (Kvale, 1992, Polkinghorne, 1983), however, it is important to acknowledge one's own assumptions, experience and knowledge from the outset and position yourself as the researcher (Birks and Mills, 2011). Subsequently, this created a practical conundrum whilst preparing for the design of this study. I am aware of my previous knowledge and substantial review in literature, due to

my previous involvement in the domain of EI and therapy (Poullis, 2007). Moreover, as part of my current study as a doctoral candidate, there is a prior proposal to the ethics and admissions office which describes the research question and clarifies the importance to the field via a thorough literature review. That publication detailed what the current study will add to the existing research and how the EI in the therapeutic relationship is largely absent, and in which I expressed the hope to inspire and provide new ground in research. Therefore, thinking pragmatically, the notion of delaying a literature review until data collection and analysis was not possible.

A grounded theory approach was deemed appropriate for this study for a number of reasons. Firstly, many of the familiar therapeutic encounter competencies (assessments, exploring, bottom-up processing, empathy, reflexive or intuitive interpretations and analysis thinking) are similar to grounded theory and directly transferable to the research domain (Luca, 2009). Grounded theory may then be best suited for understanding phenomenon in psychotherapy and counselling fields, dependent on the results gained (Charmaz, 2006). The research aim was not limited to predetermined hypotheses or quantifiable variables but was seeking to explore qualified therapists' beliefs, experiences and perceptions in great depth. This aim is similar to the therapeutic work of broadening the understanding of clients' worlds and challenging their assumptions and beliefs regarding therapy (Cooper, 2004).

Secondly, there was no clear hypothesis arising from current knowledge which could be tested and provide answers to the research questions. In grounded theory, themes emerge from the data rather than have them imposed on the participants by a researcher (Layder, 1993). Therefore, this appears to be an appropriate method for exploring therapists' subjective experience, meanings and processes pertaining to EI and therapy.

Thirdly, the types of research questions that grounded theory methodology

address are frequently open-ended and exploratory in nature and aim to generate hypotheses instead of testing them. The open-ended research question of this study was based on the primary researchers own observations in clinical and previous research experience (Poullis, 2007). This approach was selected because it is flexible and enables the researcher to respond to findings as they emerge.

5.3. Research design

The purpose of this study is to understand, analyze and interpret participants' experiences, feelings, and perception of the therapeutic relationship and its links to both EI concept and TEIQue as a trait EI measurement. Grounded theory is founded on the principle that conclusions and questions are derived not solely from the data collected but also through the techniques used to collect and analyse the data and the interpretation placed upon it by the researcher, as well as the wider social context, including social relationships and our historical and cultural 'being' in the world. Thus, a researcher must have reflexivity, meaning, "a mind that is sufficiently open to allow new and perhaps contradictory findings to originate from the participants data" (Madill et al., 2000, p. 74). It is also important to note that the richness of the descriptions produced are aspects that many phenomenological researchers assert are at the heart of any investigative research.

Qualitative research determines that the world is too chaotic to be represented and understood in straightforward, unambiguous cause and effect terms. The flexibility in methodology and creativity is of paramount importance to keep ourselves open to unfolding encounters during the process of data collection. As Braud and Anderson playfully suggested, "We need an imaginative, even outlandish, science to envision the potential of human experience … not just tidy reports." (1998, p. 24).

The researcher is acknowledging in the research design, one's own assumptions, experience and knowledge from the outset, thus, understanding psychological phenomena necessarily demands awareness of the evaluative background (Mills et al., 2006). The

researcher also acknowledges how consciousness may not simply be held in abeyance and that it poses particular methodological challenges. I support Blumer's (1969) perspective in which this researcher cautioned, "research scholars, like human beings in general, are slaves to their own pre-established images" (Blumer, 1969, as cited in Mills et al., 2006, p. 10). I also favour Murdoch's statement, "Man is a creature who makes pictures of himself and then comes to resemble the picture" (1997b, p. 75). I recognise the significance of a researcher's presuppositions and that these can both hinder and enhance the interpretation of another's lived experience, referred to as a double hermeneutic: "The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith and Osborn, 2008, p. 53)

Central to this research design is the process of reflexivity, defined by Robson (2002) as "an awareness of the ways in which the researcher as an individual with a particular social identity and background has an impact on the research process" (p. 22). Reflexivity can be described as an awareness activity evolving from one's own pre-reflective to reflective to meta-reflective knowledge, such as my engagement with prior research and practice in therapeutic relationships. To aid the reflexivity of this study, the design of this research will incorporate auditability criteria, such as audit trails in the form of memos and outlines of my personal beliefs, values and assumptions.

Reflective memo writing in grounded theory makes clear the multiplicity of influences in the reconstruction of theory. Del Barrio (1999) indicated that qualitative research usually consists of non-structural procedures from observations to interviews, from self-reports to written narratives, and focuses the study within the situation or of the individual. In this design, the gathering of information and data are open-ended, and the emphasis on interpreting the results is on understanding as opposed to judging.

I am mindful with managing my subjective knowledge of EI in interpretations and

analysis, as well as equally mindful with preserving my creativity without divorcing myself from the research process. As a researcher I acknowledge my subjectivity and the notion that I have conceptions that may be unconscious and subsequently difficult for my intentional minds. I am also aware of the risk of losing the rich and meaningful generation of data by bracketing preconceptions. As a researcher I believe Patton's (1990) notion and discussion on "empathetic neutrality" and I support an open and meta-cognitive attitude (Semerari et al., 2003) to knowledge that will allow the participants knowledge to meet with my own.

5.3.1. Sample

Sample selection in qualitative research plays a vital role in determining a study's ultimate quality (Morse, 1991). A lack of clear sampling guidelines can affect sample representativeness as well as bias results. The qualitative principles require purposeful sampling with participants that are able to "articulate, reflective, and willing to share with the interviewer" (Morse, p.127). Thus, having such guidelines, that is selective sampling, is similar to Patton's (1990) notion of information-rich cases and description of purposeful sampling. Glaser (1978) suggested that knowing how to begin the initial sampling is the first stage of data collection. Glaser advised researchers to have an idea of where to sample but not what to sample for, and where it will lead. In particular, he noted that experienced researchers will conduct the following:

> "Go to the groups which they believe will maximize the possibilities of obtaining data and leads for more data on their question. They will also begin by talking to the most knowledgeable people to get a line on relevancies and leads to track down more data and where and how to locate oneself for a rich supply of data" (Glaser, 1978, p. 45).

It seems clear from the above discussions that theoretical sampling does involve the purposive selecting of a sample at the early stages of research. Subsequently, that process initiates the theoretical sampling because it is controlled or dictated by the

developing categories. Following the guidelines of the above sampling review, this study adopts selective sampling at the initial stages followed by theoretical sampling as a variant within purposeful sampling.

The participants chosen for this study are all registered therapists practicing in the United Kingdom. The 12 participants were selected through purposive sampling, wherein individuals and settings were identified that were deemed as being most likely to offer valid material for analysis. The process of sampling carried on up to the point that no new information was being derived from the data. The information included theoretical ideas and additional properties of the categories (Charmaz, 2006). It was found that for interview participants 11 and 12 no original information or questions had emerged from the data and so here it was considered that the point of theory saturation had been attained. As a consequence no additional interviews were conducted.

A number of experienced and qualified therapists responded to an advertisement placed in the British Psychological Magazine (BPS) of the British Psychology Society, and were invited to participate in this study. The therapists were offered the hourly rate at which they would usually charge clients for their time, as an added incentive to participate in the study. The invitation to participate in this study can be found in Appendix 3a and 3b.

The criteria for participant inclusion for this study was that the participant must be an experienced therapist (more than three years practicing after qualified), must be a practicing therapist, must be willing and able to discuss their therapeutic experiences, and must be willing to take a test on trait EI. The advertisement in the BPS generated 19 therapists' requests of willingness to participate. After reviewing their biographies and therapeutic experience, a selection was made based on theoretical saturation of 7 males and 5 female therapists of varying age ranges. Following the ethical principles of research with human subjects as outlined by the British Psychological Society and City University,

study participants were assured that their details and identities would be kept confidential at all times.

5.3.2. Data collection

To allow for individual variation, this study utilized open-ended interviews with a guide of questions or general topics that the interviewer wanted to explore. Interviews are considered a good method to explore participants' meaning and experience (Charmaz, 2006). The first two interviews were held during the same week with two therapists in London but in two separate locations at their practicing address. Based on the recommendation from Hill et al. (2005), the interview questions (presented in Appendix 5a) and the results from their Trait EI scoring (Appendix 6) were provided in advance to encourage thoughtfulness and recollection of a significant case or cases. These initial interviews lasted in duration from 63 to 78 minutes, both generating vital data and information. All the data were essentially important to the research question and all the information from the interviews was used in the study.

The research interview is a form of human interaction in which knowledge and understanding evolves through a conversation (Kvale, 1996). The first two participants were each asked the same set of open-ended questions and were allowed time to pause and focus. The interviews were recorded and some notes were scribed after the interviews, which included subjects' body language that could convey some intended meaning. For instance, the first participant, who was responding to her experience of trait EI, reported:

> *"It was (laughter) that I can't remember what it said on the end something about I might not tell the truth or something like that…I can't remember. I did sort of think oh woo yeah err maybe I shouldn't be doing this job (laughs)…I just thought god nobody would have wanted to have these scores not in my job you know."*

During this participant's statement, I had noticed that not only was she laughing during this report, she was also blushing and her voice fainted. I interpreted this to mean that she was anxious and offended with the trait EI scoring, especially after considering that she did not laugh or blush when answering other questions. Through my memo (Appendix 7a), I realised that I too could be guilty of causing that discomfort when the participant was reading the interpretation of her trait EI. I found that I needed to examine my ways of conveying a question and whether I was biased in my interview. I reflected on whether I viewed the interviewee as part of the process and therefore, as evidence rather than as people. I also wondered if that could make participants defensive and less open to sharing their true experiences, which alerted me to the notion of power in the relationship between interviewer and interviewee, and to become more sensitive and consider my scientific and ethical balances. I became even more self-aware of similar notations through all the interviews and responded accordingly to the anxiety of participants over their trait EI scoring. I then reflected on and adopted more closely Kvale's (1996) suggestion for a good qualitative researcher:

- Knowledgeable: possesses deep knowledge of the interview's theme(s) but resists the temptation to 'show off' this knowledge.
- Structuring: Sets out the interview's purpose, outlines in passing and draws the interview to a close in a structured way.
- Clear: Poses short, simple questions with clarity.
- Gentle: Permits participants to complete what they want to say, etc.
- Sensitive: Adopts active listening, tries to grasp the detailed nuances.
- Open: Distinguishes those aspects of the interview topic which are of greater importance for the participant.
- Steering: maintains continual awareness of what they want to know more about.
- Critical: Resists taking everything at face value, instead always tests the validity and reliability of the participant's statements.
- Remembering: Retains earlier statements in mind and where appropriate subsequently asks for elaboration.
- Interpreting: Always manages to clarify and extend the meanings of the interviewee's statements that can then be confirmed or disconfirmed by the participant. (Kyale, 1996, pp. 148–149)

After I completed and transcribed the first two interviews, I then proceeded with the other interviews. The rest of the interviews ranged in duration between 44-65 minutes. Glaser and Strauss (1967) noted that it is a normal process that the rest of the interviews that follow to run with less time. The interviews were conducted at the participants' convenience, usually in a quiet place of their choice (e.g., their therapy rooms provided a useful setting as it enabled the participant to reflect about their practice much more authentically and automatically).

In the words of Corbin and Strauss (2008), grounded theory's purpose is to "build rather than test theory" and to "identify, develop, and relate the concepts that are the building blocks of theory" (p. 13). In this study, by using a grounded theory method, the researcher asked open-ended exploratory questions (refer to Appendix 5a) to explore the following:

- The therapeutic relationship and trait EI experiences (e.g., in your role as therapist, what is the meaning of the therapeutic relationship and experiences with clients?);
- The characteristics of therapists (e.g., based on your own experience as a therapist, what are the qualities that you perceive as important in a therapeutic relationship?);
- The therapeutic relationship via their role and experience as a therapist (e.g., can you recall any experiences with clients who brought into the session a very emotionally charged-session and how was that experience?);
- Important themes that emerged in terms of relating and responding to such emotional experiences in therapy (e.g., how did they experience the theme, how did they feel, how did they cope?);
- The therapist's understanding and perception of EI (e.g., in your role as a therapist, are you familiar with the psychological concept of EI?);
- And the therapists own experience completing and reading the trait EI interpretative scores and meaning.

The open-ended questions were based on the primary researcher's own observations as therapists and in his research life. It is important to mention that the

participant was given control over the direction that the interview took, enabling the participant to relax and focus on the subject areas in hand. In line with grounded theory, the conduct of the interview altered as fresh data threw up new areas exploration. The initial interviews were kept particularly unstructured. The therapists' responses would often lead to further topics for discussion and to ask subsequent interviewees.

5.4. Analytical strategy

The data for this study was collected and analysed in a standard grounded theory format, as illustrated in Table 4, highly adhering to Strauss and Corbin's (1998) coding processes stages:

1) Open coding (identify, name, describe, and categorize phenomena from texts)
2) Axial coding (interconnecting the categories- the process of relating codes to each other using deductive and inductive reasoning)
3) Selective coding (identifying one category as the core category and connecting each other category to it).

The data was dissembled, conceptualised and reassembled in fresh ways. I used the triadic coding scheme of open, axial and selective coding, however, I recognized the cyclical connection among the 3 phases and that the lines between these forms of coding are artificial, in the same way as the divide between data collection and analysis is. Grounded theory coding encompasses in vivo codes (e.g., focus on what is in the data), open codes (e.g., raise the conceptual level of data) and axial codes (e.g., focus on interconnections between open codes and selective codes). While it is important to accentuate that coding is a central aspect in the analysis, it is also important to note that analysis is not only coding as it also involves memoing. It must be acknowledged that in practice each of these elements of grounded theory analysis intersect as the interpretation progresses.

5.4.1. Data analysis

Following grounded theory design (Strauss & Corbin, 1990), the primary author kept a self-reflective journal, as well as analytic and theoretical memos (see Appendix 7a, 7b, 7c, 7d). I also made use of a colleague to audit my own subjectivities as a researcher and challenge data structure, processes and analysis. Figure 2 shows the cognitive map I have adopted in the research and the way raw data is to be analysed to generate themes, categories, substantive theory and formal theory. Data collection ceased when categories became saturated, new interviews offered up only redundant data, and patterns of clarity repeatedly emerged (Guba, 1978). The major categories and related content are all described in this analysis.
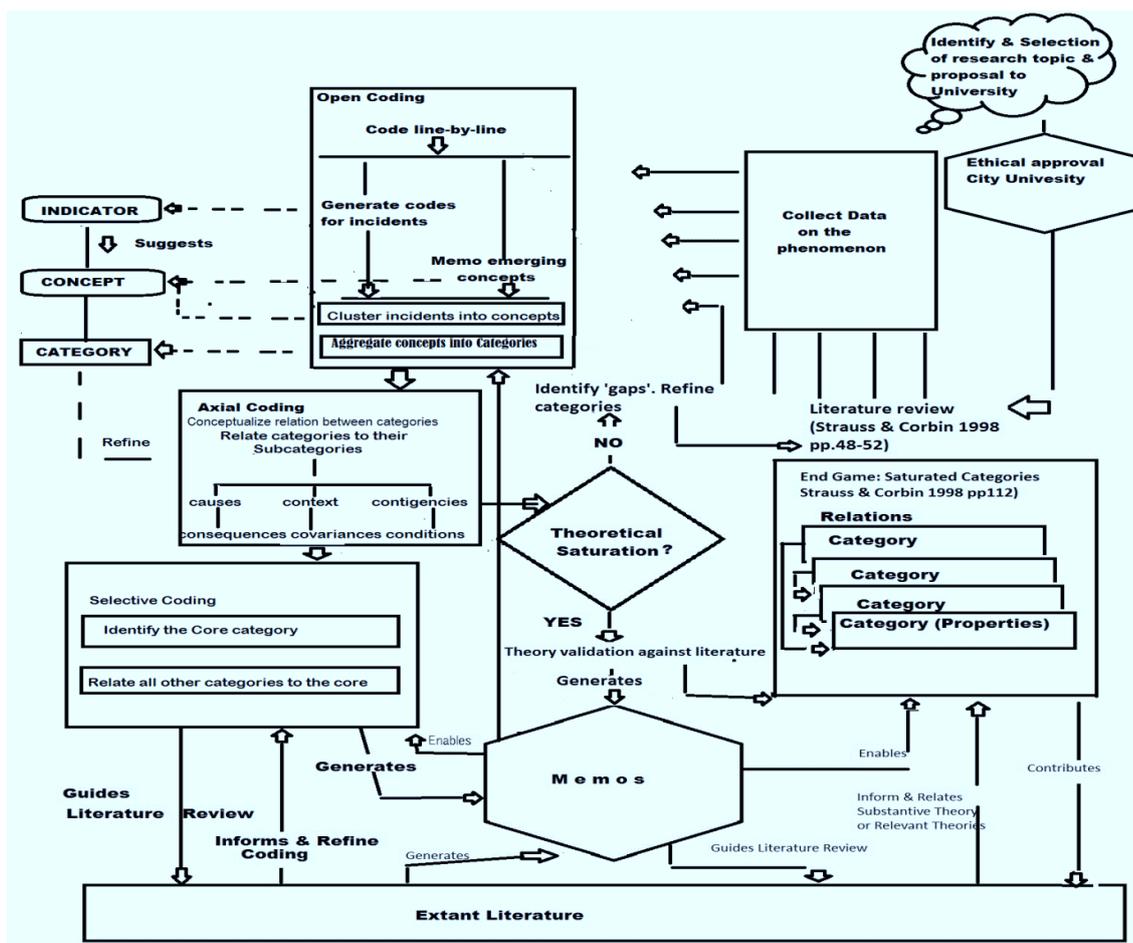
Figure 2: The grounded theory methodology cognitive map

The 12 interviews were analysed, applying the principles of grounded theory (Strauss and Corbin, 1990). The data collected were professionally transcribed, crosschecked with the audio recordings of each participant for word-for-word accuracy. The first read of the interviews was just to become well acquainted with the material. In grounded theory, data collection and analysis are not distinct stages. The analytical process involves opening up the interview transcriptions to reveal the ideas, thoughts, and meanings found therein and forming incidents of which are labelled to generate concepts. Applying grounded theory to datasets is a heuristic (i.e., a method of discovery), as well as subjective journey. For the purposes of this study, as illustrated in Appendix 9a, 9b, 9c, a lengthy process of coding, categorization, and concept formulation was conducted, which was broadly similar to the general principles of grounded theory.

The first reading of the participants' transcriptions was a process of reading and making notes, which resembled effectively unfocused thoughts and associations. During a second reading of the data, the transcriptions were analysed line-by-line, and words or sentences where underlined for emphasis or indicate initial codes. Line-by-line coding kept the process in this study from 'going narrative', or from becoming so immersed in participants' worldviews that could endanger the analytical and critical focus of the study. Line by line initial coding was instigated, maintaining closeness to the words of the participant. As this process continued, I wrote theory memos to record how the concepts, categories and dimensions developed. The data collection and line-by-line coding transformed the process to identifying meaningful data through reading and moving towards abstracting a more focused coding. The second reading followed a similar pattern of line-by-line-coding, but became less open-ended and more directed. I summarised this information and labelled it in the left-hand margin (Charmaz, 2006). As additional data were collected, further focus codes were created and existing codes were elaborated and amended (Pidgeon & Henwood, 1996).

The next stage of the analysis involved working back through the transcript, line by line, utilising the initial codes, refining and amending the initial codes to more focused codes by utilising any written memos for meaning (Charmaz, 2006). This stage of the analysis brings focused codes into a higher conceptual level and helps to identify the link between codes and indicators. This entailed a process of cutting out the individual focus codes, which were then assembled on A3 paper sheets according to patterns (refer to Appendix 8a). This visual platform, together with the process of memos, was found useful to clarify and reinforce category membership. The transcripts were read and re-read as the second phase of the focus coding process began to take place. Focus codes were amended and examined to the original data, as noted in the margins of the transcripts and a new memo was written about the focus codes links to a first-order concept possibilities. The transcripts were read a third time, and a simultaneous process of constant comparison (Glaser & Strauss, 1967) coding and analysis began as depicted in Table 3 below and Appendix 9(d). Charmaz (2006) noted how these focused codes form the framework of one's emerging theory. During this stage, several pivotal questions occupied the coding process:

- What is actually occurring in the text?
- Which category does the text fragment suggest?
- What is taking place?
- What is the participant putting across?
- What do these statements take for granted?

Although I carefully read every line of the text throughout the coding process, I was mainly focused with understanding the concept under discussion and discerning the range of possible meanings available within the wording. Grounded theory equips the researcher with guidelines on how categories and themes can be identified, how links can be made between categories, and how relationships can be established, to ultimately develop a theory for the subject area in question. The process entailed a repeated

immersion into the data, and repeated data sorting and coding. By way of summary, a diagrammatic representation of grounded theory analysis is shown Figure 3.

Open coding: discovering abstract concepts in the data; raising the conceptual level of the data
Axial coding: discovering in the data, connections between abstract concepts
Selective coding: selecting the core category by concetrating on the basic social process evident in the data; raising the level of abstraction again to the core category; elaborating the core category

Figure 3: Diagrammatic representation of grounded theory analysis Source: Punch 2014

Analysis begins with open coding and the rudiments of the coding analysis are captured in the Glaser and Strauss (1978) concept-indicator model. Coding is the concrete activity of opening up the data and labelling, which continues throughout the analysis. A description of the phases and activities used for the meta-process of grounded theory is detailed in Appendix 10 (a). The process of coding encompassed a visual platform to contemplate category hierarchy, relationship and membership as proposed by Rennie (1994). With conceptualising, this was a process of reading and highlighting sentences and phrases related to the therapeutic relationship and EI and then organizing them into focus open codes. Glaser describes these concepts as the "underlying meaning, uniformity and/or pattern within a set of incidents" (1992, p. 38). Indeed, a concept denotes a labelled phenomenon and an abstract representation of what the researcher identified between the

different focus codes as being significant. These concepts were then sorted into categories based on meaning commonalities (Strauss and Corbin, 1998). These concepts are then grouped into descriptive categories and closely examined for interrelationships, differences and similarities applying a series of analytical steps. This permits a finely detailed differentiation and discrimination among categories which are slowly evolving into higher order categories, or one underlying core category that may suggest an emergent theory (Glaser, 1998). It was of paramount importance that categories were exhausted in order to address content validity.

It is in defining the relationships between concepts that novice researchers often struggle to really achieve depth of theory. The creation of categories is at the same time an empirical and a conceptual challenge, as these categories must be empirically and conceptually grounded (Dey, 1993). Categories can vary in how abstract they are, however, as initial responses and categories were compared, more abstract categories and ideas emerged given that "different categories and their properties tend to become integrated through constant comparisons that force the analyst to make some related theoretical sense of each comparison" (Glaser & Strauss, 1967, p. 109). This process is integrative, and helps to show repeating patterns of integration within the data, enabling significant similarities (or differences) between the categories (and within them).

CATEGORY	TRANSCRIPT
FEAR ADMIRATION COURAGE IDENTIFICATION SHAME TALK	Okay. Well, the woman who just left is a good example. Because she was utterly terrified of the process and of me when she came. And, um, what I admire about her is that she has the courage to keep coming even though she's terrified. And at the beginning I simply identified her terror. "It's okay to be terrified. It's alright, you know. It's not shameful to be terrified, it's fine. Do you want to talk about how that works for you?"

Table 3: Worked example of a transcript open coding

As codes and memos accumulated, I began to perceive relationships, yet, however remain flexible to a number of possible coding paradigms and remain grounded

on data. This flexibility implies theoretical sensitivity, whereby the researcher avoids placing too much focus on any single explanation. The interviews were cut up into their meaningful focus codes and stuck onto index cards for visual reference (Rennie, 1994). The constant comparative process entails coding with another researcher and constantly comparing open codes and focus codes. This process facilitates further checking of the authenticity of the categories; the final version was assessed with a research assistant. There was a general agreement on the focus codes with only 10% disagreement. That was discussed with a grounded theorist audit supervisor and a final decision was made with amendments' to 5% of focus codes. As coding progressed, through the application of continual comparison and abstraction (see Figure 4), a number of concepts (See Appendix 8a and 8b) and their accompanying indicators (see examples on Figures 4, 5, 6 and 7) were identified. The research was facilitated by the adoption and guidance of the concept-indicators model.

As illustrated bellow, with the first interview, open coding was employed and initial codes were formulated. At this stage, the raw data (i.e., the transcript) was initially examined and coded through the following process: "data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena reflected in the data" (Strauss & Corbin, 1990a, p. 62; 1998, p. 102). This process breaks the interview into discrete threads. These threads are assembled and accumulate to form categories of similar phenomena. For example, the initial code of 'role of therapist' is derived in part from the following comment after asking Participant 1 about her perception of the therapeutic relationship as a therapist:

- Researcher (JP): Could you please describe based on your experience as a therapist the qualities that you perceive as important in a therapeutic relationship?

- Participant (P1): … comfort, encouragement and clarification (present, subtle competencies of connection) so there was a kind of about the relationship but also the role of a psychologist as well of particularly the **sort of clarification** (eliciting clients history/active listening / present) part. I guess you might think of it as may be like a parent and a child and a parent being there to explain to the child kind of how the world is (therapists role as parenting) and why things are as they are and when things go wrong helping the child to sort of make sense of them that sort of thing (role of therapist).

The category code **'containment'** is derived from the following focus codes:

Interviewer (JP): what else is important in the therapeutic relationship based on your experience as a therapist.

- Participant (P1): '…um you know not, **not putting pressure on the person to change** (connecting, openness and accepting the person)…um and then **encouragement** (focus code- hope/motivation/optimism) so something about being the person that it's often talked in terms of **one foot in the whole and one foot on the side sort** of thing (focus code- containment and empathy).

- Interviewer (JP): Being the person I hear you?

- Participant (P1): '**Being the person** that **is able to hold** (containment)some of the hope that, that the, **the patients not currently able to hold themselves** (hopelessness) and I think that's why going back to the person that I was talking **about is really difficult** (negative connotation)because **it's really hard for me to feel hopeful** about what to do…'(self-regulation /containment)

- Interviewer (JP): are you referring to a particular experience with a client now?

- Participant (P1): Yeah there was one occasion…**I think she was worried that I was going to** turn her away (reflection in action/ self-reflective) and um again she'd had lots of therapy over the years you know over the course of sort of twenty years through different bits of different services…I think that in probably my first conversation with her when I was asking about what was helpful about that and what wasn't helpful um and I think she'd

read the idea that well actually you've had all this and it's not really helped much so er and that…um and so when she came to the second session it was very, almost immediately you know …just came with massive, **massive anger** (Fear)…she started shouting (defensive reaction) um I guess **I was a bit taken** aback.(able to manage- contain feelings in self - Containment)

Both of the category codes described above 'role of therapist' and 'containment' is close to the original data and in that way it preserves the participant's experience and insider's view. While open coding, I labelled each interview text, identifying new lines of enquiry, which guided further data collection and comparative analysis (see Appendix 9a, 9b, 9c, 9d). Although I read the text line-by-line, I was mainly focused on understanding the concept being discussed and discerning the range of possible meanings found within the wording. Just labelling does not always explain what is occurring. For instance, I was more interested in the act of conceptualizing or abstracting what was occurring than in the words used to describe incidents. For example, Appendix 10(b) depicts an analysis of the first question with Participant 1 using a focus code analysis.

The writing of memos assisted the analysis process from the beginning of the interviews until the end of the study, enabling and allowing for the theoretical level through a continual process of comparison, abstraction, categorization, and dimensionalization. The memos also generated freedom, flexibility and enhanced creativity (Glaser 1978). For example, once a category, such as "hope" mentioned above with Participant 1, was identified, the analysis moved to consider the specifics and dimensions of that category. Open code categories are not one dimensional. "Hope" is a good example of a general category however the category can be divided up into different properties or components. Properties of "hope" could include optimism, courage, and even resilience. Likewise, properties can also have sub-properties, which are labelled as dimensions. For instance, experiential, spiritual, rational, and relational are dimensions

of the property of resilience. Gibbs (2010) noted a structural standpoint, emphasizing that actions can also have properties. The category "hold" could include the properties of frequency in therapeutic intervention, duration, type, and intensity. Thus, open coding requires the analysis of data to apply categories to the data and from those categories, divisions into properties and dimensions (Gibbs 2010).

In order to discover the possibly hidden dimensions that apply to data within open coding, I adopted Gibbs (2010) advice to keep probing questions about the data and what is being relayed. Examples of probes with Participant 1's "**Being the person** that **is able to hold**" comment include: what does she need to hold; who needs to hold; how often does she need to do that? By probing question around this action word hold, I determined that one of the properties that differentiates "containment" with client's "helplessness" is self-regulation or resilience. Once hidden dimensions are sought to be determined, the researcher then must return to the data and validate the questions through the text itself (Gibbs 2010).

5.4.1.1. Open Coding and the use of the concept-indicator model

Following the transcription of interviews, initial codes were formulated (see Table 4). The use of the concept-indicator model (Glaser, 1998; Strauss, 1987) was employed to assist this process. Strauss (1987) explained that "grounded theory is based on a concept-indicator model, which directs the conceptual coding of a set of empirical indicators" (p. 25). In particular, this process entails the identification, constant comparison of similarities and variations of indicators. Using this model, data were coded following line-by-line coding in which a code was generated for each "incident" that collectively could be clustered into a "concept." Figures 5 and 6 demonstrate how indicators, first order concepts and second order concepts can be integrated into open coding. "Concepts" derived from "incidents" and also provided the relationship with each other via the principles of constant comparison.

The qualitative datum is defined as discerning the range of possible meanings contained within the wording. That entails capturing information about an incident. Open coding takes in "exploring the data and identifying units of analysis to code for meanings, feelings, actions, and events" (Tavakoli, 2012, p.72). Open coding is essentially interpreting rather than summarizing (Robson 1993). The incident is the unit of analysis and represents an instance of a concept coded and classified during coding. Incidents are indicators of a concept, and refer to a word, series of words, phrase, or sentence, in the data being analysed. The constant comparison and dynamic analytical process of indicators enable identifying and further defining differences, similarities and consistencies in meaning. In other words, a triadic process of analysis exists, such as, the incidents as indicators of concepts, the constant comparison of indicators, and memoing (e.g., see Table 6) to assist the researcher's reflexivity, constant comparison, conceptualization (or abstraction), and creativity.

The triadic process of analysis generates identified categories (or variables) through an abstraction or clustering of constructs, grounded in prior line-by-line coding of incidents, indicators and properties. For example, openness, trust, and honesty (depicted in Figure 7) are categories generated through clusters (e.g., categories and properties) by prior comparison of abstract concept labelling of open coded incidents. Subsequently, the process of induction and deduction on a continual comparison of indicator to indicator first generates a conceptual code then second these indicators are compared with the emanated concepts. Dimensionalization can refer to this practice of generating categories and clustering or grouping them, which, as Strauss (1987) indicated, refers to how strategy 'a' is distinguished from strategy 'b'. The idea is to develop concepts (first order concepts and second order concepts) or categories in terms of their properties (e.g., the characteristics of a category), which are then dimensionalised (Strauss & Corbin, 1990a, pp. 69-72).

Property is a conceptual characteristic of a category but at a lesser level of abstraction than a concept or category (Glaser, 1992). Table 4 shows how I described the difference between a category and a property by using categories emanated from the open coding stage (as depicted in Appendix 8). For example, consider the category "reflective practice" as an illustration. Types of "reflective practice" constitute a category whose properties are subtle competencies of self- awareness, genuine, honesty, communication, openness. But how is this different among different types of reflective practice? For instance how can it vary under conscious and unconscious levels of reflective practising? Subsequently, instead of having a category and its properties, there are simply different variables: the types of "reflective practising" (e.g., expert self-reflection vs. novice self-awareness), as well as level of self-reflection.

If reflective practice has now a combination of variables and a combination of subtle competencies, then more categories can be created (e.g., experiential, spiritual, rational thought, and relational). Every category or dimension can be grouped into a cluster of concepts pertaining to "reflective practising." Similarly, if we consider the concept of emotional balance, there could be levels of containment (e.g., empathy vs. emotional resilience), as well as an intensity range (e.g., high to low) within each type.

Categories	Concepts or Variables	Variable clusters (i.e., variables and properties
Emotional balance	Types of containment (Empathy v Emotional Resilience)	Type of containment (e.g., Empathy v Emotional resilience) intensity of empathy: high to low, Levels cognitive, embodied or emotional or all of the above.
Connection	Types of emotional connection (Embodied v Cognitive)	Types of emotional connection (embodied v cognitive) intensity of

		novel experience, rebellious and resistance, embodied connection , emotional exhaustion, cognitive empowerment
Reflective Practice	Types of reflective practice (Expert v Novice)	Types of reflective practising (e.g. expert v novice) level: self-reflective, authentic chameleon, levels of reflective practising: experiential, spiritual, rational thought, and relational.
Clinical activities that contribute to learning and development	Competency development (Experiential training v Theoretical knowledge)	Types of competency development (experiential v theoretical knowledge), frequency, duration, activities,

Table 4: Open Coding: Developing concepts and variables

Grouping concepts is important as it enables to deduct the number of incidents or indicators of a concept which is presented in the analysis. Figure 6 represents an example of a concept indicator model, examining the category of subtle competencies of an emotional connection. The concepts which emanated from open codding are shown in Appendix 8a and 8b.

Combination of the data codes started with a thorough reading of all the transcribed interviews (192 pages in all). The process of revisiting the verbatim, listening to the recorded audio and rereading interviews assisted in a deeper connection and understanding of meaning in data. After coding data, there were approximately 515 substantive codes: after axial coding, there were 10 core categories (e.g., refer to figure of abstraction in data analysis for clarification of categories as first-order concepts) and 45 subcategories or variables describing the therapeutic relationship and its links to EI.

Deciding when to start combining the data was a challenge. The choice of beginning by open coding the whole data or to start from substantive codes was an interesting challenge in successfully managing so many substantive codes, however, the

concept-indicator model I adopted covered a lot of ground in the process of analysis. Eventually, I decided to combine the data sets with the help of categories (first-order concepts) and the facilitation of memos and variables as depicted in Appendices 7a to 7d.

Let me now demonstrate in more details the process in this study. The open coding process used in this study enabled the formation of categories as demonstrated in Table 5. However, further abstraction was necessary in order to refine categories with the assistance of memos. I began to reflect on memos and the emerged categories by moving creatively to cluster concepts under a more abstract higher order concept (second order concepts). For example, I observed based on the analysis of indicators around 515 substantive codes. I abstracted 45 subcategories or variables from the open coding process (refer to Appendix 8a and 8b) and began a deductive process of analysis via conceptualization of higher abstract concepts. Having identified a category, I started to cultivate it in terms of its particular dimensions and properties. Figures 4 and 5 show how indicators, first level concepts and second level concepts can be integrated in open coding.
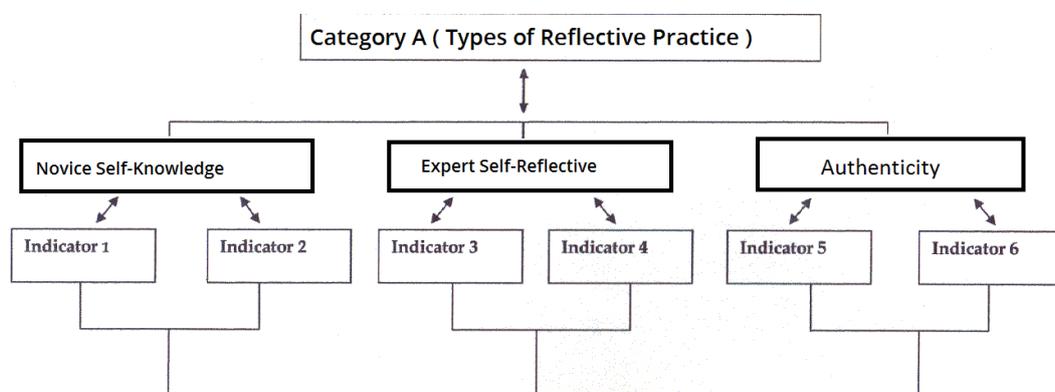
Examples from in-vivo
Indicator 1: because it's very tempting and I've been practising for about twenty years so this actually is interesting because it made me look back to how **I changed myself in this role**, (**expert v novice therapist**) and I think when you start off, often the feeling is you're trying to help people but actually **I've learnt that if you allow people to just be and accept them they find their own way of accommodating what's happened to them**, (**competencies learned via experience**) even if it's painful and difficult, and it might take time (**description of the importance of experience in the process of therapy**) (Participant 3; 78-90)
Indicator 2:... I think it's very important to, **I guess to be quite, what I say would be quite solid in yourself, you know, er, to have a good knowledge of yourself,** (**experience add to self-knowledge as therapist**) I suppose, and your, um, weak points

maybe. Um, I guess that's why I see, you know, **being in therapy … the therapist to be in therapy themselves is also quite important.(personal therapy add to self-knowledge)** Um, particularly when, you know, you do get some quite challenging work. (Participant 4; 110-125)

Indicator 3: "how is envy different from jealousy and you know a whole range of you know knowing what they are and then **understanding how they're transacted in a relationship (Self -reflection)** and how you spot what's going on, you **know and how you feel what is happening and label it correctly so you can respond correctly**, but that requires **mindfulness, (Mindfulness)** you have to pay a lot of attention to it" **(Expert Self-Reflection)** (Participant 10; 294-300).

Indicator 4: "especially if you **reflect on the whole course of therapy,(reflective practice)** a lot of things that were communicated in the first telephone calls will make sense and they will be really important and significant erm you might not be able to understand it when you just take the call **but if you have you know knowledge er from, that you gain later on in therapy experience (expert self-reflective)** it will be a very meaningful encounter.(Participant 2; 159-165)

Indicator 5: "…I really felt even a sense of hate towards her and I had a really lot of negative feelings which I found it really difficult because it wasn't usually what I would feel as a therapist even if someone is really you know disturbed… I was really, really I mean how do you work with the clients you literally hate, you don't feel you know erm. **I had to take a risk (risk)** and told he wanted me to hate him, he did not want to empathise and care and that **truthful stand (Authenticity)** had made all the difference in therapy. (Participant 2; 354-368).

Indicator 6: "But I think that in the first three minutes, I didn't lie to her, and I think that that's a big deal. I started out working with children, and children have lie detectors and creep detectors that are absolutely finely attuned. If you lie to a child, it simply stops listening. That's all. It will very rarely talk back to you or tell you, or even acknowledge inside the child that it's stopped listening, but it has, and the wall has gone up. And the only way you can engage with a child is **to be really honest (honesty)** with a child. **To be really authentic. (Authenticity)** (Participant 12; 83-97).

Figure 4: Concept-Indicator. Variable A: Reflective practice

Figure 4 lines among indicators and among concepts illustrate the way that the continuous comparison of indicators generated concepts. Lines also illustrate how the constant comparison of concepts generates variables or categories. It is important to mention that despite the fact that the above examples illustrate the concept-indicator model in the study with two indicators per concept, in the reality a number of indicators have taken place. The indicators that emerged are much more as it had to comply with the theoretical saturated concept. Part of the process was to cut the indicators up, scatter them on the floor and encompass memos in the analysis. The indicators were compared under labels and assessed to ensure that my theoretical development was in line with the

data and that memos reflected the in-vivo codes. Moreover, the auditing assistance did verify my interpretation of indicators with variables or categories and traced them back to the data.

Figure 5: Concept-Indicator: Variable B

The first concept emerged of "reflective practice" as illustrated in figure 4, because a comparison of each event with itself and other events in the in-vivo data, shows that these variables have the following characteristics in common. First, these variables assist the therapist in her/his metacognitive reflective ability to manage the dialogue and

develop a therapeutic alliance with clients. Second, via my memo reflectivity as I will further elaborate below, creating physical prints of the categories and memos and setting them out on the floor, allowed me to perceive a group of categories (or first order concepts) that support the reflective practice (second-order) concept. By visually making "comparisons" of indicators to indicators, I was able to focus on differences, similarities, and degrees of consistency of meaning among indicators, thus resulting in a coded category or concept. This process inspired my creativity and confidence as it enabled a meaningful theoretical development and clustering to be in line with the data, thus tracking my "theory of theory" back to the data.For instance, consider the example below. The in-vivo quotes (indicators) as depicted in Appendix 10(c), supported my memo writing from Participant 2 and supported my analysis for my second -order concept of "reflective practice."

More examples of other concepts are depicted in Figure 7. For instance the second-order concept of "subtle competencies of an emotional connection" is illustrated on Figure 6, and on Figure 7, the first-order concept of "Containment" is presented. It is also important to emphasize that when categories, such as the example in Figure 6 begin to accumulate and gain depth, a comparative analysis of another focus code is needed in order to group common characteristics together. For instance, when we take in-vivo codes and the particular indicators in Figure 6 evoke categories or variables of trust, openness and honesty. Then I used a higher level of abstraction to create a second order concept, of "subtle competencies of an emotional connection."

1. "Oh okay, and erm...that's really hard to say. You know, I mean I tend to adopt a rather warm and open stance, emotionally. Erm, psychoanalysts would be much more neutral, much cooler, more opaque. Erm, you know I tend to be warm, open, active, positive and let's connect, let's understand let's do some work, let's invent some experiments, let's figure out what the problem is".

2. "Okay well again that would be very different with different people so I'd say that my own sort of inclination is to be um quite sort of open and reassuring um in contract may be to a sort of blank slate to ... you know to somebody that ... I'm, I'm probably a bit more animated may be than some therapists or some psychologists".

3. "I guess that it means to me that some sort, some form of trust that is created you know between two people erm and one person who is more, in a more vulnerable position is able to trust me as a person".

4. "And there's something about that understanding that kind of I think helped her to feel safe enough to start gradually settle more and more into therapy and bring more painful issues to deal with".

5. "And so I think that the therapeutic relationship has to engage someone with real honesty right from the first second".

6. "She wasn't just talking about if I said this is confidential that it really was confidential, which was an issue. But it was something about telling her what I thought truthfully and telling her what I felt truthfully. So if she made some, she wanted to see a man um because she wanted also to understand the male point of view of the marriage".

Figure 6: Example of concept-indicator subtle competencies of an emotional connection

In this above example, the variables or categories (second order concepts) of openness, trust and honesty are analysed. My research assistant and I compared indicator with indicator, assessing the similarities and differences, in order to infer the concept. We were also constantly asking, what more abstract concepts could this data indicate? What do these 'in vivo' labels exemplify? What does this data fragment represent or stand for? What category or category property does this data fragment indicate? When comparing the categories and their properties, I generated a deductive process of analysis. This deductive process of analysis emanated the conceptualization (or abstraction) of a higher abstract concept. Cross-comparison analysis is a process of interrelating findings from several contexts to generate themes which may be used to develop new theory (Miles & Huberman, 1998). For instance, the concept of *subtle competencies of an emotional connection* summarizes the meaning of a series of statements that therapists in this study made. These verbalizations included "*Oh okay, and erm...that's really hard to say. You know, I mean I tend to adopt a rather warm and open stance, emotionally. Erm,*

psychoanalysts would be much more neutral, much cooler, more opaque. Erm, you know I tend to be warm, open, active, positive and let's connect, let's understand let's do some work, let's invent some experiments, let's figure out what the problem is" (Source Participant 2).

A statement from another participant (indicator 2) also noted, "*Okay well again that would be very different with different people so I'd say that my own sort of inclination is to be um quite sort of open and reassuring um in contract may be to a sort of blank slate to … you know to somebody that … I'm, I'm probably a bit more animated may be than some therapists or some psychologists."* This statement triggered the openness concept (indicator 1).

Similarly a number of other participants described another indicator that was similar to the previous segment of data but was different. For example the indicator 2 verbalizations, "*I guess that it means to me that some sort, some form of trust that is created you know between two people erm and one person who is more, in a more vulnerable position is able to trust me as a person.*" This prompted the researcher to think what the meaning around trust entails. This facilitated a greater level of abstraction and conceptualisation. Examples of questions asked included: How are concepts *trust* and *openness* similar? What do both these concepts entail? Do they belong to a more abstract category*?* How do these concepts relate to the therapeutic relationship? As a result, the two indicators - *openness* and *trust –* were grouped together, and the last statement would be compared with the two previous ones.

The comparison result suggested that the two concepts belonged together and the statements were classified as indicators of the concept of subtle competencies of an emotional connection. Several subcategories were developed from a comparison of the concepts. These subcategories included: 'openness' 'trust' 'honesty' 'acceptance' 'genuine' 'authentic' 'non-judgmental'. In that way, the researcher was condensing

information from several contexts to the most significant meanings (Miles & Huberman, 1994, p. 429) and at the same time, was seeking alternative options for organizing the data which could offer different findings. One could ask, how do these statements lead to the concept of subtle competencies of an emotional connection? How are the lines drawn between one and the other? According to Strauss (1987), the main element in concept formation is the posing of generative questions. This was achieved through rigorous scrutiny of the data and posing questions, such as: when, why, who how, etc.? (Strauss, 1987).

To exemplify, the following questions were set regarding the relationship between the participants' experience when in the role of therapist and the subtle competencies of an emotional connection in the therapeutic relationship. How are they related? Can we find examples of a higher-order category of 'benevolent connection?' Why are they related? Mainly, this questioning revolved around an understanding of the context and conditions of the phenomenon being studied. While this analytical stage progressed, additional comparisons were made among the categories to establish whether certain categories may actually be sub-categories of a higher-order category. This involved considering the weight of evidence emerging from the data and seeking the best fit between data and analysis. In doing this the researcher is undoubtedly adding credibility to the ultimate set of findings resulting from the researcher's interpretations.

In Figure 7, the example of containment is demonstrated using the concept indicator model. Theoretical saturation was reached when I got to multiple indicators and where adding another indicator to those already grouped, failed to generate any significant new insights into the existing concepts. The themes that emerged and category inter-relationships were subsequently evaluated in terms of existing theories (see Appendix 16 and 17).

Concept: (Containment)

Indicator 1 Indicator 2 Indicator 3 Indicator 4 Indicator 5 Indicator 6
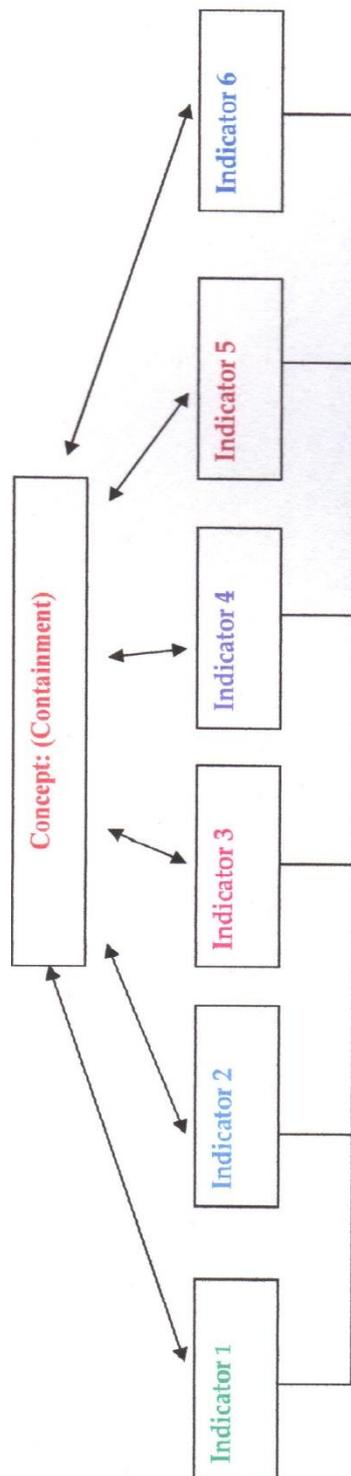
1. "Oh okay. Um so yeah just, just being able to be, to be present and to hold what is, what is um brought into the process". (Source: participant 12)

2. "…to contain or so all of sudden if it becomes er a possibility in the room or in the relationship between myself and the clients then it can become it might initially be really and being a very passive, aggressive way he would not be able to own his anger you know erm but I will not retaliate or suggest that its not allowed". (Source: participant 2)

3. "…To feel these emotions, contain these emotions so that at the end of the session she could leave in one piece' (source participant 11)

4. "….And that one I think was too close to the bone for me. I mean I was sexually abused erm um. Don't want to go there sort of thing going on then". (Source: participant 5)

5. "I guess there was that sort of sense of my own helplessness as well but um probably you know after a couple of minutes and then she started, she was really crying and er and then I ou…. er I don't know at what point it was but there was a real sort of turning point for me just in the sitting there watching and, and listening of suddenly sort of recognising something about how she was as how I'd felt in the past of when … you know being powerless and desperate and um that you know that was definitely how she was coming across and just in sort of recognising it that I'd felt like that myself at times. Similarly it just enabled me to connect with her, it sounds a bit …". (Source: participant 1)

6. "..have to be comfortable with people's emotions and that means with your own, so I actually get quite moved by a lot of what people tell me, but I don't say anything more about it, I don't try to colour what the experience is too much, but I might make suggestions, or I might say, 'I'd feel like [unclear-21:17] if that happened" you know, occasionally encourage them that it's okay". (Source: participant 3)

Figure 7: Example of concept-indicator concept (Containment)

Another pivotal ongoing stage in open coding is systematic comparison. The constant comparative method facilitates the creation of theory using systematic and explicit coding and analytic procedures. This process is explained in more detail under the process of abstracting and comparing. During the process of comparison, abstraction,

and conceptualization I had managed to write more than 200 memos to capture the conceptual and methodological development of my theory. The length of these memos varied in length from a few lines to multiple pages.

5.4.1.1.1. Abstracting and comparing

Another pivotal process in open coding is that of constant comparison (Glaser and Strauss, 1967). This process requires the researcher to simplify the data and form categories that reliably reflect the study subject (Robson, 1993). Strauss and Corbin (1998) recommend using questions, such as "What are the actors' definitions and meanings of these phenomena or situations" (p. 77). From the open coding process discussed so far, we have some concepts labeled but the labeling does not constitute the range of potential meaning. For example, if we have indicators that are grounded on incidents (i.e., indicators of a category or variable), such as participants describing in-vivo code at indicator 5 their notion of their role as a therapist, then in my analysis I made a low level abstraction and I labelled it as "honesty." However, just naming in-vivo does not always explain what is occurring, and we need memoing and a higher level of abstraction for deeper or complete sense. The diagram in Figure 8 shows the levels of abstraction in both the qualitative and quantitative contexts.
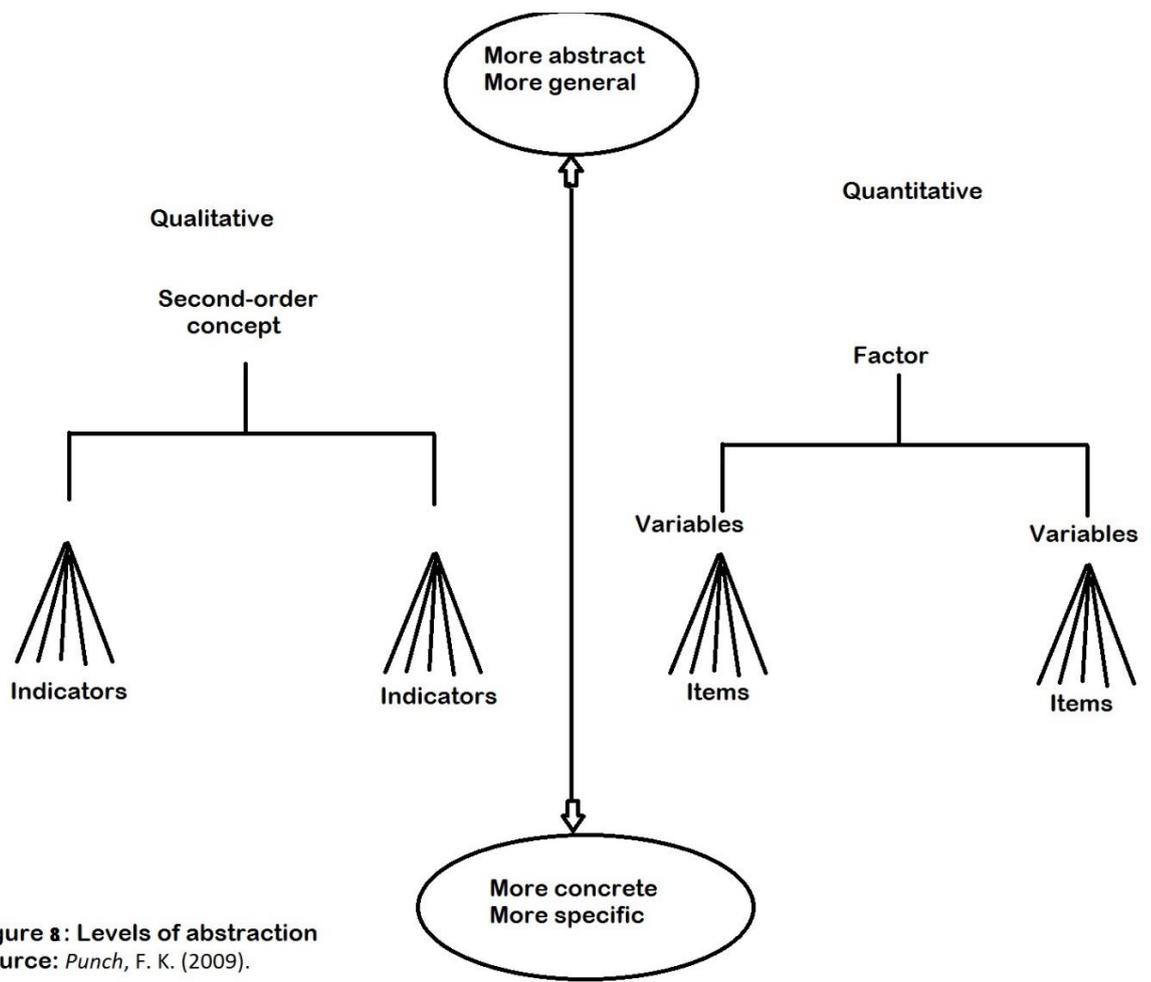
Figure 8: Levels of abstraction
Source: *Punch*, F. K. (2009).

Figure 8: abstraction in both the qualitative and quantitative contexts

Figure 9: illustrates the process of comparative analysis. It is important to note that the aforementioned process of abstracting and comparing does not yield tested theory, but it produces a substantial theory which is grounded from a number of categories and properties but is not tested scientifically(Glaser and Strauss, 1967). Thus, validity is a product of data saturation when no new concepts can emerge.

.
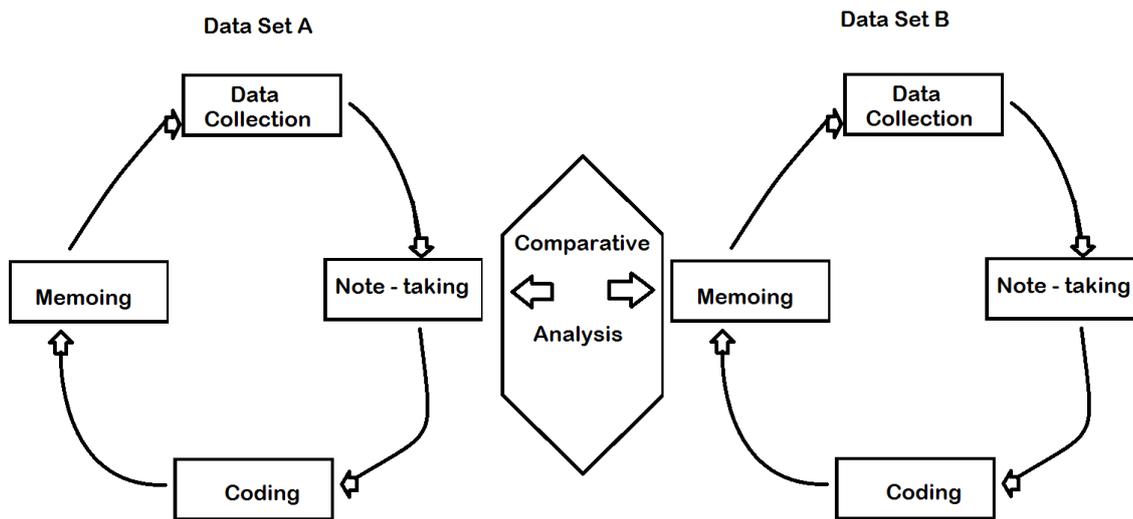
Figure 9: Comparative analysis Source: Glasser & Strauss 1967

5.4.1.2. Axial coding

Once open coding brought out distinct categories, the relationships among the categories was commenced. This involved comparisons revisions and elaborations of the categories. Axial coding comprises "intense analysis done around one category at a time in terms of paradigms items" (Strauss, 1987, p. 32). The analyst undertaking axial coding needs to have the initial categories defined and to sense how these categories relate one another, which begins to emerge during the open coding process (Strauss & Corbin, 1996). Procedurally in axial coding, I attempted to link categories to subcategories (or variables) along the lines of their dimensions and properties. It is important to note that subcategories are still categories themselves but ones which address questions of "when, where, why, who, how and with what consequences" around a focal category (Strauss & Corbin, 1996, p. 125). When looking for answers to these questions a relationship was established between structure and process with the assistance of memos (refer to Appendix 17, 18). The structure pertains to understanding and learning the "why" to the phenomenon in question, whilst the process helps one to learn about the "how" of the phenomenon (e.g., how persons act/interact).

In other words, process "denotes the action/interaction over time of persons, organizations, and communities in response to certain issues" (Strauss & Corbin 1996, p. 127). The analysis of relating structure with process sets the perspective of how structure or conditions create the circumstances in which the phenomenon under investigation arises. "One must study both structure and process to comprehend the dynamic and evolving nature of events" (Strauss & Corbin, 1996 p. 127).

The objectives of axial coding are (1) to identify the various conditions, actions/interactions, and consequences linked to a category; (2) to relate a category with its subcategories; and (3) to look for indications in the data of how the major categories may relate to one other. Questions asked in the axial coding phase, concerns the context, the conditions that an event is unfolding, and its consequences. Applying this to the research question of therapists' experiences of the therapeutic relationship and its links to EI, in axial coding, I asked questions, such as "under what conditions do therapists establish a therapeutic relationship," "what are the consequences of this," and "to whom?" I also prompted questions concerning the process (sequence of actions) by which the therapeutic relationship occurs ("how" questions). Finally, I tried combining process questions (sequence of actions) with structural questions (under what conditions) to raise more complex questions, such as "under what conditions do trust and connection in therapeutic alliances manifest?"

Categories with few or no connections with other categories were either omitted or subsumed into other categories (Rennie et al., 1998). The various focus codes impacting the therapeutic relationship and its links to EI were consolidated into 45 subcategories and 10 main categories, as shown in Table 5 and Figure 10.
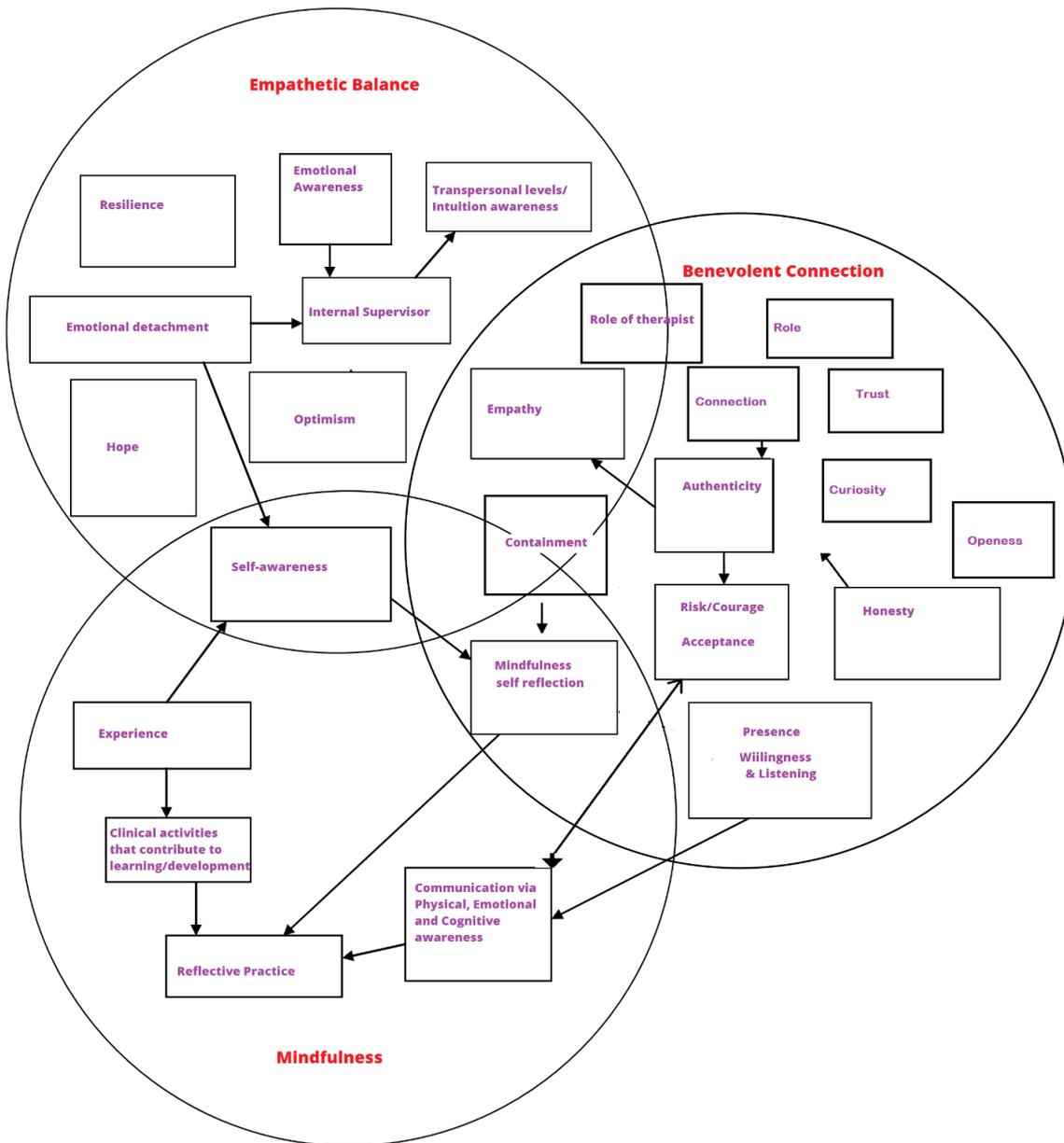
Figure 10: Model showing the most sallent relationships between categories and variables within the three categories of the core category

Categories	Concepts	Reference Appendix 9: A3 Index card of indicators data which prompted the focused codes and concept
Emotional balance	-Regulate the self -Contain Emotions -Aware of limitations -Emotional detachment Resilience Optimism Hope	"The balance between being emotionally close and available and emotionally separate so as to preserve the independence"(Participant 6;32-40) "Position yourself somewhere in the middle" (Participant 7; 162-170) "Making space for yourself" (Participant 4; 146-150)
Containment	Internal supervisor Contain Balance Hold	"To feel these emotions, contain these emotions so that at the end of the session she could leave in one piece"(Participant 11; 146-147) "to be able to contain your feelings when you're being attacked by a patient or taken by surprise by the patient or the patient's feelings are overwhelming". (Participant 11; 208-210)
Empathy	Authenticity, honesty, integrity, acceptance, non-judgmental, listening, presence, willingness, warmth, genuine	"I think, um, er, an honesty and empathetic approach, I guess, um, openness, a willingness, um, an honesty, um, a genuineness", (Participant 4; 128-130) "stuff on empathy, warmth, genuineness". (Participant 7; 287) "Therapists without empathy I think are ineffective".(Participant 7:297-299)
Subtle attributes and competencies	Openness, Authenticity, Courage, Trust, Honesty	"the ability to stay immovably present and keep trying to tune in to the chaoticness of the patient" Participant 10; 237-238). "about whether or not they can trust you to tell them the truth and to be kind while you do it" (Participant 12; 58-60)
Connection	Connection Spiritual /Transpersonal Engagement	"being able to be really be in her shoes or his shoes" (Participant 5; 66-67) "But for me, the key route is attunement."(Participant 12; 110) " spirituality again it's about being in a relationship, being connected, but also being connected truly with myself and other person"(Participant 9; 77-79).

Categories	Concepts	Reference Appendix 9: A3 Index card of indicators data which prompted the focused codes and concept
Presence	Presence Good Listening	"simply being there as somebody that can listen when somebody's in distress" Participant 1; 341-345) " because I'm there for someone in a reliable manner" (Participant 2; 76-78) "But being very, very still and very, very much present" Participant 11; 126-127)
Role of the therapist	Role of the therapist Paternal relationship Attachment Containing	"I might be perceived as the parent, the client might experience me as a parent in all sorts of situations and as a good enough mother"(Participant 2; 98-104) "the good attachment figure ought to be to the child's needs. That's how I see it today in rather simplistic terms"(Participant 8; 41-43)
Reflective practice	Self –refection Courage Authenticity Experience	"the ability to really kind of reflect on what is happening you know erm in the session". Participant 2;292-297) "If you lie to a child, it simply stops listening. That's all. It will very rarely talk back to you or tell you, or even acknowledge inside the child that it's stopped listening. And the only way you can engage with a child is to be really honest with a child. To be really authentic" Participant 12; 91-99)
Self-awareness	Communication via embodied, emotional, and cognitive awareness Experience	"what's going on is I'm feeling what I'm feeling and then there's a, kind of, a cognitive commentator who's watching the feelings, watching what's going on in my body, watching what's going on in my emotional centre, in my heart," Participant 12; 321-324) "I think the mind body system is one system, so I don't think one can really separate it out". (Participant 10 ; 212-216)

Categories	Concepts	Reference Appendix 9: A3 Index card of indicators data which prompted the focused codes and concept
Clinical activities that contribute to learning and development	EI concept Personal Therapy Supervision	"supervision is quite important" (Participant 6; 186-190) "So the answer to most emotional problems is to increase emotional intelligence. (Participant 10;357-359) " Well, I'm agreeing with the EI definition" (Participant 9; 542-545) "EI it could be a means to an end" (Participant 8; 580-586)

Table 5: Categories and subcategories from participant's indicators

Having identified a category, I started developing its specific dimensions and properties. For instance, I labelled openness, engagement, authenticity, courage, trust, honesty, acceptance, non-judgement and curiosity as "subtle competencies" because as I compared each variable against itself and other variables in the data, I became aware that all these variables facilitate the therapeutic alliance, whereas the absence of any of these variables could prompt alliance ruptures. I then defined the meaning of "subtle competencies." Following this, I considered the characteristics of the category and the ways in which these properties vary along their dimension. For instance, authenticity entails therapeutic interventions and decisions regarding different relationship stances. These different relationship stances, while similar in so far as being able to relate with the client, are not similar when comparing against each other for dimensions and specific properties. Different relationship stances might extend to how and when to be supportive, directive, respective, warm, cold, tepid, informal, or formal and thus, support our concept of "subtle competencies" variations.

 Open coding was superseded by axial coding, that puts data "back together in new ways by making connections between a category and its subcategories along the lines of their properties and dimensions" (Strauss and Corbin, 1990, p. 97). Under axial coding, the category's properties are firstly elaborated, meaning that the category is either

implicitly or explicitly dimensionalized. After this assumptions about the interactions, condition, strategies and consequences are defined and tested, increasing its association with other categories. The interrelatedness of the categories is recorded in network representations and the analyst makes coding notes and theory memos to record as many of the thoughts as possible that have occurred while the process is being undertaken.

The essence of axial coding is the interconnectedness of categories. With open coding complete there is rarely clarity as to whether a particular concept concerns a condition, a strategy or a consequence. This refers to the procedures of creating new relationships between categories, "specifying a category (e.g., phenomenon) in terms of the conditions that give rise to it; the context (e.g., its specific set of properties) in which it is embedded; the action/interaction strategies by which it is handled, managed, and carried out; and the consequences of those strategies" (Strauss & Corbin, 1990, p. 97). Therefore, codes are explored, their interrelationships are examined, and comparisons are made concerning codes and categories and existing theory. The focal category is temporarily placed at the core of the investigation and the *what, when, where, why, how* constitutes the analysis around it. It is important to accentuate that despite the focus of axial coding on process and interaction, this should be an ongoing stage at all phases of grounded theory methodology.

LaRossa (2005) discussed axial coding as a process of "developing hypotheses or propositions, which, in scientific parlance, are generally understood to be statements about the relationship between or among variables" (p. 848). As depicted in Figure 11, the study adopted Glaser's (1978) elucidation of the "six C's": Causes, Conditions, Focal Concept, Co-variances, Conditions, and Consequences.

In this study, through open coding and focus coding, I developed concepts, categories, and subcategory clusters associated with the therapeutic relationship (e.g., connecting vs containment), intensity of emotional connection vs levels of resilience, and

have begun to ask questions about these categories or variables.

I followed Strauss and Corbin's advice (1998) and placed a focal category temporarily at the centre of the analytic inquiry (e.g., levels of connecting) and answered questions about its subcategories. We then asked questions about why in order to investigate categories and subcategories that might influence the intensity of connecting within the therapeutic alliance. For example, the interview transcripts included a repeated reference to authenticity (e.g., "*The primary way is just being, being willing to say things that not necessarily the client doesn't want to hear but that aren't necessarily easy to say. Um being willing to go into unknown territory*" Participant 8, 141-146). Asking a "why" question lead me to inquire whether the level of authenticity influences the intensity of connection.

I also questioned whether the level of authenticity influences the level of trust positively as there is a possibility that patients connect with therapists when they feel safe and experience the therapist as honest, open, genuine, and non-judgmental. In this reversal of subcategory order, I also explored the consequences relating to a focal category with further questions. For instance, what are the conditions under which authenticity influences the intensity of connection? In which kind of context is the relationship between level of authenticity and intensity of connection relevant? Is the therapeutic alliance implicit or explicit, conscious or unconscious with some patients than in others? Is it more relevant in short term therapy or long term? The search for whys or consequences, contexts and conditions enables the construction of relating categories with subcategories.

```
                          Contexts
        Conditions                          Conditions

             |                                   |
             v                                   v
  ───────────────────→ Focal Category (variable) ──────→ Consequences
                       Intensity of connecting
                                |
                                |
                           Covariances
```
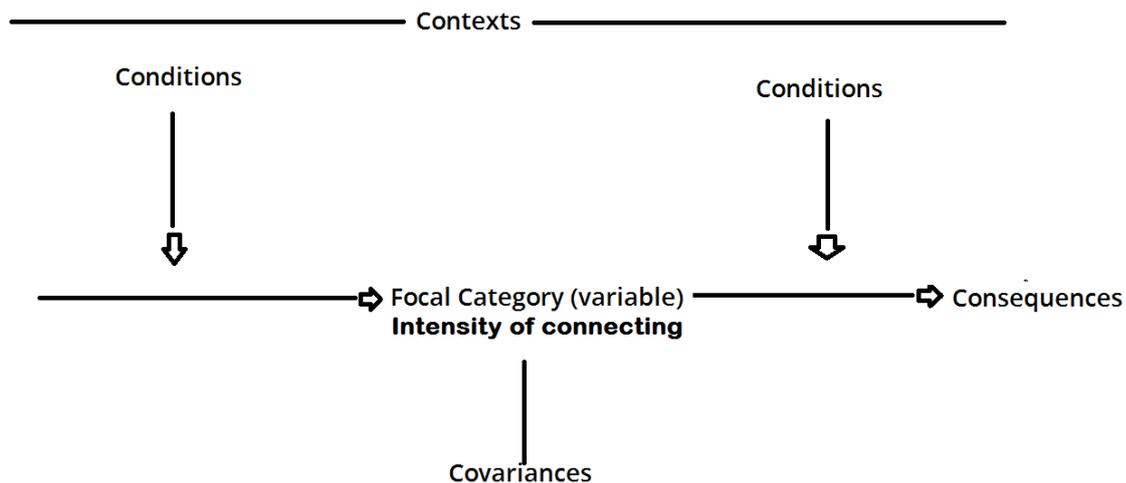
Figure 11: Axial coding

A substantive theory of the paradigm model, complete with causal conditions, context, intervening conditions, action/interaction strategies and consequences are developed and presented in Figure 12 and the categories and components are presented in Table 6. The term causal conditions refers to "the events or incidents that lead to the occurrence or development of a phenomenon" (Strauss & Corbin, 1990, p. 100). Our causal condition was the therapist experience of the therapeutic relationship and EI.

Context is "the specific sets of conditions (patterns of conditions) that intersect dimensionally at this time and place to create the set of circumstances" (Strauss & Corbin 1998, p. 132). Four categories of context conditions were developed in this research: connection between therapist and client, therapists' subtle competencies, being present and the role of the therapist. From these categories, a number of subcategories were generated, which included presence, empathy, spirituality, risk, containment, openness, authenticity, courage, trust, honesty, acceptance, non-judgment, curiosity, parenting relationship, and attachment.

Intervening conditions are "those that mitigate or otherwise alter the impact of causal conditions on phenomena, which in turn must be responded to through a form of action/ interaction" (Strauss & Corbin, 1998, p. 131). Three categories (i.e., reflective practice, embodied-emotional cognitive awareness, and training or learning) and a number of subcategories were found in this study. The subcategories included: experience, self-awareness, self-reflection, bodily, emotional and cognitive experiences, emotions, feelings, supervision, and personal therapy.

Action/interaction strategies are "purposeful or deliberate acts that are taken to resolve a problem and in so doing, shape the phenomenon in some way" (Strauss & Corbin, 1998, p. 133). Sixty-three variables (see Tables 6 and 7) across three categories were found. The three categories were emotional balance, containment and empathy.

Consequences are the results of actions/interactions and can also influence a subsequent set of actions/interactions. For this research, one category and four subcategories were derived from the data (see Table 6). The category was "clinical activities that contribute to emotional learning and professional development" and encompassed EI experiential training, supervision, personal therapy, experience, other emotional awareness and mindfulness experiential training.

Category (Axial coding)	Subcategory	Components
Connection	Presence, attuned, awareness, dyadic resonance, spirituality, transpersonal	Context and causal Conditions
Subtle attributes and competencies	Openness, authenticity, courage, trust , honesty, acceptance, non-judgmental, curiosity	
Role of therapist	Parenting relationship, Attachment	
Been present	Listening, accepting, non-judging, curiosity	

Reflective Practice	Experience, self-awareness, self-reflection	Intervening Conditions
Embodied-emotional cognitive awareness	Bodily, emotional and cognitive experiences, emotions v feelings	
Emotions and Cognitions	Emotions and cognitions	
Training and learning	supervision, experience, personal therapy	
Emotional Balance	Empathy, transpersonal levels, intuition, emotional awareness, containment, emotional detachment, resilience, hope, optimism, self-awareness, internal supervisor.	Action strategies
Containment	mindfulness, authenticity, resilience, hope, optimism, balance, internal supervisor, courage, self-awareness.	
Empathy	Authenticity, honesty, integrity, acceptance, non-judgmental, listening, presence, willingness, warmth, genuine.	
Clinical activities that contribute to emotional learning and professional development	EI experiential training, supervision, personal therapy, Experience, other emotional awareness and mindfulness experiential training.	Consequences

Table 6: Categories and Components
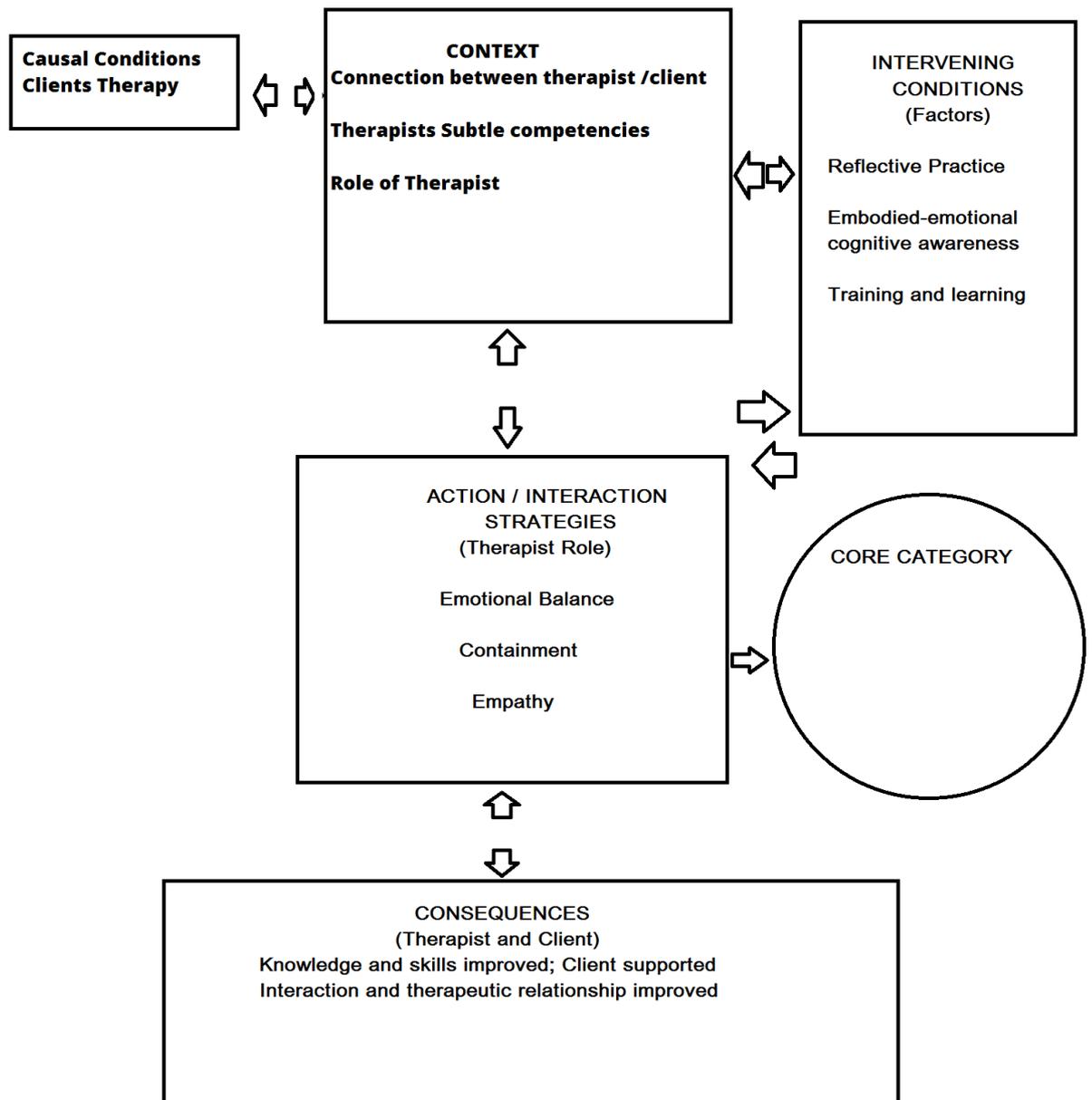
Figure 12: Paradigm model, including causal conditions, context, intervening conditions, action/interaction strategies and consequences

5.4.1.3.Selective coding.

In this final stage, the researcher integrates and refines the theory that has been developed in the open and axial coding stages. Selective coding involves identifying a core category. The core category is the single category among all the categories generated during coding. This core category is theoretically saturated and is central in its relevance. At this point, coding of other categories emphasizes their relationship to the core category. The use of a core category keeps the researcher from becoming overly broad in focus and

has analytic power through its ability to draw the other categories together to create an explaniatory whole (Strauss & Corbin, 1998). A core category in this study was selected namely, "Empathetic Balance," which explained the main therapeutic relationship process in the analysis of data while being related to the other two main categories, "Benevolent Connection" and "Mindfulness." The relationships are depicted in Figure 13 below.
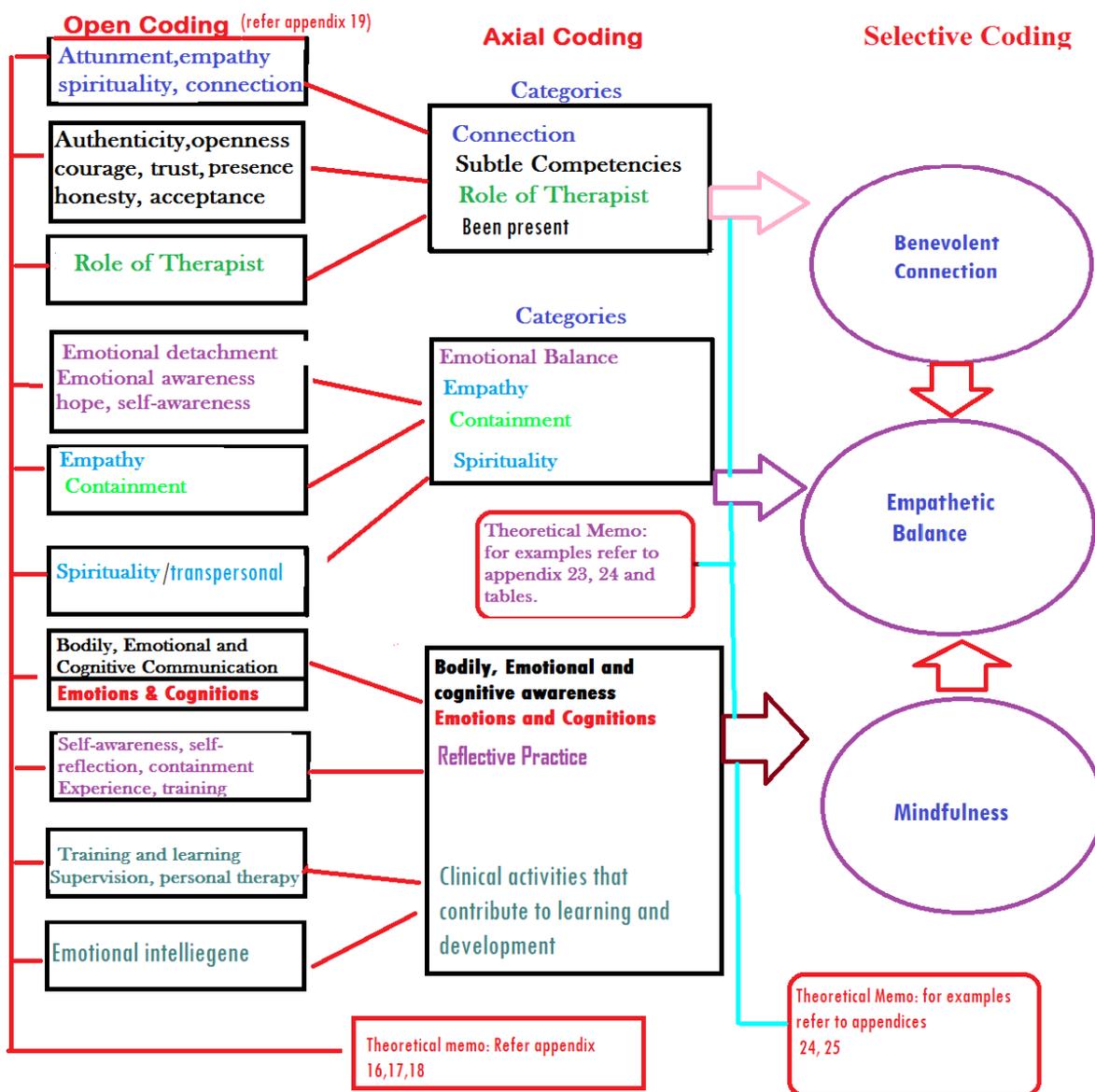
Figure 13: Relationship among categories

Thus, from these categories a central integrating focus pertaining to the participants of the study was discerned, which was a phenomenon that integrated the

categories as established in the axial coding stage. This central focus will hopefully enable much basis for discussion. High quality qualitative data and research methods are discerned by the transparency of their analysis. Increasing the study's reliability is achieve by demonstrating a link from results to data (Polit & Beck, 2004). As a result, an example of how grounded theory coding was applied to the data gathered for this research investigation can be found in the storyline memo in Appendix 19.

Morse (2009) expounded, "every application, every time grounded theory is used, it requires adaptation in particular ways as demanded by the research questions, situation, and participants for whom the research is being conducted...Grounded theory is...a particular way of thinking about data" (p. 14). The emergent grounded theory reflects the researcher's and participants' diverse perspectives and lived experiences, which are co-constructed and pragmatically linked in an interview dialogue. The emergent Empathetic Balance core theory holds promise for reconstructing the therapeutic relationship and for informing counselling psychology programs to address the potential utilization of an experiential EI training in developing mindfulness and therapeutic competencies.

5.4.1.4. Trustworthiness

Those criteria used to measure reliability and validity in quantitative research instruments are inappropriate for qualitative research (Agar, 1986, as cited in Krefting, 1991). William and Morrow (2009) suggested three main categories of trustworthiness, the balance between subjectivity and reflexivity, the integrity of the data, and the clear communication of findings. In sum, I believe trustworthiness was achieved in this study by the way the data were compiled, compared, and triangulated; how memos and a research assistant were used to balance reflexivity; and the thick or transparent descriptions of my biases and research findings. The specific trustworthiness procedures used in this study are discussed in more detail below.

Kvale (1996) proffered a view that a bad interviewer may conduct the same number of interviews as a skilled counterpart, but the data quality will be poorer, due to lack of probing of responses resulting in superficiality. Interviewing, as Kvale noted, is a craft reliant on a researcher's judgement and not "content and context free rules of method" (1996, p. 105). The interview is 'self-communicating' – it is a self-contained story which barely needs further description or explanation. Bearing this important qualification in mind, the interview process' credibility was evaluated using quality criteria developed by Kvale (1996, p. 145), which include:

- The amount of rich, spontaneous, relevant and specific answers from the interviewee.
- The brevity of the interviewer's questions and the contrasting length of the interviewee's answers.
- The interviewer's following up and clarification of the meaning of the most pertinent aspects of the responses.
- The extent to which the interview is interpreted throughout its duration.
- The extent to which the interviewer tries to check their interpretation of the answers during the interview itself.

To establish integrity or the dependability of the data, evidence was presented as to how the interpretations fit the data. For the current research, a diagrammatic audit trail, as recommended by Strauss and Corbin (1998, p. 148), was conducted. The diagram depicts the data analysis procedure and was created to underpin the dependability and confirmability of the study findings. Figure 14 shows a segment of the diagrammatic trail, illustrating how categories and subcategories were compared and consolidated to generate the theme mindfulness.

In-vivo quotes	Open Codes	Axial Codes	Selective Codes
"**I see myself if you like, as the sort of ... it's like having a barometer,** it's like being a little instrument, you have to sort of keep that working properly (laughs), What they mean **I'm just reflecting something but it's not in a sort of artificial way** (Participant 3; 332-336).	**expert self-reflective**	Reflective Practice	MINDFULNESS
"…I was really, really I mean how do you work with the clients you **literally hate, you don't feel you know erm. I had to take a risk and told he wanted me to hate him,** he did not want to empathise and care and **that truthful stand had made all the difference in therapy**. (Participant 2; 389-393).	**take honest risk / courage)**		
"… I started out working with children, and children have lie detectors and creep detectors that are absolutely finely attuned. If you lie to a child, it simply stops listening. That's all. It will very rarely talk back to you or tell you, or even acknowledge inside the child that it's stopped listening, but it has, and the wall has gone up. **And the only way you can engage with a child is to be really honest with a child. To be really authentic.** (Participant 12; 91-99).	**honesty/ authenticity**		
"I've also got that um **ability to sort of get into I can, really can feel like I'm getting into people's stories a**nd I think that has been sort of said to me in the past from people that are observed the work so there is something like er you know obviously I'm not feeling their feelings but I think that I'm may be feeling something along the lines of, of what they're talking about and what they're feeling **so there's something at that very sort of primal level but then there's also what, what feels like the sort of cognitive""** (Participant 1; 488-497)	**Emotional awareness** **Embodied /cognitive awareness**	Triad of Embodied, Rational, Emotional Awareness	
"No it was a very kind of bodily, emotionally a lot of time you know. Sometimes it can be cognitive you know sort of in the sense of you know I might feel let's say inadequate and nothing that I do is good enough you know so that's erm but sometimes I could feel you know really erm confused not knowing what is happening which could be part of" (Participant 2; 227-231)	Experience of a triad awareness Bodily, emotional Rational.		
"(Sighs). Yeah, I think probably for, well, for me, it's **probably more cognitive, um, but it's also when I'm aware of the, you know, bodily feelings as well, you know, the tension or different feelings in myself**"(Participant 5; 233-238)	**Awareness embodied / cognitive feelings**		

"because **it's a learning process you know one's learnt the theory but in terms of practice and its application then it, it is a constant learning process** and um with these two particular cases I've described the, the, the first I think um **I've learned the value of um taking risks um and measured risks and it … of, of course** it's always difficult to be absolutely confident that you've taken the right amount of risk and not too much" (Participant 6; 174-183)	**Experiential learning** **Experience generate courage for risky interventions**		
… look back to how **I changed myself in this role**, and I think when you start off, often the feeling is you're trying to help people but actually **I've learnt that if you allow people to just be and accept them they find their own way of accommodating what's happened to them**. (Participant 3; 80-84)	**Experience as therapist competencies learned via experience**	Experience	MINDFULNESS
... I think it's very important to, **I guess to be quite, what I say would be quite solid in yourself, you know, er, to have a good knowledge of yourself** (Participant 4: 110-114)	**experience add to self-knowledge as therapist**		

Figure 14: Example diagrammatic audit trail

Wolf (2003) discussed the importance of creating an audit trail when conducting qualitative research. In this study, the audit trail proved to be a useful tool in performing grounded theory analysis, because it accentuated the evidence and bias in tracking the development of the theory (Glaser & Strauss, 1999). For this study, the researcher recruited an independent counselling psychologist experienced in grounded theory to conduct the audit trail. The peer assistant evaluated the coding and categorizing of the data, which led to re-coding and re-arrangement adjustments (Creswell, 2006). Moreover, the coding and categorization claims have been tested, validated and argued in dialogue with the peer assistant and a grounded theorist supervisor who responded to my request for a verbal discussion. In order to establish a balance between reflexivity and subjectivity (Cutcliffe, 2000; Thompson, 2004) a peer assistant and a grounded theorist audit supervisor were involved as auditors in the veracity of the categories. The audit supervisor (an independent counselling psychologist experienced in grounded theory) challenged 11 percent of the emerging categories and concept.

However, after considering the criteria of "authenticity" (Lincoln & Cuba, 1986), and the reflective memos cautioning that over-reflexivity will stifle creativity (McGhee et al 2007; Thomson, 2004) 5 percent of the emerging categories (e.g., supervision, personal therapy, training and EI) where regrouped from the theme of extraneous involvement and a new category emerged as reflective practice with clinical activities training and learning. The new categories were positioned under the theme of mindfulness. The open coding, axial coding and selective coding was a process of bracketing prior knowledge via abeyance and a pre-reflective practice. The deepest reflection occurred when I was more at ease to infer a concept or category during open, axial and selective coding. Such deep pre-reflective practice was necessary to ensure a balance between creativity and minimizing possible bias of prior knowledge which could risk the interpretations during the transition of raw data to abstractions and meanings.

Another important concept within trustworthiness is the balance needed between what the interviewees reported and the researcher's interpretation of their meaning. This balance was noted as very important and was dealt with reflexivity but also with the balance of avoiding the dangers of being over-reflexive (Cutcliffe, 2000; McGhee et al., 2007). McGhee et al. (2007) cautioned that over-reflexivity will stifle creativity and inhibit production of a theoretical account that is worthy of being called "grounded theory." Similarly, Thompson (2004) debated in his article "Can the caged bird sing? Reflections on the application of qualitative research methods to case study design in homeopathic medicine," that any scientific process puts constraints on the system being considered. In the spirit of reflexivity and credibility of the study, the researcher acknowledges his own position regarding background knowledge, experience and theoretical learning on the research field. It is my opinion that the ideal role of a passive, objective observer seems implausible. I am therefore, explicit about my paradigmatic allegiances, my background, my role in data collection and my relationship to EI and the

therapeutic relationship. Another important condition for the quality of this study is the researcher's experience and training in psychotherapy, whereas clarity and accessibility are certainly two important criteria. I believe my clinical experience and relevance to the research question added to the ability and credibility of the research. Thus, the insights of the researcher and the research's assistant different perspectives added to the richness of the understanding of phenomenon under investigation and credibility.

The participation of a peer assistant researcher proved to be essential in providing triangulation during data analysis. Whilst I am wary of the danger of 'naive empiricism results' (Charmaz, 2007, p. 402) the researcher is framed within an approach that, whilst accepting that there cannot be a single category of 'EI and therapeutic experience' applicable to every therapist in the world, generalisations can be possible within broad categories. Readers of the study ought to be able to determine themselves whether the findings are applicable to other studies or other therapeutic relationship contexts. Hence, the study provides a detailed description of participants and facilitates any future researcher to make comparisons with other individuals and groups, to their own experiences or to other studies in the field of therapy.

Another major criteria adopted in this study was reflexivity. The researcher's own subjective positioning was noted at the onset of this study, and openness about the research process with an appropriate level of humility in acknowledging any limitations of the findings was established. In order to establish more credibility, triangulation was achieved by bracketing expectations and experiences via an "empathic neutrality" process, as previously expounded. Turning to the first person voice as a researcher and author of this study and examine my subjectivity and reflexivity with the peer assistant. I recognise that the lack of opportunity to discuss the way that my own past research identity development had shaped my interest, motives, creativity and perspectives. I openly challenge my notion of EI and the therapeutic relationship during this study

throughout the interviews, open coding, axial coding and selective coding processes. At times, I felt isolated in my own self-discovery in this field of research. The outpouring of support for EI from participants that I experienced in the interviews was genuinely unanticipated, and the significant defensive experience that participants felt within the experience of trait EI scoring was also surprising to me.

I clearly recognized, acknowledged, and positioned myself within the research process (Bryar, 2000) by using the principle of reflexivity, and remained cognizant for "empathic neutrality." Empathetic neutrality reminds me of the story of how Odysseus escaped from the Sirens; he could both recognize his mind's contents (the twin desires he felt to listen to the singing and to return to Ithaca) and to realise the incompatibility of these twin desires. The quality of research, though, lies not just in the variety of methods and sources, but in the practical skills of the researcher. I engaged constantly in a reflexive analysis for a more rigorous approach to data collection, which enabled me to know my own subjectivities, preconceived notions, biases and understandings of my ontological, epistemological, and methodological stances. Therefore, my previous involvement in the area of therapeutic relationship and EI was explicitly outlined at the beginning of the research. Thus, such self-awareness is giving credibility to the research project (Greene, 2007).

The current study adopts Cutcliffe's (2005) suggestion that credibility should not necessarily be confirmed with those who provided the raw data but rather the emerging theory of this analysis should 'fit' the situation and 'grab' attention because it has resonance. This study adopts Lincoln and Guba's (1985) achievement of trustworthiness and attainment of four key constructs that relate to:

1. *Credibility:* The satisfactoriness of field data, which preferably involves exploiting different types of data, gathered through different means from different participants.
2. *Dependability:* Dependability is concerned with the stability of data over time and over conditions.

3. *Transferability:* is the parallel concept of positivism's generalisability referring to the degree to which findings may be transferred to other contexts or groups and depends on the researchers' thick description of the phenomenon being studied and the richness of his or her description and interpretation.
4. *Confirmability:* The neutrality of the data that the researcher illustrates as transparentlyas possible the evidence and thought processes that have led to the findings.

The strategies deployed in the thesis to build trustworthiness are depicted in Appendix 21. The strategies conform to Lincoln's and Guba's (1986) model of trustworthiness.

Triangulation is another strategy for assessing the truth value of the research (Krefting, 1991). This triangulation provided yet another means of maintaining quality control by involving multiple sources and perspectives to lower the risk of systematic bias. I employed theoretical triangulation be comparing data and results back to related theory (Yin, 2003).

Furthermore, the quality of the study encompassed Bochner's (2001) set of criteria which blends scientific rigour with ethical integrity and artistry:

- Detail, of the commonplace, of feelings as well as facts;
- Narratives that are structurally complex and take account of time as it is experienced;
- A sense of the author, their subjectivity and 'emotional credibility';
- Stories that tell about believable journeys through the life course;
- Ethical self-consciousness: respect for others in the field, and for the moral dimensions of the story;
- A story that moves the reader at an emotional as well as rational level. (Bochner 2000, cited in Green & Thorogood, 2004, p.244)

The researcher in this study values Bochner's criteria as important based on his experience in psychotherapy and research. Additionally, the emerging theory of this study adopted the qualitative evaluation criteria of 'rigour, relevance, resonance and reflexivity' (Finlay and Evans, 2009, p. 60).

According with the principles of grounded theory methodology, the study used participants' individual language at each level of coding in order to promote the credibility of findings (Strauss & Corbin, 1990). The analysis of the data also involved engagement, constant abstraction and a dynamic process of identifying codes, and categories grounded in the data. The researcher used words that best represented the meaning of codes and categories. The descriptive categories underwent a separate audit to check validity. In the current study, quotations were taken out from an interview to develop categories and concepts, which contributed to the evaluation and rigour process. In this study, this issue was addressed by supported interpretations and meaning to codes and categories from interview data. In reinforcing this study's credibility, I also provided a thick description of the research process, adopting Krefting's (1991) trustworthiness, which is based on the grounds of transparent focus and a clear description of strategies within the study. This study is not about creating surprising new substantive theories but it is about understanding what is happening to those therapists experiencing the therapeutic relationship and the EI concept (a phenomenon) from their point of view.

Using grounded theory to analyse data from participants who are experienced therapists resulted in some advantages. As Finlay and Evans (2009) reported, a lot of the familiar clinical skills and interests of therapists (for example, empathy, interviewing skills, inferential thinking and reflexive or intuitive interpretations,) can be directly transferred to the domain of qualitative research. Subsequently, the research relationship is between the researcher and participants in which both parties contribute. In this study, I was involved in the considerable reflective evaluation of my own position with regard to the therapeutic relationship and my own working model of cognitive analytic therapy. This resulted in more work that I had first thought. The process of gathering data is primarily a co-creation of researcher and participant; therefore, the topic under investigation is more of an art or craft than science. The essence of therapy research is a

reciprocally interacting world of experience, interconnection, and interdependence.

This "intersubjective horizon of experiences needs an approach such as grounded theory to allow access to the experiences of others" (Wertz, 2005, p. 168). At the same time, those experiences must be credibly and reliably studied and reported, while avoiding polarization or dichotomy in the study of complicated entanglements. Although most methods are theory-testing, just a few actually result in theory-building (Glaser & Strauss, 1967). Through grounded theory, this topic of research resulted in a much more substantial end product.

5.5. Ethical considerations

As this project involves human respondents, there were various ethical considerations that required attention. First of all, it was necessary to apply for permission to conduct this research from the Senate Research Ethics Committee to ensure the subject matter and study methodology were sound (refer to Appendix 13). Also, correct consent forms were signed by each of the participants prior to commencing the interviews. Throughout the interviews, the researcher sought feedback from the participant to check they were feeling comfortable. The main concern was ensuring that the participants' details and identities were kept confidential; not only to ensure that the study complies with standard ethical procedures, but also to aid the participants' relaxation and honesty in the interview sessions. This was maintained by keeping passwords on the computer where the transcript and questionnaire data were stored. The researcher's safety was assured by conducting the interviews in the certified treatment rooms of the therapist, and by ensuring that a University supervisor also was aware of the interview location.

5.6. Limitations

A criticism in the field of grounded theory has been the claim that it is affected by internal misalignment (Bryant, 2002). The strongest critiques of grounded theory are its failure to shake off its positivist origins (Bryant, 2002). Cognizant of this fact, Charmaz (1983) argued that Glaser and Strauss effectively bridged the gap between theoretically "uninformed" empirical research and empirically uninformed theory. They achieved this through developing theory by grounding it in data. However the notion of "emergence" of theory from data is especially problematic (Watling & Lingard, 2012). For instance, how does theory, in fact emerge from data?

Another major issue is the prior knowledge or personal experiences and perspectives of the researcher, as Glaser (1992) called for the researcher to enter the field with "abstract wonderment" (p. 22), meaning the researcher adopts a more constructivist approach and dismisses the passive stance since is not tenable within postmodern paradigms (Bryant, 2002). The notion that the researcher must recognise and then consciously change her/his state of mind and perspective, infers that there is a truth within data that can only be revealed if the researcher can manage to be outside of the data. I view this critique as healthy and energizing for creative thinking and to adopt measures for knowledge creation. For instance, in this study, I have used reflexivity, acknowledged the researchers context, roles and knowledge construction of the paradigmatic allegiances and established a stance of "empathic neutrality" as previously expounded.

A further limitation of qualitative research is that it is interpretative, meaning it is unlikely two researchers would arrive at precisely the same conclusions since it is concerned with the subjective interpretation of meaning. On the other hand, Kippax et al. (1988) argued that, "a given experience, once we have identified it through qualitative research...is valuable within a culture or society" (p. 25). Another argument, put forward by Morgan (1996), was that the grounded approach was not repeatable and that the

findings were just specific to the particular study. On the other hand, by definition, the nature of qualitative research is not to strive for consistency or to attain consistent results; instead it is about eliciting responses from a participant or researcher at a specific point in time and specific place and in a specific context. The position of qualitative research is that we can never exactly replicate situations. Qualitative research is a combined production of researchers and participants (and readers) and their relationships. However, as Strauss and Corbin (1990) put forward, as long as the data used are comprehensive and the interpretations made are broad in conceptual terms, the developed theory can result in an adequate summary and variations to enable its application to many other related contexts. Because the theory developed from this work contained sufficient variation for EI and its links to therapeutic relationship, EI research in therapy within one context could reveal something of relevance about EI and anxiety of therapists in another related context.

As with any other qualitative methods, the subjective elements of grounded theory in this study could be criticized. However, as a qualitative researcher in this current study, I recognized that research is dynamic and co-created and that, by definition, it involves subjective interpretations. Because interpretation is inexplicably linked in the research process, any analysis must be seen as a "tentative statement opening upon a limitless field of possible interpretations" (Churchill, 2000, p. 164). These subjective interpretations are part of the process in this research through which vicarious experiences are enabled (Polkinghorne, 1983). However, grounded theory also resulted in broadening my understanding of participants' meanings and in challenging my assumptions about the phenomenon (Cooper, 2004). Therefore, as a researcher, I remained open to such claims rather than denying them, and accepted that the researcher is a central figure influencing (and actively constructing) the collecting, selecting, and interpreting of data. The

researcher anticipates a number of methodological challenges with regards to subjective inferences (refer to Appendix 20).

The researcher acknowledges his personal experience and reading of the literature on EI and the therapeutic relationship, and how these could negatively influence the interpretation of the research. Thus, the researcher imposes meaning onto the results gained. Subsequently, it would be impossible to delay, as Glaser and Strauss (1967) advocated, those experiences form part of an intersubjective research experience. Embracing researcher and participant subjectivity can have the advantage of enriching and providing a meaningful, embodied understanding of human phenomena (Luca, 2009) and therefore, promote validity.

The interviews, being open-ended in nature, ensure that the participants felt as though they were in control of the direction that the interview took. This ensured that the researcher was not placing their own ideas of the outcomes of the interviews onto the participant - rather, the researcher enabled the conversation to unfold naturally. Another limitation and paradox is the fact that grounded theory cannot claim to be objective as any experience is subjective. However, does objectivity means credibility? Beck (1993) argues that credibility is a term relating to "how vivid and faithful the description of the phenomenon is" (p. 264). In qualitative research, credibility is shown when "informants, and also readers who have had the human experience…recognize the researcher's described experiences as their own" (Beck 1993, p. 264).

Chapter Six

6.   Findings and discussion

This chapter highlights the main findings from the interviews, using grounded theory as the method of analysis. An example of how the interview transcripts were used in order to discern emergent themes, as well as a variety of categories identified through open coding, can be found in Appendix 8a and 8b. Three superordinate themes encapsulated the analysis of the interview transcripts. These were derived from, and supported by, various key categories or subcategories that were generated as a result of open coding, axial coding and selective coding analyses (see Figure 15). The conceptualization of connection and mindfulness relates to empathetic balance, derived from an increased consciousness and contemplation of balance and empathy. Table 7 depicts the most prominent themes that resulted from the study, and a more detailed discussion of each of these themes follows.

Themes	Categories (or second order concepts)	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
Empathetic Balance	Empathy	√	√		√	√	√	√	√	√		√	√
	Spirituality / Transpersonal	√	√		√	√		√	√	√	√		√
	Emotional Balance	√		√	√		√	√	√	√	√	√	√
													√
	Containment	√	√	√	√	√	√	√	√	√	√	√	√
Benevolent Connection	Connection	√	√	√	√	√	√	√	√	√	√	√	√
	Role of the Therapist			√			√			√	√		√
	Being present	√	√	√			√						√
	Subtle competencies of an emotional connection	√	√	√	√	√	√	√	√	√	√	√	√
Mindfulness	Physical, Emotional and cognitive awareness	√	√	√	√	√		√	√	√	√		√
	Clinical activities that contribute to emotional learning and professional development	√	√	√	√	√	√	√	√	√	√	√	
	Reflective Practice	√	√	√	√	√	√	√	√	√	√	√	
	Emotions and Cognitions	√	√	√	√		√	√					√

Table 7: The emerging themes and the frequency of the categories for each participant

6.1. Overview of themes

The central and most prominent themes found in this study are shown in the diagram below. The main themes that arose from selective coding were: empathetic balance, benevolent connection, and mindfulness. The subcategories that emerged through axial coding can be found in more detail in figure 15. The categories and linking concepts are further elaborated below and illustrated by verbatim quotations from the interview transcripts.
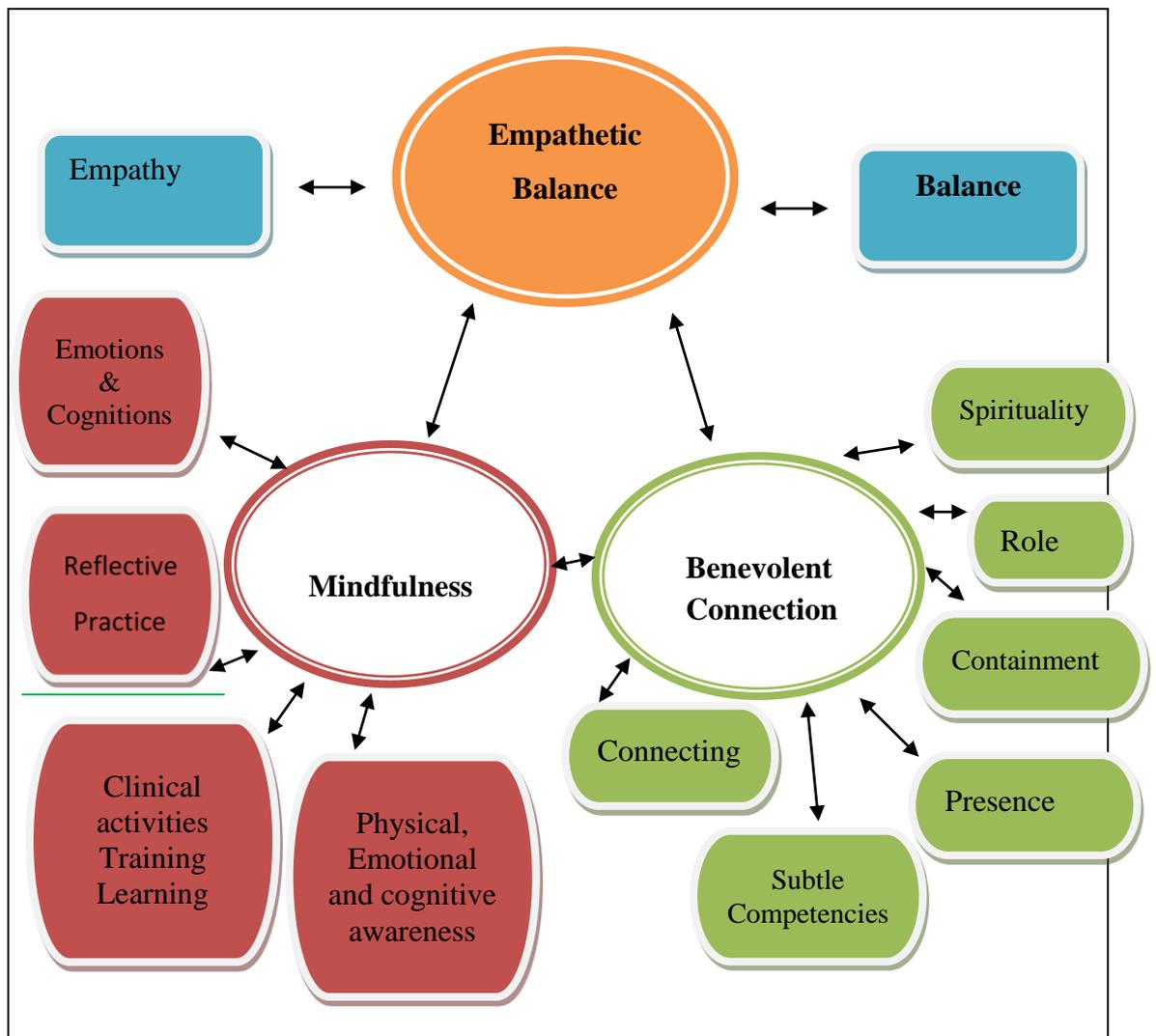
Figure 15: Mapping of the Core Emergent Themes

6.1.1. Theme A - Empathetic balance

One of the most prominent themes to emerge from the data was empathetic balance. Whilst each participant talked extensively about empathy as a main attribute of a successful therapeutic relationship, the idea that balance was necessary in order to ensure that the therapist does not become overwhelmed with emotion was prevalent throughout most, if not all, interviews.

6.1.1.1. Empathy

Various participants discussed empathy in the interviews. Participant 1, for example, claimed that the most important element of the therapeutic relationship from his perspective, was, "being able to be empathetic, being able to meet the client where they are." This was a colloquial way of expressing a portion of the Mercer and Reynolds (2002) definition of empathy, which is the ability to understand the patient's situation, perspective, and feelings and the ability to communicate that understanding. The therapist had experienced times when he himself had felt the same emotions as his client: "[I was] sort of recognizing that I'd felt like that myself at times. Similarly, it just enabled me to connect with her...I just suddenly thought God you know I really, I really know how you're feeling."

Participant 5 commented that in a particularly poor therapy session she found she was not being empathetic, which added to the sense of disconnectedness with and lack of care for the client. Participant 7 reported, "Therapists without empathy I think are ineffective." Stern (1998) reported that empathy is a necessary component of EI, as it leads to a connection with the client's subconscious emotional state to help them understand what is happening and why. Furthermore, the idea that empathy is a complex, multidimensional concept, which has moral, cognitive, emotive and behavioural components (Mercer & Reynolds, 2002), suggests that it is integral to the therapeutic relationship, as was found in the literature review. Participant 2 added that rather than

judging it empathy aims to understand human behaviour: "what the client is experiencing...and the ability to afterwards make sense of it and you know let the client know what is happening. Interpreting or facilitating you know asking certain questions that might eventually help the client to make sense of it by himself but not judge him." This reflects the third component of the Mercer and Reynolds (2002) definition of empathy, which is to "act on that understanding with the patient in a helpful (therapeutic) way" (p. 9). Thus, emotions are shared between the client and the therapist within a positive therapeutic relationship. Participant 2 explained, "To a certain degree it's his emotions not mine but now it's mine because I'm experiencing it."

The therapist expresses an important point concerning empathy. He must convert empathy into an act that assists the client in some way, such as helping the client make sense of feelings and thoughts. Participant 3 also used empathy to get to the root of the client's problems: "[I]t's not like in counselling where you might just say the same thing back again...you have to be aware of what people are feeling but you can't sort of lose it, you can't sort of just sit there being sympathetic. I see my job as helping them come to terms with that thing so in a way you have to be a bit stronger about it than whatever it is, you have to contain it somehow in yourself." The above comments address all of the components of empathy, which include understanding, communicating, and acting on that understanding. Participant 3 also raised an interesting point in terms of feedback. The acting on the clinical empathy does not mean simple mirroring feedback of what the client said, which is typical in some types of counselling. Participant 3 attempted to assimilate the same feelings and then use feedback as an act of therapeutic counselling. As Participant 3 suggested, the therapist must be able to control the feelings once assimilated so they do not overwhelm the therapist, which can then result in biased feedback.

Similar to Participants 1, 2 and 3, viewing the situation from someone else's perspective, as opposed to simply seeing things through one's own eyes, is also an

important aspect of therapy. Participant 4 claimed that the most important element of therapy for her is the, "empathetic approach, I guess...maybe through the empathy, being able to, sort of, see it through someone else's eyes, maybe. You know, not always from my own."

Therapists are subject to the same subjective interpretation of feelings that the client is subject to, which can actually lead to a distortion of the empathetic feelings. In other words, the therapist has an EI made up of the eclectic mix of positive traits that include relationship skills, self-motivation, happiness, and self-esteem, among others. Participant 5 pointed out that some attempts to empathise fail and those times are surprising to the therapist: "I can get quite surprised when I, you know, when I get it wrong and I can get it oh get it really wrong really I'm really way off here." It's possible the therapist's own EI has blocked attempts to develop the empathy needed to provide the appropriate feedback to the client. Participant 12 alluded to the same issue, describing the entire therapeutic relationship as "an exercise in attunement" and cautioning, "our job as therapists is to feel where the person is when they come. And to see if we can attune to that place, and keep our own observer, without judgment and free, to see what's going on."

Maintaining clinical empathy requires the therapist to process client's feelings without judgment, and that can be difficult if the therapist's own self-awareness and introspection distort the therapist's empathy. However, if we follow Solomon (2003) in defining emotions as judgements, it would appear that a clinician could not attune to emotions without judgement because they are one and the same. In the Salovey and Mayer (1990, 1997) EI model, a component of EI includes "an ability to regulate one's own emotions and an ability to use emotions to solve problems" (p. 189). Empathy then, as one component of EI, requires therapists to manage their own emotions to better counsel a client.

Most participants claimed that they generally do "feel a great deal of empathy [or] a great deal of pain depending on what's going on and [of the client's] concern" (Participant 6). Participant 1 agreed and reported, "I have...a lot of feelings for her...because I know it's really hard for what she's going through." Attunement, or attuning to someone else's emotions, is often used in place of the word empathy. Participant 2 commented, "that can also be a certain aspect of empathy when you attune to someone else's feelings." Participant 6 on the other hand called this '"being emotionally available," and claimed that, "it's important as a human being to be emotionally available," so as not to "become too, as it were, clinical about it" - the therapy.

Often when a participant had a difficult experience in therapy, it was when it was hard to empathise with the client, or when there were inhibitors to the development of an emotional connection. Participant 2 commented:

> "I found it really difficult to kind of empathise with her. I really felt even a sense of hate towards her and I had a really lot of negative feelings which I found it really difficult...there are times when I could really probably empathise with people and see things from their perspective but there are probably other times when I'm really you know, I don't know, I might not be open to listen to anyone else because I'm, for example, I'm in an emotional turmoil myself and I'm not open to kind of see other people's pain or how they feel you know because I'm really kind of closed off in my own [world]."

This account reflects the difficulty therapists may encounter in managing their own feelings so as to not to interfere with the empathetic process. This reflects the emotional facilitation of thinking as a component of EI in the expanded Mayer and Salovey (1997) EI model. The words "I might not be open to listen to anyone" and "I'm really kind of closed off in my own [world]" indicate the therapist is involved in a personal cognitive process that prevents empathy.

6.1.1.2. Empathetic balance

In Goleman's model (1995), empathetic balance would fall within the five factors of EI (knowing, managing, motivating, recognizing, and handling), but particularly in the factors of knowing one's own emotions and managing emotions. Maintaining balance would be a form of self-regulation (intrapersonal) competency, which influences the therapist-patient relationship (interpersonal). The Bar-On (1997) EI model also encompasses the competencies influencing the internal attunement to the patient's feelings and emotions and the external expression of that attunement. Participant 9 similarly recognized the importance of knowing the feelings in self and others, an important part of Mayer and Salovey's (1997) EI definition:

> "This is mine, this is my stuff. This is … doesn't belong to me, just wait one second, what I'm feeling, what I'm thinking it's not my normal way of thinking or feeling … which in it means something, oh, between my relationship, it means something about all relationship than anybody else would experience, which is important to help the client to gain awareness about the impact that she has on me. Or it could be also a window in her inner world, which then is really how she feels."

Thus, Participant 9 attempted to portray the complexity of the interplay between contradictions, incongruity, and awareness, as the therapist is accumulating knowledge about the relationship with the client. This interplay is also advocated by Fonagy et al. (1991) and Main (1991), who emphasized the ability to engage in meta-cognition and connect with the work on theory of mind. In the same line of synthesis, Salovey and Mayer (1997) employed this structure of coherence to label this set of mental abilities as EI (Mayer, DiPaolo & Salovey, 1990; Mayer & Salovey, 1997; Mayer, Salovey & Caruso, 2000). This is also consistent with previous discussions in the literature review on the concept of transference (Samuels, 2006), as the process of a person recreating his or her patterns of emotional experience in the context of the current therapeutic

relationship. Similarly, Knox's (2001) theory maintains that implicit memory is the basis for transference.

Participant 6 noted that one of the most important aspects as an empathetic therapist is to find "balance between being emotionally close and available and emotionally separate so as to preserve the independence ... That balance between emotional distance and emotional closeness ... those seem to me to be the key features." This participant also reported, "I need to maintain a stability of my own so as to be helpful." This idea also supports the work of Winnicott (1971), who reported that clients need to "use the therapist" (p. 121) for working through feelings and beliefs regarding early experiences. The therapist is not the provider of experience for clients, but rather clients find their own experience within the therapeutic relationship.

The idea that a therapist cannot be helpful if they are 'lost' in the emotions was expounded by Participant 7:

> "You've got to position yourself somewhere in the middle ... where you can
> ... understand what people are feeling, feel it yourself to some extent too, to
> be able to help them deal with it, but yet not be swamped by it, to the extent
> that you cannot actually be therapeutic . . . I'm here to experience and try
> and be helpful to deal with this problem, because they're not dealing with it
> ... You know that experiencing, um, some awful trauma is helpful to people.
> Re-experiencing it in a therapeutic relationship is helpful, that's the
> evidence of it. But it needs to be directed. It can't be swamped ... you need
> to have some balance ... It's being moved but not swamped."

The need for balance is expressed in this participant's words of "middle," "deal with," and "directed." The word "contain" was also used by a number of participants to denote the same meaning as balance. For instance, Participant 11 stressed that it is important "to feel these emotions, contain these emotions so that at the end of the session she could leave in one piece." This also links to Bion's (1962, 1970) concept of 'containment' and developmental theory of the 'good-

enough mother' that is translated into the 'good-enough therapist.' In understanding

the child, the mother is seen as understanding both the cause of the child's distress

and also experiencing how the distress feels (e.g., empathy).Similarly, all

containment done in therapy is loving, encouraging, understanding, and accepting.

However, the vital issue is that the mother does not feel overwhelmed by these

negative feelings herself, and in a similar position, the therapist must 'contain' the

experience of the client's emotional pain but regain a balance and not be *swamped*.

Participant 1 commented: "if a session is sort of really emotionally difficult . . . I'll

sort of recruit my internal supervisor if you like and so I'll sort of clock into an

awareness of me feeling like it's really difficult. . . . I maybe slow down." The words

'internal supervisor,' 'awareness' and 'slow down' show how the participant is

engaging in a process of managing the difficult feelings and maintaining

equilibrium or balance. The balance is necessary if emotions are to be "used in

functional ways," as George (2000) reported necessary for EI. Maintaining balance

requires that therapists appraise not only the emotions of others, but also their own,

and, more important, regulate them, which are important facets of EI theory (Mayer

& Salovey, 1997). As Participant 7 reported, "we all have experienced anxiety and

low mood. ... And that helps, I think, to consider one's own experience." Therapists,

like any other human being, are feeling creatures, and thus, they must appraise and

regulate their own emotion, as Participant 3 reported:

> "I see myself if you like, as the sort of ... it's like having a barometer, it's
> like being a little instrument, you have to sort of keep that working properly
> (laughs), so if you don't pay attention to the build-up of feelings in yourself
> it can sort of go over the top sometimes"

Thus, balance is described as a 'barometer' that prevents therapists from being so

involved with clients' emotions that they cannot be helpful. In addition, balance helps the

therapist to journey toward a more empathetic place. The therapist plays an attachment role in the therapeutic relationship, and this is akin to Winnicott's (1963) child development ideas, discussed in the literature review. As Participant 2 contemplated:

"Let's say anger was not really allowed in relationship with the mother that was not strong enough to contain or so all of sudden if it becomes er a possibility in the room or in the relationship between myself and the clients then it can become it might initially be really and being a very passive, aggressive way he would not be able to own his anger you know erm but I will not retaliate or suggest that it's not allowed erm you know."

The need for emotional balance is expressed in the words "contain," "not retaliate," and "suggest that it's not allowed." In other words, the therapeutic relationship provides a developmental trajectory in which the client begins in a state of great dependence, and from this state, progresses to a state of relative dependence, and then later "towards independence," with the facilitating therapeutic relationship space (environment) providing the arena for the maturational processes to drive this trajectory. Balance is necessary for this therapeutic maturation to occur. Balance also helps the therapist deal with the challenge of sexual attraction. Regarding sexual attraction, containment, and boundaries, Participant 8 said about a client, "I'm very fond of er she's er I think she's very attractive, she makes a lot of money you know er but part of it is I think oh gee if I wasn't her therapist you know I, I would, I would be interested in her, you try to keep that out of it." The participant links boundaries and containment and the importance of maintaining emotional balance.

The question of whether empathy can be learned is something that emerged in the interviews, with Participant 7 reporting:

"Empathy is quite interesting, because a question came out about a trainee who was lacking in empathy. 'Can it be trained?' . . . I'm not sure that the evidence is very clear cut about whether you can increase something which isn't there, or at least is very lacking. But certainly it's important."

The idea that empathy cannot be trained is perhaps one that does not sit very well with those who advocate EI, simply because if EI is measured and malleable like cognitive intelligence, which can be learned, then EI can be learned also. EI is, however, mainly learned during childhood, and therefore is something that is subconsciously - and often quickly - learned by those children that have emotionally intelligent parents (Siegel, 2001). Thus, given that empathy is a major facet of EI, it stands to reason that empathy can be taught and learned. This is similar to Ciarrochi, Forgas and Mayer's (2001) conceptualisation of self-actualisation, wherein they claim that individuals must continually work towards being the best that they can be. Thus, it stands to reason, that people should, and can, continually work towards being the most empathetic that they can be (Ciarrochi, Forgas & Mayer, 2001). The theme of empathetic balance emerged out of the results because the terms 'empathy,' 'containment,' and 'balance in empathy' (and variations of these terms) were mentioned in almost all participant interviews. Of course, the theme of empathetic balance is interlinked with the next theme, emotional connection and attachment, which has subtle but important differences (as well as similarities) with empathetic balance.

The awareness that there should be an empathetic balance in the therapeutic setting could refer to the discussion of transference in the literature, which suggests that feelings are 'transferred' from the client to the therapist (Samuels, 2006), who must identify these emotional projections and utilize, unpack, and make sense of them in an effective manner before passing or reflecting them back to the client in what is termed 'countertransference' (Sedgwick, 1994). This process enables a subconscious undercurrent to be present between the therapist and the client, and allows the therapist to react to - but not become too involved in - the client's emotional projections and experiences. This process ensures that the therapist always remains a calming, constant

presence. These ideas are all intrinsically interlinked with the idea of the therapist achieving an empathetic balance within the therapeutic relationship.

6.2. Theme B - Benevolent connection

The idea of an emotional connection and attachment was prevalent throughout most of the interviews, and underscored most participants' ideas of what constituted a successful therapeutic relationship. For this reason, it was the theme that the participants talked most about, and its links with EI are subtle but nevertheless present. The role of the therapist was also a sub-theme of this category because of its links with attachment, as was presence, which relates to the idea of an intrinsic, alive, 'present' emotional connection.

6.2.1. Connecting

Participant 8 commented that one of the most important facets of a healthy therapeutic relationship is connecting, claiming that, with one troubled client, "it felt like we were able to make that connection and I was feeling really hopeful." Thus, connecting is related to hope that the client can benefit from the therapeutic relationship. Participant 11 commented that a connection is vital, claiming that, "You have to make a connection. And that connection is subtle. It's not just an intellectual connection...meeting on some kind of emotional level." However, Participant 11 did not view hope as a necessary component of connecting, but rather truthfulness was key; "telling [the client] what I felt truthfully...actually about unlocking people to enable them to find their own capacities including emotional capacity so that may or may not include hope." Yet, a connection is of course more than simply one person reaching out to another, as Participant 11 described, but rather it requires the input of two people. This harkens to the central unconscious connection between the client and the therapist described by Sedgwick (1994) that can lead to mutual attraction, mutual understanding, mutual respect, and thus, a possibility of healing.

Participant 8 commented that one client:

> "Wanted to connect as well. Maybe that's something actually I mean you know it's not just me that's staring that you know there's two people in the relationship so er I guess it's about what the other person's coming with and how much they are able to connect or not."

Other participants described this mutuality in a variety of ways. Interestingly, Participant 9 viewed the emotional connection between the therapist and client as "like a bridge. It's a meeting between two persons … I'm a specialist in social science, he's a specialist of his own experience. If we don't create a relationship between both of us, well, nothing is possible." Participant 9 reported that someone lacking emotional connection with another as being "cut out of the world." In a similar vein to empathy, where often transference and countertransference underscore the therapeutic relationship, Participant 3 asserted the emotional connection between the therapist and the client as "like a mirror I suppose, it's so that they can see themselves." In this way, Participant 3 did not attempt to colour the connection with her own views, rather she claimed:

> "I try to see what that person is needing and I try to be completely blank about it. It doesn't matter. They should be able to say anything they want to say and then by reflecting back to them, responding to them, they get a picture and then they can correct me if I'm not quite there or whatever, so that they see the picture clearly, so they can actually see what they're doing . . . once people see what's going on they start to be able to recognise in themselves how it feels when that happens and make those connections, and that's when the emotional awareness part comes in, connects with the behaviours, but obviously it's a very gradual process, which sometimes takes a long time."

In order to create an appropriate emotional connection with a client, it is important to know one's own limitations as a therapist. Participant 3 described this as being "completely blank," which could be decidedly difficult. Therapists would have to self-regulate their feelings, moods, and emotions to create such a blank person. Without the

blankness, it will be more difficult to establish a connection. Participant 12 described *attunement* as the most valuable thing. Participant 4 viewed it as most important to "have a good knowledge of yourself, I suppose, and your...weak points maybe," to be "quite solid in yourself" - something that is often aided by personal therapy for therapists, and the willingness of therapists to enter therapy. Interestingly, Participant 7 defined emotional connection as "being present. So, unless one has some degree of understanding of phenomenology and the developed capacity to bracket off the intrusion of agendas, habits, assumptions, dogmas, it would be very difficult."

Another description of connecting was from Participant 10, who saw the therapeutic relationship between client and therapist as a form of teaming up. The participant reported:

> "Therapy only works if the client and the therapist are teamed up in some way, you know if they're performing some kind of team to solve one person's problems. And if that doesn't happen, then the outcomes are usually very bad. So, the therapist has to be able to have a set of social skills and atonement abilities to deal with the range of people that come with problems."

The introduction of the concept of 'team' from this participant is not surprising. Any relationship requires a mutual exchange, but successful relationships lead to mutually beneficial exchanges. The therapist is able to connect emotionally with the client only if the client is willing to share, and that leads to a possibility of positive outcomes as the therapist provides counselling feedback. The focus must be on the client, of course, but if there is too much focus, Participant 10 claimed that the therapeutic relationship can become "lopsided." Yet the ability to maintain the relationship, emotional connection, and focus on the client is not always easy, especially in the first few years of being a therapist, which is something that Participant 10 admitted:

> "When I started off being very self-conscious, you know trying to do interventions very mechanically, trying to follow a model, do everything right,

to the point where you often neglect the warmth of the relationship, you know
one is too busy trying to do the job properly and of course when all that stuff
becomes second nature then it is much easier to concentrate on the relationship .
. . I think that it took 10 years for the tools to become almost unconscious so that
they appear in your mind rather than having to reach for them. So the
conversation is flying along and something will just pop out of there."

The idea that more forces are at work within the therapeutic relationship than
meets the eye is something that a variety of participants commented on, and this is also
supported by the idea, discussed in the literature review, of implicit procedural
knowledge. According to Siegel (2001), implicit procedural knowledge is where many
memories are hardwired into the unconscious self, and that these all work to influence
how we think, and interact, with others, including in the therapeutic setting. It is these
implicit memories that the therapist must seek to draw out for the client, in order for them
to be acknowledged and dealt with. In some cases, this led to the next sub-theme found
within participants' interviews, spirituality.

6.2.2. Transpersonal / Spirituality.

The connection between client and therapist was often described in terms of
something outside of the two people in the room. Participant 12 included a spiritual or
transpersonal perspective in defining the meaning of the therapeutic relationship by
suggesting "the therapeutic relationship, in my experience of 15 or 20 years of doing this,
happens within the first three minutes. And if it doesn't happen, it isn't going to."

Participant 9 referred to the emotional connection as "a taste of spirituality which
means me, the client, and something bigger than us," and added, "spirituality is being
connected with myself and what's going on for me, and being able to connect with
someone else." Thus, for Participant 9, connecting with another person is almost
transcending reality and the notion of a higher power outside of the two of them, yet
embedded within the relationship. This perspective identifies how the whole person is

capable of being transformed through multisensory engagement, which can lead to different ways of knowing, being, and doing (Braud, 1998). Participant 5 echoed the sentiment that the emotional connection in the therapeutic relationship transcends the everyday relationships that are available to the client, and Participant 7 described the mystery of the emotional connection by noting, "Ontology is a mystery that shifts further and further away from us, we can't grasp it."

Furthermore, the relationship between the therapist and the client is described by other participants as being subconscious rather than unconscious. For example, Participant 12 reported, "[I]f we're used to being attuned to people, then we know things. Sometimes without knowing them consciously." This is a point echoed by Palmer (1998) who posited that *knowing* may occur through an "intuitive intelligence" (p. 173). Whilst it is not always possible to describe the exchange that occurs between therapist and client, it appears that most participants believe that there are greater forces at work, whether spiritual, from a higher power, or from a subconscious activity in the brain and body. That idea of spiritual circulation is akin to Jung who noted, "There is no linear evolution; there is only circumambulation of the self" (1965, p. 196).

This appears to focus on the substantial effect that spiritual experiences and deep transpersonal encounters between client and therapist can have. "The transpersonal relationship is the timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual dimension of the healing relationship" (Clarkson, 2003, p. 187)

6.2.3. Difficulties in forming an emotional connection

What happens when therapists are not able to create that blank person discussed earlier and personal emotions intrude? What if therapists cannot marshal their emotions? As was the case with empathy, the inability to develop an emotional connection can create worry and unsettledness. Participant 8 reported:

"[One client was] the first person that I've actually felt that I don't like and that I can't find something to connect with … and that just feels really … well, different and worrying [sic] and just something that I've not experienced before. ... I'm normally able to find something, there'll be something somewhere and it's normal ... it doesn't take that long actually to find a connection."

This passage offers a sound example of reflective practice, and the participant reflects at different levels on connection while showing awareness of the potential impact of not connecting. Similarly, Participant 6 had had negative experiences of therapy, which were more often than not the result of not being able to find an emotional connection with a client:

"At the other end of the scale is someone I've worked with who I found very difficult to build ... an emotional um relationship with ... with this particular woman um it was possible to go through the mechanics of the process but without the essential emotional engagement which I think resulted in it being a much less rich experience for her well and for me."

Thus, it appears that the inability or the resistance from clients or therapists towards an emotional connection, bond, or engagement can lead to difficulties, and therefore, therapists should recognise such limits and bring the therapy to a close, as was noted by Participant 6:

"I've learned that it's not very helpful to continue to pursue a therapeutic process when clearly there is no therapeutic engagement and the resistance is such that it's not making any progress and therefore it's better simply to confront that and if necessary draw the therapy to a close."

Participant 8 reported words like "don't like" and "can't find." Participant 6 actually called the client "very hostile and very um challenging." The hesitation in the description would seem to indicate that the therapist did not like calling a patient challenging but does admit that the client was defensive.

6.2.4. Subtle attributes and competencies of an emotional connection

All participants have substantial attributes and competencies of a good therapist for enabling an emotional connection under the following data emerging categories: openness, acceptance, clarity, honesty, flexibility, alive, courage, safety, care, trust, and patience. The findings also support Norcross's (2002) framework of therapeutic relationships as discussed in literature review, such as the alliance, empathy, cohesion, self-disclosure, goal consensus and collaboration, positive regard, congruence, feedback, repair of alliance ruptures, management of countertransference and relational interpretation. Participant 8 claimed that the most valuable assets of a sound emotional connection are "comfort, encouragement, and clarification...time for me to get to know the person and time for them to get to know me... and relating to people." For Participant 2, a good emotional connection within the therapeutic relationship is constituted of trust, listening, the ability not to be judgmental, and a personal compatibility: "a therapeutic relationship usually works the best when there's some sort of compatibility between the personality of myself as a human being, regardless of my, you know, interpreting approach and knowledge and the personality of the client." Gaining a client's trust leads to an "understanding ... to feel safe enough to start gradually settle more and more into therapy and bring more painful issues to deal with," Participant 2 further reported. Thus, trust and openness may lead to progress.

The notion of trust and openness to facilitate the connection process is also related to implicit memories as explained by Epstein (1991). The implicit memory is context specific and is composed of both rational and experiential cognitive systems. The experiential system is the more emotional one and is based on things like feelings and vibes that are actually a response to past experiences. Some participants' responses seemed to indicate that a therapist must overcome the client's and therapist's implicit memories to gain a client's trust. For example, Participant 8 commented on the need for

the client to "feel safe" and to bring openness to the session. Without the implicit (and explicit) memories there were be no learned feelings to overcome.

This phenomenon is echoed by Participant 9, who reported that the healing factor of any therapeutic relationship is prevalent in the connection that the two people in the therapy setting have. This therapist suggested that it is easier to emotionally connect with another if a relationship is formed that is "more on a dialogical relationship, which means more human to human, on a more equal level." Furthermore, Participant 3 reported that it is about being "reliable" and being "consistent," yet at the same time being "flexible to what they need me to be ... my relationship has to vary depending on them to some extent."

Safety and security are also two very prominent ideals for a good therapeutic relationship, and are two elements that are related closely to trust. Participant 8 spoke of safety and trust as components of a successful therapist-client relationship. Participant 5 echoed this comment:

> '[The] best I can generally hope for is a good relationship where I feel pretty confident, eighty-five, ninety percent, at least eighty-five percent confident that my client feels eighty-five, ninety-five percent safe with me erm but that's the very best. There's no more to it, there's no substance to it.'

Of course, the subtle balance that should be maintained between challenging clients and ensuring that they feel safe and cared for is difficult, but important, and must change and adapt to certain clients, depending on their needs. Participant 10, for instance, claimed that he tends "to adopt a rather warm and open stance, emotionally ... active, positive and let's connect, let's understand let's do some work, let's invent some experiments, let's figure out what the problem is" approach with his clients. At the same time, this therapist reported that working with clients can be "quite challenging, quite confronting, you know I don't pussyfoot around," depending on the client's needs, and how the participant feels the client is most likely to have a positive motivation and

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experience. Altering the therapeutic connection to adapt to the client as an individual was also explored by Participant 6, who reported:

> "For me, it differs with each person I'm working with. It manifests itself in different ways, it develops at a different pace, it can be ruptured by different things, it can be easier or more difficult to maintain depending on the nature of the process and the transaction."

The honesty that clients require provides the crux of Participant 12's therapy practice, as this therapist reported:

> "I think that the therapeutic relationship has to engage someone with real honesty right from the first second... the only way you can engage with a child is to be really honest with a child. To be really authentic. Not to talk down to that little child, not to put on any kind of a face, just to be there in the room, in that moment.... And that's exactly the way I am with adults."

The need for hope and optimism was also discussed by Participant 3 and was added as a valuable asset in therapeutic relationship:

> "Optimism yes, I believe in the value of hope, I don't believe there's any such thing as false hope, it doesn't mean anything at all because hope stimulates you in your system, it's very important."

Participant 4 noted honesty and genuineness within an empathetic approach were vital for the therapist and stated: "honesty and empathetic approach, I guess, um, openness, a willingness, um, honesty, um, genuineness." The genuineness or authenticity of the therapist's responses to the client can create those "now moments" during which something important happens. Stern et al. (1998) described an important moment as a "moment of meeting" during which the relationship changes. The authentic moment does not even have to be verbally explicit, and that is reflected in Participant 12's comment, "not to put on any kind of face, just be there in the room, in that moment." One major element of the emotional connection between both the client and the therapist that

Participant 12 reported as essential to the therapeutic relationship is courage, claiming that the therapeutic relationship is "two very brave people trying to be honest with each other ... trying to trust a complete stranger is a big deal for any two human beings." Therefore, Participant 12 further claimed, "courage ... That's the primary quality. I think courage to get out of the way of the processes between you and another person. To leave yourself out of the room. And to let what is happening happen." The ability to have the aforementioned competencies will create the context of trust and connection. As also suggested by Stupp (1986), the therapist's skills comprise the ability to create a certain interpersonal context, and in that context to facilitate particular kinds of learning.

6.2.5. Presence

Being present is a predominant theme in the literature concerning the therapeutic relationship. In these interviews, being present also emerged and described in terms of the emotional connection that the participants felt with their clients. A solid, safe, 'alive' emotional connection was very much rooted in the present day, when the therapist engaged fully with the client on a cognitive and emotional level. Participant 1 stated that the therapeutic practice should be focused on:

> "Being present with the client and attending to their needs, you know, finding out what they need, where, where they want to go um assessing what are their skills, what are their abilities to, to get where they want to be and what are they going to have to do to get there, what's the reparative work that they're going to have to do in terms of erroneous beliefs or irrational beliefs to use the rational emotive behavior therapy lingo and what are the skills that they're going to have to learn that they didn't get growing up, what are the traumas, the losses. I think a lot of clients have to have a lot of grieving that they have to do."

Furthermore, being present was related to the therapist consistency and time reliability, a key variable of the therapeutic relationship. According to Participant 2, being there involves being "physically present ... week after week at a particular time,

consistent." In being present, the therapist is letting the client know that "during the fifty minutes time that you are with him you are fully present and you are there for him. ... And you are communicating somehow with you know you do care about what goes on."

When dealing with difficult emotions, Participant 2 claimed that he "will kind of sit with it, try to make sense of it, understand it" and that it is important to be "very still and very, very much present." Participant 1 viewed that the crux of the therapeutic relationship with clients was "going with [the client], being with her through those emotions helping her to deal with them effectively er to give her reassurance." Participant 12 concurred, reporting:

> "You have to just be with what they're feeling ... [Other therapists] want to fix stuff just because whatever the patient is feeling is scary. So you have to be willing to be with that level of pain, just be with it, without trying to fix it or change it, run away from it, minimise it, identify it, label it or anything else, just be with it. …You have to be right there. So you can't avoid feeling the things yourself. ... And if I feel moved or tearful, I tell my patient that is what I'm feeling."

Participant 1, however, claimed that being available in the present also has its implications for the past and the future, reporting that it is important to "engage with what's going on and in the here and now but relate it to the past, use it to predict the future or create in the future what the client wants." Again, this is in keeping with the idea of displacement of memories and feelings that individuals may have had when they were growing up, which can manifest as negative tendencies or anxieties in the present. The idea of presence in the therapeutic relationship also relates to the notion of 'now moments,' as just mentioned and as discussed in the literature review, which are charged moments of truth (Stern, 1998). These moments are important, and a therapist being present, Stern (1998) noted, is the only way that these moments can be tapped into.

6.2.6. Role of the therapist.

Most of the participants discussed the role that they play as a therapist in the emotional connection that they experience within the therapeutic relationship. Interestingly, different participants saw the role that the therapist played slightly differently. For example, Participant 8 described the relationship with the client as being "[l]ike a parent and a child and a parent being there to explain to the child kind of how the world is and why things are as they are; and when things go wrong, helping the child to sort of make sense of them." This parental figure is also reflected in Participant 2's notion of the therapeutic relationship:

> "There's something also to a certain degree quite paternal in that relationship because you're, you know, me, myself as a therapist I'm in a kind of more powerful position. I'm working with someone who is vulnerable and if you think about...all sorts of processes that happens in therapy so er I might be perceived as the parent, the client might experience me as a parent."

Whilst this is a fairly common experience and interpretation of the therapist-client relationship, it is not always a beneficial one or one that works, as Participant 4 reported about one client:

> "I represent her, um, abusive father sometimes, you know, someone who is quite controlling of her, as a child, and so sometimes she will see me as controlling of her, er, particularly when I'm trying to … I guess, trying to get to help her to look at changing some of her behaviours, because she has a lot around the emotion dysregulation so when she gets angry, for instance, she finds it very difficult, once it, sort of, takes off, she finds it very difficult to control it."

Participant 1 viewed the paternal element of the therapeutic relation as being a form of attachment that is made between the client and the therapist, an attachment that did not happen correctly during the client's childhood, which is why "the clients are having problems today." The idea of the therapist being a substitute figure and a surrogate parent that the client can 'attach' themselves to is prevalent in many therapy theories, and

is one that resonates quite strongly with Participant 1's view of herself within the relationship. Attachment functions, and specifically attachment to the therapist, could mirror and emanate clues for the therapist of the early attachment pattern of the child to the mother. This is also linked to the idea of meta-cognition and reflective functioning (Main, 1991; Fonagy et al., 1996), as does Bion's (1962) concept of 'containment.' Participant 1 claimed that the lack of emotional connection that a client has with others in their lives often leads the therapist to play the role of the figure that the client can attach themselves onto, which comes with responsibilities:

> "Part of it I think is being sensitive to the client's needs as mum or the good attachment figure ought to be to the child's needs. That's how I see it today in rather simplistic terms ... [I am] a substitute for emotional connection with her partner of twenty-two years er that's where the issue that brought her to therapy."

This verbatim is asserting the vital role of a good attachment and this means that the therapist must be able to tolerate clients relating in ways that belong to early stages of human development. This connects with the work of Freud (1924e cited in Akhtar, 2009 p. 233) in his paper 'Neurosis and Psychosis' and the idea that "in the psychoses the ... ego in the service of the id, withdraws itself from a part of reality" (Freud, 1924e cited in Akhtar, 2009 p. 233). The "corrective emotional experience" relates to this participant's descriptions as discussed in the literature review. Emotions are influenced by early experiences, such as attachment, and are influenced by cognitive appraisal (Lazarus, 1994). This is also linked to Mayer and Salovey's (1997) ideas about our capacity to recognize and regulate emotions in ourselves and in others (Mayer and Salovey, 1990; Goleman, 1985; Bar-On, 1997).

Playing the role of an attachment figure means accommodating and accepting the client's needs. The therapist takes the role of the mother during the developmental stages of the child (but now an adult) and offers now a new experience of resolving

contradictions and incongruity. The patient, now in the relationship with the therapist, needs to experience the child within and resolve it by recognising that she or he has mixed feelings resulting from the contradictory behaviour of the parents. Main (1991) suggested that it is the mother's ability to reflect on the child's internal state. Participant 3, for instance, reported:

> "I changed myself in this role, and I think when you start off, often the feeling is you're trying to help people but actually I've learnt that if you allow people to just be and accept them they find their own way of accommodating what's happened to them."

The category of the parenting role is consistent with the notion of reflective functioning of Fonagy et al. (1991). The therapeutic relationship re-enacts the parental role which is like the mother's ability to reflect on the child's internal state. Similarly, the client in a secure relationship with the therapist (e.g., parental role) can take for granted that his or her mental state will be properly reflected on and responded to appropriately (Fonagy et al., 1991). Adapting to the client's needs resonates with most of the participants, especially in terms of the roles that they play. Most participants concurred that they are different as therapists than they are in their own social and personal lives, and that the therapeutic relationship is, above all, a professional relationship, where the therapist is 'playing a role,' as Participant 6 indicated:

> "If I put my therapist hat on, I'm quiet by nature, I've a high positive regard about my client, because when I'm working with very, very disturbed clients, if I don't succeed when there is a chance for them, well, I would have given up this job."

Participant 4 concurred:

> "[T]he professional relationship is different to a personal relationship. Although there are aspects, maybe, of you that you bring in, but you don't do it in the same way as you do on an outside, er, personal relationship."

Forming attachments to therapists or viewing them as parental figures is common in successful therapeutic relationships. This finding may also relate to the idea that when an individual is growing up, their subconscious or early relationships with their parents may not have been wholly satisfying, or the guidance that they perhaps should have received in order to view the world as 'fundamentally friendly' as opposed to 'fundamentally threatening' was wanting.

6.3. Theme C - Mindfulness

The term mindfulness was used thoughtfully by most participants; others did not so much use this term but described its meaning when discussing the roles of self-awareness, self-reflection, emotion and cognition within the therapeutic relationship. Mindfulness suggests that being aware of one's own emotions and those of others, and working to unpack these emotions and cognitively make sense of them, is an important tool in a successful therapeutic alliance. Seven linking concepts connect the three mindfulness categories in the model. Bodily, emotional and cognitive awareness refers to the therapeutic relationship encounters with the process of communication at the levels of cognition, emotions and body. As the research participants talked about experiences of self-awareness, self-reflection, containment, and past experiences, it emanated the category of reflective practice. The category of clinical activities that contributed to learning and development constituted the variables of supervision, personal therapy, training and the potentiality of EI experiential training. EI was placed under mindfulness because it is mainly a process of action –interaction strategies and as a background condition that promotes a positive therapeutic relationship. In order to understand how emotions and cognitive considerations go hand in hand, emotions will be discussed first, and all the issues that arose during the interviews concerning emotions, and then the place of cognition in emotion as viewed by the participants will be presented and discussed.

6.3.1. Emotions

Therapists deal with emotions as a component of EI, and therefore, it was important to learn what ideas practicing therapists possess about emotions. Most participants had a similar idea of what emotions were, and why they existed. Participants seemed to support previous concepts of emotions as discussed in the literature review. Popular concepts of emotions are those, for instance, of Lazarus (1994) and Solomon (2003), who both viewed emotions as elicited according to an individual's interpretation or evaluation of important events or situations. In particular, Solomon (2003) suggested that emotions are not feelings but judgments, a web of constitutive judgments through which things appear in a particular way. Participant reported similarly, "for me, emotion, it's a sign which gives information." Whilst Participant 10 also noted "…human beings have an ability to use words with meanings, you know because we have a symbolic system called language but other than that we communicate with emotion, which is a subliminal communication through the body, tone of the voice, through the eyes, physical posture, hands waving about, you know, all of that stuff is mostly communicating emotion."

Moreover, Damasio (1999) argued that consciousness is dependent on or founded upon an awareness of the somatic environment, which supports Rowan's (1998) concept of linking as a term describing a specific type of empathy and an embodied nature of the connection between client and therapist. Participant 10 described emotion as a complex reaction that engages both our mind and body and summarized:

> "I think the mind body system is one system, so I don't think one can really separate it out. I mean the cognitive bit of me was in a panic trying to think of something to say, you know, the fight flight stuff was going on in the body, and also there's a certain amount of "fucking bitch, Jesus I hate you."

The description of the participant's notion of emotions encapsulates the primitive mammal's function of flight-or-fight system, as well as a subliminal communication

through body language. That was further supported by Participant 7, saying "emotions are powerful… they're often primitive stuff to avoid you getting into trouble." Whereas, the relationship of emotions to needs was noted by Participant 3:

> "[Emotions] tell us what to do physically as an animal, emotions are instructions in a way about our situation and they lead to behaviours which are about survival basically, so I think they're in your body and that's how to read them and that's how I read them in other people, because my body will react to what they're saying, although my mind is thinking 'I need to follow that up.'

These comments support the view of researchers such as Mayer, Salovey and Caruso (2000), who suggested emotions convey information about relationships. As was discussed in the literature review, these researchers indicated that "emotions reflect relationships between a person and a friend, a family, the situation, a society, or more internally, between a person and a reflection or memory" (p. 26).

The idea that emotions are a symbolic language is an important one, and is an idea that is prevalent in most of the participant interviews. Emotions teach humans important elements pertinent to their survival, such as their needs, whether danger is near, and so on. They can be communicated also, as Participant 10 noted, "through an unconscious, habitual activity, and reflects the whole idea of what transference and counter transference is often about." Along a similar vein, Participant 11 reported that emotions are "the neglected side of our psyches...it's when we react to something not with our heads, but in our body, our hearts ... in ways that we usually don't understand." This statement supports the idea that the body is an organ of information, which echoes Merleau-Ponty's (1962) view that an understanding of our life world begins as an embodied experience. Thus, emotions appear to be whole-body experiences, which take over our senses. Participant 1 reported that even negative emotions "provide energy, emotional energy, you know, the word emotion is the same route word as motion, movement so they're what get us going."

This is important to keep in mind, especially given that the literature has found that some emotions, even the negative ones, have useful properties, and that being able to access and utilize a whole spectrum of emotions has many benefits (Mayer, Salovey & Caruso, 2008).

6.3.2. Difference between feelings and emotion

Prior research seems to indicate there is a difference between feelings and emotions, but at the same time, their interrelatedness is also documented. For example, Mayer and Solovey (1997) labelled a skill set in their EI model as the perception and expression of emotion that requires identifying and expressing emotions in one's physical states, feelings, and thoughts.

Participant 4 distinguished between feelings and emotion:

> "Emotions for me are, um, things that we have, er, I guess, are linked very much in to past experiences. Um, so whereas the feeling can be what you're experiencing in the moment, I guess it's what links in to past experiences and, er, my past experiences, I guess, in my … which is what my emotion will come from, I guess, my experience. Um, and what links into the feeling that I'm experiencing in the present."

Distinguished so, emotions relate to the past experiences that individuals had, and feelings relate to the way that they are experiencing the present. Given the complexity of this description, Participant 3 admitted, "I think emotions and feelings can become merged, but I suppose it's important, yeah, to separate out what is, um, where the emotion is coming from, maybe." In contrast to Participant 4, Participant 11 did not define feelings and emotions in terms of their place in the past or present, but rather reported that they are regulated differently:

> "I like a distinction...between feelings and emotions. Feelings are something we have so I'm feeling angry, I know that I'm angry, I know why that I'm angry and I'm not out of control. And an emotion is something that has us, completely lost control, emotion wells up from somewhere and we can't regulate it or not

easily.... I think that's a very important distinction is actually quite neglected."

Thus, the difference between emotions and feelings, according to these participants, is one wherein feelings can be easily regulated, and emotions are more difficult to regulate, as they are beyond reason. Participant 11 further explained that whilst it is "very important to have feelings in any human interaction...a lot of the time emotions take over and we don't know what we're doing." Thus, from Participant 11's perspective, emotions are much more primitive than feelings, and "they're certainly more unconscious."

6.3.3. Emotions and cognition

As noted previously in our literature review, emotion and cognitive control are integrated, and at times, working in harmony (Gross, 1998). The interconnectedness of thought and emotion in the brain is now further understood due to neural imaging and research on the development of consciousness (Damasio, 1994, 2000, 2003). Davidson (2003) claimed that assuming that emotions are independent from cognition is one of the seven deadly sins of cognitive neuroscience. Though trait EI theories (e.g., Bar-On, 1997; Petrides & Furnham, 2001) are non-cognitive, most of the participants reported a place for cognition in emotion. For example, Participant 1 reported, "the ... triple F as I like to call it, you know, fight, flight or freeze, you know, that's very primitive, I mean, it's wired into our whole brain so it's going to operate there." Participant 8 claimed that emotions are "sort of bodily, it's a sort of feeling ... at that level but also a sort of cognitive level that it goes hand in hand really." To explain further, Participant 8 stated:

> "I may be feeling something along the lines of, of what they're talking about and what they're feeling so there's something at that very sort of primal level but then there's also what, what feels like the sort of cognitive … processing of that and just er I guess I would go away from a session and I'll be really there in my head and … and I'll be sort of I'll maybe carry on thinking about that and making sense of it."

Most of the participants reported a place for cognition in emotion. Some participants did not believe that emotion and cognition were separable, in the way that other participants noted. Participant 1 reported that "we do have emotions, sensations, call them what you will, that arise from certain situations that also influence our thinking." Participant 3 suggested that she uses emotions to understand the client:

"I've learned that boredom is a really interesting thing to monitor in myself. I very rarely become bored and it usually means that someone has a very passive, aggressive defense system problems … I am feeling what I am feeling and then a kind of, a cognitive commentator, who's watching the feeling, what's going on in my body"

Furthermore, Participant 3 suggested that:

"the behaviour that follows the emotion, the emotion leads you to think what you must do about it, I think that's what the emotion part of an animal is, so if I'm feeling fear then that's because it's not safe."

The idea that cognition follows emotion is explicitly discussed by Participant 7, who stated:

"I think probably one feels it first, cos part of the thing about therapy is that you think about your own reactions during the … whatever model of therapy you do...and then think about it. "Why did I feel so much about that?" So it's the thinking bit comes, I think, second to the emotional response. That comes first. Some people will argue that in fact what's happened is a very fast, um, cognitive processing which goes to the, um, emotional response, but I'm not sure that that's the case. But anyway, it feels like the emotional response comes first and then you think about what you're having. It's rather like when you're thinking about transference and countertransference."

The separation of cognitive and emotional experiences, despite the fact that they may be occurring simultaneously, or one almost immediately after another, can be

identified in the idea of the 'internal supervisor' or cognitive 'observer' that practically all the participants mention, as a tactic with which to regulate and monitor the situation, to make sense of the emotions that they are feeling or that others are feeling. This is similar to the theory of Solomon (1984), who noted, "An emotion, as a system of judgments, is not merely a set of beliefs about the world, but rather an active way of structuring our experience, a way of experiencing something" (p.54). Participant 8 finds the internal supervisor useful for therapy:

> "I've sort of recruited my internal supervisor then I might be thinking oh you know I wonder what's going on here and I wonder how he's feeling and I wonder how this is repeating a pattern for this guy from other situations in his life so I suppose in many respects I make a kind of, I use the sort of psychodynamic theory to make most sense of how emotion's important in, in therapeutic work."

> Participant 9 also mentioned this internal phenomenon:

> "There is...what we call an internal supervisor in my head…there is...a voice in my head who are telling me … there is something going on here." Which ... is a bit like if I internalise my supervisor, which then I am able to just think, "Okay ... there is … when I can feel my body raising and feeling a bit more agitated, there is a voice who tells me, 'Okay, calm down, breathe, stay with the client, it's okay'."

> Participant 12 also referred to a commentator:

> "I'm feeling what I'm feeling and then there's a, kind of, a cognitive commentator who's watching the feelings, watching what's going on in my body, watching what's going on in my emotional centre, in my heart, and saying, I don't know what it's saying actually, it's just, kind of, describing it so that, oh, I don't know it's an observer, really."

Participant 3 also described this observer as though, in a room with "two or three people . . . you're watching what's going on between the two people." Participant 11

claimed that, in the actual therapy setting:

> "The therapist has to be able to think very fast and very widely and very deeply... it seems to require fast thought in order for the conversation to keep going, deep thought in order to understand. Then it has to be expressed in a way that isn't just cognitive but actually touches the heart."

The thinking that occurs in the therapeutic relationship, then, is based upon present emotions that need to be addressed. Other participants, such as Participant 2, however, thought that cognitively assessing a situation when you are experiencing emotion to be unlikely. For example, Participant 2 claimed:

> "When you are able to reflect and understand your emotions then you can afterwards talk about it and discuss it with people and make sense of it. It's usually when this actually happens it might be too difficult to kind of have some sort of cognitive understanding you just kind of, especially when it's very powerful you know when you're angry yeah you might be a while that you're angry but you're not thinking about it because now you are busy being angry you know."

Emotions are powerful and should be given due respect and attention for their own sake, as Participant 8 indicated:

> "Cognitive processes have been given far too much um sort of dominance and attention at the expense of actually ... you know attending much more to emotions ... when the level of somebody's emotion is so great that just tinkering around with cognition is not really a very good well it's not really an answer."

The notion that emotions are real and powerful, and that parts of the brain are required in order to make sense of these emotions, were in some cases described as awareness, which summed up the idea of the cognitive brain and emotions working together to help the therapist be of use to the client in the therapy setting. As does Mayer and Salovey's (1997) EI concept and the perception, appraisal, and expression of emotions, which is also akin to affect consciousness that refers to the "mutual relationship

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between activation of basic affective experiences and the individual's capacity to consciously perceive, tolerate, reflect upon and express these experiences" (Solbakken et al., 2011, p. 5). However, many of the participants felt that others within social sciences desire to intellectualise emotions and other experiences, in order to rationalise and make sense of them. Some of the participants criticized such rationalization, especially when discussing EI itself, and the power of emotions. Also, many participants reported that there is an almost indescribable, subconscious spirituality that occurs within the therapeutic relationship - something that transcends reality, cognitive rationalism, and theory. These ideas all impacted on the ways in which these participants viewed EI, and the subtle interplay between emotions and cognitive processes.

6.3.4. Physical, emotional and cognitive awareness

Participants, when describing the process and interaction of the therapeutic relationship, identified bodily, emotional, and cognitive awareness as pivotal in this encounter. These perceptual phenomena are important in order to understand the therapeutic process. Participant 5 claimed to experience emotions cognitively:

> "An emotion is something that I feel. I experience it at a visceral level. I feel it in my body. I also experience it cognitively...But it's got far, far more impact at the visceral level (long pause). And the meaning it's got for me...is so important."

The cognitive experience almost seems to be an afterthought, however, the embodied part of cognition and emotions were noted by several participants, reflecting the influence of the embodied cognition approach (Damasio et al., 1991) and the notion that the body affects and influences the mind in a continual and substantive manner which cannot be reduced to neural activity (Damasio, 2000).

According to the embodied approach, not only our body plays a special role in cognition at multiple levels, but also other bodies constitute a special object for

perception. Related is the idea of intersubjectivity and the term 'co-phenomenology' postulated by Cornejo (2008), which suggests that comprehension is possible only when people are sharing similar experiences as a result of their being-in-the-world. When analysed in this way, meaning deploys at the same time in social, phenomenological, and biological dimensions. This idea supports Damasio, who noted that feeling, emotion, and biological regulation each have a role to play in human reason: "The lowly orders of our organism are in the loop of high reason" (Damasio, 1994, p. xiii). In the same way, Participant 10 appears to not believe that there is a distinction between body, emotion, and cognition, reporting that emotions are both:

> "I think the mind body system is one system, so I don't think one can really separate it out. I mean the cognitive bit of me was in a panic trying to think of something to say, you know, the fight flight stuff was going on in the body."

Most of the participants asserted a number of feelings before thinking during the therapeutic encounter, and some others noted that the therapeutic encounter is experienced as a physical and cognitive practice. For example, Participant 6 noted, "I think it's the physiological feeling is followed by the cognitive explanation." The importance of body language as communication was expressed by Participant 12 by saying: "To pick up all the little clues about somebody's voice, their body language, to ask questions, to keep eye contact. To modulate your voice so that it's safe in the room. And then to just listen with your whole body to what's happening." The body language can communicate a level of connection and engagement.

Body language can also act as a way of animated communication and connection to the client's experience. For instance Participant 1 noted:

> "[I]f somebody tells me something that's quite um surprising or horrible or shocking I would be very likely to, to react to that so rather than just sit here and say that sounds like that was really awful or um I'd think I'd probably, there would be more animation in my voice and in my face really so I would say gosh that's,

that's really awful, really did that happen, what did you do or how you know so be that … I think there would be more emotion there."

The body language and 'animation' in the therapist's voice and face communicates empathy and attunement with the client's feelings. Constructing a therapeutic relationship is in itself a process of an embodiment experience (Merleau-Ponty, 1962). The aforementioned descriptions by participants describe the therapist's body as a subject of perception providing invaluable information regarding the intersubjective space between therapist and client (Shaw, 2004).

6.3.5. Reflective practice

The participants in this study clearly emphasized the importance of reflective practice in the process of therapeutic relationship. For example, Participant 2 described the task of listening even before the therapeutic relationship was established and stated:

> "especially if you reflect on the whole course of therapy a lot of things that were communicated in the first telephone calls will make sense and they will be really important and significant erm you might not be able to understand it when you just take the call but if you have you know knowledge er from, that you gain later on in therapy it will be a very meaningful encounter."

Schön (1982), in his book "The reflective practitioner," calls such a process a repertoire of examples, images, understandings, and actions: "When a practitioner makes sense of a situation he perceives to be unique, he sees it as something already present in his repertoire" (p.138). The therapist's repertoire includes the whole of his/her experiences insofar as it is accessible for understanding and action. Participant 6 also noted "being a therapist then it's all to do with what's going on in the room um er rather than you know what er various learned texts might say." Thomas Kuhn (1977) called such processes "thinking from exemplars." Once a new problem is seen to be analogous to a problem previously solved, then "both an appropriate formalism and a new way of attaching its symbolic consequences naturally follow" (Kuhn, 1977, p.183).

Whilst Participant 4 used the words "created in me" as a capacity to understand mental states, this subject also noted "I reflect on that and it can be completely different to actually my interpretation of them. But it's something that is created in me, which is partly what they, um, they have in themselves." This is reflected in the literature as mentalization and is defined as the capacity to understand human behaviour in terms of underlying mental states (i.e., thoughts, feelings, wishes, and needs) (Fonagy et al., 1998).

The spectrum of reflective practice in the therapeutic encounter was also noted by Participant 12 who explained, "You know, it's an exercise in attunement. Our job as therapists is to feel where the person is when they come ... you're not going to suddenly get angry or suddenly get afraid, you're not going to deliver your own anxieties to this child or try and control him in some way." Whilst Participant 2 noted "some sort of unconscious communication that kind of things might have taken place for quite sometime before more erm reflective kind of understanding." The participants' responses also supported Schön's (1982) viewpoint of knowing in action. This researcher stated from the reflective practicing perspective that knowing has certain properties: "There are actions, recognitions, and judgements which we know how to carry out spontaneously; we do not have to think about them prior to or during their performance. We are often unaware of having learned to do these things; we simply find ourselves doing them" (Schön, 1982, p. 54).

The following subcategories regarding participants reflective practice were co-constructed: self-reflection, self-awareness, experience and clinical training. Especially where self-reflection and self-awareness were experienced as is illustrated by the following quotes: "an awareness of what those feelings are so with this woman that I first started talking about just er oh this is, the thoughts that I was having like oh this is really reminding me how difficult this is going to be" (Participant 1). Another therapist, Participant 3, noted "it's just about acknowledging how they feel, sort of not asking them

how they feel because that suggests you don't know, but sort of reflecting." Participant 10 further emphasized the challenges and complex multifaceted nature of a "transacted relationship" and noted:

> "how is envy different from jealousy and you know a whole range of you know knowing what they are and then understanding how they're transacted in a relationship and how you spot what's going on, you know and how you feel what is happening and label it correctly so you can respond correctly, but that requires mindfulness, you have to pay a lot of attention to it."

The research participants also accentuated the importance of experience, as Participant 9 indicated, "for me, a good therapist with a lot of experience, it's someone who can be in this therapeutic relationship and acknowledging." The importance of experience overlaps with four empirical investigations that emphasised the direct client work as the most pivotal element in how therapists learn about employing therapy (Morrow-Bradley & Elliott, 1986; Orlinskt et al., 2001; Rachel son & Clancy 1980; Ronnestaad & Skovholt, 2003).

6.4. Clinical activities that contribute to learning and professional development

Clinical activities that contribute to learning and professional development emerged as a category, suggesting the importance of supervision and therapists' own personal therapy in facilitating their subtle competencies within the process of the therapeutic relationship. Most participants noted the themes and importance of clinical activities that contribute to emotional learning and competencies. For instance, six participants reported supervision to be more useful than trait EI. The majority of participants noted that personal supervision was important for building up their competence. Subsequently, it is also documented in the literature review that therapist competence, along with therapeutic alliance, is related to client outcomes and may well be one of the key common factors across psychotherapies (Trepka, Rees, Shapiro & Hardy, 2004). The importance of personal supervision was highlighted by Participant 9,

"I remember needed to call my supervisor to be able to express how I felt," as well as by Participant 2:

> "My ability to work as a psychologist, I think the best way is if an external observer…either monitors my work and gets to know me in different situations…my clinical work…as sample from my clinical work and engage with me in supervision on one to one level."

The words 'ability,' 'external observer,' and 'supervision' emphasize the idea that supervision engages a dialogical approach and creates the space and trust allowing an open relationship for monitoring therapeutic work and reflexivity. Monitoring provides information otherwise difficult to obtain. Participant 7 noted "the other subtle bits about whether you're really accurate about seeing someone, is very difficult to measure, partially that's why one uses live supervision." Monitoring also provides support, according to Participant 6:

> "So er and I think er supervision is quite important in that respect so that when I have my supervision which is a … not group but er one to one supervision um it's, it's of great value to me to be able to express my own feelings and to receive some reassurance about what's going on and particularly when we've got to a point where she's got very close to the edge to be reassured about um the level of risk and the way in which that's being properly managed."

The importance of supervision is cited in the literature review and supports the notion that supervision broadens therapists' competencies and enables to explore new ways of being (Bambling, King, Rauer, Schweitzer & Lambert 2006; Orlinsky & Rønnestad, 2005).

6.4.1. Emotional intelligence

When participants responded to the possible links of EI in therapeutic relationships based on their personal experience with clients, an interesting array of perspectives emerged. For instance, Participant 4 seemed to accept that the concept of EI was relevant in the therapeutic relationship: "I think EI is probably, er, very true about what goes on, and probably not as overtly, sort of, aware of the description that you have there." Participant 12 used the words "oh absolutely, yeah" responding to the question of the link between EI and what the therapist in doing in therapeutic relationship. Whereas, some participants accepted the relevance of EI in therapy, some questioned its applicability in training or therapist selection process. For instance, Participant 5 suggested, "there is a great difference between therapists own perceptions of their own various emotions and emotion traits. And using it not as a tool of selection but using it as a tool for education." Thus, this participant argues the trustworthiness of TEIQue (as a self-reported method) in selection or training and potentially suggests its use as an educational instrument.

Many of the participants reported using various facets of EI in their therapy practice, yet there was also a sense that the self-reported TEIQue inventory cannot adequately explain or describe the subtle yet very real emotional connection, mindfulness, presence, and empathy that the therapist and the client share and experience. The TEIQue was generally perceived by participants as not significantly relevant or as an appropriate instrument for professional development or training. For instance, Participant 1 argued:

> "… that was quite a surprise really … I really struggle with that so you know … it's just that it didn't um feel so much like this was a particularly good or true representation of me ... I'm just thinking like about that hope one seeing as I've … so I got 10% for optimism er organ …What so I need to be the pessimistic in, in an optimistic team. … It's funny that because I'm in a group, a psychology group where I've got this reputation for being the one that's too optimistic in myself."

The participant expressed the great surprise at the scoring and interpretation but also her disapproval in its use or application for therapist training. Participant 10 had the same reservations and stated: "I think EI is a sort of overarching label for a whole bunch of stuff." Furthermore, Participant 10 noted that therapy is a subversive activity, as it is always trying to get people to think for themselves and not dictate what to think or feel:

> "I had a patient who came to see me the other day she had been to her doctor with anxiety and depression and the doctor had given her a CD-ROM and said she had to come into surgery one a week and work on the computer and that's your therapy…I mean how you define EI may be this questionnaire? ... okay … or read Goldman's book … maybe go supervision or personal therapy and work it through organically otherwise you have no integrity with it."

This participant encapsulated the enormous challenges of applying EI theory into actual training and practice. One aspect of such challenge between EI concept and measuring EI, was questioned by Participant 9, who stated: "How can we quantify if it's not true behavioural attitude in the room and I think it would take some of them, then we will cluster as, well, this is the concept, or, it's a representation of spirituality." The meaning of words used in the TEIQue was also debated by Participant 3 as arbitrary and ambiguous, and noted:

> "[S]ee on this scale what the difference is between empathy and emotional perception, I would imagine empathy is more of a mental thing than a ... I used to ... I don't know, um, that ... I don't know whether it matters whether ... if I feel what someone's feeling I don't know whether the empathy bit is relevant then, according to this it doesn't really matter does it? I've got 96% on emotional perception and 61% on empathy and I don't understand what would be the difference and what's that actually distinguishing between on this questionnaire, what's it saying. I mean do you know?"

Participant 3 was confused over the TEIQue wording, whereas Participant 8 expressed discomfort about the question of using the TEIQue in training: "I don't know the answer to that Joseph because um it, it does in a way it brings up the question of how invasive or how intrusive is the training process going to be er to or on the individual involved." However, Participant 3 admitted that with some changes it can be used as part of training by saying:

> "So yeah, there are probably about ten things on there. How many, one, two, three, four, five, yeah ten things on there that you could pull out and say these could be turned into things, I don't know, CPD or whatever (laughs), but probably you wouldn't need all of them"

In a similar frame of mind, Participant 9 asserted the intrusive issues of such any test and noted:

> "all this kind of test can be used if it's explained properly and not used, I suppose, to shame or to give a, er, a view of the, er, to a trainee, because keeping in mind I did this test and I have 18 years of therapy and 10 years of experience, I just wonder if someone who just in this three first months of therapy or training or the first two years or three years with less than 400 hours of one to one, and you get emotional management sixteen percent, you just think, "Well, how can I help a client manage his emotion?"

Some of the participants, however, did report some of the TEIQue facets to be relevant but needed changes in order to adapt to therapeutic relationship or for playing a role in continuing professional development. For instance, Participant 4, referring to the TEIQue usefulness as a training tool, asserted:

> "No, I think this would be really, really useful, actually, er, to have. Um, because, I mean, I think half and half, I'd probably say three quarters of it is probably right, and I guess, er, you know, if you're thinking about, um, trying to improve or trying to, um, think about what … how you are as a therapist, I guess

this is really important, you know, to have some, sort of, score or some, sort of, um, judge I guess of how you are, which I guess could be invaluable.."

In a similar frame of mind, Participant 6 suggested the test as a means-to-an-end but not to become clinical about it and noted:

"… enter discussion even if it's internal discussion to get the thinking going and the engagement of the cognitive functions … [E]xperiential techniques er the use of instruments of this sort to provide an agenda for debate er and an, an, an awareness and understanding of how one interacts with other people, how one interacts with different situations, how one deals with um different challenges whether that's um managing aggression or managing indifference or managing er transferences of various."

The participant proposes the use of TEIQue test as part of educational and cognitive engagement. Supervision and patient feedback rather than any use of instrument for professional development or training, was suggested by Participant 7 who stated:

"… would I rely on that versus live supervision? No. I'd rely on live supervision and patient feedback, cos what it does, it doesn't claim to do any more than have a snapshot of what you, the respondent, feels about answering those things."

Supervision was described by Participant 7 as an important process of engaging with the therapist's own perception and their clients by using supervision. In general, participants favoured supervision and not the psychometrics for professional training development. While there may be substantial differences of opinion between participants about EI and its practical application in training and professional development, it seems better to at least begin to think about its use and practical adaptability. Despite the diversification of responses among participants with regards to the EI concept and its links to the therapeutic relationship, it is in many ways a positive association. For instance, Mayer and Salovey's (1997) perception, appraisal, and expression of emotions

and level-two emotional facilitation of thoughts could be associated with participants' descriptions of containment, emotional balance, mindfulness, connection, or emotional stability. The second stage of Mayer and Salovey's (1997) emotional facilitation of thoughts could be associated with participants' notions of acceptance, presence, connection, openness, courage, empathy, and congruence.

6.5. Distinct contributions to the theory of EI and therapeutic relationships from grounded methodology

Through the diligent process of open, axial, and selective coding, empathy and its balance was one of the prominent themes that emerged from the standard grounded theory approach used in this study. This finding coincides with Petrides and Furnham's (2001) trait EI model identified through self-assessment, with trait empathy being an integral ability component of EI. This is also mirrored in Goleman's (1995a) mixed model of EI through self-assessment, which identifies empathetic awareness as the ability to recognise emotions in other individuals. Most important, there is a considerable conceptual overlap between Mayer and Salovey's (1997) EI model and the first two branches of EI. Thus, emotion-perception, as an ability to tune-in to what the other person is feeling, and emotion-integration, as the ability to relate what it's like to experience that feeling, emerged from the current study as categories of "empathy" and "benevolent connection." Carl Rogers described this process as a fifth condition of constructive personality change in therapy and noted "the therapist is experiencing an accurate empathetic understanding of the clients' awareness of his own experience" (Kirschenbaum & Henderson, 1990, p. 226). This function of empathetic awareness also takes a more expressive form when an individual's dispositions are verbally appraised, and personally identified by another person. This was evident with Participant 1 who noticed how important it was to articulate their own experiences meeting the same emotionally driven event(s) reported by patients during a therapeutic session, providing credence to the notion of empathy held by Mercer

and Reynolds (2002) that communicating an understanding of a person's feelings is a strong sign of empathy.

A key contribution of the empathy component in EI theory is its interrelatedness with therapeutic relationships, which is apparent in the interview script for Participant 5, who claimed an unsuccessful therapy session was, in part, influenced by a lack of empathetic awareness in terms of the recognition of common experiences between the therapist and patient. This finding also supports the idea proposed by Mercer and Reynolds (2002) that empathy helps to fill the void in personal connection between what the patient's intrinsic state of dispositions are, and the similar experiences shared by the therapist to elicit deeper understanding. Several studies have been conducted to explore the potential relationship benefits in therapy sessions, particularly in accounts of patients seeking help for eating disorders.

Costin and Johnson (2002) found that patients with therapists who do not share their own similar experiences of overcoming eating disorders, expressed less successful therapy outcomes than those patients who had more open therapists who displayed a more active empathetic awareness by revealing their personal history. However, even in the absence of experiential connection between the therapist and patient, the empathetic awareness may be a vital component of EI that, when actively recognised through verbal communication, could fortify the patient's willingness to share more personal details and generally engage in a more positive manner.

The study's emerged theme of empathetic balance on the other hand, refers to the abilities to label emotions and understand the relationships associated with shifts of emotions, which is Mayer and Salovey's (1997) branch 3. This ability to understand and analyse emotions, also corresponds to Fonagy and colleagues' (1997) notion of reflective functioning as an ability to identify and understand mental processes taking place in self and others.

Finally, the theme of mindfulness refers to strategies and abilities to stay open to feelings (containment) and to reflectively monitor and regulate emotions to promote emotional growth. The theme of mindfulness is also akin to affect regulation strategies as noted by Schore (2003).

Chapter Seven

7. Conclusion and discussion

This This study was an investigation of the role of EI in therapy, the therapist's perspective of trait EI in therapy, and the meaning of the therapeutic relationship from therapists' perspectives. Based on interviews with 12 counselling psychologists and therapists and an analysis of their responses using a grounded theory approach, a number of findings resulted. The most prominent themes identified through the data were empathetic balance, emotional connection, and mindfulness, all of which are related to EI theory. As a result, these three core themes were central in answering the following research question: How does the therapist's experience of the therapeutic relationship relate to EI theory?

From the discussion in the previous chapter, we can see that there are profound differences in the way that the EI concept and measurements can appear in the therapeutic setting. The participants' descriptions of the therapeutic relationship and the emerging themes of empathetic balance, mindfulness and benevolent connection could be interestingly related and linked to any of the EI models (Mayer & Salovey, 1997; Goleman, 1995; Bar-On, 1997).

The most prominent themes presented highlighted the necessity of the concept of EI for a successful therapeutic relationship. Participants' concepts of the container/contained, empathetic balance, connection, and mindfulness all had profound similarities with EI theory, denoting essentially the same process in therapeutic relationships. EI was used in subtle, notably subconscious ways. Therapists, in their relationships with clients, must use this intelligence to balance and contain emotions therapeutically. Therapists must be able to manage this skill to create balance between their empathy and their ability to look at situations objectively.

In addition, therapists must be able to create emotional connections with their clients (either consciously or unconsciously) by communicating properly, being present, and meeting their clients' therapy needs of warmth and openness. Furthermore, therapists, according to the sample in this study, must be mindful to judge situations accurately, adapt to their clients' needs, and work objectively. These main themes (and the derived categories and subcategories) were important elements of empathetic balance and needed subtle attributes and emotional competencies for therapists. The next step for future research is to establish the experiential training in EI as a key achievement for the development of higher self-awareness of mental states. The potential value of this mind-set for the therapist is enormous if a therapist can be facilitated to think about experience as a process and not simply as content, he remarkably enhances his empathetic balance capabilities. Examples of such methods are found in the experiential (Gendlin, 1996; Greenberg, Rice, & Elliott, 1996) and affect focused (Fosha, 2000; McCullough, et al., 2003) traditions.

A number of important questions arise when more evidence can establish the use of EI in therapy. How can we teach EI? What mental attitudes can we develop in experiential training? How can we teach subjective states or empathy? Can we teach how the reflective self reflects upon mental experiences, conscious or unconscious? How can we teach the identification of intrapsychic conflict, unconscious motivation, defensive processes, and the causal linking of these processes? And under what conditions EI can be used to enhance the therapist's capacity to perceive and understand oneself and others in terms of mental states, conscious/unconscious desires, destructive feelings, core beliefs, motivations, meaning, and reasons? Investigations led by these questions amplify how a therapist with a rudimentary capacity of EI and under the necessary cognitive and experiential learning conditions. Exercises that enhance mindfulness, for example, mindful walks, self-genograms, case studies, role playing group activities, and an

expansion of the "Being a therapist syllabus" (Hen & Goroshit, 2011), could potentially develop and make use of a more advanced level of the reflective-self function. For instance, the ability to think about another person's thoughts about a third person's feelings and mental states, which coincides with the third branch of EI construct emotional understanding (Mayer & Salovey, 1997) and considerably overlaps with psychological mindedness (McCallum & Piper, 1996). This mental state means the identification of intrapsychic conflict, unconscious motivation, defensive processes, and the causal linking of such processes.

However, the TEIQue test was not regarded as an important training tool or a valid recruitment measure for applicants in counselling and psychotherapy programs. Instead, supervision was noted as the way to develop mindfulness and competencies. This was akin to the previous notion that supervisors put the limits in place in the supervisory process by examining the intersubjective matrix (Auerbach & Blatt, 2001; Brown & Miller, 2002). In addition to this, our discussion in the findings section of Chapter 6 showed that there are substantial differences in the understanding and meaning of words on the TEIQue measurement among participants.

A number of caveats must be noted regarding the present study. Most qualitative approaches, not just grounded theory, have frequently been criticised for being subjective. By the same token, we could also argue that all quantitative and qualitative methods, if executed poorly, could result in biased research outcomes. It was, therefore, of paramount importance to consider the concept of reflexivity and the researcher's reflections upon the possible bias (e.g., how research design decisions related to the analysis methods used in the study) and its effect on this research. Concerning the researcher's personal reflexivity, a number of limitations must be considered.

Despite the limited sample size, the findings of this study indicated some critical directions for the use of EI in therapy as a means for training and career development.

Although I spent many years researching the concept of EI in education and clinical practice, I needed to think through my responses to EI as it related to participants in their therapy role. This involved reflecting on questions for improving future studies, perhaps by considering the gender, ethnicity, age, spirituality, and sexuality of participants. Those factors might affect the therapeutic relationship and, subsequently, the depth and findings of this study. Due to the sample size and purpose of this thesis, the effectiveness of the TEIQue questionnaire as a reliable and valid instrument in therapy could have resulted in further limitations for the outcome of this study. The geography, inter-rater reliability, and self-report date in general could also have negatively affected the findings.

The second limitation was that the methodology could have resulted in greater reliability had the interview questions been more focused. Although it was important that the researcher maintain control over the direction of the interviews, a number of questions were not wholly relevant, or focused, towards the research purpose. A pilot study might have been useful in separating the relevant items from the irrelevant ones.

A third, and perhaps related, limitation was the many categories that arose from the data analysis approach. Although interesting, some of these categories were not wholly relevant to the subject of EI in the therapeutic relationship, such as the process or models that the therapists use in their practice. The scope of this paper was not sufficient to discuss all these categories; however, they could be included in a more extensive paper to discuss their role in the way participants make sense of their role as therapist in the therapeutic relationship. A list of these emerging categories has been provided in Appendix 8a and 8b.

The axial-coding process resulted in the identification of many subcategories and themes; the selective-coding process was used to identify core themes or categories from the findings of this study. Three core themes drawn from the data were prevalent and salient to the subject matter at hand and to most of the interview transcripts. Thus, these

were chosen as the most important core themes from which subthemes were discussed. However, it might have been helpful to ensure that the themes drawn from the data could not be reduced further into a core theme from which the research question could be addressed. Doing so would have required more time and resources, and a third opinion on the themes produced through grounded theory for this study.

To fully understand the role of EI in therapy, additional research must be conducted. Questions to research could include these: Is EI something that therapists naturally employ, whether consciously or subconsciously? Is EI transpersonal? Can EI be taught to therapists? Considerably more work must be done to determine the effects of different types of EI measurements. Given the negative reactions toward the TEIQue questionnaire gleaned from the participants in this study, one focus of future research could be an exploration of therapists' reactions to a variety of empathy measurement scores and comparison of therapists' results and reactions. Designing an EI test specifically for therapists might also be useful. Given the lack of relevance, many of the meanings of questions and results from the instrument used in this study seemed to be confusing and ambiguous. For instance, some skills that are desirable in a social setting might not be desirable in a therapeutic setting.

Future research on EI in therapy and training should embrace a mixed design, incorporating EI inventories and supervision methods. Ideally, objective tests, such as the TEIQue or Bar-On (1997), can be adapted to measure empathetic balance, benevolent connection and mindfulness as a learning process in clinical supervision. The model of EI in therapy needs to acknowledge the necessity for therapists to observe, feel, intuit, think, introspect, imagine and self-reflect in their own data gathering. Thus, attitude itself will influence the phenomena of engagement. However, it will remain essential to explore the complex issue of transpersonal relationship and intersubjectivity, which does not readily submit to objective measurement. The best means for learning about the

transpersonal relationships and intersubjectivity may be supervision since the intersubjective matrix, including supervisor countertransference, is accessible to all participants. Intersubjective engagement is to recognise that therapeutic alliance is best achieved in a climate of care and mutual respect. The therapeutic relationship needs to offer such care, with openness and acceptance and not impose it in an intellectual engagement. The therapeutic process must accept humans' need for autonomy, self-determination, and provide security and safety in making mistakes. In this therapeutic relationship model, EI needs to acknowledge the fluidity of human engagements, as a dynamic and autonomous process engaging the past and the present, the felt and the unknown, the transpersonal and the visible. An understanding of this process and the ability to put it into effect generally mark an empathically intelligent person.

Any future study should also have more resources available to encompass a larger sample based on a judgment sample (purposeful sample). In this process, the researcher actively selects the most productive sample to answer the research question and enhances reflexivity and the framework of the variables that may affect an individual's contribution. It could also be advantageous to study a broad range of participants, recruiting both male and female interviewers and a special expertise sample. Important variables to consider in sample selection should include gender, ethnicity, spirituality, sexuality, experience, and therapeutic practice model orientation. Useful potential candidates for the study could also be recommended by participants (a snowball sample of subjects). During interpretation of the data, researchers must consider therapists who support emerging explanations and, perhaps more important, participants who disagree (confirming and disconfirming samples). The experiences of such a diversified sample could be vital in considering the narratives of therapists and comparing and contrasting the emerging themes among groups with common attributes.

The issue of objectivity is critical for any construct being conceptualized, and the method and type of EI measurement are of paramount importance. Through the participants' narratives of the therapeutic process, the theme of mindfulness became evident. The process of mindfulness entails an embodiment experience, emotions, and cognitive aptitudes for processing those experiences. Therefore, any measurement adopted should include cognitive aspects as well in contradiction to Bar-On's (1997) and Petrides and Furnhan's (2001) views that the EI is a non-cognitive ability. Other important themes were also found interacting in the therapeutic relationship for the therapists' interventions, such as the themes of connection and empathetic balance, which were both supported by clinical activities/training and learning. Training on EI is part of mindfulness and reflective practice.

Objectivity is also critical for any construct being conceptualized as a trustworthy and valid measure. Considering that the EI measure was divided between two conceptualizations of EI, a self-report test of trait EI (or trait emotional self-efficacy) and a tested ability EI (or cognitive-emotional ability), biases and correct responses must be considered. A number of participants in this study noted this type of self-report can be unconsciously or consciously manipulated to reflect a nice self-image. Perhaps having significant others who know the participants score the participants could result in limiting the self-distortion bias. Although trait EI can be adapted to changes over the cognitive issues, another core challenge has remained as to how, and in what way, the inventory should be administered to avoid self-bias responses. Perhaps future research could be conducted to investigate the use of such measurement by encompassing cognitive aspects to reason and understand emotions as well as facets of balancing emotions and relevant competencies for emotional connection.

Another important theme that cannot be accounted for through the use of any change in the EI measurement is transpersonal and spiritual relationship. Determining

whether EI is a measurable quality is a core issue within the transpersonal theme in this study that has not been countable in any conceptualisation of EI. In search of a correct response to measure EI, both self-reported measures, such as trait EI, and consensual scoring have been utilized in studies. In the consensual scoring method, more and less correct answers to items are endorsed according to normative averages. Thus, if the group agrees that a face (or case study, verbatim, etc.) conveys an emotion of loss or rage, then that becomes the correct response. Target scoring based on the patient's case study could also be part of such a test whereby a supervisor becomes the judge and assesses what the patient is portraying at the time the target individual is experiencing some emotional activity.

Another possible improvement to the study could be the use of ability EI, trait EI, and reports of the experiences of therapists or expertise in formulating another version of EI. The further exploration of these measurements could result in adding to a new theory on the practical adaptation of EI (ability vs. trait) in training and professional development counselling programs. These ideas relating to the validity and usefulness of EI in therapists' training and professional development should be studied and explored further if the true meaning and use of EI is ever to be discovered. Furthermore, results gained from therapists' studies of EI with that of individuals or therapists who are affected by conditions on the autistic spectrum, such as Asperger's syndrome, should be cross-referenced for comparison. The following questions could be addressed: Are those therapists with a low EI always affected by autistic spectrum disorders? Can those with Asperger's syndrome ever gain high EI scores?

This thesis argues that EI models and therapeutic relationship overlap and EI experiential and cognitive training can lead to sustainable improvements in empathetic balance and therapeutic relationship outcomes. Empathy and its balance was one of the prominent themes that emerged. In particular, participants in the study characterized an

important part of their therapeutic intervention as the ability to correctly perceive process, understand and respond under the right therapeutic involvement and dynamics. The current research offers two main contributions. First, it describes new ideas of how EI can be applied in the therapeutic relationship process and how the therapeutic competences (e.g., resilience, empathy, intuitive interpretations, inferential thinking, reflexivity, psychological control, autonomy and ability to relate to others) are similar to EI concept. Second, it reports a qualitative study of how a self-reported trait measurement of EI (TEIQue) is perceived and experienced by qualified therapists with their professional competencies and emotional literacy. In particular, is trait EI measurement relevant to those therapeutic competences and transformative to clinicians training program? If so, can it be used as a training tool to familiarise trainees with discriminating features in therapeutic interventions? This present study is among the first to investigate EI among psychotherapists. Over the last 30 years, evidence points to the crucial role of emotional abilities and dispositions for life success and psychological wellbeing.

7.1. Summary of the key findings and their practical application

There is a conceptual overlap between EI and the current study's research themes of therapeutic relationship competencies. Mayers and Salovey's (1997) perception, appraisal and expression of emotions and emotional facilitation of thought is linked with the themes and categories that emerged from the study. Thus, emotion-perception, as the ability to tune in to what the other person is feeling, and emotion-integration, as the ability to relate what it is like to experience that feeling, emerged under the category of "empathy" and "benevolent connection" in the current study. The second branch of Mayer and Salovey (1997), namely emotional understanding, overlaps and could be linked to the data theme of mindfulness, as well as the emergent categories of reflective practice, self-awareness, emotions and cognition, and awareness. It is also akin to reflective functioning (Fonagy & Target, 1999). Whilst the higher branch 4 of Mayer and Salovely (1997)

affects regulation and the reflective regulation of emotion to promote emotional and intellectual growth, the branch resonates with the participants theme of empathetic balance.

The most prominent themes presented highlighted the potential value of EI in counselling and psychotherapy programmes. This supports the usefulness of developing EI experiential learning programs training in order to increase professional reflective-practising and focusing one's own need for empathetic balance that could contribute to an effective therapeutic relationship.

A number of important outcomes emanated from this research experience. First, using EI as part of developing emotional learning and building on therapeutic competencies, there appears to be a lack of a clear theoretical rationale and techniques of which EI training programs can emerge from their current dubious bases.

Second, we need to address and investigate how the themes emerged as important in the therapeutic relationship and the existing EI re-integration of a research measure is appropriate for implementation in training. While measures of therapist process or therapeutic relationship intervention (e.g., Trait EI) could help trainees gain knowledge and understanding, 'what to do as a therapist', client process measures, on the other hand, would help trainees to perceive what is happening in the session. This research was focused on the process of therapy and therapist subjective experience of therapy and trait EI. Further studies need to encompass more information on the outcome and process.

Third, and final, we need to develop appropriate EI teaching modules for psychotherapy training purposes, using a series of group training sessions, including group discussion and role plays. Supervision, and perhaps an expert consensus panel, can limit the limitations of trait EI or ability EI pitfalls. Psychotherapy and counselling training teams offer an ideal environment in which such modules can be successful. Training would be implemented early in the doctoral program and discussion on EI

cognitive and experiential learning can be offered under supervision. Knowledge is context-based and it is important in an EI learning program to understand all the meaning behind tacit judgements, values, emotions and intentions that are communicated in therapeutic settings. Engaging therapists in EI reflection experiential and cognitive exercises could create a process of challenging a set of beliefs and values about one's personal biases and foster learning from that experience.

The current study expands the literature of therapist training by examining the concept of EI as a self-reflection process to aid therapists as a scaffold learning experience in the supervised clinical setting. Hen and Goroshit (2011) is a pioneer example of EI adaptation as a cognitive experiential training programme. The program, however, is not adapted to counselling and psychotherapy training. The idea of an EI experiential training process may aid therapists as a scaffold to support learning from the clinical setting. Despite the fact that supervision is an essential part of psychotherapy training, this task is outside of the clinical work context. Self-reflection process on one's clinical work in a more self-directed task within therapy provides opportunities for novices to learn from experts, which directly relates to the supervision setting in therapy training.

In this study, I did not seek to present myself as an all-knowing expert but rather as an honest individual conveying my doubts and the limitations of the existing status quo in the therapeutic relationship and EI research. Throughout this mindfulness, I remained reflective to avoid a closed judgement on the issue under investigation. However, I am also mindful of exuding a sense of "knowing it all."

References

Ackerman, S., & Hilsenroth, M. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*(2), 171-185. doi:10.1037/0033-3204.38.2.171

Ackerman, S., & Hilsenroth, M. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1-33. doi:10.1016/s0272-7358(02)00146-0

Adams, S. (1998). *Journey to Cubeville*. Kansas City, Mo.: Andrews McMeel Pub.

Adolph, S., Hall, W., & Kruchten, P. (2011). Using grounded theory to study the experience of software development. *Empirical Software Engineering*, *16*(4), 487-513. doi:10.1007/s10664-010-9152-6

Akerjordet, K., & Severinsson, E. (2004). Emotional intelligence in mental health nurses talking about practice. *Int J Ment Health Nurs*, *13*(3), 164-170. doi:10.1111/j.1440-0979.2004.0328.x

Akhtar, S. (2009). *Comprehensive Dictionary of Psychoanalysis*, London: Karnac.

Allen, J. G., & Fonagy, P. (Eds.). (2006). *Handbook of mentalization-based treatment. West Sussex,* UK: Jon Wiley Ltd. doi:10.1002/9780470712986

Almog, J. (2002). *What Am I? Descartes and the Mind–Body Problem*. Oxford: Oxford University Press

Alexander, F., & French, T. (1946). *Psychoanalytic Therapy: Principles and Application*. Lincoln: University of Nebraska Press.

Anderson, M. (2003). Embodied Cognition: A field guide. *Artificial Intelligence*, *149*(1), 91-130. doi:10.1016/s0004-3702(03)00054-7

Andrew, F., & Robinson, J. (1991). Measures of subjective well-being. In J. Robinson, P. Shaver, L. Wrightsman & F. Andrew, *Measures of personality and social psychological attitudes* (1st ed., pp. 61-114). San Diego: Academic Press.

Assagioli, R. (1991). *Transpersonal development*. London: Crucible.

Atwood, G., & Stolorow, R. (1984). *Structures of subjectivity*. Hillsdale, N.J.: Analytic

Press.

Appelbaum, S.A. (1973). Psychological-mindedness: Word, concept and essence. *International Journal of Psychoanalysis, 54, 35–46.*

Auerbach, J., & Blatt, S. (2001). Self-reflexivity, intersubjectivity, and therapeutic change. *Psychoanalytic Psychology*, *18*(3), 427-450. doi:10.1037//0736-9735.18.3.427

Austin, E., Saklofske, D., & Mastoras, S. (2010). Emotional intelligence, coping and exam-related stress in Canadian undergraduate students. *Aus. J. Of Psych.*, *62*(1), 42-50. doi:10.1080/00049530903312899

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. Hubble, B. Duncan & S. Miller, *The heart & soul of change* (1st ed., pp. 133-178). Washington, DC: American Psychological Association.

Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research*, *16*(3), 317-331. doi:10.1080/10503300500268524

Bandura, A. (1986). *Social foundations of thought and action*. New Jersey: Prentice Hall.

Barbour, R. (1984). Social work education: tackling the theory/practice dilemma. *British Journal Of Social Work*, *14*(6), 557-577.

Bar-On, R. (1996). *The Bar-On The Emotional Intelligence Inventory (EQ-I): A test of emotional intelligence*. Toronto: Multi-Health System.

Bar-On, R. (1997). *The Bar-On Emotional Quotient Inventory: Technical manual*. Toronto, Canada: Multi-Health System.

Bar-On, R. (2004). The Bar-On Emotional Quotient Inventory (EQ-i): Rationale, description and psychometric properties. In G. Geher, *Measuring emotional intelligence: Common ground and controversy* (1st ed.). Hauppauge, NY: Nova Science.

Bar-On, R. (2006). The Bar-On Model of Emotional-Social Intelligence (ESI). *Psicothema*, *18*, 13-25. doi:10.1037/a0027377

Bar-On, R. (2012). The Impact of Emotional Intelligence on Health and Wellbeing. In A. Di Fabio, *Emotional Intelligence - New Perspectives and Applications* (1st ed., pp. 29-50). InTech.

Bar-On, R., & Parker, J. (2000). *The handbook of emotional intelligence*. San Francisco, Calif.: Jossey-Bass.

Bar-On, R., Brown, J., Kirkcaldy, B., & Thom√©, E. (2000). Emotional expression and implications for occupational stress; an application of the Emotional Quotient Inventory (EQ-i). *Personality And Individual Differences*, *28*(6), 1107-1118. doi:10.1016/s0191-8869(99)00160-9

Baron-Cohen, S., & Goodhart, F. (1994). The ‚Äòseeing-leads-to-knowing‚Äô deficit in autism: The Pratt and Bryant probe. *British Journal Of Developmental Psychology*, *12*(3), 397-401. doi:10.1111/j.2044-835x.1994.tb00642.x

Baron-Cohen, S., Tager-Flusberg, H., & Cohen, D. (1993). *Understanding Other Minds: Perspectives from Autism*. Oxford: Oxford University Press.

Barrett, L., Ochsner, K., & Gross, J. (2007). On the automaticity of emotion. In J. Bargh, *Social psychology and the unconscious: The automaticity of higher mental processe* (1st ed., pp. 173-217). New York: Psychology Press.

Beck, A., & Clark, D. (1997). An information processing model of anxiety: Automatic and strategic processes. *Behaviour Research And Therapy*, *35*(1), 49-58. doi:10.1016/s0005-7967(96)00069-1

Beck, C. (1993). Qualitative Research: The Evaluation of Its Credibility, Fittingness, and Auditability. *Western Journal Of Nursing Research*, *15*(2), 263-266. doi:10.1177/019394599301500212

Beebe, B., & Stern, D. (1977). Engagement-Disengagement and Early Object Experiences. In N. Freedman & S. Grand, *Communicative Structures and Psychic Structures* (1st ed., pp. 35-55). New York: Plenum Press.

Beebe, J. (1988). Primary ambivalence toward the self: Its nature and treatment. In N. Schwartz-Salant & M. Stein, *The Borderline Personality in Analysis (Chiron clinical series)* (1st ed., pp. 98-127). Wilmette, IL: Chiron.

Bein, E., Anderson, T., Strupp, H., Henry, W., Schacht, T., Binder, J., & Butler, S.

(2000). The effects of training in time-limited dynamic psychotherapy: changes in therapeutic outcome. *Psychotherapy Research*, *10*(2), 119-132. doi:10.1080/713663669

Bennett-Levy, J. (2005). Therapist Skills: A Cognitive Model of their Acquisition and Refinement. *Behavioural And Cognitive Psychotherapy*, *34*(01), 57-78. doi:10.1017/s1352465805002420

Bergin, A. (2014). The evaluation of therapeutic outcomes. In A. Bergin & S. Garfield, *Handbook of psychotherapy and behavior change* (1st ed.). New York: Wiley.

Berman, J., & Norton, N. (1985). Does professional training make a therapist more effective?. *Psychological Bulletin*, *98*(2), 401-407. doi:10.1037//0033-2909.98.2.401

Bernard, J., & Goodyear, R. (2004). *Fundamentals of clinical supervision* (3rd ed.). Boston: Allyn and Bacon.

Bhochhibhoya, A., Branscum, P., Taylor, E., & Hofford, C. (2014). Exploring the Relationships of Physical Activity, Emotional Intelligence, and Mental Health among College Students. *American Journal Of Health Studies*, *29*(2), 191-197.

Bieschke, K., Fouad, N., Collins, F., & Halonen, J. (2004). The scientifically-minded psychologist: Science as a core competency. *J. Clin. Psychol.*, *60*(7), 713-723. doi:10.1002/jclp.20012

Binder, J. L. (2004). *Key competencies in brief dynamic psychotherapy*: Clinical practice beyond the manual. New York: Guilford

Bion, W. (1962). *Learning from experience*. London: Maresfield.

Bion, W. (1970). *Attention and interpretation*. London: Tavistock.

Bion, W., & Bion, F. (2005). *The Tavistock seminars*. London: Karnac.

Birks, M., & Mills, J. (2011). *Grounded Theory: A Practical Guide*. Los Angeles, Calif.: Sage.

Bishop, R. S., Lau, M., Shapiro, S., Carlson, L., Anderson, D. N., Carmody, J., Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice,* 11, 230–241. http://dx.doi.org/10.1093/clipsy.bph077

Blumer, H. (1969). *Symbolic Interactionism: Perspective and Method*. Berkeley, CA: University of California Press.

Bochner, A. (1984). The function of communication in interpersonal bonding. In C. Arnold & J. Bowers, *The Handbook OF Rhetoric and Communication* (1st ed., pp. 544-621). Thousand Oaks, CA: Sage.

Bochner, A. (2001). Narrative's Virtues. *Qualitative Inquiry*, *7*(2), 131-157. doi:10.1177/107780040100700201

Booth-Kewley, S., & Friedman, H. (1987). Psychological predictors of heart disease: A quantitative review. *Psychological Bulletin*, *101*(3), 343-362. doi:10.1037//0033-2909.101.3.343

Boud, D. (1999). Avoiding the traps: seeking good practice in the use of self assessment and reflection in professional courses. *Social Work Education*, *18*(2), 121-132. doi:10.1080/02615479911220131

Boud, D., Keogh, R., & Walker, D. (1985). *Reflection, turning experience into learning*. London: Kogan Page.

Bower, G. (1981). Mood and memory. *American Psychologist*, *36*(2), 129-148. doi:10.1037/0003-066x.36.2.129

Bowlby, J. (1958). The nature of the child‚Äôs tie to his mother. *International Journal Of Psycho-Analysis*, *39*(5), 350-373.

Bowlby, J. (1969). *Attachment and loss*. New York: Basic Books.

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory*. London: Routledge.

Boyatzis, R., & Kolb, D. (1991). Assessing Individuality in Learning: the learning skills profile. *Educational Psychology*, *11*(3-4), 279-295. doi:10.1080/0144341910110305

Brackett, M., & Mayer, J. (2003). Convergent, Discriminant, and Incremental Validity of Competing Measures of Emotional Intelligence. *Personality And Social Psychology Bulletin*, *29*(9), 1147-1158. doi:10.1177/0146167203254596

Bradberry, T., & Greaves, J. (2009). *Emotional intelligence*. San Francisco: Publishers

Group West.

Brannick, M., Wahi, M., Arce, M., Johnson, H., Nazian, S., & Goldin, S. (2009). Comparison of trait and ability measures of emotional intelligence in medical students. *Medical Education*, *43*(11), 1062-1068. doi:10.1111/j.1365-2923.2009.03430.x

Braud, W. (1998). Can Research Be Transpersonal?. *Transpersonal Psychology Review*, *2*(3), 9-17. doi:10.1080/08873267.2013.749660

Braud, W., & Anderson, R. (1998). *Transpersonal research methods for the social sciences*. Thousand Oaks, Calif.: Sage Publications.

Braver, T., Cohen, J., & Barch, D. (2014). The role of the prefrontal cortex in normal and disordered cognitive control: A cognitive neuroscience perspective. In R. Knight & D. Stuss, *Principles of frontal lobe function* (1st ed., pp. 428-448). Oxford: Oxford University Press.

Brown, L., & Miller, M. (2002). The triadic intersubjective matrix in supervision: the use of disclosure to work through painful affects. *International Journal Of Psychoanalysis*, *83*(4), 811-823. doi:10.1516/tdhv-gwpp-4hx7-vm9x

Bruner, J. (1957). *Contemporary Approaches to Cognition* (pp. 41-69). Cambridge, Ma.: Harvard University Press.

Brushweiler-Stern, N., & Tronick, E. (1997). *Mechanisms of change in psychoanalytic therapy: Implicit relational knowing, the ‚Äúsomething more‚Äù than interpretation*. Presentation, Boston.

Bryant, A. (2002). Re-Grounding Grounded Theory. *Journal Of Information Technology Theory And Application*, *3*(1).

Bryant, A., & Charmaz, K. (2007). *The SAGE handbook of grounded theory*. Los Angeles: SAGE.

Buber, M. (1958). *I and Thou*. New York: Scribner.

Buck, R. (1984). *The communication of emotion*. New York: Guilford Press.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: the use of grounded theory, discourse analysis and narrative analysis. *J Family*

Therapy, *27*(3), 237-262. doi:10.1111/j.1467-6427.2005.00314.x

Burns, D., & Auerbach, A. (2014). Therapeutic empathy in cognitive-behavioural therapy: Does it really make a difference?. In P. Salkovskis, *Frontiers of cognitive therapy* (1st ed., pp. 135-164). London: Guilford Press.

Burns, D., & Nolen-Hoeksema, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioral therapy: A structural equation model. *Journal Of Consulting And Clinical Psychology*, *60*(3), 441-449. doi:10.1037//0022-006x.60.3.441

Cadman, C., & Brewer, J. (2001). Emotional intelligence: a vital prerequisite for recruitment in nursing. *Journal Of Nursing Management*, *9*(6), 321-324. doi:10.1046/j.0966-0429.2001.00261.x

Caplan, M., Hartelius, G., & Rardin, M. (2003). Contemporary viewpoints on transpersonal psychology. *Journal Of Transpersonal Psychology*, *35*(2), 143,Äì162.

Carroll, J. (1993). *Human cognitive abilities*. Cambridge: Cambridge University Press.

Catto, G. (2005). GMC and the future of revalidation: building on the GMC's achievements. *British Medical Journal*, *330*(7503), 1205-1293. doi:10.1136/bmj.330.7503.1293-d

Chapin, S. (1967). *The social insight test*. Palo Alto, CA: Consulting Psychologists Press.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R. Emerson, *Contemporary field research: A collection of readings* (1st ed., pp. 109-126). Boston, MA: Little Brown Company.

Charmaz, K. (1990). ,ÄòDiscovering,Äô chronic illness: Using grounded theory. *Social Science & Medicine*, *30*(11), 1161-1172. doi:10.1016/0277-9536(90)90256-r

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln, *Handbook of qualitative research* (1st ed., pp. 509-535). Thousand Oaks, CA: Sage.

Charmaz, K. (2003). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. Lincoln, *Strategies of qualitative inquiry* (1st ed., pp. 249-291).

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London: Sage.

Charmaz, K. (2006). *Constructing grounded theory*. London: Sage Publications.

Charmaz, K. (2007). Constructionism and the grounded theory method. In J. Holstein & J. Gubrium, *Handbook of constructionist research* (1st ed.). London: Guilford Press.

Chenitz, W., & Swanson, J. (1986). *From Practices to Grounded Theory: Qualitative Research in Nursing*. Menlo Park, CA: Addison-Wesley.

Cherniss, C. (2001). Emotional intelligence & organizational effectiveness. In J. Cherniss, C. Cherniss & D. Goleman, *The emotionally intelligent workplace: how to select for, measure, and improve emotional intelligence in Individuals, Groups, and Organizations* (1st ed., pp. 1-12). San Francisco, CA: John Wiley & Sons.

Cherniss, C., & Goleman, D. (2001). Training for emotional intelligence. In J. Cherniss, C. Cherniss & D. Goleman, *The Emotionally Intelligent Workplace: How to Select For, Measure, and Improve Emotional Intelligence in Individuals, Groups, and Organizations* (1st ed., pp. 209-233). San Francisco, CA: John Wiley & Sons.

Churchill, S. (2000). Phenomenological psychology. In *Encyclopedia of psychology*. Oxford: Oxford University Press.

Ciarrochi, J., Chan, A., & Caputi, P. (2000). A critical evaluation of the emotional intelligence construct. *Personality And Individual Differences*, *28*(3), 539-561. doi:10.1016/s0191-8869(99)00119-1

Ciarrochi, J., Deane, F., & Anderson, S. (2002). Emotional intelligence moderates the relationship between stress and mental health. *Personality And Individual Differences*, *32*(2), 197-209. doi:10.1016/s0191-8869(01)00012-5

Ciarrochi, J., Forgas, J., & Mayer, J. (2001). *Emotional intelligence in everyday life*. Philadelphia, PA: Psychology Press.

Clark, M., & Fiske, S. (1982). *Affect and cognition*. Hillsdale, NJ: Erlbaum.

Clarke, A. (2005). *Situational Analysis: Grounded Theory After the Postmodern Turn*. Thousand Oaks, Calif.: Sage Publications.

Clarke, A. (2014). Feminisms, grounded theory, and situational analysis. In S. Hens-Biber & D. Leckenby, *Handbook of feminist research methods* (1st ed., pp. 315-376). Thousand Oaks, CA: Sage.

Clarkson, P. (1990). A Multiplicity of Psychotherapeutic Relationships. *Br J Psychotherapy*, *7*(2), 148-163. doi:10.1111/j.1752-0118.1990.tb01329.x

Clarkson, P. (1995). *The therapeutic relationship*. London: Whurr.

Clarkson, P. (2002). *The Transpersonal Relationship in Psychotherapy: The Hidden Curriculum of Spirituality*. London: Whurr.

Clore, G. (1994). Why emotions are never unconscious. In P. Ekman & R. Davidson, *The nature of emotions. Fundamental questions* (1st ed., pp. 285-290). New York: Oxford University Press.

Connell, R., Crawford, J., Kippax, S., Dowsett, G., Baxter, D., Watson, L., & Berg, R. (1989). Facing the Epidemic: Changes in the Sexual Lives of Gay and Bisexual Men in Australia and Their Implications for AIDS Prevention Strategies. *Social Problems*, *36*(4), 384-402. doi:10.2307/800822

Cooper, M. (2004). Towards a relationally-orientated approach to therapy: empirical support and analysis. *British Journal Of Guidance & Counselling*, *32*(4), 451-460. doi:10.1080/03069880412331303268

Cooper, M. (2005). Therapists‚Äô experiences of relational depth: A qualitative interview study. *Counselling And Psychotherapy Research*, *5*(2), 87-95. doi:10.1080/17441690500211130

Cooper, R., & Sawaf, A. (1997). *Executive EQ*. New York: Grosset/Putnam.

Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, *13*(1), 3-21. doi:10.1007/bf00988593

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain*. (2nd ed.). New York, NY: W.W. Norton

Cornejo, C. (2008). Intersubjectivity as Co-phenomenology: From the Holism of Meaning to the Being-in-the-world-with-others. *Integr. Psych. Behav.*, *42*(2), 171-178. doi:10.1007/s12124-007-9043-6

Coyne, I., & Cowley, S. (2006). Using grounded theory to research parent participation. *Journal Of Research In Nursing*, *11*(6), 501-515. doi:10.1177/1744987106065831

Creswell, J. (1997). *Qualitative inquiry and research design*. Thousand Oaks: Sage Publications.

Curtis, L., Moriarty, J., & Netten, A. (2009). The Expected Working Life of a Social Worker. *British Journal Of Social Work*, *40*(5), 1628-1643. doi:10.1093/bjsw/bcp039

Cutcliffe, J. (2005). Adapt or adopt: developing and transgressing the methodological boundaries of grounded theory. *J Adv Nurs*, *51*(4), 421-428. doi:10.1111/j.1365-2648.2005.03514.x

Dallos, R. (2006). *Attachment narrative therapy*. Maidenhead, Berkshire, England: Open University Press.

Damasio, A. (1995). *Descartes' error: emotion, reason, and the human brain*. New York: Avon Books.

Damasio, A. (1999). *The feeling of what happens*. New York: Harcourt Brace.

Damasio, A. (2003). *Looking for Spinoza*. Orlando, Fla.: Harcourt.

Damasio, A. (2010). *Self comes to mind*. New York: Pantheon Books.

Damasio, A., Damasio, H., & Tranel, D. (1991). Somatic markers and the guidance of behavior: Theory and preliminary testing. In H. Levin, H. Eisenberg & A. Benton, *Frontal Lobe Function and Dysfunction* (1st ed., pp. 217-229). New York: Oxford University Press.

Danielsen, R., & Cawley, J. (2007). Compassion and Integrity in Health Professions Education. *The Internet Journal Of Allied Health Sciences And Practice*, *5*(2), 1-9.

Daus, C., & Ashkanasy, N. (2005). The case for the ability-based model of emotional intelligence in organizational behavior. *J. Organiz. Behav.*, *26*(4), 453-466. doi:10.1002/job.321

David, S. *Emotional intelligence*. Melbourne, Australia: University of Melbourne.

Davies, M., Stankov, L., & Roberts, R. (1998). Emotional intelligence: In search of an elusive construct. *Journal Of Personality And Social Psychology*, *75*(4), 989-1015. doi:10.1037//0022-3514.75.4.989

Dawda, D., & Hart, S. (2000). Assessing emotional intelligence: reliability and validity of the Bar-On Emotional Quotient Inventory (EQ-i) in university students. *Personality And Individual Differences*, *28*(4), 797-812. doi:10.1016/s0191-8869(99)00139-7

Day, A., & Carroll, S. (2008). Faking emotional intelligence (EI): comparing response distortion on ability and trait‚Äêbased EI measures. *J. Organiz. Behav.*, *29*(6), 761-784. doi:10.1002/job.485

De Jaegher, H., Di Paolo, E., & Gallagher, S. (2010). Can social interaction constitute social cognition?. *Trends In Cognitive Sciences*, *14*(10), 441-447. doi:10.1016/j.tics.2010.06.009

del Barrio, C., Mart√≠n, E., Montero, I., Guti√©rrez, H., Barrios, √Å., & de Dios, M. (2008). Bullying and social exclusion in Spanish secondary schools: National trends from 1999 to 2006. *International Journal Of Clinical And Health Psychology*, *8*(3), 657-677.

Dennis, T. (2006). Emotional self-regulation in preschoolers: The interplay of child approach reactivity, parenting, and control capacities. *Developmental Psychology*, *42*(1), 84-97. doi:10.1037/0012-1649.42.1.84

Denzin, N., & Lincoln, Y. (1994). *Handbook of qualitative research*. Thousand Oaks: Sage Publications.

Dey, I. (1993). *Qualitative data analysis a user-friendly guide for social scientists*. London: Routledge.

Dey, I. (1999). *Grounding grounded theory*. San Diego: Academic Press.

Dey, I. (2004). Grounded theory. In C. Seale, G. Gobo, J. Gubrium & D. Silverman, *Qualitative research practice* (1st ed., pp. 80-93). London: Sage.

Dey, I. (2007). Grounding categories. In A. Bryant & K. Charmaz, *The Sage handbook of grounded theory* (1st ed., pp. 167-190). London: Sage.

Dixon-Woods M, Cavers D, Agarwal S, Annandale E, Arthur A, Harvey J, Sutton, A.J.,
& Young, B.(2006). Conducting a critical interpretive synthesis of the literature on
access to healthcare by vulnerable groups. *BMC Medical Research Methodology,6-
35.*

do Rozario, L. (1997). Shifting paradigms: The transpersonal dimensions of ecology
and occupation. *Journal Of Occupational Science*, *4*(3), 112-118.
doi:10.1080/14427591.1997.9686427

Doehrman, M. (1976). Parallel process in supervision and psychotherapy. *Bulletin Of
The Menninger Clinic*, *40*(1), 3-104.

Duan, C., & Hill, C. (1996). The current state of empathy research. *Journal Of
Counseling Psychology*, *43*(3), 261-274. doi:10.1037//0022-0167.43.3.261

Dunne, C. (2011). The place of the literature review in grounded theory research.
International Journal Of Social Research Methodology, *14*(2), 111-124.
doi:10.1080/13645579.2010.494930

Dunn, R., Callahan, J. L., & Swift, J. K. (2013). Mindfulness as a transtheoretical
clinical process. *Psychotherapy, 50, 312–315*. http://dx.doi.org/10.1037/a0032153

Eakin.J.M. & Mykhalovskiy, E. (2003). Reframing the evaluation of qualitative health
research: reflection on a review of appraisal guidelines in the health sciences.
Journal of Evaluation in Clinical Practice 9 (2):187-194

Eborall, C., & Garmeson, K. (2001). *Desk Research on Recruitment and Retention in
Social Care and Social Work*. London: Department of Health.

Eisner, E., & Guba, E. (1979). Toward a Methodology of Naturalistic Inquiry in
Educational Evaluation. *Educational Evaluation And Policy Analysis*, *1*(2), 73.
doi:10.2307/1163902

Ekman, P. (2004). *Emotions revealed*. New York, N.Y.: Henry Holt and Co.

Ekman, P., & Davidson, R. (1994). *The nature of emotion* (pp. 409-430). New York:
Oxford University Press.

Ellis, M., & Ladany, N. (1997). Inferences concerning supervisees and clients in clinial
supervision: An integrative review. In C. Watkins Jr, *Handbook of Psychotherapy
supervision* (1st ed., pp. 567-607). New York: Wiley.

Emmons, R. (2000). Is Spirituality an Intelligence? Motivation, Cognition, and the Psychology of Ultimate Concern. *International Journal For The Psychology Of Religion*, *10*(1), 3-26. doi:10.1207/s15327582ijpr1001_2

Epstein, R. (1999). Mindful Practice. *JAMA*, *282*(9), 833. doi:10.1001/jama.282.9.833

Epstein, S. (1991). Cognitive-experiential self-theory: Implications for developmental psychology. In M. Gunnar & L. Sroufe, *Self-processes and development: Vol. 23. Minnesota Symposia on Child Psychology* (1st ed., pp. 79-123). Hillsdale, NJ: Erlbaum.

Epstein, S., & Meier, P. (1989). Constructive thinking: A broad coping variable with specific components. *Journal Of Personality And Social Psychology*, *57*(2), 332-350. doi:10.1037//0022-3514.57.2.332

Eysenck, M., Payne, S., & Santos, R. (2006). Anxiety and depression: Past, present, and future events. *Cognition & Emotion*, *20*(2), 274-294. doi:10.1080/02699930500220066

Farber, B., & Golden, V. (1997). Psychological mindedness in psychotherapists. In M. McCallum & W. Piper, *Sychological Mindedness. A Contemporary Understanding* (1st ed.). Mahwan, NJ: Erlbaum.

Fauth, J., Gates, S., Vinca, M.A., Boles, S., and Hayes, J.A., (2007) Big ideas for psychotherapy training. Psychotherapy: *Theory, Research, Practice, Training, 44, 384-391*

Fiedler, F., & House, R. (1994). Leadership theory and research: A report of progress. In C. Cooper & I. Robertson, *Key reviews in managerial psychology* (1st ed., pp. 97-116). New York: John Wiley & Sons.

Finlay, L., & Evans, K. (2009). *Relational-centred research for psychotherapists*. Chichester, UK: Wiley-Blackwell.

Fiske, S., & Taylor, S. (1991). *Social cognition* (2nd ed.). New York: McGraw-Hill.

Flores-Gonzlez, L. (2008). Phenomenological Views on Intersubjectivity: Towards a Reinterpretation of Consciousness. *Integr. Psych. Behav.*, *42*(2), 187-193. doi:10.1007/s12124-007-9044-5

Fonagy, P., & Target, M. (1996). Playing with reality: I. Theory of mind and the normal

development of psychic reality. *The International Journal Of Psychoanalysis*, *77*(2), 217-233.

Fonagy, P., Gergely, G., & Target, M. (2007). The parent-infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry, 48, 288 –328*. doi:10.1111/j.14697610.2007.01727.x

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self.* London, UK: Karnac

Fonagy, P., & Target, M. (1999). An interpersonal view of the infant. In A. Hurry, *Psychoanalysis and Developmental Therapy* (1st ed.). Madison, CT: International Universities Press.

Fonagy, P., & Target, M. (2000). Playing with reality: III. The persistence of dual psychic reality in borderline patients. *The International Journal Of Psychoanalysis*, *81*(5), 853-873. doi:10.1516/0020757001600165

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development And Psychopathology*, *9*(4), 679-700. doi:10.1017/s0954579497001399

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., & Mattoon, G. et al. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal Of Consulting And Clinical Psychology*, *64*(1), 22-31. doi:10.1037/0022-006x.64.1.22

Fonagy, P., Steele, M., Steele, H., Moran, G., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *12*(3), 201-218. doi:10.1002/1097-0355(199123)12:3<201::aid-imhj2280120307>3.0.co;2-7

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective Functioning manual. Version 5*. London: University College London.

Ford, M., & Tisak, M. (1983). A further search for social intelligence. *Journal Of Educational Psychology*, *75*(2), 196-206. doi:10.1037//0022-0663.75.2.196

Forgas, J. (2000). *Feeling and thinking*. Cambridge: Cambridge University Press.

Fonagy, P., & Bateman, A. (Eds.). (2012). *Handbook of Mentalizing in mental health*

practice. Arlington, VA: American Psychiatric Publishing, Inc

Forgas, J., Bower, G., & Krantz, S. (1984). The influence of mood on perceptions of social interactions. *Journal Of Experimental Social Psychology*, *20*(6), 497-513. doi:10.1016/0022-1031(84)90040-4

Fosha, D. (2000). *The transforming power of affect*. New York: BasicBooks.

Fox, S., & Spector, P. (2000). Relations of emotional intelligence, practical intelligence, general intelligence, and trait affectivity with interview outcomes: it's not all just ,ÄòG‚Äô. *J. Organiz. Behav.*, *21*(2), 203-220. doi:10.1002/(sici)1099-1379(200003)21:2<203::aid-job38>3.3.co;2-q

Fox, W. (1990). Transpersonal Ecology: "Psychologising" ecophilosophy. *Journal Of Transpersonal Psychology*, *22*(1), 59-96.

Frank, J. (1971). Therapeutic factors in psychotherapy. *American Journal Of Psychotherapy*, *25*(3), 350-361.

Freud, S. (1915). *Instincts and their Vicissitudes*. London: Hogarth Press.

Freud, S. (1924). *Neurosis and Psychosis* (pp. 149-153).

Freud, S. (1958). The dynamics of transference. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 97-108). London: Hogarth Press, (Original work published 1912)

Freud, S. (1958). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 122-144). London: Hogarth Press, (Original work published 1913)

Freud, S. (2001). On beginning the treatment. In *The standard edition of the complete psychological works of Sigmund Freud, Volume XII: The case of Schreber, papers on technique and other works* (1st ed., pp. 121-144). Vintage Classics.

Freud, S., & Strachey, J. (1949). *An outline of psychoanalysis*. New York: W.W. Norton.

Freud, S., & Strachey, J. *The claims of psycho-analysis to scientific interest*.

Friedman, M. (1988). The Healing Dialogue in Psychotherapy. *Journal Of Humanistic*

Psychology, *28*(4), 19-41. doi:10.1177/0022167888284003

Fulgencio, L. (2007). Winnicott‚Äôs rejection of the basic concepts of Freud‚Äôs metapsychology. *International Journal Of Psychoanalysis*, *88*(2), 443-461. doi:10.1516/t255-875g-6717-15x0

Furnham, A., & Petrides, K. (2003). Trait emotional intelligence and happiness. *Social Behavior And Personality: An International Journal*, *31*(8), 815-823. doi:10.2224/sbp.2003.31.8.815

Garber, J., Braafladt, N., & Weiss, B. (1995). Affect regulation in depressed and nondepressed children and young adolescents. *Development And Psychopathology*, *7*(01), 93. doi:10.1017/s0954579400006362

Gardner, H. (1983). *Frames of mind*. New York: Basic Books.

Gardner, K., & Qualter, P. (2010). Concurrent and incremental validity of three trait emotional intelligence measures. *Aus. J. Of Psych.*, *62*(1), 5-13. doi:10.1080/00049530903312857

Geher, G., Warner, R., & Brown, A. (2001). Predictive validity of the emotional accuracy research scale. *Intelligence*, *29*(5), 373-388. doi:10.1016/s0160-2896(00)00045-3

Gendlin, E. (1996). *Focusing-oriented psychotherapy*. New York: Guilford Press.

George, J. (2000). Emotions and Leadership: The Role of Emotional Intelligence. *Human Relations*, *53*(8), 1027-1055. doi:10.1177/0018726700538001

Gianino, A. (1998). The mutual regulation model: The infant‚Äôs self and interactive regulation. Coping and defense capacities. In T. Field, P. McCabe & N. Schneiderman, *Stress and coping* (1st ed., pp. 47-68). Hillsdale, NJ: Erlbaum.

Gibbs, G. (2010). *Selective Coding. Grounded Theory*. Presentation, University of Huddersfield.

Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, Calif.: Sociology Press.

Glaser, B. (1992). *Emergence vs forcing*. Mill Valley, CA: Sociology Press.

Glaser, B. (1995). *Grounded theory, 1984-1994*. Mill Valley, CA: Sociology Press.

Glaser, B. (1998). *Doing grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B. (2001). *The grounded theory perspective*. Mill Valley, Calif.: Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine Pub. Co.

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam Books.

Goleman, D. (1995). EQ What's your emotional intelligence quotient?. *UTNE*. Retrieved from http://www.utne.com/science-and-technology/emotional-intelligence-quotient-test.aspx#axzz3KT9uzI80

Goleman, D. (1998). *Working with emotional intelligence*. New York: Bantam Books.

Goleman, D. (2001). Emotional intelligence: Issues in paradigm building. In Cherniss & D. Goleman, *The emotionally intelligent workplace* (1st ed., pp. 13-26). San Francisco: Jossey-Bass.

Goulding, C. (2002). *Grounded theory*. London: SAGE.

Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105-112. doi:10.1016/j.nedt.2003.10.001

Grant, L. (2013). Hearts and Minds: Aspects of Empathy and Wellbeing in Social Work Students. *Social Work Education*, *33*(3), 338-352. doi:10.1080/02615479.2013.805191

Gray, J. (2004). Integration of Emotion and Cognitive Control. *Current Directions In Psychological Science*, *13*(2), 46-48. doi:10.1111/j.0963-7214.2004.00272.x

Greenberg, L. (2002). *Emotion-focused therapy*. Washington, DC: American Psychological Association.

Greenberg, L. (2004). Emotion‚Äìfocused therapy. *Clin. Psychol. Psychother.*, *11*(1), 3-16. doi:10.1002/cpp.388

Greenberg, L., & Safran, J. (1987). *Emotion in psychotherapy*. New York: Guilford Press.

Greenberg, L., Rice, L., & Elliott, R. (1996). *Facilitating emotional change* (2nd ed.). New York: Guilford Press.

Green, J. & Thorogood, N. (2004). Qualitative Methods for Health Research. London: Sage.

Greene, J. (2007). *Mixed methods in social inquiry*. San Francisco, CA: Jossey-Bass.

Greenspan, M., & Kulish, N. (1985). Factors in premature termination in long-term psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *22*(1), 75-82. doi:10.1037/h0088529

Grencavage, L., & Norcross, J. (1990). Where are the commonalities among the therapeutic common factors?. *Professional Psychology: Research And Practice*, *21*(5), 372-378. doi:10.1037//0735-7028.21.5.372

Griffin, S., & Mascolo, M. (1998). On the nature, development, and function of emotion. In S. Mascolo & M. Griffin, *What develops in emotional development* (1st ed.). New York: Plenum.

Grof, S. (2000). Psychology of the future: lessons from modern consciousness research. *Choice Reviews Online*, *38*(04), 38-2431-38-2431. doi:10.5860/choice.38-2431

Gross, J. (1998). Antecedent- and response-focused emotion regulation: Divergent consequences for experience, expression, and physiology. *Journal Of Personality And Social Psychology*, *74*(1), 224-237. doi:10.1037//0022-3514.74.1.224

Gross, J. J. (Ed.). (2007). *Handbook of emotion regulation*. New York, NY:Guilford.

Grubb III, W., & McDaniel, M. (2007). The Fakability of Bar-On's Emotional Quotient Inventory Short Form: Catch Me if You Can. *Human Performance*, *20*(1), 43-59. doi:10.1207/s15327043hup2001_3

Guilford, J. (1967). *The nature of human intelligence*. New York, N.Y., [etc.]: McGraw-Hill.

Hall, J. (1992). Psychological-mindedness: a conceptual model. *American Journal Of Psychotherapy*, *46*(1), 131-140.

Hamel, S., Leclerc, G., & Lefran√ßois, R. (2003). A Psychological Outlook on the Concept of Transcendent Actualization. *International Journal For The Psychology*

Of Religion, *13*(1), 3-15. doi:10.1207/s15327582ijpr1301_02

Hartsfield, M. (2003). *The Spirit of Transformational Leadership: Emotions or Cognition?*. Virginia Beach: Regent University. Retrieved from http://ww.cbfa.org/Hartsfield.pdf

Hatcher, R. (1999). Therapists' Views of Treatment Alliance and Collaboration in Therapy. *Psychotherapy Research*, *9*(4), 405-423. doi:10.1093/ptr/9.4.405

Hatcher, R., & Lassiter, K. (2007). Initial training in professional psychology: The practicum competencies outline. *Training And Education In Professional Psychology*, *1*(1), 49-63. doi:10.1037/1931-3918.1.1.49

Haynes, R., Corey, G., & Moulton, P. (2003). *Clinical supervision in the helping professions*. Pacific Grove, CA: Brooks/Cole.

Heidegger, M. (1962). *Being and time*. New York: Harper.

Heine, R. (1953). A comparison of therapeutic relationships in psychoanalytic, nondirective and Adlerian therapy. *American Journal Of Psychotherapists*, *7*, 16-23.

Hen, M., & Goroshit, M. (2011). Emotional Competencies in the Education of Mental Health Professionals. *Social Work Education*, *30*(7), 811-829. doi:10.1080/02615479.2010.515680

Henry, W., & Strupp, H. (1994). The therapeutic alliance as interpersonal process. In A. Horvath & L. Greenberg, *The working alliance: Theory, research, and practice* (1st ed., pp. 51-84). New York: Wiley.

Hersoug, A., Monsen, J., & Havik, O. (2001). Quality of working alliance in psychotherapy; therapist variables and patient/therapist similarity as predictors. *Journal Of Psychotherapy Research*, *10*(4), 205-216.

Hertel, J., Sch√ºtz, A., & Lammers, C. (2009). Emotional intelligence and mental disorder. *J. Clin. Psychol.*, *65*(9), 942-954. doi:10.1002/jclp.20597

Hill, C., Knox, S., Thompson, B., Williams, E., Hess, S., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal Of Counseling Psychology*, *52*(2), 196-205. doi:10.1037/0022-0167.52.2.196

Hilsenroth, M., Defife, J., Blagys, M., & Ackerman, S. (2006). Effects of training in short-term psychodynamic psychotherapy: changes in graduate clinician technique. *Psychotherapy Research*, *16*(3), 293-305. doi:10.1080/10503300500264887

Hochschild, A. (1983). *The managed heart*. Berkeley: University of California Press.

Hodgson, L.K. & Wertheim, E.H. (2007). Does good emotion management aid forgiving? Multiple dimensions of empathy, emotion management and forgiveness of self and others. Journal of Social and Personal Relationships, 24, 6, p. 931-949.

Hoffmann, E. (2007). Open-Ended Interviews, Power, and Emotional Labor. *Journal Of Contemporary Ethnography*, *36*(3), 318-346. doi:10.1177/0891241606293134

Holosko, M. (2003). The History of the Working Definition of Practice. *Research On Social Work Practice*, *13*(3), 271-283. doi:10.1177/1049731503013003003

Horvath, A. (2004). *Training and supervision for the ‚Äòcommon factors'*. Presentation, 112th Annual Convention of the American Psychological Association, Honolulu.

Horvath, A. (2005). The therapeutic relationship: Research and theory. *Psychotherapy Research*, *15*(1-2), 3-7. doi:10.1080/10503300512331339143

Horvath, A., & Bedi, R. (2002). The alliance. In J. Norcross, *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (1st ed., pp. 37-70). New York: Oxford University Press.

Horvath, A., & Symonds, B. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal Of Counseling Psychology*, *38*(2), 139-149. doi:10.1037//0022-0167.38.2.139

Horvath, A., Gaston, L., & Luborsky, L. (1993). The therapeutic alliance and its measures. In L. Miller, L. Luborsky, J. Barber & J. Docherty, *Psychodynamic treatment research* (1st ed., pp. 247-273). New York: Basic Books.

Hurley, J. (2008). The necessity, barriers and ways forward to meet user-based needs for emotionally intelligent nurses. *Journal Of Psychiatric And Mental Health Nursing*, *15*(5), 379-385. doi:10.1111/j.1365-2850.2007.01243.x

Hurley, J., & Rankin, R. (2008). As mental health nursing roles expand, is education expanding mental health nurses? an emotionally intelligent view towards preparation for psychological therapies and relatedness. *Nursing Inquiry*, *15*(3),

199-205. doi:10.1111/j.1440-1800.2008.00412.x

Husserl, E., & Gibson, W. (1931). *Ideas: General Introduction to Pure Phenomenology*. London: G. Allen & Unwin.

Ikiz, F. (2009). Investigation of counselor empathy with respect to safe schools. *Procedia - Social And Behavioral Sciences*, *1*(1), 2057-2062. doi:10.1016/j.sbspro.2009.01.361

Jaeger, A. (2003). Job competencies and the curriculum: an inquiry into emotional intelligence in graduate professional education. *Research In Higher Education*, *44*(6), 615,Äì 639.

Jahangard, L., Haghighi, M., Bajoghli, H., Ahmadpanah, M., Ghaleiha, A., Zarrabian, M., & Brand, S. (2012). Training emotional intelligence improves both emotional intelligence and depressive symptoms in inpatients with borderline personality disorder and depression. *Int J Psych Clin Pract*, *16*(3), 197-204. doi:10.3109/13651501.2012.687454

Jensen, A. (1998). *The g factor*. Westport, Conn.: Praeger.

Johnson, C., Hayes, J., & Wade, N. (2007). Psychotherapy with troubled spirits: A qualitative investigation. *Psychotherapy Research*, *17*(4), 450-460. doi:10.1080/10503300600953520

Jung, C. (1958). The Psychology of the Transference. In R. Hull, *The collected works of C.G. Jung (Vol 16)* (1st ed.). Princeton, NJ: Princeton University Press.

Jung, C. (1969). *On the nature of the psyche*. Princeton, N.J.: Princeton University Press.

Jung, C. (1971). *Psychological types*. Princeton, N.J.: Princeton University Press.

Jung, C., & Jaffe, A. (1965). *Memories, dreams, reflections*. New York: Vintage Books.

Karlsson, R., & Kermott, A. (2006). Reflective-functioning during the process in brief psychotherapies. *Psychotherapy: Theory, Research, Practice, Training*, *43*(1), 65-84. doi:10.1037/0033-3204.43.1.65

Kelley, H. (1967). Attribution theory in social psychology. In D. Levine, *Nebraska Symposium on Motivation* (1st ed., pp. 192-238). Lincoln: University of Nebraska

Press.

Knightg, G. (2005). The use of the ‚Äòcorrective Emotional Experience‚Äô and the search for the bad object in psychotherapy. *American Journal Of Psychotherapy*, *59*(1), 30-41.

Knox, J. (2001). Memories, fantasies, archetypes: an exploration of some connections between cognitive science and analytical psychology. *J Anal Psychol*, *46*(4), 613-635. doi:10.1111/1465-5922.00270

Kohut, H. (1959). Introspection, empathy, and psychoanalysis: An examination of the relation between mode of observation and theory. In P. Ornstein, *The Search for the Self, Vol. 1* (1st ed., pp. 205-232). New York: International Universities Press.

Kaslow, N., Dunn, S. and Smith, C. (2008). Competencies for Psychologists in Academic Health Centers (AHCs). *Journal of Clinical Psychology in Medical Settings*, 15(1), pp.18-27.

Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *American Journal of Occupational Therapy*, *45*(3), 214-222. doi:10.5014/ajot.45.3.214

Krupnick, J., Sotsky, S., Simmens, S., Moyer, J., & et al,. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal Of Consulting And Clinical Psychology*, *64*(3), 532-539. doi:10.1037/0022-006x.64.3.532

Kuhn, T. (1977). *The essential tension* (pp. 293-319). Chicago: University of Chicago Press.

Kvale, S. (1995). The Social Construction of Validity. *Qualitative Inquiry*, *1*(1), 19-40. doi:10.1177/107780049500100103

Kvale, S. (1996). *Interviews*. Thousand Oaks, Calif.: Sage Publications.

Laming, W. (2009). *The Protection of Children in England: A Progress Report*. London: House of Commons.

Larsen, R.J., Prizmic, Z. (2004). *Affect regulation*, In: R.F. Baumeister, Handbook of self-regulation: Research, theory and applications (pp. 40-61). Guilford Press

Lajoie, D., & Shapiro, S. (1992). Definitions of transpersonal psychology: the first twenty-three years. *Journal Of Transpersonal Psychology*, *24*(1).

Lambert, M. (1983). *Psychotherapy and patient relationships*. Homewood, Ill.: Dorsey Press.

Lambert, M. (1986). Implications on psychotherapy outcome research for eclectic psychotherapy. In J. Norcross, *Handbook of Eclectic Psychotherapy* (1st ed.). New York: Brunner-Mazel.

Lambert, M., & Ogles, B. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert, *Bergin & Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed.). New York: Wiley.

LaRossa, R. (2005). Grounded Theory Methods and Qualitative Family Research. *Journal Of Marriage And Family*, *67*(4), 837-857. doi:10.1111/j.1741-3737.2005.00179.x

Layder, D. (1993). *New strategies in social research*. Cambridge, UK: Polity Press.

Lazarus, R. (1982). Thoughts on the relations between emotion and cognition. *American Psychologist*, *37*(9), 1019-1024. doi:10.1037/0003-066x.37.9.1019

Lazarus, R. (1991). *Emotion and adaptation*. New York: Oxford University Press.

Lazarus, R. (2014). The stable and the unstable in the motions. In P. Ekman & R. Davidson, *The nature of emotions. Fundamental questions* (1st ed., pp. 306-310). New York: Oxford University Press.

LeDoux, J. (1996). *The emotional brain*. New York: Simon & Schuster.

Leible, T., & Snell, W. (2004). Borderline personality disorder and multiple aspects of emotional intelligence. *Personality And Individual Differences*, *37*(2), 393-404. doi:10.1016/j.paid.2003.09.011

Leiper, R., & Casares, P. (2000). An investigation of the attachment organization of clinical psychologists and its relationship to clinical practice. *British Journal Of Medical Psychology*, *73*(4), 449-464. doi:10.1348/000711200160651

Leuner, B. (1996). Emotional intelligence and emancipation. *Praxis Kinderpsychol Und Kinderpsychiatrie*, *15*, 193-203.

Lewis, M. (2005). Bridging emotion theory and neurobiology through dynamic systems modeling. *Behavioral And Brain Sciences*, *28*(02). doi:10.1017/s0140525x0500004x

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, Calif.: Sage Publications.

Lincoln, Y., & Guba, E. (1986). But is it Rigorous? Trustworthiness and Authenticity. In D. Williams, *Naturalistic Evaluation* (1st ed., pp. 73-84). San Francisco: Jossey-Bass.

Lizeretti, N., Oberst, U., Chamarro, A., & Farriols, N. (2006). Evaluation of emotional intelligence in patients with psychopathology: preliminary results using the TMMS-24 and the MSCEIT. Evaluaci√≥n de la inteligencia emocional en pacientes con psicopatolog√≠a: resultados preliminares usando el TMMS-24 y el MSCEIT. *Ansiedad Y Estre¬¥S*, *12*(2-3), 355-364.

Loren, L., & Dietrich, E. (1997). Merleau-Ponty, embodied cognition, and the problem of intentionalit. *Cybernetics And Systems*, *28*(5), 345-358. doi:10.1080/019697297126056

Luborsky, L. (1975). Comparative Studies of Psychotherapies. *Arch Gen Psychiatry*, *32*(8), 995. doi:10.1001/archpsyc.1975.01760260059004

Luborsky, L. (1985). Therapist Success and Its Determinants. *Arch Gen Psychiatry*, *42*(6), 602. doi:10.1001/archpsyc.1985.01790290084010

Luborsky, L., Crits-Christoph, P., McLellan, A., Woody, G., Piper, W., & Liberman, B. et al. (1986). Do therapists vary much in their success? Findings from four outcome studies. *American Journal Of Orthopsychiatry*, *56*(4), 501-512. doi:10.1111/j.1939-0025.1986.tb03483.x

Luborsky, L., Diguer, L., Seligman, D., Rosenthal, R., Krause, E., & Johnson, S. et al. (1999). The Researcher's Own Therapy Allegiances: A ‚ÄúWild Card‚Äù in Comparisons of Treatment Efficacy. *Clinical Psychology: Science And Practice*, *6*(1), 95-106. doi:10.1093/clipsy.6.1.95

Luca, M. (2009). A therapist‚Äôs portrait of a clinical encounter with a somatizer. In L. Finlay & K. Evans, *Relational-centred research for psychotherapists: Exploring meaning and experience* (1st ed.). London: John Wiley and Sons.

Lyons, L., & Woods, P. (1991). The efficacy of rational-emotive therapy: A quantitative review of the outcome research. *Clinical Psychology Review*, *11*(4), 357-369. doi:10.1016/0272-7358(91)90113-9

Lyons‚ÄêRuth, K. (1999). The two‚Äêperson unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanalytic Inquiry*, *19*(4), 576-617. doi:10.1080/07351699909534267

MacLeod, C., Campbell, L., Rutherford, E., & Wilson, E. (2004). The causal status of anxiety-linked attentional and interpretive bias. In J. Yiend, *Cognition, emotion and psychopathology: Theoretical, empirical and clinical directions* (1st ed.). Cambridge: Cambridge University Press.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal Of Psychology*, *91*(1), 1-20. doi:10.1348/000712600161646

Main, M. (1991). Metacognitive knowledge, metacognitive monitoring, and singular (coherent) vs. multiple (incoherent) models of attachment: Some findings and some directions for future research. In P. Marris, J. Stevenson-Hinde & C. Parkes, *Attachment Across the Life Cycle* (1st ed., pp. 127-159). New York: Routledge.

Mallinckrodt, B., & Nelson, M. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal Of Counseling Psychology*, *38*(2), 133-138. doi:10.1037/0022-0167.38.2.133

Malterer, M., Glass, S., & Newman, J. (2008). Psychopathy and trait emotional intelligence. *Personality And Individual Differences*, *44*(3), 735-745. doi:10.1016/j.paid.2007.10.007

Mann, K., Gordon, J., & MacLeod, A. (2007). Reflection and reflective practice in health professions education: a systematic review. *Adv In Health Sci Educ*, *14*(4), 595-621. doi:10.1007/s10459-007-9090-2

Maree, J., & Fernandes, M. (2003). The impact of emotional intelligence on solution-focused therapy with an adolescent. *Early Child Development And Care*, *173*(5), 499-508. doi:10.1080/0300443032000086908

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Marshall, C., & Rossman, G. (1995). *Designing qualitative research* (3rd ed.). London: Sage.

Martin, D., Garske, J., & Davis, M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal Of Consulting And Clinical Psychology*, *68*(3), 438-450. doi:10.1037//0022-006x.68.3.438

Martinez-Pons, M. (1997). The Relation of Emotional Intelligence with Selected Areas of Personal Functioning. *Imagination, Cognition And Personality*, *17*(1), 3-13. doi:10.2190/68vd-dfxb-k5aw-pqay

Martins, A., Ramalho, N., & Morin, E. (2010). A comprehensive meta-analysis of the relationship between Emotional Intelligence and health. *Personality And Individual Differences*, *49*(6), 554-564. doi:10.1016/j.paid.2010.05.029

Martin, J. R. (1997). Mindfulness: A proposed common factor. *Journal of Psychotherapy Integration,* 7, 291–312. http://dx.doi.org/10.1023/B:JOPI.0000010885.18025.bc

Mary, B. (2000). An examination of case study research. *Nurse Researcher*, *7*(2), 61-78. doi:10.7748/nr2000.01.7.2.61.c6112

Maslow, A. (1971). *The farther reaches of human nature*. New York: Viking Press.

Matthews, G., & Zeidner, M. (2000). Emotional intelligence, adaptation to stressful encounters, and health outcome. In R. Bar-On & J. Parker, *The handbook of emotional intelligence: Theory, development, assessment, and application at home, school, and in the workplace* (1st ed., pp. 458-489). San Fransisco, CA: Jossey-Bass.

Matthews, G., Zeidner, M., & Roberts, R. (2004). *Emotional intelligence*. Cambridge, Mass.: MIT Press.

Mavroveli, S., Petrides, K., Rieffe, C., & Bakker, F. (2007). Trait emotional intelligence, psychological well-being and peer-rated social competence in adolescence. *British Journal Of Developmental Psychology*, *25*(2), 263-275. doi:10.1348/026151006x118577

Mayer, J. (2000). Spiritual Intelligence or Spiritual Consciousness?. *International Journal For The Psychology Of Religion*, *10*(1), 47-56.

doi:10.1207/s15327582ijpr1001_5

Mayer, J., & Salovey, P. (1997). What is emotional intelligence. In P. Salovey & D. Sluyter, *Emotional development and emotional intelligence: Implications for educators* (1st ed., pp. 3-31). New York: Basic Books.

Mayer, J., DiPaolo, M., & Salovey, P. (1990). Perceiving Affective Content in Ambiguous Visual Stimuli: A Component of Emotional Intelligence. *Journal Of Personality Assessment*, *54*(3-4), 772-781. doi:10.1080/00223891.1990.9674037

Mayer, J., Roberts, R., & Barsade, S. (2008). Human Abilities: Emotional Intelligence. *Annu. Rev. Psychol.*, *59*(1), 507-536. doi:10.1146/annurev.psych.59.103006.093646

Mayer, J., Salovey, P., & Caruso, D. (2000). Selecting a measure of emotional intelligence. The handbook of emotional intelligence. *American Psychologist*, *1*(3), 232-242.

Mayer, J., Salovey, P., & Caruso, D. (2007). *Emotional IQ test*. Needham, MA: Virtual Knowledge.

Mayer, J., Salovey, P., & Caruso, D. (2008). Emotional intelligence: New ability or eclectic traits?. *American Psychologist*, *63*(6), 503-517. doi:10.1037/0003-066x.63.6.503

Mayer, J.D., Roberts, R.D. & Barsade, S.G. (2008). Human abilities: emotional intelligence. *Annual Review of Psychology, 59, 507-536*.

McCallum, M., & Piper, W. (1996). Psychological mindedness. Psychiatry: Interpersonal and Biological Process. *Psychological Assessment*, *59*(1), 48-64.

McCann, T., & Clark, E. (2004). Grounded theory in nursing research: Part 1 ‚Äì Methodology. *Nurse Researcher*, *11*(2), 7-18. doi:10.7748/nr2004.01.11.2.7.c5918

McCann, T., & Clark, E. (2004). Grounded theory in nursing research: Part 3 ‚Äî Application. *Nurse Researcher*, *11*(2), 29-39. doi:10.7748/nr2004.01.11.2.29.c5920

McCarty, C. (1994). Determining Sample Size for Surveys. *Field Methods*, *6*(3), 5-5. doi:10.1177/1525822x9400600302

McCullough, L. (2003). *Treating affect phobia*. New York: Guilford Press.

McGhee, G., Marland, G., & Atkinson, J. (2007). Grounded theory research: literature reviewing and reflexivity. *Journal Of Advanced Nursing*, *60*(3), 334-342. doi:10.1111/j.1365-2648.2007.04436.x

McLeod, J. (1994). *Doing counselling research*. London: Sage Publications.

McMenamin, I. (2006). Process and Text: Teaching Students to Review the Literature. *PS: Political Science & Politics*, *39*(01). doi:10.1017/s1049096506060306

Megnes, Y., & Van Meijel, B. (2006). Quality of life for long-stay patients of psychiatric hospitals: a literature study. *J Psychiatr Ment Health Nurs*, *13*(6), 704-712. doi:10.1111/j.1365-2850.2006.01018.x

Mercer, S. (2003). An empathy-based consultation quality measure for use in CAM and conventional-care settings. *Focus On Alternative And Complementary Therapies*, *8*(1), 153-153. doi:10.1111/j.2042-7166.2003.tb05818.x

Merleau-Ponty, M. (1962). *Phenomenology of perception*. London: Routledge.

Mikolajczak, M., Luminet, O., & Menil, C. (2006). Predicting resistance to stress: Incremental validity of trait emotional intelligence over alexithymia and optimism. *Psicothema*, *18*, 79-81.

Miles, M., & Huberman, A. (1994). *Qualitative data analysis an expanded sourcebook*. Thousand Oaks: SAGE.

Miles, M., & Huberman, A. (1994). *Qualitative data analysis*. Thousand Oaks: Sage Publications.

Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal Of Nursing Practice*, *12*(1), 8-13. doi:10.1111/j.1440-172x.2006.00543.x

Morgan, M. (1996). Qualitative research: a package deal?. *The Psychologist*, *9*(1), 31-32.

Morrison, T. (2006). Emotional Intelligence, Emotion and Social Work: Context, Characteristics, Complications and Contribution. *British Journal Of Social Work*, *37*(2), 245-263. doi:10.1093/bjsw/bcl016

Morrow, S. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal Of Counseling Psychology*, *52*(2), 250-260. doi:10.1037/0022-0167.52.2.250

Morrow, S., & Smith, M. (1995). Constructions of survival and coping by women who have survived childhood sexual abuse. *Journal Of Counseling Psychology*, *42*(1), 24-33. doi:10.1037//0022-0167.42.1.24

Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. *American Psychologist*, *41*(2), 188-197. doi:10.1037//0003-066x.41.2.188

Morse, j. (2001). Situating grounded theory within qualitative inquiry. In R. Schreiber & P. Stern, *Using grounded theory in nursing* (1st ed., pp. 1-16). New York: Springer.

Morse, J. (1991). *Qualitative nursing research*. Newbury Park, Calif.: Sage Publications.

Mostow, A., Izard, C., Fine, S., & Trentacosta, C. (2002). Modeling Emotional, Cognitive, and Behavioral Predictors of Peer Acceptance. *Child Development*, *73*(6), 1775-1787. doi:10.1111/1467-8624.00505

Murdoch, I. (1997). The Idea of Perfection. In P. Conradi, *Existentialists and Mystics: Writings on Philosophy and Literature* (1st ed., pp. 299,Äì336). London: Penguin.

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., & Watson, P. (1998). *Qualitative research methods in health technology assessment: a review of the literature*. Health Technol Assessment.

Negi, N., Bender, K., Furman, R., Fowler, D., & Prickett, J. (2010). Enhancing Self-Awareness: A Practical Strategy to Train Culturally Responsive Social Work Students. *Advances In Social Work*, *11*(2), 223-234. Retrieved from http://journals.iupui.edu/index.php/advancesinsocialwork/article/view/482/1787

Norcross, J. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research And Practice*, *31*(6), 710-713. doi:10.1037//0735-7028.31.6.710

Norcross, J. (2002). *Psychotherapy relationships that work*. New York: Oxford

University Press.

Noruzi, A. (2005). "Google Scholar: The new generation of citation indexes." *Libri 55(4): 170-180.*

Onions, P. (2006). *Grounded Theory Applications in Reviewing Knowledge Management Literature*. Presentation, Leeds Metropolitan University Innovation North Research Conference, Leed.

Orlinsky, D., & Howard, K. (1986). The psychological interior of psychotherapy; explorations with the therapy session reports. In L. Greenberg & W. Pinsof, *The psychotherapeutic process; a research handbook* (1st ed.). New York: Guildford.

Orlinsky, D., & Howard, K. (1986). The relation of process to outcome in psychotherapy. In S. Garfield & A. Bergin, *Handbook of psychotherapy and behaviour change* (1st ed.). New York: John Wiley.

Orlinsky, D., & Howard, R. (1986). The relation of process to outcome in psychotherapy. In S. Garfield & A. Bergin, *Handbook of psychotherapy and behaviour change* (1st ed.). New York: John Wiley.

Orlinsky, D., Botermans, J., & R√∏nnestad, M. (2001). Towards an Empirically Grounded Model of Psychotherapy Training: Four Thousand theRapists Rate Influences on Their Development. *Australian Psychologist*, *36*(2), 139-148. doi:10.1080/00050060108259646

Orlinsky, D., Norcross, J., Ronnestad, M., & Wiseman, H. (2005). Outcomes and impacts of the psychotherapists own psychotherapy: A research review. In J. Geller, J. Norcross & D. Orlinsky, *The Psychotherapist's Own Psychotherapy : Patient and Clinician Perspectives* (1st ed., pp. 214-230). New York: Oxford University Press.

Orlinsky, D., R√∏nnestad, M., & AmbuÃàhl, H. (2005). *How psychotherapists develop*. Washington, DC: American Psychological Association.

Orr, L. (2001). *How emotional intelligence facilitates spiritual formation*. Azusa Pacific University, CA: Dissertation Abstracts International.

Paivio, C.S. (2013). Essential process in emotion-focused therapy. American Psychological Association, 50,3, 341-345.

Palmer, B., Donaldson, C., & Stough, C. (2002). Emotional intelligence and life satisfaction. *Personality And Individual Differences*, *33*(7), 1091-1100. doi:10.1016/s0191-8869(01)00215-x

Palmer, H. (1998). *Inner knowing*. New York: J.P. Tarcher/Putnam.

Panksepp, J. (2001). The Long-Term Psychobiological Consequences of Infant Emotions: Prescriptions for the Twenty-First Century. *Neuropsychoanalysis*, *3*(2), 149-178. doi:10.1080/15294145.2001.10773353

Parkinson, B. (1994). Emotion. In *Companion encyclopaedia of psychology*. London: Routledge.

Patton, M., & Patton, M. (1990). *Qualitative evaluation and research methods*. Newbury Park, Calif.: Sage Publications.

Patton, M., & Patton, M. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, Calif.: Sage Publications.

Payne, S. (2007). Grounded theory. In E. Lyons & A. Coyle, *Analysing qualitative data in psychology* (1st ed., pp. 65-86). London: Sage.

Payne, W. (1986). A study of emotion: Developing emotional intelligence; Self-integration; relating to fear, pain and desire. *Dissertation Abstracts International, Human Social Science*, *47*(01), 203.

Pawson, R. (2006). *Evidence - based Policy. A Realist Perspective*. London: Sage.

Pawson, R., Greenhalgh, T., Harvey, G., & Walshe, K. (2005). Realist review-A new method of systematic review designed for complex policy interventions. *Journal of Health Services Research & Policy, 10, 21-34*. doi:10.1258/1355819054308530

Peikoff, L. (1993). *Objectivism*. New York: Meridian.

Perraud, S., Delaney, K., Carlson-Sabelli, L., Johnson, M., Shephard, R., & Paun, O. (2006). Advanced Practice Psychiatric Mental Health Nursing, Finding Our Core: The Therapeutic Relationship in 21st Century. *Perspect Psychiat Care*, *42*(4), 215-226. doi:10.1111/j.1744-6163.2006.00097.x

Petrides, K. (2011). Ability and trait emotional intelligence. In T. Chamorro-Premuzic, A. Furnham & S. von Stumm, *The Blackwell-Wiley handbook of individual*

differences (1st ed., pp. 656-678). New York: Wiley.

Petrides, K. V. (2009). *Technical manual for the Trait Emotional Intelligence Questionnaires* (TEIQue; 1st ed., 1st printing). London: London Psychometric Laboratory.

Petrides, K., & Furnham, A. (2000). On the dimensional structure of emotional intelligence. *Personality And Individual Differences*, *29*(2), 313-320. doi:10.1016/s0191-8869(99)00195-6

Petrides, K., & Furnham, A. (2001). Trait emotional intelligence: psychometric investigation with reference to established trait taxonomies. *Eur. J. Pers.*, *15*(6), 425-448. doi:10.1002/per.416

Petrides, K., & Furnham, A. (2003). Trait emotional intelligence: behavioural validation in two studies of emotion recognition and reactivity to mood induction. *Eur. J. Pers.*, *17*(1), 39-57. doi:10.1002/per.466

Petrides, K., & Furnham, A. (2007). Trait emotional intelligence. *Eur. J. Pers.*, *15*(6), 425-448. doi:10.1002/per.416

Petrides, K., Frederickson, N., & Furnham, A. (2004). The role of trait emotional intelligence in academic performance and deviant behavior at school. *Personality And Individual Differences*, *36*(2), 277-293. doi:10.1016/s0191-8869(03)00084-9

Petrides, K., Furnham, A., & Martin, G. (2004). Estimates of Emotional and Psychometric Intelligence: Evidence for Gender-Based Stereotypes. *The Journal Of Social Psychology*, *144*(2), 149-162. doi:10.3200/socp.144.2.149-162

Petrides, K., Prez-Gonzlez, J., & Furnham, A. (2007). On the criterion and incremental validity of trait emotional intelligence. *Cognition & Emotion*, *21*(1), 26-55. doi:10.1080/02699930601038912

Petrides, K., Pita, R., & Kokkinaki, F. (2007). The location of trait emotional intelligence in personality factor space. *British Journal Of Psychology*, *98*(2), 273-289. doi:10.1348/000712606x120618

Petrides, K., Sangareau, Y., Furnham, A., & Frederickson, N. (2006). Trait Emotional Intelligence and Children's Peer Relations at School. *Social Development*, *15*(3), 537-547. doi:10.1111/j.1467-9507.2006.00355.x

Phelps, E., & Sharot, T. (2008). How (and Why) Emotion Enhances the Subjective Sense of Recollection. *Current Directions In Psychological Science*, *17*(2), 147-152. doi:10.1111/j.1467-8721.2008.00565.x

Picard, R., Vyzas, E., & Healey, J. (2001). Toward machine emotional intelligence: analysis of affective physiological state. *IEEE Trans. Pattern Anal. Machine Intell.*, *23*(10), 1175-1191. doi:10.1109/34.954607

Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes, *Doing qualitative analysis in psychology* (1st ed.). Hove: Psychology Press.

Pizarro, D., & Salovey, P. (2002). Being and becoming a good person: the role of emotional intelligence in moral development and behavior. In J. Aronson, *Improving Academic Achievement: Impact of Psychological Factors on Education* (1st ed., pp. 247‚Äì 266). San Diego, CA: Academic Press.

Platsidou, M. (2013). Trait emotional intelligence predicts happiness but how? an empirical study in adolescents and young adults. *International Journal Of Wellbeing*, *3*(2), 197-209.

Plutchik, R. (1984). Emotions and Imagery. *Journal Of Mental Imagery*, *8*, 105-112.

Podsakoff, P., MacKenzie, S., & Podsakoff, N. (2012). Sources of Method Bias in Social Science Research and Recommendations on How to Control It. *Annu. Rev. Psychol.*, *63*(1), 539-569. doi:10.1146/annurev-psych-120710-100452

Polit, D., & Beck, C. (2004). *Nursing research*. Philadelphia: Lippincott Williams & Wilkins.

Polkinghorne, D. (1983). *Methodology for the human sciences*. Albany: State University of New York Press.

Polkinghorne, D. (1992). Postmodern Epistemology of Practice. In S. Kvale, *Psychology and Postmodernism* (1st ed.). London: Sega.

Ponsi, M. (2000). Therapeutic alliance and collaborative interactions. *The International Journal Of Psychoanalysis*, *81*(4), 687-704. doi:10.1516/0020757001600101

Ponterotto, J., & Grieger, I. (2007). Effectively Communicating Qualitative Research. *The Counseling Psychologist*, *35*(3), 404-430. doi:10.1177/0011000006287443

Poullis, J. (2007). *The therapist emotional experience of the therapeutic relationship and Its links to emotional intelligence theory*. A Dissertation Submitted in Partial Fulfilment of the MA in Counselling. Retrieved from http://www.researchgate.net/publication/258517545_The_therapist_emotional_experience_of_the_therapeutic_relationship_and_Its_links_to_emotional_intelligence_theory_A_Dissertation_Submitted_in_Partial_Fulfilment_of_the_MA_in_Counselling

Punch, K. (1998). *Introduction to social research*. London: SAGE Publications.

Punch, K. (2009). *Introduction to research methods in education*. Los Angeles: Sage.

Rachelson, J., & Clance, P. (1980). Attitudes of psychotherapists toward the 1970 APA standards for psychotherapy training. *Professional Psychology*, *11*(2), 261-267. doi:10.1037//0735-7028.11.2.261

Radford, M. (2002). Educating the Emotions: Interior and Exterior Realities. *Pastoral Care In Ed*, *20*(2), 24-29. doi:10.1111/1468-0122.00226

Radhakrishnan, A., & G, U. (2010). Emotional Intelligence and its Relationship with Leadership Practices. *IJBM*, *5*(2). doi:10.5539/ijbm.v5n2p65

Rajan-Rankin, S. (2013). Self-Identity, Embodiment and the Development of Emotional Resilience. *British Journal Of Social Work*. doi:10.1093/bjsw/bct083

Rajan-Rankin, S. (2013). Self-Identity, Embodiment and the Development of Emotional Resilience. *British Journal Of Social Work*. doi:10.1093/bjsw/bct083

Reason, P. (2002). Justice, sustainability, and participation: Inaugural professiorial lecture. *Concepts And Transformation*, *7*(1), 7-29. doi:10.1075/cat.7.1.03rea

Redfield, J., Murphy, M., & Timbers, S. (2002). *God and the evolving universe*. New York: Jeremy P. Tarcher/Putnam.

Reinharz, S., & Davidman, L. (1992). *Feminist methods in social research*. New York: Oxford University Press.

Rennie, D. (1994). Clients' deference in psychotherapy. *Journal Of Counseling Psychology*, *41*(4), 427-437. doi:10.1037//0022-0167.41.4.427

Rennie, D. (1998). Grounded Theory Methodology: The Pressing Need for a Coherent

Logic of Justification. *Theory & Psychology*, *8*(1), 101-119. doi:10.1177/0959354398081006

Rennie, D. (1998). Reply to Corbin: From One Interpreter to Another. *Theory & Psychology*, *8*(1), 129-135. doi:10.1177/0959354398081008

Rennie, D. (2000). Grounded Theory Methodology as Methodical Hermeneutics: Reconciling Realism and Relativism. *Theory & Psychology*, *10*(4), 481-502. doi:10.1177/0959354300104003

Rennie, D. (2004). Reflexivity and Person-Centered Counseling. *Person-Centered & Experiential Psychotherapies*, *44*(2), 182-203. doi:10.1080/14779757.2006.9688400

Rieck, T., & Callahan, J. (2013). Emotional intelligence and psychotherapy outcomes in the training clinic. *Training And Education In Professional Psychology*, *7*(1), 42-52. doi:10.1037/a0031659

Roberts, R., Pallier, G., & Nelson-Goff, G. (1999). Sensory processes within the structure of human cognitive abilities. In P. Ackerman, P. Kyllonen & R. Roberts, *Learning and Individual Differences Vol. 15* (1st ed., pp. 339-368). Washington, DC: American Psychological Association.

Roberts, R., Zeidner, M., & Matthews, G. (2001). Does emotional intelligence meet traditional standards for an intelligence? Some new data and conclusions. *Emotion*, *1*(3), 196-231. doi:10.1037//1528-3542.1.3.196

Robson, C. (1993). *Real world research*. Oxford, UK: Blackwell Publishers.

Roessler, K. K. (2011). A corrective emotional experience – or just a bit of exercise? The relevance of interpersonal learning in Exercise on prescription. *Scandinavian Journal of Psychology 52, 354–360*

Rogers, C. (1951). *Client-centered therapy*. Boston: Houghton Mifflin Co.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal Of Consulting Psychology*, *21*(2), 95-103. doi:10.1037/h0045357

Rogers, C. (1959). A Theory of Therapy, Personality and Interpersonal Relationships as Developed in the Client-centered Frame. In S. Koch, *Psychology: A Study of a Science. Vol. 3: Formulations of the Person and the Social Context* (1st ed.). New

York: McGraw Hill.

Rogers, C. (1961). *On becoming a person*. Boston, MA: Houghton Mifflin.

Rogers, C. (1980). *A way of being*. Boston, MA: Houghton Mifflin.

Rogers, C., Kirschenbaum, H., & Henderson, V. (1990). *The Carl Rogers reader*. Boston: Houghton Mifflin.

Ronnestad, M., & Skovholt, T. (1993). Supervision of Beginning and Advanced Graduate Students of Counseling and Psychotherapy. *Journal Of Counseling & Development*, *71*(4), 396-405. doi:10.1002/j.1556-6676.1993.tb02655.x

Ronnestad, M., & Skovholt, T. (2003). The Journey of the Counselor and Therapist: Research Findings and Perspectives on Professional Development. *Journal Of Career Development*, *30*(1), 5-44. doi:10.1177/089484530303000102

Roseman, I., & Smith, C. (2001). Appraisal theory: Overview, assumptions, varieties, controversies. In K. Scherer, A. Schorr & T. Johnstone, *Appraisal processes in emotion: Theory, methods, research* (1st ed.). Oxford: Oxford University Press.

Rosenzweig, S. (2002). Some implicit common factors in diverse methods of psychotherapy. *Journal Of Psychotherapy Integration*, *12*(1), 5-9. doi:10.1037/1053-0479.12.1.5

Rowan, J. (1998). Linking its place in therapy. *International Journal Of Psychotherapy*, *3*, 245-254.

Rowan, J. (2004). Three levels of therapy. *Counselling And Psychotherapy Journal*, *15*(9), 21.

Rydon, S. (2005). The attitudes, knowledge and skills needed in mental health nurses: The perspective of users of mental health services*. *Int J Ment Health Nurs*, *14*(2), 78-87. doi:10.1111/j.1440-0979.2005.00363.x

Safran, J., & Muran, J. (2000). *Negotiating the therapeutic alliance*. New York: Guilford Press.

Safran, J. D., Muran, J. C., & Samstag, L. W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice.* (pp. 225-255). New

York: Wiley

Safran, J., & Reading, R. (2008). Mindfulness, meta-communication and affect regulation in psychoanalytic treatment. In S. Hick & T. Bien, *Mindfulness and the Therapeutic Relationship* (1st ed.). New York: Guildford.

Saklofske, D., Austin, E., & Minski, P. (2003). Factor structure and validity of a trait emotional intelligence measure. *Personality And Individual Differences*, *34*(4), 707-721. doi:10.1016/s0191-8869(02)00056-9

Salami, S. (2011). Personality and Psychological Well-Being of Adolescents: The Moderating Role of Emotional Intelligence. *Social Behavior And Personality: An International Journal*, *39*(6), 785-794. doi:10.2224/sbp.2011.39.6.785

Salovey, p. (2001). Applied emotional intelligence: Regulating emotions to become healthy, wealthy, and wise. In J. Ciarrochi, J. Forgas & J. Mayer, *Emotional intelligence in everyday life: A scientific inquiry* (1st ed., pp. 168-184). Philadelphia, PA: Psychology Press.

Salovey, P., & Grewal, D. (2014). The science of emotional intelligence. *Current Directions. Psychological Science*, *14*(6), 281-285.

Salovey, P., & Mayer, J. (1989). Emotional Intelligence. *Imagination, Cognition And Personality*, *9*(3), 185-211. doi:10.2190/dugg-p24e-52wk-6cdg

Samuel, A. (1993). *The political psyche*. London: Routledge.

Samuels, A. (2006). Transference/Countertransference. In R. Papadopoulos, *Handbook of Jungian psychology* (1st ed.). New York: Routledge.

Sanchez-Ruiz, M., Mavroveli, M., & Poullis, J. (2013). Trait Emotional Intelligence In Higher Education. *Personality And Individual Differences Journal*, *54*(5), 658-662.

Sandelowski, M., Holditch-Davis, D., & Harris, B. (1992). Using qualitative and quantitative methods: the transition to parenthood of infertile couples. In J. Gilgun, K. Daly & G. Handel, *Qualitative Methods in Family Research* (1st ed., pp. 301-323). Newbury Park, CA: Sage.

Saunders, S. (1999). Clients' assessment of the affective environment of the psychotherapy session: Relationship to session quality and treatment effectiveness. *J. Clin. Psychol.*, *55*(5), 597-605.

Scheier, M., & Carver, C. (1985). Optimism, coping, and health: Assessment and implications of generalized outcome expectancies. *Health Psychology*, *4*(3), 219-247. doi:10.1037//0278-6133.4.3.219

Scheler, M. (1970). *The nature of sympathy*. [Hamden, Conn.]: Archon Books.

Schneider, T., Lyons, J., & Williams, M. (2005). Emotional intelligence and autonomic self-perception: Emotional abilities are related to visceral acuity. *Personality And Individual Differences*, *39*(5), 853-861. doi:10.1016/j.paid.2005.02.025

SchoÃàn, D. (1983). *The reflective practitioner*. New York: Basic Books.

Schore, A. (2001). Minds in the making: attachment, the self-organizing brain and developmentally-orientated psychoanalytic psychotherapy. *British Journal Of Psychotherapy*, *17*(3), 299-328. doi:10.1111/j.1752-0118.2001.tb00593.x

Schore, A., & Schore, A. (2003). *Affect dysregulation & disorders of the self*. New York: W.W. Norton.

Schulte, M., Ree, M., & Carretta, T. (2004). Emotional intelligence: not much more than g and personality. *Personality And Individual Differences*, *37*(5), 1059-1068. doi:10.1016/j.paid.2003.11.014

Schutte, N., Malouff, J., Bobik, C., Coston, T., Greeson, C., & Jedlicka, C. et al. (2001). Emotional Intelligence and Interpersonal Relations. *The Journal Of Social Psychology*, *141*(4), 523-536. doi:10.1080/00224540109600569

Schutte, N., Malouff, J., Hall, L., Haggerty, D., Cooper, J., Golden, C., & Dornheim, L. (1998). Development and validation of a measure of emotional intelligence. *Personality And Individual Differences*, *25*(2), 167-177. doi:10.1016/s0191-8869(98)00001-4

Schutte, N., Malouff, J., Simunek, M., McKenley, J., & Hollander, S. (2002). Characteristic emotional intelligence and emotional well-being. *Cognition And Emotion*, *16*(6), 769-785. doi:10.1080/02699930143000482

Schutte, N., Malouff, J., Thorsteinsson, E., Bhullar, N., & Rooke, S. (2007). A meta-

analytic investigation of the relationship between emotional intelligence and health. *Personality And Individual Differences*, *42*(6), 921-933. doi:10.1016/j.paid.2006.09.003

Sedgwick, D. (1994). *The wounded healer*. London: Routledge.

Segall, M. (1999). *Human behavior in global perspective*. Boston: Allyn and Bacon.

Semerari, A., Carcione, A., Dimaggio, G., Falcone, M., Nicolo, G., Procacci, M., & Alleva, G. (2003). How to evaluate metacognitive functioning in psychotherapy? The metacognition assessment scale and its applications. *Clin. Psychol. Psychother.*, *10*(4), 238-261. doi:10.1002/cpp.362

Sevdalis, N., Petrides, K., & Harvey, N. (2007). Trait emotional intelligence and decision-related emotions. *Personality And Individual Differences*, *42*(7), 1347-1358. doi:10.1016/j.paid.2006.10.012

Shabani, J., Hassan, S., Ahmad, A., & Baba, M. (2010). Exploring the Relationship of Emotional Intelligence with Mental Health among Early Adolescents. *IJPS*, *2*(2). doi:10.5539/ijps.v2n2p209

Shapiro, D. (1985). Recent applications of meta-analysis in clinical research. *Clinical Psychology Review*, *5*(1), 13-34. doi:10.1016/0272-7358(85)90027-3

Shaw, R. (2004). The Embodied Psychotherapist: An Exploration of the Therapists' Somatic Phenomena Within the Therapeutic Encounter. *Psychotherapy Research*, *14*(3), 271-288. doi:10.1093/ptr/kph025

Siegel, D. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships 'mindsight' and neural integration. *Infant Mental Health Journal*, *22*(1-2), 67-94. doi:10.1002/1097-0355(200101/04)22:1<67::aid-imhj3>3.0.co;2-g

Simon, A., Sohal, A., & Brown, A. (1996). Generative and case study research in quality management. Part I: Theoretical considerations. *Int J Qual & Reliability Mgmt*, *13*(1), 32-42. doi:10.1108/02656719610108288

Simpson, R., & Keegan, A. (2002). How Connected Are You? Employing Emotional Intelligence in a High-Tech World. *Nursing Administration Quarterly*, *26*(2), 80-86. doi:10.1097/00006216-200201000-00009

Skovholt, T., & Jennings, L. (2004). *Master therapists*. Boston: Pearson.

Slaski, M., & Cartwright, S. (2002). Health, performance and emotional intelligence: an exploratory study of retail managers. *Stress And Health*, *18*(2), 63-68. doi:10.1002/smi.926

Smith, J. (2003). *Qualitative psychology*. London: SAGE Publications.

Smith, J., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. Smith, *Qualitative psychology: a practical guide to research methods* (2nd ed., pp. 53-80). London: Sage.

Smith, L. (2001). Toward delivering on the promise of appraisal theory. In L. Kirby, *Appraisal processes in emotion: Theory, methods, research* (1st ed.). Oxford: Oxford University Press.

Smith, M., & Glass, G. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*(9), 752-760. doi:10.1037/0003-066x.32.9.752

Social Work and Social Policy Department, Faculty of Health and Social Care,. (2010). *Ôø°Self-Awareness and Personal Development in Social Work Education ‚Äì A Pilot Programme of Experiential Workshops*. Anglia Ruskin University.

Solbakken, O., Hansen, R., & Monsen, J. (2011). Affect integration and reflective function: Clarification of central conceptual issues. *Psychotherapy Research*, *21*(4), 482-496. doi:10.1080/10503307.2011.583696

Solomon, R. (1984). *The Passions: The Myth and Nature of Human Emotions*. New York: Doubleday.

Solomon, R. (2003). *Not passion's slave*. Oxford: Oxford University Press.

Solomon, R. (2003). *What is an emotion?*. New York: Oxford University Press.

Spearman, C. (1927). *The abilities of man*. New York: Macmillan.

Spruill, J., Rozensky, R., Stigall, T., Vasquez, M., Bingham, R., & Olvey, C. (2004). Becoming a competent clinician: Basic competencies in intervention. *J. Clin. Psychol.*, *60*(7), 741-754. doi:10.1002/jclp.20011

Stankov, L. (2000). Structural extensions of a hierarchical view on human cognitive abilities. *Learning And Individual Differences*, *12*(1), 35-51.

Stein, D. (1984). On the relationship between therapist experience and psychotherapy outcome. *Clinical Psychology Review*, *4*(2), 127-142. doi:10.1016/0272-7358(84)90025-4

Stein, D., & Lambert, M. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced?. *Journal Of Consulting And Clinical Psychology*, *63*(2), 182-196. doi:10.1037//0022-006x.63.2.182

Stein, M. (1989). Gratitude and Attitude: A Note on Emotional Welfare. *Social Psychology Quarterly*, *52*(3), 242. doi:10.2307/2786719

Stein, N., Trabasso, T., & Liwag, M. (1993). The representation and organization of emotional experience: Unfolding the emotion episode. In M. Lewis & J. Haviland, *Handbook of emotions* (1st ed., pp. 279-300). New York: Guilford Press.

Stern, D. (1977). *The first relationship*. Cambridge: Harvard University Press.

Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Stern, D. (2004). *The present moment in psychotherapy and everyday life*. New York: W.W. Norton.

Stern, D. (2007). On solid ground: Essential properties for growing grounded theory. In A. Bryant & K. Charmaz, *The Sage handbook of grounded theory* (1st ed., pp. 114-126). London: Sage.

Stern, D., Bruschweiler-Stern, N., Harrison, A., Lyons-Ruth, K., Morgan, A., & Nahum, J. et al. (1998). The process of therapeutic change involving implicit knowledge: Some implications of developmental observations for adult psychotherapy. *Infant Mental Health Journal*, *19*(3), 300-308.

Sternberg, R. (1985). *Beyond IQ: A triarchic theory of human intelligence*. New York: Cambridge University Press.

Sternberg, R., & Caruso, D. (1985). Practical modes of knowing. In E. Eisner, *Learning the ways of knowing* (1st ed., pp. 133-158). Chicago: University of Chicago Press.

Sternberg, R., & Ruzgis, P. (1994). *Personality and intelligence*. Cambridge: Cambridge University Press.

Stolk, Y., & Perlesz, A. (1990). Do Better Trainees Make Worse Family Therapists? A Followup Study of Client Families. *Family Process*, *29*(1), 45-58. doi:10.1111/j.1545-5300.1990.00045.x

Stolorow, R., & Atwood, G. (2002). *Contexts of Being: The Intersubjective Foundations of Psychological Life*. London: Analytic Press.

Stolorow, R., Atwood, G., & Branchaft, B. (1994). *The Intersubjective perspective*. Northvale, N.J.: J. Aronson.

Stolorow, R., Atwood, G., & Orange, D. (2002). *Worlds of Experience Interweaving Philosophical and Clinical Dimensions in Psychoanalysis*. New York, N.Y.: Basic Books.

Storbeck, J., & Clore, G. (2005). With Sadness Comes Accuracy; With Happiness, False Memory: Mood and the False Memory Effect. *Psychological Science*, *16*(10), 785-791. doi:10.1111/j.1467-9280.2005.01615.x

Storbeck, J., & Clore, G. Turning on and off affective and categorical priming with mood. *Manuscript Submitted For Publication*.

Strauss, A. (1987). *Qualitative analysis for social scientists*. Cambridge [Cambridgeshire]: Cambridge University Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and technique*. Newbury Park, Calif.: Sage Publications.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology. An overview. In N. Denzin & Y. Lincoln, *Handbook of qualitative research* (1st ed., pp. 273-285). Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks: Sage Publications.

Strubing, J. (2007). Research as pragmatic problem-solving: The Pragmatist roots of empirically-grounded theorizing. In A. Bryant & K. Charmaz, *The Sage handbook of grounded theory* (1st ed., pp. 580-601). London: Sage.

Strupp, H. (1979). Specific versus non-specific factors in psychotherapy. A controlled study of outcome. *Archieves Of General Psychiatry*, *36*(10), 1125. doi:10.1001/archpsyc.1979.01780100095009

Strupp, H. (1980). Humanism and psychotherapy: A personal statement of the therapist's essential values. *Psychotherapy: Theory, Research & Practice*, *17*(4), 396-400. doi:10.1037/h0085938

Strupp, H. (1986). Psychotherapy: Research, practice, and public policy: How to avoid dead ends. *American Psychologist*, *41*(2), 120-130. doi:10.1037//0003-066x.41.2.120

Strupp, H. (1993). The Vanderbilt psychotherapy studies: Synopsis. *Journal of Consulting and Clinical Psychology, 61, 431–433*

Taibbi, R. (1993). The way of the supervisor: Facing fear, rigidity, power, and death. *Family Therapy Networker*, *17*(3), 50-55.

Taylor, G.J., Bagby, M., & Parker, J. (1989). Psychological-mindedness and the alexithymia construct. *British Journal of Psychiatry, 154, 731–732.*

Tapia, M. (2001). Measuring emotional intelligence. *Psychological Reports*, *88*(2), 353-364. doi:10.2466/pr0.2001.88.2.353

Tarnas, R. (2006). *Cosmos and psyche*. New York, N.Y.: Viking.

Taylor, G. (2001). Low emotional intelligence and mental health. In: J. Ciarrochi and J. Forgas, ed., *Emotional Intelligence in everyday life: A scientific inquiry*, 1st ed. Philadelphia: Psychology Press, pp.67-81.

Tavakoli, H. (2012) A Dictionary of Research Methodology and Statistics in Applied Linguistics Tehran: Rahnama Press.

Thompson, T. (2004). Can the caged bird sing? Reflections on the application of qualitative research methods to case study design in homeopathic medicine. *BMC Medical Research Methodology*, 4(1), p.4.

Thorndike, R. and Stein, S. (1937). An evaluation of the attempts to measure social intelligence. *Psychological Bulletin*, 34(5), pp.275-285.

Throndike, E. (2014). Intelligence and its Uses. *The Harpers Monthly*, 140(1), pp.227-235.

Thurstone, L. (1938). *Primary mental abilities*. Chicago: Univ. of Chicago Press.

Timulak L. (2014). Witnessing Clients' emotional transformation: An Emotion-focused

therapist's experience of providing therapy. Journal of Clinical Psychology, 70, 8, 741-752.

Tischler, L., Biberman, J. and McKeage, R. (2002). Linking emotional intelligence, spirituality and workplace performance. *Journal of Managerial Psych*, 17(3), pp.203-218.

Tomkins, S. and Karon, B. (1962). *Affect, imagery, consciousness*. New York: Springer Pub. Co.

Traill, R. (2000). *Physics and philosophy of the mind*. Black Rock, Vic.: Ondwelle Publications.

Trepka, C., Rees, A., Shapiro, D., Hardy, G. and Barkham, M. (2004). Therapist Competence and Outcome of Cognitive Therapy for Depression. *Cognitive Therapy and Research*, 28(2), pp.143-157.

Tronick, E. (1989). Emotions and emotional communication in infants. *American Psychologist*, 44(2), pp.112-119.

Tronick, E. (2007). *The neurobehavioral and social emotional development on infants and children*. New York: W.W. Norton.

Truax, C. and Carkhuff, R. (1967). *Toward effective counseling and psychotherapy*. New York: Aldine Pub. Co.

Tulving, E. (1983). *Elements of episodic memory*. Oxford [Oxfordshire]: Clarendon Press.

Urquhart, C. (2004). The evolving nature of grounded theory method: The Case of the information systems discipline. In: A. Bryant and K. Charmaz, ed., *The Sage handbook of grounded theory*, 1st ed. London: Sage, pp.339-360.

Van der Zee, K., Thijs, M. and Schakel, L. (2002). The relationship of emotional intelligence with academic intelligence and the Big Five. *Eur. J. Pers.*, 16(2), pp.103-125.

Vaughan, F. (2002). What is Spiritual Intelligence?. *Journal of Humanistic Psychology*, 42(2), pp.16-33.

Wasserman, S. and K. Faust (1994). *Social network analysis: Methods and*

applications. Cambridge (UK), Cambridge University Press.

Watling, C. and Lingard, L. (2012). Grounded theory in medical education research: AMEE Guide No. 70. *Med Teach*, 34(10), pp.850-861.

Weber, R. (1990). *Basic content analysis*. Newbury Park, Calif.: Sage Publications.

Wechsler, D. (1940). Non-intellective factors in general intelligence. *The Journal of Abnormal and Social Psychology*, 37(1), pp.444-445.

Wechsler, D. (1943). Non-intellective factors in general intelligence. *The Journal of Abnormal and Social Psychology*, 38(1), pp.101-103.

Wechsler, D. (1958). *The measurement and appraisal of adult intelligence*. 3rd ed. Baltimore: Williams & Wilkins.

Weinstein, M. and Broda, M. (2009). Dialectics, dialogics and other ways of reading us. *Cult Stud of Sci Educ*, 4(4), pp.799-801.

Wertz, F. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology*, 52(2), pp.167-177.

Wessman, A. and Ricks, D. (1966). *Mood and personality*. New York: Holt, Rinehart and Winston.

West, W. (2011). Using the tacit dimension in qualitative research in counselling psychology. *Counselling Psychology Review*, 26(4), pp.40-45.

Wheeler, S. (1996). *Training Counsellors: The assessment of Competence*. London: Cassell.

Wilks, S., Spivey, C. and Rajan-Rankin, S. (2013). Self-Identity, Embodiment and the Development of Emotional Resilience. *British Journal of Social Work*.

Williams, E. and Morrow, S. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research*, 19(4-5), pp.576-582.

Winnicott, D. (1960). *The maturational processes and the facilitating environment*. New York: International Universities Press.

Winnicott, D. (1963). From Dependence towards Independence in the development of the Individual. In: *The maturational process and the facilitating environment*, 1st

ed. London: Karnac.

Winnicott, D. (1971). *Playing and reality*. New York: Basic Books.

Wiseman, H. and Egozi, S. (2006). Personal therapy for Israeli school counselors: Prevalence, parameters, and professional difficulties and burnout. *Psychotherapy Research*, 16(3), pp.332-347.

Witt, J., Proffitt, D. and Epstein, W. (2004). Perceiving distance: A role of effort and intent. *Perception*, 33(5), pp.577-590.

Wolf, Z. (2003). Exploring the Audit Trail for Qualitative Investigations. *Nurse Educator*, 28(4), pp.175-178.

Wong, C., Day, J., Maxwell, S. and Meara, N. (1995). A multitrait-multimethod study of academic and social intelligence in college students. *Journal of Educational Psychology*, 87(1), pp.117-133.

Yin, R. (2003). *Case study research*. 3rd ed. Thousand Oaks: Sage Publications.

Zahi, A. (2009). Spiritual-transpersonal hypnosis. *Contemp. Hypnosis*, 26(4), pp.263-268.

Zajonc, R. (1980). Feeling and thinking: Preferences need no inferences. *American Psychologist*, 35(2), pp.151-175.

Zajonc, R. (2001). Feeling and thinking: Closing the debate over the independence of affect. In: J. Forgas, ed., *Feeling and Thinking: The Role of Affect in Social Cognition*, 1st ed. Cambridge: Cambridge University Press.

Zeidner, M., Matthews, G. and Roberts, R. (2009). *What we know about emotional intelligence*. Cambridge, Mass.: MIT Press.

Zeidner, M., Roberts, R. and Matthews, G. (2002). Can Emotional Intelligence Be Schooled? A Critical Review. *Educational Psychologist*, 37(4), pp.215-231.

Zetzel, E. (1956). Current concepts of transference. *International Journal of Psychoanalysis*, 37, pp.369-376.

Doctoral research appendices

Appendix 1 (A) : Being a Therapist' Syllabus

(Hen & Goroshit 2011)

Theme	Teaching Strategy	Assignment
Introduction to therapy, emotions and emotional states	Reflective: Students are asked to list five things they think about themselves and five things they feel about themselves and to share their answers in small groups	Danielsen, R. & Cawley, J. (2007) 'Compassion and integrity in health professions education', Journal of Allied Health Science and Practice, vol. 5, no. 2, pp. 1 –9
Identifying one's own emotions and emotional states	Case study: Students read four short vignettes regarding conflict situations, and are asked to express their feelings and thoughts in each situation. They share this information in groups of	Prepare a summary of the sharing in class, to be used in the following class
Identifying one's own emotions and emotional states	two, examining the differences in emotional perception	Reading for next class: Beresford, P., Croft, S. & Adshead, L.(2008) '"We don't see her as a social worker": a service usercase study of the importance of the social worker's relationship and humanity', British Journal of Social Work,vol. 38, no. 7, pp. 1388 – 1407
	Group work: Students share and analyze the information from the last class, this time in groups of six. They are asked to prepare short presentations on identifying emotions and emotional states (including a	
Identifying one's own emotions and emotional states	search for theoretical information) Presentations	Students prepare a short summary about how they felt in class and how they expressed these feelings
Expression of emotions	Role-playing: Each group receives a short story to act out in class. Students from other classes are invited to join the group and express their feeling and thoughts about the situation in the	
Identifying others' emotions and emotional states	short story, and about the actors. Discussion about the way people express their feelings	Reading for next class: Reupert, A. (2007) 'Social worker'suse of self ', Clinical Social Work Journal, vol. 35, no. 2, pp.107– 116
Understanding emotions in oneself (why do I feel the way I do?)	Reflective: Students are shown a short film about an anorexic teenager. In small groups they talk about their feeling towards the anorexic teenager, her family, teacher, and therapist, and try to identify their emotional states	Reading for next class: Lum, W. (2002) 'The use of self of the therapist', Contemporary Family Therapy, vol. 24, no. 1, pp.181– 197
Regulation of emotions	Reflective: Students are shown part of the film again. They are requested to look at the feelings they had in the last class and try to understand why they felt the way they did towards each character in the film, followed by	Reading for next class: Duan, C. & Hill, C. E. (1996) 'The current stage of empathy research', Journal of Counseling Psychology, vol. 43, no. 3, pp. 261– 274
Regulation of emotions	sharing in small groups	
	Lecture: The relationship between thoughts and feelings	Reading for next class:
	Case study: Students read four short vignettes regarding conflict situations, and are requested to identify their feelings and thoughts in each situation. Then they are asked to find ways to	Neumann, M., Bensing, J., Mercer, S.,Ernstmann, N., Ommena, O. & Pfaff, H. (2009) 'Analyzing the "nature" and "specific effectiveness" of clinical empathy: a theoretical

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Utilization of emotions	regulate their feelings by means of their thoughts. This information is shared in small groups and discussed with the entire class Short film on the fish market in Seattle. Class discussion about how we use our emotions in the relational context and in therapy	overview and contribution towards a theory-based research agenda', Patient Education and Counseling, vol. 74, pp. 339– 346 Reading for next class: Mayer, J. D., Roberts, R. D. & Barsade, S. G. (2008) 'Human abilities: emotional intelligence', Annual Review of Psychology, vol. 59, pp. 507– 536Mayer, J. D., Salovey, P. & Caruso, D. R. (2000) 'Models ofemotional intelligence', in Handbook of Intelligence, ed. R. J.Strenberg, Cambridge University Press, New York, pp. 396–420
Utilization of emotions: Being empathetic?	Lecture: Describe what empathy is and what it is not	
Theory: emotional intelligence	Discuss the emotional dimension of empathy and the five emotional competencies that make up this category	
Theory: emotional intelligence and social work	In small groups: Relate how empathy is critical for superior performance whenever the job focus is on people Lecture: Defining emotional intelligence and its key components according to Mayer and Salovey (1997 Small groups: Work on Morrison's (2007) article and class discussion	Reading for next class: Morrison, T. (2007) 'Emotional intelligence, emotion and social work: context, characteristics, complications and contribution', British Journal of Social Work, vol. 37, no. 2, pp. 245– 263Skinner, C. & Spurgeon, P. (2005) 'Valuing empathy and emotional intelligence in health leadership: a study of empathy, leadership behavior and outcome effectiveness', Health Services Management Research, vol. 18, pp. 1– 12
Theory: emotional intelligence and social work		Jaeger, A. J. (2003) 'Job competencies and the curriculum: an inquiry into emotional intelligence in graduate professional education', Research in Higher Education, vol.44, pp. 615– 639. Students are requested to prepare a reflection on the process they experienced in this course
Summary	Case study: In groups of two, students are asked to analyze a case study, emphasizing their and others' emotional intelligence and trying to apply theory to course experience Class discussion: Can emotional intelligence be taught? How does it apply to social work and to me (the student) as a developing health professional?	Final paper: 1. Reflection: my class experience during this course 2. Theoretical background: emotional intelligence and empathy (based on readings) 3. Integration of personal experience with EI theory.

Appendix 1 (B) : Snowball sampling from a citation network at three levels

Adopted from: Lecy, Jesse D. and Beatty, Kate E., (2012) Representative Literature Reviews Using Constrained Snowball Sampling and Citation Network Analysis (January 1).

Appendix 2: MSCEIT branches

The first branch of the MSCEIT is one's ability to perceive emotions, or more specifically, an individual's ability to interpret facial expressions and other visual social cues that correlate with emotions (Ekman, 2003). Salovey and Mayer (1990) argued that the emotion-perception system is an evolutionarily system that in early stages of development enables empathetic mirroring between infant and caregiver. The perception of emotions is also measured by the extent to which participants correlate picture imagery and colours with moods and feelings, particularly from the conveyed viewpoint of the designer (Arnheim, 1974). However, this facet of perceiving emotion can be criticised for being confounded by subjectivity considering the use of colour and pattern in art embodies qualitative differences, such as cultural values (Davies, 1998).

The second branch to the MSCEIT is measuring the extent to which individuals utilise emotions to supplement thoughts. One of the ways this is assessed is by collecting data on the individual's ability to distinguish between emotions and other tactile/sensory information (Cisamolo, 1990). This is evident where a therapist's own personal memories, experiences and feelings, assist the therapeutic process via empathizing with the client's experiences. Mood awareness in the process of therapy may elicit the cognitive system which could stimulate thought for diverse perspectives on clients' presenting issues. For example, the measurement of emotional facilitation is the extent to which a client in therapy might elicit a positive mood in a therapist which enables to build rapport and sustain the therapeutic relationship; in contrast, a client might influence a negative mood in a therapist which requires the therapist's awareness on how to read those feelings and allow for diverse perspectives to emerge to help implement thoughts and mental representations about a particular emotional issue, such as dealing with the loss of a significant person in their life (Isen, 2001).

Both branches of the MSCEIT just described can be thought of as two different

aspects of empathy. Rogers (1959) suggested that empathy first requires the ability to "perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the 'as if' condition" (p. 210f). Both MSCEIT branches appear to coincide with Rogers's description, as it requires a therapist to feel and share another person's emotions and have a sense of what it's like to experience that feeling but without losing the focus of a separate self so the therapist can help the other.

The third branch of the MSCEIT focuses on the ability to not only understand one's own and others' emotions, but also to see the relationships between emotions. To understand another's emotions, one must be able to identify another person's emotional transition from one state to another and then to discern its meaning, For example, another person may be experiencing fear, which may emerge as insecure behaviour, which can then impact their self-esteem and social relationships. Accordingly, this branch coincides with one's metacognitive capacity and the concept of psychological mindedness – defined as "a person's ability to see relationships among thoughts, feelings and actions, with the goal of learning the meanings and causes of his experience and behaviour" (Applebaum, 1973, p. 36). This psychological mindedness enables consciousness and awareness of motives, psychological processes, and inner experiences of the self, as well as of relationships with others (Hall, 1992). Reflective practising (Schon, 1983) also corresponds with the third MSCEIT branch as it encompasses reflective self-awareness (e.g., being aware of our own biases), reflective self-awareness (e.g., mindfulness of what is going on for therapists themselves during the therapeutic encounter), and critical reflexivity (e.g., it entails questioning our relationship to our own culture). Reflective functioning (Fonagy, Steele, Steele, Moran & Higgits, 1991) is also akin with the third MSCEIT branch as it involves the capacity for understanding mental states.

The fourth and final branch of MSCEIT is the measurement of the individual's

ability to manage emotions during different hypothetical situations. This is measured by presenting participants with scenarios that elicit certain feelings, and asking how they would cope and moderate those feelings under emotional intensity (Gross, 1998). Another important measurement for the fourth branch to MSCEIT is the assessment of managing emotions in relationships. This is tested by asking participants how they would try to influence someone else's emotionally affective states in order to implement a desired outcome (Ford & Tisak, 1983). The fourth branch similarly refers to affect regulations and effective strategies to manage emotional states in oneself and others (Safran & Reading, 2008; Schore, 2003).

Research study: THE ROLE OF EMOTIONAL INTELLIGENCE IN THERAPY.

Dear colleagues I am interested to interview qualified therapist on the topic of therapeutic relationship and the links to emotions and the theory of emotional intelligence concept which I will provide some information. The project is part of my Post Chartered DPsych in Counselling Psychology at City University. I will need an hour of your time and I am willing to pay for your rate of the session. If interested please email me on ▮▮▮▮▮▮▮▮▮▮ or call me on ▮▮▮▮▮▮▮. Thank you in advance for your consideration. Joseph poullis

Appendix 3 (B): Information for prospective participants

Invitation to Take Part in Counselling Research

Dear Colleague,

Thank you for taking the time to read this information sheet. My name is Joseph Poullis and I am Chartered Counseling Psychologist doing research on the Post-Chartered ("Top-up") DPsych at City University in Counselling Psychology.

I am pursuing to investigate the role of trait emotional intelligence and the concept of it within the therapeutic process and outcomes and I would like to invite your participation in the study. I am willing pay for your one hour of participation at your provided session rate. **Topic: The Therapist's Emotional Experience of the Therapeutic Relationship and its Links to Emotional Intelligence Theory.**

Definitions In this research -

Emotional Intelligence has been described as an ability to appraise oneself and others' emotions, an ability to regulate one's own emotions, and an ability to use emotions to solve problems (Salovey & Mayer, 1997). The therapist's awareness of the entire gamut of his feelings and thoughts is crucial for sensitive and subtle management of the therapist's reaction. This self-awareness enables the therapist to take responsibility for a pre-reflective contribution to the feelings transferred from the client, and for passing it back to the client as therapeutically appropriate. The therapist has to remain open and receptive about his own emotions and should be able to empathise the affect, cognition and behaviour or other reactions responses of the clients.

What is this about?

EI has been described an ability to appraise oneself and others' emotions, an ability to regulate one's own emotions, and an ability to use emotions to solve problems (Salovey & Mayer, 1997). The therapist is being placed in a similar psychological dilemma within the therapeutic relationship. What is of interest is the process in which the

therapist recognizes the psychological act of transferring unbearable feelings in another, as akin to the process where the therapist needs to be aware of what evoked the feeling, and how our self- awareness or lack of it ultimately shapes the therapeutic project. In other words it is a process of identifying the feelings in ourselves and the client, and managing those aspects of ourselves that carry the potential for pre-reflective complicity with the client's destructive tendencies in the therapeutic encounter. The therapist's awareness of the entire gamut of his feelings and thoughts is crucial for sensitive and subtle management of the therapist's reaction. This self-awareness enables the therapist to take responsibility for a pre-reflective contribution to the feelings transferred from the client, and for passing it back to the client as therapeutically appropriate. The purpose of this study is to investigate what therapist themselves experience as being part of the therapeutic relationship and how they will perceive the facets explained in the emotional intelligence theory and if it is relevant to the therapeutic relationship.

Who can participate?

Qualified therapist. The term therapy refers to counselling and/or psychotherapy

Confidentiality

In order to respect privacy and meet ethical requirements for confidentiality personally identifying details such as name and/or email address are not being collected in this survey.

How to take part

Taking part is voluntary and you have the right to withdraw at any point during the survey, or to choose not to submit on completion. If you would like any more information or have any concerns with regard to taking part in this study, please feel free to contact me via my E-mail: ███████████████████████ phone ███████████

Ethical approval

This research has been approved by City University Ethics committee.

What is expected from you?

If you are willing to participate I will email you the trait emotional intelligence inventory (Teique). The TEIQue is underpinned by an academic research program based at University College London (UCL) and you will need about 15 minutes to complete it. Once you completed it please forward it back in order to enteryour scores on a UCL computerised system with a private code to protect your anonymity. The scoring and report will be provided by the Psychometric Laboratory at University College London (UCL) and I will be the only one who will know the name of each report. I will then forward the report to you three days before the day of our interview in order to discuss its relevance to yourself and your therapeutic work.

More about TEIQue

For more information about the inventory please visit the web site www.teique.com.

What if you have worries about the study?

Should you have any concerns about the conduct of this study you can contact my academic supervisor Dr Don Rawson or the Chair of Social Sciences Research Committee through the course administration office on the number below:

City University London

SocialSciences Building,

Northampton Square

London EC1V 0HB Tel: ▓▓▓▓▓▓▓▓▓▓▓

If you have any further questions and/or concerns with regards to this study please do not hesitate to contact myself Joseph Poullis (Researcher) by using the following contact details: ▓▓▓▓▓▓▓▓

Thank you in advance for your time.

Joseph Poullis

Appendix 4: Participants consent form

Project Title: The Therapist's Emotional Experience of the Therapeutic Relationship

and its Links to Emotional Intelligence Theory I agree to take part in the above

University research project. I have had the project explained to me, and I have read the

Explanatory Statement, which I may keep for my records. I understand that agreeing to

take part means that I am willing to:

1) be interviewed by the researcher

2) allow the interview to be audiotaped

3) complete questionnaires asking me about emotional intelligence

4) make myself available for a further interview should that be required

5) use a computer to transcribe the interview and analyse it

Data Protection
This information will be held and processed for the following purpose(s): To analyse the data and compare the themes with the literature review in the area of therapeutic relationship and Emotional intelligence.

- I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.
- No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.
- I understand that I will be given a transcript of data concerning me for my approval before it is included in the write up of the research.
- I consent to the audiotapes to be heard by the researcher supervisor
- I consent to the use of sections of the audiotapes in publications.
- I agree to City University recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998. Withdrawal from study (this clause must be included in all consent forms)
- I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

Name: ....(please print)
Signature..
Date:.....................................
Address:...

Appendix 5 (A): Interview schedule

Introduction to the interview: Thank you for accepting the invitation for this research. As you have read from the emails and attached handouts I am interested to know your views about the therapeutic relationships and the concept of Emotional intelligence. In particular I am interested in your emotional experience within the therapeutic relationship and in your experience in responding to the Traits EI report.

Explaratory questions on therapeutic relationship

1. As a therapist what is the meaning of the therapeutic relationship based on your role and experiences with clients?
2. Please describe an actual experience you have had with a client in therapy that will help me to understand what the therapeutic relationship means to you?
3. What did you think or feel about the experience?
4. What was the meaning of the experience for you?

Characteristics of Therapists
5. Could you please describe based on your own experience as a therapist, the qualities that you perceive as important in a therapeutic relationship?

Therapeutic relationship experience

6. Can you recall any experiences with clients who brought into the session a very emotionally (heavy) session and how was that experience?

• How do you understand emotions?
• Are you describing it as physiological, behavioural or cognitively Could you tell me more?

7. Can you reflect any important themes that emerged for yourself in terms of relating and responding to this emotional experience in therapy?
   • How did you experience that?
   • How did you feel ?
   • Did you physically feel anything ?
   • Did you think at the same time or latter
   • Was it physically, cognitive, affect or behavioural
   • Was it difficult or easy to hold the session?
   • How where you able to cope with the thinking and feelings at the same time
   • Can you tell me more, and how it was easy or how it was hard and difficult?
Therapist's understanding and perception of Emotional intelligence perception

8. Emotional Intelligence has been described as an ability to appraise oneself and others' emotions, an ability to regulate one's own emotions, and an ability to use emotions to solve problems (Salovey & Mayer, 1997).
9. As a therapist do you have are you familiar with the psychological concept of emotional intelligence.
10. Based on your experience as a therapist when encountering clients in sessions do you perceive any similarities with the definition of Emotional intelligence?

Therapist's personal experience of Trait Emotional Intellligence test and their scores

11. Reflecting back on the interview and your scores in the trait EI can you please describe your experience?
12. Can you comment on your own experience as a therapist and compare them with the facets of EI that you personally scored in the test? Therapist's personal experience of the therapeutic relationship and how they perceive its links to emotional intelligence
13. Based on your experience as a therapist when encountering clients in therapy sessions do you identify any similarities with the definition of Emotional intelligence?
14. Can you comment on your own experience of the therapeutic relationship and compare them with the facets of EI that you know?
15. Can you please identify any personal perceptions concerning the importance of emotional intelligence to your work as a therapist?

Summarising Questions

16. In your opinion, will emotional intelligence theory be of any use in understanding the therapeutic relationship by combined- or integrated training programs?
17. Finally based on your experience as a therapist, do you think there is any relationship or link between the therapeutic relationship and Emotional Intelligence.

Ending the interview

18. What haven't I asked that you think we should have? Thank you for participating in this research. Could I ask you if you have any questions that you would like to ask me?

Appendix 5 (B): Debrief for participants

Thank you for taking part in this research project, your participation is extremely valuable. The purpose of this research is to gain a more in-depth understanding of the process in the therapeutic relationship and the possible links with the concept and measurements of trait emotional intelligence.

Should you have any questions or concerns about this study or should you wish to withdraw your consent or participation at any time, you can contact me directly on ▮▮▮▮▮▮ or ▮▮▮▮▮▮▮▮ . If you decide to withdraw from the research, the recording of your interview and any reports and transcripts will be destroyed.

If you have any diffuculties or concerns about this research or the conduct of the interview and you do not wish to share with me, you may contact my supervisor: Dr Don Rawson or the Chair of Social Sciences Research Committee through the course administration office on the number below:

CityUniversity London

SocialSciences Building,

Northampton Square

London EC1V 0HB Tel: ▮▮▮▮▮▮▮▮

In addition, if you would like to receive a copy of the findings of the study, please email me with your postal

address and I will forward a copy of the results when the study is completed.

I would like to thank you again for your input and time in this research.

Joseph Poullis

Reflect on and write about how I personally relate to the participant and or phenomenon

03 August 2010

Personal relationship to the study: Therapeutic relationship and its links to EI:

Connection and different emotional levels.

I can relate to the phenomenon of connection as the heart of the relationship. In my own role as therapist experienced different degrees of interpersonal connections within a therapeutic alliance. There are connections that exist on primarily an intellectual level, an emotional level, or even a "practical level. The quality of connection (i.e. level of depth) on any dimension matters, too. Connections at a purely superficial level have shown me to end therapy at the beginning before we got anywhere although they sometimes intense. In those levels of connections I found intellectualization to damage the authenticity of trust and hides the person from connecting with their own feelings in order to connect with me as a therapist. Connecting at the level of respecting the client's characteristics is important too as that psychological level of connection prompts the question on how do we respect each other's unique personality characteristics? But with the same token how do we as therapist are able to tune in to client's needs and do not ignore the deeply and meaningfully connections? such as the emotional level. Spiritual plates and psychological needs.

Reflect on and write about my study research questions.

13 August 2010

Research question: link between the EI and therapeutic relationship

Challenging my assumption of a link between the EI and therapeutic relationship is part of the healthy development of theory and I should be open to such critics not to allow the subjectivity and interpretation from developing to bias and cherry picking process. I

thought that such a response excludes EI from the therapy context in any possible way for training. Could the test of Trait EI provoked the participants (therapists') willingness to be more open. Shall I talk about the reaction to the trait EI and possible defence or that will divert the study away from its aim and research question? I have to be more sensitive on the trait EI scoring when I interview participant, I also need to step back and contain my own anxiety that the outcome of the study will be an affirmation that EI could be nothing in the participant's experiences and perception. I need to take a 'subtle realist' position. Ensure the 'truth' and trustworthiness of the account by following other participants' experiences.

Reflect on and write about my code choices and their operational definitions

28th of August 2010

Code definition: Emotional connection and cognitive process- responding to the present moment

The in-vivo coding noted: "It's not what the answer that the patient is looking for but what's the answer that, comment that's going to be helpful? That it seems to me requires fast thought in order for the conversation to keep going, deep thought in order to understand. Then it has to be expressed in a way that doesn't just, isn't just cognitive but actually touches the heart".   The therapist describes an experience where he was metaphorically using 'touches the heart' my choice of word was an emotional connection but will it also mean a spiritual connection or transpersonal. Looking at the definition: The *transpersonal* is defined as "experiences in which the sense of identity or self extends beyond (trans) the individual or personal to encompass wider aspects of humankind, life, psyche or cosmos". I will stay with the code emotional connection and cognitive process as in my opinion is more close to the meaning of data. I will however be aware if transpersonal or spiritual will be more explicitly emerging from data and interviews.

Reflect on and write about the emergent patterns, categories, themes, and concepts

01st of September 2010

Emergent patterns, categories, themes, and concepts: Emotional Balance

Discovering categories: once I open up the text and have the first order concepts or categories abstracted and compared (refer to appendix G) I then began to group certain concepts under a more abstract higher order concept (second order concepts). For example, I observed based on the indicators around 60 categories and properties. I abstracted 42 categories from the open coding process and began my analysis.

Naming categories and properties : once a category was identified I began to develop it in terms of its specific properties and dimensions. For instance, I labelled "emotional awareness", "self-awareness" and "emotional detachment" "Reflective practising" in the same group of variables that share the characteristic of emotional balance. I came up with the word balance because if I compare each event against itself and other events in the in-vivo data, I observed that these variables have the following characteristic in common: They assist the therapist to manage the dialogue and their interpersonal relationship with clients. Thus, balance means 'bracketing' therapist's personal bias and protect therapists from becoming overwhelm with client's feelings e.g., helplessness and "stuck".

Reflect on and write about the possible networks (links, connections, overlaps, flows) among the codes, patterns, categories, themes and concepts.

10th of September 2010

Networks: Empathy, Containment, Connection, Reflective practice, Supervision, training and EI.

A codeweaving attempt with this data excerpt is: "the therapeutic relationship entails a number of important cornerstones in maintaining and sustaining an alliance. The emotional competencies of empathy, meaningful emotional connections, management or regulation of feelings in self and others e.g. containment and an overall ability to maintain

a psychological or emotional balance is the key elements. Supervisor, personal therapy and other EI or training instruments, which are focusing on professional developmental skills, as the aforementioned core categories, can assist the outcome of the therapeutic alliance however is not a cause and effect but rather a mean to an end. Trait EI is not a valid instrument to advance a theory on its own merits as to its applicability in therapy or training, but the EI concepts does share common characteristics with the core processes of emotional balance, deep meaningful connection with clients and awareness of the self and others internal psychic world.
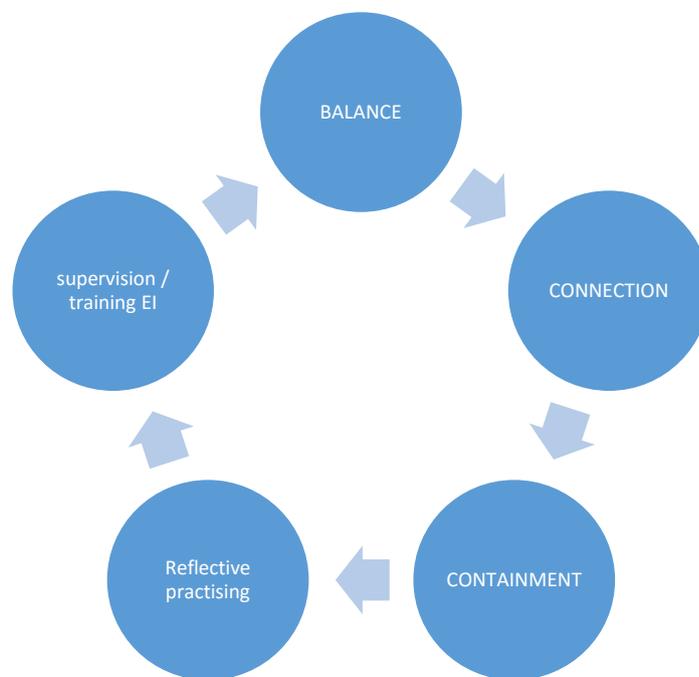
An analytic memo sketch on codeweaving for the study

Reflect on and write about an emergent or related existing theory

30th of September 2010

Theory: EI could play a role in therapeutic training if it will be adapted to a more experiential learning exercise and not a test.

A number of important outcomes emanated from this research experience. First, using EI as part of developing emotional learning and build on therapeutic competencies, appear to lack a clear theoretical rationale and techniques of which EI training programs can emerge from their current dubious bases.

Second we need to address and investigate how the themes emerged as important in the therapeutic relationship and the existing EI re-integration of a research measure is appropriate for implementation in training. While measures of therapist process or therapeutic relationship intervention (e.g., Trait EI) could help trainees to have knowledge and understanding, 'what to do as a therapist', client process measures on the other hand would help trainees to perceive what is happening in the session. This research was focused on the process of therapy and therapist subjective experience of therapy and trait EI. Further studies need to encompass more information on the outcome and process.

Thirdly we need to develop appropriate EI teaching module for psychotherapy training purposes, using a series of group training session, including group discussion, role plays, lectures and homework focused on perception, appraisal and expression of emotion, emotional facilitation of thinking, understanding and analysing emotions and reflective regulation to promote emotional and intellectual growth. Supervision and perhaps an expect consensus panel can limit the limitations of trait EI or ability EI pitfalls. Psychotherapy and counselling training teams offer an ideal environment in which such modules can prosper. Training would be implemented early in the doctoral program and discussion on EI facets would be offered in an experiential learning context under supervision.

The theory of metacognitive functioning is relevant here. Wells and Purdon's definition (1999) of metacognition is of particular interest: 'the aspect of information processing that monitors, interprets, evaluates and regulates the contents and processes of its organization'. This definition is of heuristic value for two reasons. First of all it so wide

as to include many of the clinical phenomena which have already been analysed. For instance, the reference to 'contents and processes' includes both the ability to recognize the various elements (specific thoughts and emotions) of one's mental state, and the ability to comprehend behaviour in terms of intentionality and variations over time in intentional states (i.e. processes).

Metacognitive contents are the ideas and beliefs linked to a particular mental phenomenon: beliefs about beliefs. A typical problematic metacognitive belief is that found by Salkovskis (Salkovskis, 1985, 1989; Salkovskis et al., 1995) in patients with OCD, for whom thinking about performing a particular action increases the probability of its being performed.

When Ulysses met the Sirens, he was able both to recognize the contents of his mind (the desires he had at the same time to both listen to the singing and to go back to Ithaca) and to understand the incompatibility of the two desires. He was also able to acknowledge and foresee the variation of his mental states affected by time and circumstances (he would stop longing for Ithaca when influenced by the singing and he would start longing for it again when the singing stopped). In the end, he was able to enact a regulation strategy (binding himself to the mast). A poorer cognitive ability, such as for instance, the ability to monitor only the contents present in a precise moment, would have had catastrophic effects.

Moreover, besides cognitive activities (monitors, interprets, evaluates), Wells and Purdon's definition also includes regulation and so it allows us to consider in the clinical study of metacognition those regulation disorders which are psychopathologically significant.

Secondly, although it is a broad definition, it underlines that there are different activities that could be disturbed in clinical situations. In fact some patients might have only a monitoring disorder, some others only a regulation disorder and so on. Whilst we have

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started out from Wells and Purdon's definition, we have however focused on metacognitive functions, i.e. the whole set of abilities that allow us to understand mental phenomena and work them out in order to tackle tasks and master mental states that are a source of subjective sufferance (Carcione & Falcone, 1999; Carcione, Falcone, Magnolfi, & Manaresi, 1997).

Reflect on and write about any problems with the study.

10th of October 2010

Problem: Thinking about a study that could entail both therapists and clients EI before and after a therapy process

*The study that can d*evelop into more empirical stages via an established EI training with an experiential program and therapist; then to test clients outcome before the therapist training EI program and after.

Reflect on and write about any personal or ethical dilemmas with the study.

22nd October 2010

Ethics: EI score and reaction to participants

I am still hesitant as to the way the participants' experienced their Trait EI scoring and if it had an impact on their practice after I left. I wonder if I should not have encompassed the test scores and just the experience of it. I also wonder if less resistance will come out if the scores were not disclosed.

Reflect on and write about future directions for the study.

01st November 2010

Future Directions: experiential EI programs

Perhaps a need to develop experiential training and then test it to see if its developing competencies. Appendix M indicate a promising development of experiential EI programs and it could be an idea to develop and refine the content and analysis for maximum performance. Perhaps reflective knowledge for experiential learning could develop the EI concept and also the knowledge and the theory of metacognitive functioning is relevant here.

Schon (1983) and Iszak Mark Gregory (2007), righly expose the failings of models of education and practice based on principles of technical rationality, have highlighted a significant niche for reflection in training and practice.

Iszak (2007) in his dissertation noted an important need for self-reflective practice. The dissertation is called "Achieving self-reflective practice: A comparative psychoanalytic approach to the training of clinical psychology doctoral students". This new emphasis, drawing from psychoanalytic concepts of self-reflection, self-analysis, and work ego, has aimed to take into account the potentials and the obstacles of more fully realizing and utilizing the self of the trainee, and may contribute to definition and clarity of reflective practice, as well as means to achieve it. Recommendations are directed toward professional psychology with hopes that a substantial framework for reflective practice can be established and competencies for reflective practice to be formulated.

A1: Memo 1: Trait EI and therapist initial reaction 8th of August

Reflecting on the attitude of the participant in the session – I am becoming aware that the participant was less reluctant to discuss the Trait EI experience and its links to Therapeutic relationship. The feeling I was getting was a general implicit defence to open up the possible perspective of EI and its use as building up competencies. I need to listen to the recorded session and see if I was prompting his defensive reaction or not. If I divert the question to explore the resistance if that is a theme with participants then I might be moving away from the research question and aims of study?

A02 Memo 6: The dilemma of participant resistance in EI testing August 13th, 2010

Re-reading participants response to their experience of the trait EI test … I feel some of those quotes have a different meaning hard to capture in words. Or perhaps the possibility of multiple understandings and interpretations. However do I allow more time to reflect the other participants contribution as this quote from the participant 12 really through my assumptions from literature review out of the window.

P12:   Yeah, I think that, um (laughs) you're probably not going to like this, but I think that it would be a really good instrument to take apart, er, in terms of the research component of the programme, to … so that students could understand the precise ways in which those questions are loaded. "Have you stopped beating your wife, Joseph?"

Challenging my assumption of a link between the EI and therapeutic relationship is part of the healthy development of theory and I should be open to such critics not to allow the subjectivity and interpretation from developing to bias and cherry picking process. I thought that such a response excludes EI from the therapy context in any possible way for training. However I must be honest here and take a 'subtle realist' position. Ensure the 'truth' and trustworthiness of the account by following other participants' experiences. A will treat the above response as a beginning of an audit trail, maybe allow my thinking to emerge from different participants descriptions around the theme of emotional balance and perhaps the link to the EI?

A03 Memo 6: The dilemma of participant resistance in EI testing August 12th, 2010

The question remains as to the willingness of therapist to participate openly in the

interview without prejudice to the Trait EI scoring. There has been very little research on the assessment of therapist competence and therapy quality. Therapy quality needs to be distinguished from *therapist competence*, the latter notion referring to an attribute of a therapist, not a treatment. Therapist competence in this context may be defined as "the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects." Thus when assessing therapist competence one is assessing the therapist's capacity to provide a treatment to an acceptable standard. This requires evaluating the therapist's knowledge of the treatment and its use, and the therapist's ability to implement it. This particular type of competence has been described as "*limited-domain intervention competence*" (Barber, Sharpless, Klostermann, & McCarthy, 2007) as it refers to the therapist's ability to implement a specific form of treatment. Psychotherapists have to possess a range of other abilities; for example, more global psychotherapeutic ones (Barber et al., 2007; Sharpless & Barber, 2009, the ability to assess patients well, and the ability to select treatments appropriately. These attitudes of therapist perception of psychometric "competencies" are outside the scope of the present study but it will be an interesting line for future research.

A04 Memo 39: Supervision and connection August 28th, 2010

Re-reading field notes from interview with participant 8 and 12, noted the many references to the need of therapist for an external observer- supervision and not psychometric testing to assist the training of competencies; in particular, the connection between unconscious communication and emotional interaction in supervision. Appears that supervision holds therapist "together"—part of making sense of that all—is also the 'glue' attunes therapists to understand barriers in a space for reflection. So … supervision brings connection but trait EI creates resistance.

A5 Memo 41- Checking device February 10ᵗʰ 2011

As a checking device, Seibold provided the constructivist grounded theorist with a series of consciousness-raising questions to ask themselves in order to provoke thinking about the power differentials that might exist in the research relationship and to ensure a conscious, ongoing commitment to participant-driven research:

How is this [person] like me? How [are they] not like me?

How are these similarities and differences being played out in our interaction?

How is that interaction affecting the course of the research? How is it illuminating or obscuring the research problem?

A05 Memo 42: Trait EI Contradictory facets April 11th, 2011

Reading participants 3 remarks " I've got 96% on emotional perception and 61% on empathy and I don't understand what would be the difference and what's that actually distinguishing between on this questionnaire, what is it saying…that is a good question what do you entail in an EI inventory and claim is valid?

A6 Memo: 47 Personal Therapy May 12th , 2011

 Three participants mention that personal therapy is got more valid use that Trait EI measurement.

A7. Memo: 48 rebelion against May 15, 2011

I probably empathise with people and see things from their perspective but there are probably other times when I'm really you know, I don't know I might not be open to listen to anyone else because I'm in an emotional turmoil myself and I'm not open to kind of see other people's pain or how they feel you know because I'm really kind of closed off in my own self, so there could be times like that So then if I scored high here I wouldn't say that this is just me I would say its me sometimes maybe you know but other times …(Field Interview Participant 2)

A8 Memo: 49 Igniting doubts June 19, 2011

Glaser (1998, p. 68) also suggests that exposure to established theoretical ideas could leave the researcher 'awed out' by the work of others, thus their sense of self-worth and competence in the realm of theory development. How do I relate to this as a researcher?

A9 Memo: Contradicting vires EI acknowledged Trait EI is struggling   June 25th 2011

There seems to be a little support of Trait EI as a valid training method but there is a support that the EI concept is relevant

A1: Memo : 05.08.10

Questions to focus in Line by Line coding and then in focus coding

Who is she/ he?
What does she/he do in her therapeutic appproach?
What do you think she meant by that?
What are they supposed to do?
Why did she/he said that?
Why is that said?
What happens after _____?
What would happen if _____?
What do you think about _____?

A2: Memo : 02/11/2010 - Sensitive to EI

I need to modify any emerging theory, exploring cases that do not fit as well as those which might generate new knowledge. The number of participants seems to have crash down the idea of trait EI as part of an important measurement in training and therapy. I wonder if I am *Sensitivity to negotiated realities* – While participant validation may be necessary I must be aware as a researcher of the power differentials and participant reactions to the research. It is particularly important to explain any differences between the researcher's interpretations and those of the participant(s).

A 3: Memo : 01.02.2011 - Emotional Balance

But most importantly theoretical memos are written about codes and their (potential) relationships with other codes. How and why was the core category of emotional balance selected? On what grounds? There are lots of participants that talk about containment and presence and openness and acceptance and the ability to stay with the client in their role as therapist. I think Emotional balance is a concept to capture their descriptions and my interpretation of their meaning. Do the theoretical findings of emotional balance seem significant? All participants seem to share a common description of some level of containment and balance of feelings. The feelings that are described as physical, emotional and cognitive and share the purpose of regulating emotions and accept the client unconditionally. That seems to relate to the concept of EI but the test used and the participants experiences are so varied and most therapist do not agree with the way the test captures their self. Some of them found the facet of controlling others very

traumatised as they do not attempt in therapy to control their clients. As participant 8 noted:

'Um I think the one area and I noticed this then after when I got the scores back and the one area where I scored the lowest was on the, the questions about I, I, I'm guessing these made up that profile about controlling someone else's emotions or regulating someone else's emotions and I, I was really kind of unclear about where to come from on that. In other words part of it was okay if … part of it is sort of a, a prejudice from the past coming from an addiction background where you, where the whole idea of, of um controlling other people's thoughts and feelings is not a good one and I think I bring that into the therapeutic process so it's like if I'm working with a client I'm not going to try to control where their feelings go, I am going to try to work with those feelings in an effective manner'

Trait EI seems to be intrusive in some participants' reactions and I wonder how their defence might put them off from engaging with the inventory. Perhaps my questions should explore more the EI concept but again I want to find out their experiences on that trait EI.

A4: Memo 12: 01.02.12- Confusing categories with concepts and subcategories

I find Strauss and Corbi 1990 category and concepts confusing as sometimes denote same things. I will consider the word variable for categories as that help me understand the notion and differences.

A5 Memo: 14: 23.02.12.

I reflect on Savin-Baden and Fisher, 2002 ideas that the integrity of the research process and the quality of the findings must have criteria. Thus such criteria would need to allow researchers to "acknowledge that trust and truth are fragile…I wonder if I need to consider the possibility of not finding any links to EI and just report that.

Trait EI discredited v & EI Theory validated - *Evidence Trait EI is not a valid measure for most therapist*

A03 Memo 6: The dilemma of participant resistance in EI testing November 12th, 2010

The question remains as to the willingness of therapist to participate openly in the interview without prejudice to the Trait EI scoring. There has been very little research on the assessment of therapist competence and therapy quality. Therapy quality needs to be distinguished from *therapist competence*, the latter notion referring to an attribute of a therapist, not a treatment. Therapist competence in this context may be defined as "the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects." Thus when assessing therapist competence one is assessing the therapist's capacity to provide a treatment to an acceptable standard. This requires evaluating the therapist's knowledge of the treatment and its use, and the therapist's ability to implement it.

Index card of indicators data which prompted the focused codes and concept

Within – concept and indicators

A3 sheet representing indicators and focus code: Emotional balance

- ✓ "The balance between being emotionally close and available and emotionally separate so as to preserve the independence"(Participant 6;32-40)
- ✓ "Position yourself somewhere in the middle" (Participant 7; 162-170)
- ✓ "Making space for yourself" (Participant 4; 146-150)
- ✓ "You accumulate other people's stuff, just putting filters in reverse and letting it go as well" (Participant 3;102-111)
- ✓ " I felt you know I should be aware of my limitations" (Participant 2; 384-387)
- ✓ "Recruit my internal supervisor" (Participant 1;470-475)
- ✓ "Regulate myself" (Participant 9; 241-250)
- ✓ "Regulate the self" (Participant 10; 240-250)
- ✓ "To feel these emotions, contain these emotions" (Participant11; 127-133)
- ✓ "I'll be able to pick up the pieces and stay with her pain" (Participant 3; 79-80)
- ✓ "The problem I think for therapists is how do you position yourself between being so insensitive that you can't feel anything or being completely swamped by people's emotions to the extent that you can't actually be therapeutic, because you're swamped with something terrible that they're experiencing". (Participant 7: 182-187)
- ✓ "Directed in the sense of trying to make sense of the things, not just being lost in the emotion, but thinking about the story, if one's going through a story, re-experiencing" (Participant 7: 220-222)
- ✓ "That's, er, I always think that's a good response, to be moved by it and not swamped as I said before. It's being moved but not swamped".(Participant 7;387-388)
- ✓ "preserve one's sense of being as a therapist it's necessary to have a distance er that er er ensures that you don't get so enmeshed with what's going on, that you cease to be of relevance of use, of value, of, of objectivity so it's that sort of difference, that balance that seems to me to be important" (Participant 6 ;87-91)
- ✓ "and not to get, to run the risk of becoming disabled by what's going on" (Participant 6: 258).
- ✓ "And for me, a good therapist with a lot of experience, it's someone who can be in this therapeutic relationship and acknowledging" Participant 9;176-177,
- ✓ "built up over that time a considerable emotional closeness but taking account of the nature of what's being dealt with a) I haven't experienced it obviously and b) um I need to maintain a stability of my own so as to be helpful um and thus I need to avoid getting so

engrossed with what she's bringing into the process that it becomes disabling so" Participant 6; 123-130)

A3 sheet representing indicators and focus code: EI definition validation

- ✓ "Absolutely there is a link what therapist do with Emotional intelligence concept" (Participant 12;140-143)
- ✓ "The idea of emotional intelligence is relevant (Participant 3; 624-628)
- ✓ Absolutely wait a minute we're psychologists and we're not talking about emotion (Participant 11;482-489)
- ✓ "Yeah, absolutely, yeah, and that was true of Golman's work, sure.(Participant 10; 366)
- ✓ So the answer to most emotional problems is to increase emotional intelligence. (Participant 10;357-359)
- ✓ Well, I'm agreeing with the definition (Participant 9; 542-545)
- ✓ EI it could be a means to an end (Participant 8; 580-586)
- ✓ EI is relevant to therapy. It might be a way of actually thinking about those people who might have problems as therapists (Participant 7; 612-616)
- ✓ Very true about what goes on, and probably not as overtly, sort of, aware of the description that you have there.(Participant 4; 246-260)
- ✓ Well I don't think there is any doubt (Participant 5; 449-464)
- ✓ I think it encapsulates um fortunately more or less what I've been saying um so in that sense it's reassuring (Participant 6; 302-323)
- ✓ EI is fundamentally relevant to the therapeutic relationship (Participant 11; 195-213)
- ✓ "Yeah, I think there must be a link. Um, I wouldn't know exactly what it is, but it's probably being comfortable with emotions and not running away from it and trying to explain it, denying it in people or being afraid, it's just allowing emotion and that starts off with allowing it in oneself, and recognising in oneself" (Participant 3; 802-806).
- ✓ I would say it relates like yeah that it's quite fundamental really (Participant 1; 693-697)
- ✓ To a certain degree there could be (Participant 2; 766-772)
- ✓ "Hugely relevant…this is you know sort of standard stuff but this is absolutely essential" (Participant 5; 329-332)
- ✓ "people's emotional experience. So I think yeah it's, it would be a good thing I, I think that would be useful for training programmes" (Participant 1; 913-914)

A3 sheet representing indicators and focus code: Therapist learning - supervision

- ✓ An external observer you know either monitor my work and gets to know me(Participant 2; 689-683)
- ✓ The supervisor or someone who works with (Participant 8; 669-671)
- ✓ I remember needed to call my supervisor or ex colleague to be able to express how I felt (Participant 9; 236-237)

- ✓ supervision is quite important (Participant 6; 186-190)
- ✓ "Sometimes it was hard to just have space to reflect about it and think about it erm you know therapeutically erm but with the help of supervision"(Participant 2; 456-458)

A3 sheet representing concept: indicators and focus code for emerging main category (Subtle attributes and competencies in therapy process).

A3 sheet representing indicators and focus code: Trust
- ✓ "some form of trust that is created you know between two people erm and one person who is more, in a more vulnerable position is able to trust me as a person who has the qualification experience (Participant" 1, 44-48)
- ✓ "I find the therapeutic relationship incredibly important in terms of, er, building trust and, um, rapport". (Participant 4;28-30)
- ✓ "one way of having a relationship where people feel comfortable about telling you about what, er, they're actually thinking and feeling during the sessions that they have" (Participant 7; 147-149)
- ✓ "about whether or not they can trust you to tell them the truth and to be kind while you do it" (Participant 12; 58-60)
- ✓ "People they should invite you and you should win the trust to be invited" (Participant 5; 133)
- ✓ "as she tried to engage, and her terror was in the way, so then we talk about, "Okay, well, there's this terror in the way, you keep defending yourself, you keep fighting me. I'm on your side, you don't need to fight me." Now when she saw that, that it wasn't me, you know, that she could come toward me and I wasn't going to change, I wasn't going to judge her, I wasn't going to defend myself, I wasn't going to do any of these things, then she started to relax. And now she can bring her worst here, and so the trust developed." (Participant 12; 83-90)

i.   **A3 sheet representing indicators and focus code: Been Present**
- ✓ "Be there is just you know physically present erm you know reliable manner because I'm there week after week at a particular time, consistent erm be there in a sense that I'm engaging with him and responding to what he is saying whether it's verbally, whether it's not verbally". (Participant 2, 59-62)
- ✓ "And there's something very kind of holding or containing you know about that relationship because I'm there for someone in a reliable manner" (Participant 2; 76-78)
- ✓ "and weirdly you do almost nothing except just be present and just be conscious of what she's actually feeling, and there's always another bit of me that's aware of this" Participant 3; 117-123)
- ✓ "it's a sounding board; it's a way of helping them to see what they're actually feeling and doing, probably doing as a consequence." (Participant 3; 29-34)

- ✓ "The focus is always on the patient, not on you even, even though you are thinking what's happening to me, what's happing to me, what's happening to the patient, what's happening between us in a space between" (Participant 11; 110-115)
- ✓ "is being sensitive to the client's needs as mum or the good attachment figure ought to be to the child's needs" (Participant 8; 40-43).
- ✓ "But being very, very still and very, very much present" Participant 11; 126-127)
- ✓ "Well I think it's just you know being, being present with the client and, and attending to their needs you know finding out what they need" Participant 8; 211-213)
- ✓ "to be present with her while she struggles with her reality of that so that's what I mean." (Participant 8; 163-165)
- ✓ "the ability to stay immovably present and keep trying to tune in to the chaoticness of the patient" Participant 10; 237-238).
- ✓ "I'm there for someone in a reliable manner". (Participant 2, 75-78)
- ✓ And my ability also knowing not to push her when she was not ready but to stay with where she was. (Participant 2, 241-243).
- ✓ "…as I'm the one that's, sort of, trying to make her change or the one that's losing interest in her and therefore is abusive towards her, you know, so, er, I suppose like that." (Participant 4; 92-94)
- ✓ "engaged in thinking about what it feels like to have that kind of problem as well as trying to understand how people think about it, which is, kind of, those two things and what they're doing about it".(Participant 7: 380-383)
- ✓ "the empathetic response and trying to understand correctly, rather like Beck says, um, that old native American expression, "You can't understand me unless you've walked in my moccasins for a fortnight."(Participant 7: 438-440)
- ✓ "but always present in, in the process and ready to work with what, what is there… just being able to be, to be present and to hold what is, what is um brought into the process."(Participant 6; 210-217)
- ✓ "a therapist who is a non-reactive, who just sits there and maintains connection and doesn't move and is just open and available and "okay, so you don't like me today, that's fine".(Participant 10; 229-232)

ii. A3 sheet representing indicators and focus code: Connection
- ✓ "You attune to what someone needs of you. Er you attune to what he's capable of doing or not capable of doing at a specific period time" (Participant 2; 289-286)
- ✓ "being able to (long pause) be really be in her shoes or his shoes erm." (Participant 5; 66-67)
- ✓ "But for me, the key route is attunement." (Participant 12; 110)
- ✓ "You have to make a connection. And that connection is subtle. Er it's not just an intellectual connection, it's not just a

meet in a pub and have a friendly conversation connection it's actually got to be um a meeting on some kind of emotional level. "(Participant 11; 31-35~)

✓ "connecting and um and that I'd say …" (Participant 1; 423-425)

✓ **"I tend to be warm, open, active, positive and let's connect, let's understand"** (Participant 10; 110-112)

✓ So its what you say, the way that you say you know your body language as well erm your ability to listen and to empathise. (Participant 2; 315-320)

✓ "I'm trying to help them to see what's going on and I think once people see what's going on they start to be able to recognise in themselves how it feels when that happens and make those connections," (Partcipant 3; 54-59)

✓ to build a therapeutic alliance and to maintain that there has to be a degree of emotional closeness, emotional availability (Participant 6: 81-84)

✓ "For me, I lived two years in a Buddhist Monastery with monks and I think, for me, spirituality it's being connected with myself and what's going on for me, and being able to connect with someone else."(Participant 9; 67-75)

✓ "spirituality again it's about being in a relationship, being connected, but also being connected truly with myself and other person"(Participant 9; 77-79).

✓ "trying to create a bridge between" (Participant 9;135

✓ "is being sensitive to the client's needs as mum or the good attachment figure ought to be to the child's needs" (Participant 8; 40-43).

✓ "yeah so being able to engage with what's going on and in the here and now but relate it to the past" (Participant 8; 230-325).

✓ **"**but then when I met her it felt like I was able to reassure her and it felt like we were able to make that connection" Participant 1; 553-555)

iii. A3 sheet representing indicators and focus code: Empathy

✓ I think that to empathise but in a sense that you can really well to a certain degree understand what the client is experiencing erm is important and the ability to afterwards make sense of it and you know let the client know what is happening(Participant 2;280-283)

✓ "probably a lot of times empathising with her and you know with her pain and being able to understand about"(Participant 2; 241-247)

✓ "I just suddenly thought god you know I really, I really know how you're feeling well as much as you know I've, I've felt like you're looking at the moment and um and I guess I was just" Participant 1; 405-409)

✓ "is being sensitive to the client's needs as mum or the good attachment figure ought to be to the child's needs" (Participant 8; 40-43).

- ✓ **"I tend to be warm, open, active, positive and let's connect, let's understand"** (Participant 10; 110-112)
- ✓ So its what you say, the way that you say you know your body language as well erm your ability to listen and to empathise. (Participant 2; 315-320)
- ✓ So in that way the emotional engagement has been very important(Participant 6: 121)
- ✓ "I think, um, er, *an honesty* and empathetic approach, I guess, um, openness, a willingness, um, an honesty, um, a genuineness", (Participant 4; 128-130)
- ✓ "stuff on empathy, warmth, genuineness". (Participant 7; 287)
- ✓ "Therapists without empathy I think are ineffective".(Participant 7:297-299)
- ✓ "the empathetic response and trying to understand correctly, rather like Beck says, um, that old native American expression, "You can't understand me unless you've walked in my moccasins for a fortnight."(Participant 7: 438-440)
- ✓ "I feel a great deal of empathy um a great deal of pain depending on what's going on and concern because this particular person has been and is from time to time still very very close to the edge" (Participant 6;162-164)
- ✓ "is being sensitive to the client's needs as mum or the good attachment figure ought to be to the child's needs. That's how I see it today in rather simplistic terms"(Participant 8; 41-43)
- ✓ "it's just about acknowledging how they feel, sort of not asking them how they feel because that suggests you don't know, but sort of reflecting how they" (Participant 3; 273-275)

iv. A3 sheet representing indicators and focus code: Good Listening
- ✓ "You attune to what someone needs of you. Er you attune to what he's capable of doing or not capable of doing at a specific period time" (Participant 2; 289-286)
- ✓ "Oh yeah we need to be able to listen to someone erm (pause) and to be able to obviously communicate particular something's with the client in a way that will not be you know judgmental" (Participant 2; 314-317)
- ✓ "simply being there um to … as somebody that can listen when somebody's in distress" Participant 1; 341-345)
- ✓ So its what you say, the way that you say you know your body language as well erm your ability to listen and to empathise. (Participant 2; 315-320)
- ✓ "willingness to hear it" (Participant 1; 119)

v. A3 sheet representing indicators and focus code: Openness
- ✓ So its what you say, the way that you say you know your body language as well erm your ability to listen and to empathise. Erm understand what is going on with the client's needs. It's important also in all sorts of ways to convey to the client erm you know that he mentions that you know he's important (Participant 2; 315-320)

- ✓ "Um (pause) I think being open, yeah, and willing to accept, er, mistakes, or be willing, being open to look at everything that goes on" (Participant 4; 122-123).
- ✓ "quite sort of open and reassuring um in contract may be to a sort of blank slate to" (Participant 1; 86-90)
- ✓ "Um, I think it's important to be honest, to be open, um, to be willing, to look at aspects of yourself, I guess, as well" (Participant 4; 115-117).
- ✓ "I mean, certainly the way I work is I do tend to, sort of, work in a more open way, I suppose, a more warm way, um, which I guess, for me, sort of, works quite well because it helps them to build trust".(Participant 4; 117-120
- ✓ "I think, um, er, *an honesty* and empathetic approach, I guess, um, openness, a willingness, um, an honesty, um, a genuineness", (Participant 4; 128-130)
- ✓ "Um, the fact that one has a therapist and can be open about it helps" (Participant 7; 156).
- ✓ "Er, one of the main (sighs) who (pause) … well, for me, it's, er, one of the major, it's not being defensive". Participant 9; 201-203)
- ✓ So in that way the emotional engagement has been very important(Participant 6: 121)
- ✓ "..which is about being non defensive" (Participant 9; 206;210)
- ✓ "I tend to be warm, open, active, positive and let's connect, let's understand" (Participant 10; 110-112)
- ✓ "a therapist who is a non-reactive, who just sits there and maintains connection and doesn't move and is just open and available and "okay, so you don't like me today, that's fine".(Participant 10; 229-232)
- ✓ "Well immovability and openness, you know constancy and erm, you know that is containing"(Participant 10; 233-235)

vi. **A3 sheet representing indicators and focus code: Courage /risk**
- ✓ "Um, I think it's important to be honest, to be open, um, to be willing, to look at aspects of yourself, I guess, as well" (Participant 4; 115-117).
- ✓ "resilience um because a lot of as you know the therapeutic process is about being resilient, whether it's resilience to um being able to manage other people's distress or to be able to hold a process or to be able to um deal with um er strong counter transferences"(Participant 6; 368-371)
- ✓ "as she tried to engage, and her terror was in the way, so then we talk about, "Okay, well, there's this terror in the way, you keep defending yourself, you keep fighting me. I'm on your side, you don't need to fight me." Now when she saw that, that it wasn't me, you know, that she could come toward me and I wasn't going to change, I wasn't going to judge her, I wasn't going to defend myself, I wasn't going to do any of these things, then she started to relax. And now she can bring

her worst here, and so the trust developed." (Participant 12; 83-90)

✓ "I think a lot of clients have to have a lot of grieving that they have to do and back to taking a risk that question I think part of what's risky in this process is you know helping a client move to a place where they're able to look back on their lives and see" Participant 8; 218-226)

✓ "Courage. (Pause). That's the primary quality. I think courage to get out of the way of the processes between you and another person." Participant 12; 191-195)

✓ "it's two very brave people trying to be honest with each other" (Participant 12; 40-45)

✓ "Um and then encouragement so something about being the person that it's often talked in terms of one foot in the whole and one foot on the side sort of thing so being the person that is able to hold some of the hope that, that the, the patients not currently able to hold themselves"(Participant 1; 350-355).

✓ "if I'm addressing the issue of risk exactly but it, it has to do with all of that of you know not knowing where this path is going to lead".(Participant 8; 156-159)

✓ "The primary way is just being, being willing to say things that not necessarily the client doesn't want to hear but that aren't necessarily easy to say. Um being willing to go into unknown territory".(Participant 8;141-146)

✓ "the ability to stay immovably present and keep trying to tune in to the chaoticness of the patient" Participant 10; 237-238).

✓ The fact that we could actually address the fact that he was so angry about what had happened.(Participant 7; 98-100)

✓ "the first I think um I've learned the value of um taking risks um and measured risks and it … of, of course it's always difficult to be absolutely confident that you've taken the right amount of risk and not too much".(Participant 6; 180-183)

✓ "unless some risk is taken carefully measured as it is then there is less likely to be the progress that needs to be made particularly with this particular person who needs to deal with the experience that she's had by er recounting it for the first time in thirty years and being able then to understand it and to let go of it" (Participant 6; 188-184)

✓ "For example, last week I was working with an anorexic, she's very, very skinny, and she was, er, raging, really, like, a primal rage, you know, shouting and being very angry and I was seeing her shouting at me, and, um, I had inside of me a feeling of extreme fear".(Participant 9; 163-167)

✓ maybe the first time in their life, then they shout Or they express their rage because they've never been able to express their rage to their parent or to their ex partner or so on, which is about being non defensive but also providing what's" Participant 9; 206;210"

vii.   A3 sheet representing indicators and focus code; Honesty

✓ "Um, I think it's important to be honest, to be open, um, to be willing, to look at aspects of yourself, I guess, as well" (Participant 4; 115-117).

- ✓ "I think, um, er, an honesty and empathetic approach, I guess, um, openness, a willingness, um, an honesty, um, a genuineness", (Participant 4; 128-130)
- ✓ The fact that we could actually address the fact that he was so angry about what had happened.(Participant 7; 98-100)
- ✓ **"**But it was something about telling her what I thought truthfully and telling her what I felt truthfully" (Participant 11; 53-56)
- ✓ "If you lie to a child, it simply stops listening. That's all. It will very rarely talk back to you or tell you, or even acknowledge inside the child that it's stopped listening. And the only way you can engage with a child is to be really honest with a child. To be really authentic" Participant 12; 91-99)

viii.   A3 sheet representing indicators and focus code: Authentic

- ✓ **"I had to take a risk** and told he wanted me to hate him, he did not want to empathise and care and that **truthful stand** had made all the difference in therapy".(Participant 2; 354-368).
- ✓ And the only way you can engage with a child is **to be really honest** with a child. **To be really authentic.** (Participant 12; 83-97).
- ✓ "being careful here in a way that to a certain degree her parents might care about you know a child and do a different kind of job than them" Participant 2; 241-247)
- ✓ "The primary way is just being, being willing to say things that not necessarily the client doesn't want to hear but that aren't necessarily easy to say. Um being willing to go into unknown territory".(Participant 8;141-146)
- ✓ "as she tried to engage, and her terror was in the way, so then we talk about, "Okay, well, there's this terror in the way, you keep defending yourself, you keep fighting me. I'm on your side, you don't need to fight me." Now when she saw that, that it wasn't me, you know, that she could come toward me and I wasn't going to change, I wasn't going to judge her, I wasn't going to defend myself, I wasn't going to do any of these things, then she started to relax. And now she can bring her worst here, and so the trust developed." (Participant 12; 83-90)
- ✓ "I guess to be quite, what I say would be quite solid in yourself, you know, er, to have a good knowledge of yourself, I suppose, and your, um, weak points maybe"(Participant 4: 110-112)
- ✓ "I think, um, er, *an honesty* and empathetic approach, I guess, um, openness, a willingness, um, an honesty, um, a genuineness", (Participant 4; 128-130)
- ✓ " Congruent, integrity, generosity, (long pause) talking, (long pause) patience and perseverance".(Participant 5; 225-230)
- ✓ "If you lie to a child, it simply stops listening. That's all. It will very rarely talk back to you or tell you, or even acknowledge inside the child that it's stopped listening. And

the only way you can engage with a child is to be really honest with a child. To be really authentic" Participant 12; 91-99)
- ✓ "stuff on empathy, warmth, genuineness". (Participant 7; 287)
- ✓ but I genuinely want to feel how that is for that person, so that I can actually resonate it, I actually feel it with them for a while, … you have to be aware of what people are feeling but you can't sort of lose it, you can't sort of just sit there being sympathetic." Participant 3; 97-105)

A3 sheet representing indicators and focus code: role of therapist.

i. **Role of therapist**
- ✓ "and there is something also to a certain degree quite paternal in the relationship because you're you know me, myself as a therapist I am in a kind of more powerful positon" (Participant 2; 92-95)
- ✓ "I might be perceived as the parent, the client might experience me as a parent in you know all sorts of situations erm and as a good enough mother"(Participant 2; 98-104)
- ✓ "the good attachment figure ought to be to the child's needs. That's how I see it today in rather simplistic terms"(Participant 8; 41-43)
- ✓ Well immovability and openness, you know constancy and erm, you know that is containing, and that's all, that's what babies need they need a mother that sits there and doesn't move they go and explore and come back and so the atonement is maintained which is what containment is, it the ability to stay immovably present and keep trying to tune in to the chaoticness of the patient" (Particpant 10 233-238)
- ✓ "there were certain lets say anger was not really allowed in relationship with the mother that was not strong enough to contain or so all of sudden if it becomes er a possibility in the room or in the relationship between myself and the clients" (Participant 2; 302-306)
- ✓ "so I guess thinking about that relationship with her then the … one of the ideas would be that they could have a different sort of relationship that would be healing of, of past um unhelpful relationships um and that then she would gain the confidence through that to realise that re… different sorts of positive relationships were possible". (Participant 1; 299-304)
- ✓ "the role of a psychologist as well of particularly the sort of clarification part. I guess you might think of it as may be like a parent and a child and a parent being there to explain to the child kind of how the world is and why things are as they are and when things go wrong helping the child to sort of make sense of them that sort of thing."(Participant 1; 336-341)
- ✓ "So in terms of my role with her I think first of all it's to validate her perception that yes she probably did some things to … that were wrong um" (Participant 8; 62-64)
- ✓ "that she could come toward me and I wasn't going to change, I wasn't going to judge her, I wasn't going to defend myself, I

wasn't going to do any of these things." (Participant 12; 83-90)

- ✓ "I guess, is that I represent her, um, abusive father sometimes, you know, someone who is quite controlling of her, as a child, and so sometimes she will see me as controlling of her, er, particularly when I'm trying to" (Participant 4; 77-81)
- ✓ "I put my therapist hat, I'm quite by nature, I've a high positive regard about my client, because when I'm working with very, very disturbed clients"(Participant 9; 501-504)
- ✓ "because I'm attuned to that patient, I'm not the same with everybody." (Participant 12; 40)
- ✓ "I'm playing a role of being immoveable, unshockable, wholly reliable and always there … I don't mean always there but always present in, in the process and ready to work with what, what is there"(Participant 6; 209-212)
- ✓ "I changed myself in this role, and I think when you start off, often the feeling is you're trying to help people but actually I've learnt that if you allow people to just be and accept them they find their own way of accommodating what's happened to them," Participant 3; 81-8

A3 sheet representing indicators and focus code: Containment

- ✓ "that the therapist is self contained, that the therapist is reasonably at ease with themselves, not too easily upset by either the emotions of the patient, or comments that the patient might make or the attacks the patient might make"(Participant 11; 99-103)
- ✓ "Well immovability and openness, you know constancy and erm, you know that is containing, and that's all, that's what babies need they need a mother that sits there and doesn't move they go and explore and come back and so the atonement is maintained which is what containment is, it the ability to stay immovably present and keep trying to tune in to the chaoticness of the patient" (Participant 10; 233-238)
- ✓ "To feel these emotions, contain these emotions so that at the end of the session she could leave in one piece"(Participant 11; 146-147)
- ✓ "I said earlier you've got to be able to contain your feelings when you're being attacked by a patient or taken by surprise by the patient or the patient's feelings are overwhelming". (Participant 11; 208-210)
- ✓ "With the angry wife and abused daughter I think I was pretty good at putting it out of mind…that one I think was too close to the bone for me. I mean I was sexually abused erm um"(Participant 5; 291-297)
- ✓ "I see my job as helping them come to terms with that thing so in a way you have to be a bit stronger about it than whatever it is, you have to contain it somehow in yourself."(participant 3; 104-107)
- ✓ "you have to be comfortable with people's emotions and that means with your own, so I actually get quite moved by a lot of what people tell me, but I don't say anything more about it,"(Participant 3; 285-289).

- ✓ "balance between being emotionally close and available and emotionally separate so as to preserve the independence" (Participant 6; 70-71)
- ✓ "I need to avoid getting so engrossed with what she's bringing into the process that it becomes disabling so I think that's a good example of how that balance is struck and, and maintained er sometimes you know with more or less ease"(Participant 6; 127-131)
- ✓ "not just being lost in the emotion, but thinking about the story, if one's going through a story, re-experiencing" (Participant 7:220-222)
- ✓ "But it's something that is created in me, which is partly what they, um, they have in themselves, that they don't want or they try and project onto me to try and … to hold for them" (Participant 4; 59-62)
- ✓ "I think it's very important to, I guess to be quite, what I say would be quite solid in yourself,"(Participant 4; 110-111)

A3 sheet representing indicators and focus code: Reflective Practice

- ✓ "I think it's very important to, **I guess to be quite, what I say would be quite solid in yourself, you know, er, to have a good knowledge of yourself,** I suppose, and your, um, weak points maybe. Um, I guess that's why I see, you know, **being in therapy** … **the therapist to be in therapy themselves is also quite important**.(Participant 4; 110-125)
- ✓ "I reflect on that and it can be completely different to actually my interpretation of them. But it's something that is created in me, which is partly what they, um, they have in themselves," (Participant 4; 57-62)
- ✓ Um, particularly when, you know, you do get some quite challenging work. (Participant 4; 110-125)
- ✓ "especially if you **reflect on the whole course of therapy** a lot of things that were communicated in the first telephone calls will make sense".(Participant 2; 159-165)
- ✓ "being a therapist then it's all to do with what's going on in the room um er rather than you know what er various learned texts might say".(Participant 6; 397)
- ✓ "emotions that other people have and to be able to understand them, to relate to them but also to be able to keep the space between one's own emotions and the emotions of the people that one's working with"(Participant 6: 266-270)
- ✓ "You know, it's an exercise in attunement. Our job as therapists is to feel where the person is when they come." (Participant 12; 20-24)
- ✓ "you're not going to suddenly get angry or suddenly get afraid, you're not going to deliver your own anxieties to this child or try and control him in some way" (Participant 12; 38-39)

A3 sheet representing indicators and focus code: Self –Reflection / practice

- ✓ "I reflect on that and it can be completely different to actually my interpretation of them. But it's something that is created in me, which is partly what they, um, they have in themselves," (Participant 4; 57-62)

- ✓ "an awareness of what those feelings are so with this woman that I first started talking about just er oh this is, the thoughts that I was having like oh this is really reminding me how difficult this is going to be"(Participant 1; 550-553)
- ✓ "And as I've said before, that stepping back and thinking about, "Why am I feeling like this when I'm working with someone?" um, is an important issue" (Participant 7; 430-435).
- ✓ "And for me, a good therapist with a lot of experience, it's someone who can be in this therapeutic relationship and acknowledging" (Participant 9; 176-179)
- ✓ how is envy different from jealousy and you know a whole range of you know knowing what they are and then understanding how they're transacted in a relationship and how you spot what's going on, you know and how you feel what is happening and label it correctly so you can respond correctly, but that requires mindfulness, you have to pay a lot of attention to it" (Participant 10; 294-300).
- ✓ "some sort of unconscious communication that kind of things might have taken place for quite sometime before more erm reflective kind of understanding"(Participant 2; 274-276)
- ✓ "Er, then there is this, well, I think Patrick Casement will speak about internal supervisor" (Participant 9; 355)
- ✓ "it's about being aware of my emotional life and being also aware of trying to adapt myself to the emotional life of my client" (Participant 9; 437-441).
- ✓ "it's just about acknowledging how they feel, sort of not asking them how they feel because that suggests you don't know, but sort of reflecting how they" (Participant 3; 272-274).
- ✓ "if you think the unconscious processes I'm kind of communicating with what the clients might convey not in words so I might experience all sorts of experiences of feeling in the room that I might reflect on afterwards" (Participant 2; 64-68.

Focus code: Self-awareness

- ✓ Or the ability to really kind of reflect on what is happening you know erm in the session but I'm experiencing and being to make sense of that". Participant 2;292-297) "The key was, the in, for me was the insight that we were on the edge of a psychotic state" Participant 11; 157-159)
- ✓ "the ability to engage one's own emotions in a constructive" Participant 6; 326-327)
- ✓ " is to um be comfortable with who you are er by way of being aware of your own er personality" (Participant ;6 348 – 350)

A3 sheet representing indicators and focus code: Bodily, emotional and cognitive awareness

- ✓ "It was felt quite physical, um ... sense of stillness that I knew was very important, I could feel, feel it quite tight in my, in my back"(Participant 11; 152-153)
- ✓ "An emotion is something that I feel. I experience it at a vistral [ph] level. I feel it in my body. I also experience it cognitively (long

pause). But it's got far, far more impact as the vistral [ph] level (long pause). And the meaning it's got for me (long pause) is so important"(Participant 5; 233-237)

✓ "all that just whizzes around in your mind as you're trying to find the way to let this person out of whatever it is, you know, um, but your body is telling you really what the feelings are," (Participant 3; 307-310)

✓ "what we call emotions are a complex of, kind of, um, thinking, feeling, behaving and physical sensations. It's … they're not really just a simple thing that you can label with a word, it's often they're much more complicated than that." (Participant 7; 310 -314)

✓ "what's going on is I'm feeling what I'm feeling and then there's a, kind of, a cognitive commentator who's watching the feelings, watching what's going on in my body, watching what's going on in my emotional centre, in my heart," Participant 12; 321-324)

✓ "I suppose it is a sort of um it's a sort of bodily, it's a sort of feeling, it, it … at that, at that level but also to a sort of cognitive level that it goes hand in hand really" (Participant 1; 480-483)

✓ "I think the mind body system is one system, so I don't think one can really separate it out. I mean the cognitive bit of me was in a panic trying to think of something to say, you now, the fight flight stuff was going on in the body, and also there's a certain amount of "fucking bitch, Jesus I hate you".(Participant 10 ; 212-216)

✓ "it will be often physiological, which means, um, an example, if I'm scared I will start to feel a bit more" (Participant 9; 332-334)

✓ "No it was a very kind of bodily, emotionally a lot of time you know. Sometimes it can be cognitive you know sort of in the sense of you know I might feel lets say inadequate and nothing that I do is good enough" (participant 2; 227-231)

✓ "it's probably more cognitive, um, but it's also when I'm aware of the, you know, bodily feelings as well, you know, the tension or different feelings in myself" (Participant 4; 216-218)

✓

A3 sheet representing indicators and focus code: Feelings v Emotions

✓ "In English we don't even, we use feelings or emotions almost as if they mean the same thing and maybe they don't but it's actually appearing to tune into the feelings of the patient but for the patient is the key for therapeutic relationship"(Participant 11; 36-39)

✓ "I like a distinction that [unclear-15.33] makes between feelings and emotions. Feelings are something we have so I'm feeling angry, I know that I'm angry, I know why that I'm angry and I'm not out of control. And an emotion is something that has us, completely lost control, emotion wells up from somewhere and we can't regulate it or not easily" (Participant 11; 225-229)

✓ "The emotions are probably more primitive yeah. They're certainly more unconscious."(Participant 11; 237-238)

✓ "emotions I think are evolved functions, they're present in all mammals pretty much, erm, they're quite elaborated in human beings because we have a complex symbolic language with this to elaborate our emotion but fight, flight the fear anger system is present in all mammals" (Participant 10;241-245)

A3 sheet representing indicators and focus code: Feelings and Cognitive Awareness

- ✓ "The patient has in some sense to feel understood and the job of the therapist is to check that that understanding is going on, and that understanding is always going over a feelings level as well as an intellectual level".(Participant 11; 39-42)
- ✓ "I'm may be feeling something along the lines of, of what they're talking about and what they're feeling so there's something at that very sort of primal level but then there's also what, what feels like the sort of cognitive" (Participant 1; 494-497)

A3 sheet representing indicators and focus code: Spirituality

- ✓ "spirituality is a good one…how can we quantify if it's not true behavioural attitude in the room and I think it would take some of them, then we will cluster as, "Well, this is the concept", or, "It's a representation of spirituality."(Participant 9; 571-576)
- ✓ ." I think, for me, spirituality it's being connected with myself and what's going on for me, and being able to connect with someone else (Participant 9; 69-71)
- ✓ "some sort of unconscious communication that kind of things might have taken place for quite sometime" (Participant 2; 274-276)
- ✓ "what we call emotions are a complex of, kind of, um, thinking, feeling, behaving and physical sensations. It's … they're not really just a simple thing that you can label with a word, it's often they're much more complicated than that." (Participant 7; 310 -314)
- ✓ "I think that to call a therapeutic relationship it's a sort of therapeutic relationship level eight sort of, kind of level" (Participant 5; 44-46)
- ✓ "A relationship has a life of its own" (Participant 12; 72-75)
- ✓ "but I mean a lot of emotional communication is unconscious" Participant 10; 275-276)

A3 sheet representing indicators and focus code: competencies learned via experience

- ✓ "because it's very tempting and I've been practising for about twenty years so this actually is interesting because it made me look back to how I changed myself in this role,and I think when you start off, often the feeling is you're trying to help people but actually I've learnt that if you allow people to just be and accept them they find their own way of accommodating what's happened to them, even if it's painful and difficult, and it might take time" (Participant 3; 78-90)
- ✓ "you might not be able to understand it when you just take the call **but if you have you know knowledge er from, that you gain later on in therapy experience** it will be a very meaningful encounter".(Participant 2; 159-165)
- ✓ "and I think at the beginning when we practice, there is that internal supervisor, "Am I doing this right, is this going okay?" But I've been doing this for a long time and it is not there, and whenever it is, it wrecks things".(Participant 12; 113-114)

- ✓ "being a therapist then it's all to do with what's going on in the room um er rather than you know what er various learned texts might say".(Participant 6; 397)
- ✓ Anyway having done all, all of that at, at … I trained oh ten years ago I suppose in cognitive analytic therapy and during that time I've um obviously worked in that discipline (Participant 6; 41-44)
- ✓ "The therapeutic relationship, in my experience of 15 or 20 years of doing this, happens within the first three minutes. ("Participant 12: 20)

A3 Sheet representing indicators and focus code: Supervision / Therapist training learning

- ✓ "one to one supervision um it's, it's of great value to me to be able to express my own feelings and to receive some reassurance about what's going" (Participant 6; 186-187)
- ✓ "I have an external supervisor that I take my work to after the fact. (Participant 12; 113-114).
- ✓ "My ability to work as a psychologist, I think the best way is if an external observer you know either monitor my work and gets to know me"(Participant 3; 691-693)
- ✓ "That's why I'm always in favour of everybody having supervision"(Participant 7; 560)
- ✓ "I remember needed to call my supervisor or ex colleague to be able to express how I felt" (Participant 9; 236-237)

A3 sheet representing indicators and focus code: Trait EI test discredited

- ✓ "I think the, I'm not sure what the test was actually trying to achieve in the end because I think that it's included areas that probably belong in another dimension and that dimension might be introversion".(Participant 11; 257-259)
- ✓ "Well I'm not sure they're all competencies, most of them are not actually. Self esteem and optimism and happiness are nothing to do with competencies. Um emotion management might be a competency, assertiveness is partly a competency. Sociability is not a competency. Um yeah so you can't call it competency" (Participant 11; 430-434)
- ✓ "No I'd just emphasise again that there were times where this was getting very close to emotions like introversion and it didn't seem to recognise that fact er because somebody's, somebody's too keen on introducing some concept in the organisation world and making a load of money and I wish I'd thought of it" (Participant 11; 563-567)
- ✓ "I find some of traits annoying and some of them are "oh they're fine", you know erm, I don't really know what... short of going through it trait by trait, I mean I think research has to find some kind of system to measure so you have define some kind of traits in order to have something to measure but how you decide what the traits is just an endless process" Participant 10; 381-391)
- ✓ "I mean that is crazy, I didn't answer it like that, I don't know what's happened with that questionnaire, I mean with that question, I mean that makes no sense at all, so I don't know whether I answered it wrong, you know filled in the wrong blob or something." Participant 10; 407-411)
- ✓ "I didn't recognise myself, there were criteria or there were scores than, I'm sure, would have give to my best friend, or people who know me would have said, "No, it's not you." (Participant 9; 451-453)

- ✓ "I'd probably want to rework the questionnaire slightly because I think it sounds as if it's been designed as a general assessment and it isn't quite there for the relationship, the therapeutic relationship assessment," (Participant 3; 738-741)
- ✓ "No I read it before I came to remind myself. There are certain things that I could relate to but others" (Participant 2; 546-547)
- ✓ "No it does it all by itself no, no. I think it will be really limiting" Participant 2; 657)
- ✓ "I'm perceiving that therapy and supervision to have more value for therapist learning that this test"(Participant 2; 684-687)
- ✓ "I just thought god nobody would have wanted to have these scores not in my job you know." Participant 1; 766-767)
- ✓ "didn't um feel so much like this was a particularly good or true representation of me but I don't know maybe it was just the way I read it. I suppose I also looked at the scores as well and so they looked like really low scores" Participant 1; 828-831)
- ✓ "I did like the comment at the back that says these scores suggest that the participant might have been throwing the scores. (laughs) Right well yeah I probably could if I wanted to you know anyway "(Participant 8; 500-503)
- ✓ "some of those questions are, "How capable do you feel about your ability to control other people?" You didn't ask me if I wanted to control them. I have no desire to control other people. I wouldn't begin to try. It's a non-question. And actually, if I was given to being pissed off, I'd probably get quite pissed off with that." (Participant 12; 460-463)
- ✓ "I don't see that this instrument measures a person's ability to put themselves in another person's shoes"(Participant 12; 502-504)
- ✓ "And it doesn't measure that capacity for empathy. It keeps … the instrument keeps it on a theoretical level, it's about what people say, it's not about what they do… I can feel whether someone's narcissistic need for validation is getting in the way in the room" (Participant 12; 505-507).
- ✓ "It's certainly not, um, in terms of my understanding of what's happening in terms of clinical and counselling courses at the moment"(Participant 7; 639-641)
- ✓ "This instrument er provides the agenda, this is sort of many, one of many, many that provides an agenda for discussion and for understanding." Participant 6; 407-409

Appendix 8 (B): Focus codes and variable gained from the open coding stage

- Empathy
- Attuned
- Dyadic resonance
- Expert
- Hope
- Resilience
- Optimism
- Supervision
- Reflective practice
- Experience
- Personal therapy
- Mindfulness
- Emotional awareness
- Training
- Motivation
- Healing
- Spirituality / Transpersonal/Intuition
- Coping
- Self-awareness
- Self reflection
- Context Perspective
- Connection
- Engagement
- Accepting
- Non judgemental
- Being present
- Honesty / Integrity
- Anger
- Fear
- Patience
- Role of Therapist
- Containment
- Parenting
- Acknowledgement
- Physiology / Emdodied
- Past-present-future
- Risk
- Trait EI discredited
- Willingness and Listening attentively
- Boundaries
- Experience
- **Trait EI in training**
- Bodily, emotional and cognitive experience
- Perseverance

Appendix 11: TEIQUE Inventory

		DISAGREE COMPLETELY						AGREE COMPLETELY
1.	I'm a follower, not a leader	1	2	3	4	5	6	7
2.	Those close to me often complain that I don't treat them right	1	2	3	4	5	6	7
3.	Many times, I can't figure out what emotion I'm feeling	1	2	3	4	5	6	7
4.	I couldn't affect other people's feelings even if I wanted to	1	2	3	4	5	6	7
5.	If I'm jealous of someone, I find it difficult not to behave badly towards them	1	2	3	4	5	6	7
6.	I get stressed by situations that others find comfortable	1	2	3	4	5	6	7
7.	I find it difficult to sympathize with other people's plights	1	2	3	4	5	6	7
8.	In the past, I have taken credit for someone else's input	1	2	3	4	5	6	7
9.	On the whole, I can cope with change effectively	1	2	3	4	5	6	7
10.	I don't seem to have any power at all over other people's feelings	1	2	3	4	5	6	7
11.	I have many reasons for not giving up easily	1	2	3	4	5	6	7
12.	I like putting effort even into things that are not really important	1	2	3	4	5	6	7
13.	I always take responsibility when I do something wrong	1	2	3	4	5	6	7
14.	I tend to change my mind frequently	1	2	3	4	5	6	7
15.	When I argue with someone, I can only see my point of view	1	2	3	4	5	6	7
16.	Things tend to turn out right in the end	1	2	3	4	5	6	7
17.	When I disagree with someone, I generally prefer to remain silent rather than make a scene	1	2	3	4	5	6	7
18.	If I wanted to, it would be easy for me to make someone feel bad	1	2	3	4	5	6	7
19.	I would describe myself as a calm person	1	2	3	4	5	6	7
20.	I often find it difficult to show my affection to those close to me	1	2	3	4	5	6	7
21.	There are many reasons to expect the worst in life	1	2	3	4	5	6	7
22.	I usually find it difficult to express myself clearly	1	2	3	4	5	6	7
23.	I don't mind frequently changing my daily routine	1	2	3	4	5	6	7
24.	Most people are better liked than I am	1	2	3	4	5	6	7
25.	Those close to me rarely complain about how I behave toward them	1	2	3	4	5	6	7
26.	I usually find it difficult to express my emotions the way I would like to	1	2	3	4	5	6	7
27.	Generally, I'm able to adapt to new environments	1	2	3	4	5	6	7
28.	I often find it difficult to adjust my life according to the circumstances	1	2	3	4	5	6	7
29.	I would describe myself as a good negotiator	1	2	3	4	5	6	7
30.	I can deal effectively with people	1	2	3	4	5	6	7
31.	On the whole, I'm a highly motivated person	1	2	3	4	5	6	7
32.	I have stolen things as a child	1	2	3	4	5	6	7
33.	On the whole, I'm pleased with my life	1	2	3	4	5	6	7
34.	I find it difficult to control myself when I'm extremely happy	1	2	3	4	5	6	7
35.	Sometimes, it feels like I'm producing a lot of good work effortlessly	1	2	3	4	5	6	7
36.	When I take a decision, I'm always sure it is the right one	1	2	3	4	5	6	7
37.	If I went on a blind date, the other person would be disappointed with my looks	1	2	3	4	5	6	7
38.	I normally find it difficult to adjust my behaviour according to the people I'm with	1	2	3	4	5	6	7
39.	On the whole, I'm able to identify myself with others	1	2	3	4	5	6	7
40.	I try to regulate pressures in order to control my stress levels	1	2	3	4	5	6	7
41.	I don't think I'm a useless person	1	2	3	4	5	6	7
42.	I usually find it difficult to regulate my emotions	1	2	3	4	5	6	7
43.	I can handle most difficulties in my life in a cool and composed manner	1	2	3	4	5	6	7
44.	If I wanted to, it would be easy for me to make someone angry	1	2	3	4	5	6	7
45.	On the whole, I like myself	1	2	3	4	5	6	7
46.	I believe I'm full of personal strengths	1	2	3	4	5	6	7
47.	I generally don't find life enjoyable	1	2	3	4	5	6	7
48.	I'm usually able to calm down quickly after I've got mad at someone	1	2	3	4	5	6	7
49.	I can remain calm even when I'm extremely happy	1	2	3	4	5	6	7
50.	Generally, I'm not good at consoling others when they feel bad	1	2	3	4	5	6	7
51.	I'm usually able to settle disputes	1	2	3	4	5	6	7
52.	I never put pleasure before business	1	2	3	4	5	6	7
53.	Imagining myself in someone else's position is not a problem for me	1	2	3	4	5	6	7
54.	I need a lot of self-control to keep myself out of tr							
55.	It is easy for me to find the right words to describe my feelings							
56.	I expect that most of my life will be enjoyable	1	2	3	4	5	6	7
57.	I am an ordinary person	1	2	3	4	5	6	7

Appendix 12: Facets of TEIQUE

The Adult Sampling Domain of Trait Emotional Intelligence

Facets	**High scorers perceive themselves as…**
Adaptability	…flexible and willing to adapt to new conditions.
Assertiveness	…forthright, frank, and willing to stand up for their rights.
Emotion perception (self and others)	…clear about their own and other people's feelings.
Emotion expression	…capable of communicating their feelings to others.
Emotion management (others)	…capable of influencing other people's feelings.
Emotion regulation	…capable of controlling their emotions.
Impulsiveness (low)	…reflective and less likely to give in to their urges.
Relationships	…capable of having fulfilling personal relationships.
Self-esteem	…successful and self-confident.
Self-motivation	…driven and unlikely to give up in the face of adversity.
Social awareness	…accomplished networkers with excellent social skills.
Stress management	…capable of withstanding pressure and regulating stress.
Trait empathy	…capable of taking someone else's perspective.
Trait happiness	…cheerful and satisfied with their lives.
Trait optimism	…confident and likely to "look on the bright side" of lif

CITY UNIVERSITY LONDON

Senate Research Ethics Committee

Application for Approval of Research Involving Human Participants

Return one original and 15 additional copies of the completed form and any

accompanying documents to Anna Ramberg, Secretary to the Senate Research Ethics

Committee, City Research Development and International Relations Office,

Northampton Square, London, EC1V 0HB.

Refer to the separate guidelines while completing this form.

PLEASE NOTE

- Please determine whether an application is required by going through the checklist before filling out this form.

- Ethical approval **MUST** be obtained before any research involving human participants is undertaken. Failure to do so may result in disciplinary procedures being instigated, and you will not be covered by the University's indemnity if you do not have.

- You should have completed <u>every</u> section of the form

- The Signature Sections <u>must</u> be completed by the principal investigator (the supervisor and the student if it is a student project)

Project Title:
Therapists experience of the therapeutic relationship and the role of emotional intelligence
Short Project Title (no more than 80 characters):
How qualified therapists experience the therapeutic relationship and how they comment on an emotional intelligence inventory.
Name of Principal Investigator(s) (*all* students are require to apply jointly with their supervisor and all correspondence will be with the supervisor):

Dr Don Rawson	
Post Held (including staff/student number):	
Research Supervisor for Professional Doctorate in Counselling Psychology and PhD	
Department(s)/School(s) involved at City University:	
Psychology	
If this is part of a degree please specify type of degree and year	
Post Chartered DPsych in Counselling Psychology	
Date of Submission of Application:30.01.09	
1. Information for Non-Experts	

Lay Title (no more than 80 characters)

Therapists' experience of the therapeutic relationship and its role with emotional intelligence theory.

Lay Summary / Plain Language Statement (no more than 400 words)

I am interested in knowing the therapists' experiences of the therapeutic relationship and their understanding of an Emotional Intelligence Questionnaire. The term therapist refers to counselling psychologist and other registered psychotherapists in the three main associations in the UK (the British Association for Counselling and Psychotherapy, British Psychological Society, and United Kingdom Council for Psychotherapy).

The specific aim is:

The ultimate purpose of this investigation is to create a link between research and practice in relation to the therapeutic relationship and the concept of Emotional Intelligence.

1. Explore the therapeutic relationship competencies as documented in previous research and its relationship *with Trait Emotional Intelligence concept (emotion-related traits and self-perceived abilities).*

2. Evaluate the Trait Emotional Intelligence Questionnaire (TEIQue) as reported by the co-researchers interview and consider its relevance in the therapeutic process.

3. Investigate the meaning of the therapeutic relationship as described by therapists and its links to existing therapeutic relationship competencies as reported in the literature.

4. Consider the relevance of the findings for developing a new theory and more enhancing counselling programs.

The results can provide further ground for exploring how the trait EI facets inform the therapy process and relates to existing documented evidence of competencies and skills in the therapeutic relationship process. This could have clear implications for the current counselling programs.

The sampling process continued until no new information came from the data. This included theoretical ideas and additional properties of the categories (Charmaz, 2006). It was found for interviews Participant 11 and 12 that no fresh information or questions emerged from the data and at this point it was considered that theory saturation had been reached. No further interviews were conducted.

Clark, A. E. (2003). *Disciplining reproduction; modernity, American life sciences and the problems of sex.* Berkely, CA: University of California Press.

Lempert, L. B. (2010). *Asking questions of the data: memo writing in the grounded theory tradition.* In A. Bryant, & C. Charmaz. (2010).*The Sage handbook of grounded theory.* London: Sage.

Morse, J. M. (2010). *Sampling in grounded theory.* In: A. Bryant. & C. Charmaz. *The Sage Handbook of Grounded Theory.* London. Sage.

Appendix 15: Example of a flip flop technique

Another characteristic pertaining to therapist and therapeutic relationship is "listening" which has the characteristics of being "good". To better understand what is implied by "good listening", we can ask the opposite. What would happen to the therapeutic alliance and its process when therapist are not listening? Would not listening make a difference in therapeutic alliance with the clients? Once we think through what "good listening" might mean, we can then return to our interview with more questions to ask about what "good listening" might mean in terms of level, type, and frequency of therapeutic relationship. Moreover, the concept "good listening" might have properties such as frame of therapy, model of therapy, experienced versus novel therapists. This raises other important questions. If good listening makes the therapeutic relationship better and why some therapists are not adopting it?

Focused code and concept: Validation of EI

Participant 10 reflected on the impact of cognitive behavioural therapy and the experiences of his clients who suffer due to inappropriate focus on emotions focus therapies. The participant indicated that he recognised how the client was feeling and that her needs was to express her feeling with another human who could empathise and connect within a therapeutic relationship. This may have reflected studies that the reciprocation and transferability of an empathetic relationship is more vital to the clinical outcome than the therapy itself (Orlinski, Grawe, and Parks, 1994). Rowan and Jacobs (2003) suggested that only through openly sharing can empathy be activated in the therapeutic relationship. This is particularly evident several examined cases of cognitive behavioural therapy, where the therapist's empathetic awareness and other EI competencies such as self-regulation of feelings, play a pivotal role in aiding trust and comfort in order for a patient's adequate recovery from issues, such as depression (Burns, Auerbach, 1996). Participant 10 also proposed that "you need emotionally intelligent people to be therapists". Participant's 10 narrative implies training for therapists on feelings and self-awareness rather that techniques.

> " I had a patient who came to see me the other day she had been to her doctor with anxiety and depression and the doctor had given her a CD-rom and said she had to come into the surgery once a week and work on the computer and that's your therapy, you now, she'd gone twice and then thinks fuck this and pay him money and she spent the whole hour crying about a whole bunch of stuff in her life "ooooh eeer", you can't cry with a CD, you know, you have to have a relationship you know that tunes in with "okay what's your trouble" and then out it comes. I mean that's why you need emotionally

intelligent people to be therapists, I mean how you define emotional intelligence may be this questionnaire is helpful, okay I don't know, maybe you can use that to shape up some training courses, maybe. You know, you could just get people read Daniel Golman's book and then decide and tell you what they thought of it, I don't know, it's a hard question to answer, I mean the government is always trying to come up with fool proof training programmes for everything. In the government as far as I can see doesn't believe in education as the Greeks developed it, Socratic dialogue all that stuff, all that important stuff upon which Western liberal democracy is being built is now being replaced with training workers to do specific kinds of jobs. You don't want to make them intelligent, you don't want to educate them because then they'll cause trouble and leave or go and do something else, so they want hip replacement surgeons to do just do 4 hip replacements a day until they retire, they don't give a shit about anything else, they're quite soviet in that regard. And the risk is that therapy goes the same way. If therapy becomes just a sausage factory in the NHS." (Participant 10; 526-550)

Participant 11 explained his belief that EI is "fundamentally relevant to the therapeutic relationship" and accentuates the importance as therapist to "contain your feelings when you're being attacked by a patient or taken by surprise by the patients overwhelming feelings". This is similar to Branch 4 of EI similarly refers to affect regulations and effective strategies to manage emotional states in oneself and others (Safran & Reading 2008; Schore 2003). Participant 11 suggested that any prospective candidates wishing to train in psychotherapy or counselling psychology should be:

"high on these kind of perceptions empathy, relationships, self control, regulation, low impulsivity, stress management" (Participant 11; 276-283)

Participant's 10 coincides with the two branches of EI, emotional perception and emotional integration, both branches commonly describe empathy. These requires a therapist to feel and share another person's emotions and having a sense of what it's like to experience that feeling but without losing

the focus of a separate self so we can help the other. Similarly the explanation could imply reflective functioning (Fonagy, Steele, Steele, Moran and Higgits 1991) and is also akin with the EI third branch as it involved the capacity for understanding mental states.

Participant 4 suggested that the process in her therapeutic interventions is to evaluate what is happening with a client internal mental state, regulate her reactions and reflect on her own work. This may also imply represent the first branch to the MSCEIT measurement scale and EI construct of 'perceiving emotions', and the second branch in which individuals utilise emotions to supplement thoughts. This is evident where therapist's own personal memories, experiences and feelings, assist the therapeutic process via empathizing with the client's experiences.

> "I think about what I do with my clients, I mean, I think I do do that and I probably do evaluate them and allow, and regulate myself, I suppose, accordingly, I mean, although I'm very aware of what goes on, I think sometimes you hold the two things, whereas you can see what's going on and you, because it's the therapeutic relationship, you're not necessarily reacting from, you know, from how you might react in a real, er, er, does that make sense, in a, er, because you're trying to understand, I guess, the client, um, I think the way, well, the way I use it is with counter-transference and transference that goes on, so it's about as if you've got, um, part of, er, someone sitting on your shoulder, sort of, reflecting on what's going on in the room, so you might not immediately, sort of, reflect your own personal view back.(Participant 4;249-260)

Participant 4 reflected on her own experience as a therapist and the importance of reflecting practising. Reflective practising (Schon 1983) also corresponds with the third EI Branch as it encompasses reflective self-awareness (e.g., being aware of our own biases), reflective self-awareness e.g., mindfulness of what is going on for therapists themselves during the

therapeutic encounter), and Critical reflexivity (e.g. it entail questioning our

relationship to our own culture

Shon, D. A. (1983). The reflective practinioner: how professionals think in action. New York: Basic Books.
Fonagy, P., Steele M., Steele, S., Moran G.S., Higgitt, A.C. (1991). The Capacitt for understanding mental states: Reflective Self in Parent and Child and its significance for security of attachment. Infant Mental Health Journal 12, 3, 210-218.

Safran J.D. & Reading R. (2008). Minfulness, metacommunication and affect regulation in psychoanalytic treatment. In Hick S, Bien T (Eds), Mindfulness and the Therapeutic Relationship. New York, Guildford.

Orlinsky, D.E., & Howard, R.I. (1986). The relation of process to outcome in psychotherapy. In S.L. Garfield and A.E. Bergin. *Handbook of psychotherapy and behaviour change*. New York; John Wiley.

The central/ core category of this study is: Subtle competencies

Authenticity, acceptance, openness, honesty, trust, courage, were some of the Focused codes that could possibly transform into a category during this cycle of memo writing and analysis.

Therapist adopt a number of subtle competencies during their role as therapist. They connect with their patients through a process of containment and connection. Therapist reflective practising as an action and their reflective practice in their choice of therapeutic interventions and balance.

I have generally constructed the term Subtle competencies as a desirable quality in therapeutic relationship among therapists and others. The term in positive context suggests interpersonal attributes and therapeutic judgment. But subtle competencies also means factual knowledge, generic clinical skills, orientation-specific technical skills. when therapists exhibit subtle competencies they carefully select their therapeutic interventions to accomplish a therapeutic alliance or a therapeutic relationship. They also use subtle competencies to maintain a level of emotional distance and distinguish their feelings between themselves and their clients. Containment and connection suggests a struggle to keep authenticity. Also it denotes self-care and a therapeutic balance, thus avoiding "burn out" or emotional exhaustion in the process of therapy. Therapists' authenticity, courage and therapeutic risk means to be directive and confrontational with clients, which lies on the opposite side of acceptance and non-judging attributes. Therapists subtle competencies encompass supportive acceptance and directive courageous therapeutic risks and challenges. The therapist must determine when and when not to be confrontational, when to be gentle and tender, warm, and when to come on like cold, formal and informal or gangbuster. Therapist are in a subtle way

confrontational when they are authentic. And when they are authentic and accepting they are confrontational in a subtle way. The clients trust the therapist when they are genuine and authentic and take the courage to be confrontational. Can these skills be taught to therapists? Carl Rogers work makes me reflect on how different was with various clients. An authentic chameleon transcending and adapting but not losing his authenticity. Can authenticity be a learning competency? Can I call it competency or a trait or part of the new concepts of emotional intelligence? Can the word subtle competencies undermine the clinical effectiveness of authenticity? Or is it to artificial?

The interview transcripts included references on "presence", for example the category we code around is "space between us". I will present a section of the interview from one of the participants and then writing a memo about it. noted:

> "Um you can have a perfectly deep conversation in a pub, people do. But the focus is different. The focus is always on the patient, not on you even, even though you are thinking what's happening to me, what's happing to me, what's happening to the patient, what's happening between us in a space between?... Here I knew that the trick was to stay with her. Next door to a psychotic state and then come out the other side. So actually I said very, very little but simply sat with her and the picture so there were in a sense three of us. To feel these emotions, contain these emotions so that at the end of the session she could leave in one piece" (Participant 11;110-144).

We then refer to a memo: "space between" can be described as strategic act, an action/interaction. It consists of the "type of focus" (a relationship between therapists and client). The space between is also a process. The participant talks about how you need to "contain these emotions" till the end of the session so that the patient could leave in one piece. Conditions that are brought out in this verbatim shows another phenomenon, "the focus on the patient". The conversation took place in the context of "therapy". The conditions expressed were "what is happening to me in the role as therapist" and "what is happening to the patient". Consequences of the "space between" are noted bellow in the participant's case. These include "to avoid a psychotic state" and the relationship between two phenomena of "the space between" and the "focus on the patient". A

therapist presence and focus in the patient was just enough to hold the session.

- Interviewer: Mhm and if I'm going to ask you to recall a session, an emotionally heavy if I can call that session then perhaps to help me understand maybe more through that experience?
- Partcipant: okay let's take a session in which the key was saying almost nothing. She had a schizophrenic mother so her upbringing was very difficult. She was going through various changes in her life, she was actually quite depressed she was presented in a hospital context for depression. Responds well to therapy, bringing in these pictures but in one session in particular she brought a picture ... just a, a low horizon with water, seawater very grey and a huge moonlight object that was actually touching the water so a very... And she is very depressed doesn't do, isn't, isn't the right word really because it doesn't conjure how she was, she was deeply confused, deeply at sea and I could see that it would actually be quite easy to push this patient into a psychotic state. People talk a lot about the damage you can do in psychotherapy and they talk about decompensation. You don't often here people actually give a concrete example, I've never come across anybody who would actually give a frequency at which something like that can happen. Here I knew that the trick was to stay with her. Next door to a psychotic state and then come out the other side. **So actually I said very, very little but simply sat with her and the picture so there were in a sense three of us.** To feel these emotions, contain these emotions so that at the end of the session she could leave in one piece. (Participant 11: 125-149)

Memo: Examining the properties of "the space between" the interviewee noted that "space between" were physically for two people but mentally for three (e.g., sat with her and the picture so there were in a sense three of us).

Appendix 19: Storyline memo

Storyline memo:

This analysis examines the ideal contexts that facilitates the therapeutic relationship. It encompasses the therapists experiences from doing therapy and is of considerable value in clinical practice. A majority of participants reported as the core factor in the therapeutic relationship a benevolent connection. This pivotal connection its central in alleviating distress and fostering a secure attachment. Depending on the success of such a connection and level of trust, the client then becomes attached to their therapist's in the "space between". The "space between" is a psychological arena whereas fears, anxieties and all the clients subjective "demons" are reborn and dare to re-experienced. The therapist takes the parental role and re-enacts unconsciously similar implicit feelings, thoughts and behaviours in the client via a process of regression and inner conceptions of self and others. The development of a close, connected, secure, and trusting relationship was dependent on three factors (connection, subtle attributes and the role of therapists) that formed subcategories (presence, containment, empathy, courage) to the core category. The participants agreed that a profound level of a number of subtle competencies (e.g., openness, trust, honesty, authenticity empathy), presence, containment are all enabling the client to gradually experience closeness, safety and trust and fosters the therapeutic relationship. Conditions leading to therapeutic relationship was authenticity, warmth, openness, spirituality, the role of the therapist. The category to capture all these causal conditions is named as "Benevolent connection". This competencies supports the notion that when therapists are aware of these subtle competencies, subsequent professional development occurs that fosters experiences which are necessary for the causal conditions of a benevolent connection. Benevolent connection created the context out which the different types of therapeutic mindfulness and awareness emerged as

intervening conditions and action strategies emerged. Benevolent connection and intervening conditions (therapists EI, reflective practice, emotional and cognitive awareness) might affect the therapeutic relationship as active agent of change (e.g., affect regulation) and provide the necessary conditions that can facilitate active interventions (e.g., reflective practising, therapeutic mindendess). Such background conditions is necessary to assist a benevolent connection, empathy, and balance all necessary for the therapeutic alliance. Intervening conditions such as types of reflective practising was viewed to have different levels, expert v novice, and the previous experience as therapist contribute to a deeper level of reflective practising: experiential, spiritual, rational thought, and relational. An overarching theme was that the therapist regarded "empathy" and "Balance". Burnout can become a potential barrier to achieving the goal of therapeutic relationship. Therapist reflection could be a protective factor against burnout or possibly alleviate the emotional exhaustion and a sustainable balance. Subsequently it generate a core category, namely, Empathetic Balance, with the analytic power and the ability to pull the other categories together and form the explanatory whole. The active therapists is continuously growing in self-knowledge and awareness via personal examination and clinical learning. The therapist support from supervision and clinical training was also paramount to the development of the category mindfulness as part of action/interaction strategies to balance and contain the therapeutic process. This study was the first of its kind, empirically investigating what therapist think of the EI within the therapeutic relationship. Although preliminary, these categories identified important aspects of the EI as a process of reflection or an element of mindfulness and part of action/interaction strategies in professional development and the therapeutic alliance. Continual reflection on one's therapeutic work may reinvigorate therapists to develop new strategies and ways of thinking about their clients and their approach to therapeutic relationship. The concept of Emotional intelligence was relevant as part of clinical

training and a subcategory of mindfulness. The importance of been aware of the EI judgment in therapeutic interventions and in experiential training of understanding all the meaning behind the feelings in self and others and possible intentions that are communicated between the "space between". Mindfulness is a critical task for self-reflection and the source that facilitates the greatest learning for therapists. Using mindfulness and EI on one's learning of therapeutic competencies, can be one method of reinforcing protective factors against burnout and empathetic balance.

Appendix 20: Anticipated methodological challenges

The patterns evident in the data may be suspect to subjective inferences drawn from the researcher. This means, although the researcher attempts to commence data collection without biases and expectations, there is an element of pattern recognition that may affect how certain themes are constructed (McLeod, 2010). It is therefore an important acknowledgement in this study to scrutinise what data patterns are identified and how this information is used in an appraisal to develop logical equations and concepts. However, attribution theory is focused on the comfortable generalisations and explanations ordinary individuals give to relationships with other people and events (Fiske & Taylor, 1991), which does not take into account objective reasoning that one would apply through empirical research. With the multifaceted social environment of individuals, such as culture, it is understandable for why people have a tendency to attribute explanations to make sense of such a mosaic of complex data in everyday life. Heider (1958) addressed this tendency through an analogy by saying people are much like ignorant psychologists attempting to decode this world of multiple relationships with varying emotional and transactional implications.

The notion held by attribution theory that provokes a degree of strict scrutiny during the grounded methodological process is the perception of cause and effect in the relationships between data patterns, which in some situations, there are none. There are two forms of attribution tendencies which will be countered by the rigorous objective process of data collection through grounded methodology. Firstly, the behaviours expressed by other individuals across different social situations are categorised by the observer into one explanation, which is usually underpinned by an intrinsic trait, such as personality being the causal variable. However, the second attribution tendency is to direct the cause of the individual's own behaviour onto extraneous variables that are outside the degree of intrinsic control, such as blaming failed relationships on bad luck.

The disparity between the two forms of attributions is an important factor worth noting during data analysis between the therapy practitioner and the client. This is because the therapists' observations of the client may be expressed in the qualitative data as focused more on intrinsic variables explaining the emotionally driven behaviours of the client, which would otherwise be attributed to extraneous causes, according to Heider (1958).

One of the most pioneered theoretical approaches to attribution has been developed by Kelley's (1967) covariation model. Kelley formulated a conceptual framework for logical judgement based on the information accessible to individuals, which takes into consideration of specific actions that may have either internal (personal) or external (environmental) causes. Hence, the inception of the term 'covariation' pertains to the many different pieces of social and interpersonal information available across different angles to any given situation at multiple times, which are ultimately used to construct a verdict. Kelley (1967) also argued that there are three sources of information that individuals examine for patterns in explaining behaviour, much like the manner in which a detective pursues clues in support of evidence for a developing theory. Consensus is the first type of causal information that influences attribution judgement, and is the degree to which other individuals express similar behavioural characteristics in a comparable situation. This is a form of pattern validation and consistency, much in the same way grounded methodology collects data to find consistent themes and qualitative correlations that may construct new theories. The second type of causal information is distinctiveness, which is the extent an individual expresses the same observable characteristics across similar circumstances and social scenarios with other people. The third causal information used to create theoretical judgement is consistency, which is the likelihood of the individual behaving precisely the same way every single time the situation occurs. It can be argued this third piece of information is rather difficult to attain given the complex and changeable nature of human behaviour, particularly when

dispositions in emotion are a strong mediator of expressive actions, even when certain behaviours are natural to the individuals' personality traits.

Identifying causality based on the correlation of consistent behaviours and their relationship with personality and dispositional traits is therefore the logical process of creating theory from information sources. However, in some cases, as might be anticipated in qualitative studies of therapeutic relationships, insufficient data may detriment empirically based judgement and the formulation of theories from grounded methodology. It is imperative then to design this study with sufficient sample sizes and data collection variables, in order to address cross-situational consistencies and validations of emerging themes and behavioural patterns. The consistency of data in this study must also have, to some extent, consideration of the passage of time and how it may skew certain behavioural information in terms of the participants' history and future experiences. In accordance with Kelley's (1967) argument, changeable behavioural expressions are standardised in their susceptibility to past experiences, which play a significant role in mediating an individual's coping mechanisms and key moments of social reactions. To counter the possible confounding influence of researcher attribution during the process of data collection and analysis, this qualitative study diligently applied the methodological principles of the social constructionist and objectivist stances in grounded theory.

Appendix 21: Lincoln's and Guba's (1986) model of trustworthiness

Criterion	Qualitative approach	Action taken by researcher
Truth value	Credibility	• Interview techniques based on quality criteria for an interview as proposed by (Kvale 1996) • Continuous discussion with peers and the panel of experts, contributing to deeper reflexive analysis. • Structural coherence and analysis of inconsistencies between interviews and interpretation. • Peer discussion of the research findings with impartial colleagues experiences in qualitative methods. • questioning, the flip-flop technique. • Reflexivity (assessing my own biases as a researcher and bracketed them)
Applicability	Transferability	• Description of the research methodology, literature control and verbatim quotations taken from interviews.
Consistency	Dependability	• Maintaining an audit trail for review by the Peer assistant and supervisors. • Peer discussion of the research findings with impartial colleagues experiences in qualitative methods. • keeping a research diary and memo writing. • Reflexivity (assessing my own biases as a researcher and bracketed them) • questioning, the flip-flop technique.
Neutrality	Confirmability	• Maintaining an audit trail for review. The audit trail consisted of the researchers' memos throughout the research process, including raw data, evidence of the analysis and data reduction, reconstruction, and synthesis (Wolf, 2003) • The discussions with the expert panel regarding coding and categories helped to ensure the confirmability of the findings. • Reflexivity (assessing my own biases as a researcher and bracketed them) • Reflexive analysis to assess the influence on my background and perception as these will influence neutrality. • keeping a research diary and memo writing

Section C: Professional Practice Advanced Client Study:

Cognitive Analytic Therapy Applied to a Child Sexual Abuse

Survivor

Section D: Critical literature review: The importance of

positive emotions to mental health

Abstract

This section presents prior research related to the field of positive psychology. Specifically, the paper contains a review of research efforts and studies relevant to the relationships found among positive, emotional and mental states, wellbeing, and survival. In this paper, the researcher also explored the causes and outcomes of positive emotional states and their implications for cognitive functioning, such as social thought processes and social behaviour. The results of the review show a link between positive mental states and mental health.

1. Introduction

This section presents prior studies and experimental research efforts relevant to the field of positive psychology and its relationship to the humanistic paradigm. It assesses or reviews results concerning the causes and outcomes of positive emotional states and addresses the role of positive emotions in psychotherapy. The determining mechanisms of and relationships among mixed emotional experiences, positive emotional and mental states, wellbeing, and survival are also presented. The paper concludes with a summary and recommendations for future research.

1.1.Methods for literature review

The purpose of the review was to examine the current field and investigate the importance of positive emotions to mental health. Doing so involved several approaches, largely encompassing a critical interpretive synthesis (CIS) approach (Dixon-Woods et al., 2006). Included were systematic keyword searches in 16 electronic databases, including PsychArticles, PsycInfo, and EMBASE, undertaken between 2011-2014. Keywords included *positive emotions*, *positive psychology*, and *positive emotions and mental health* (Appendix 1). A more detailed depiction of the literature review with CIS is in Appendix 2. The aim of CIS was to synthesize existing quantitative and qualitative research reports. These techniques located over 4430 records, 187 of which are included with the review. The title and abstracts of the remaining references were screened to exclude material not in the English language or not relevant to the topic.

A purposive sampling strategy was applied (Dixon-Woods et al., 2006). Inclusion criteria were: papers clearly related to positive emotions and positive psychology, clinical studies, followed by literature likely to inform the emerging analysis. This process adhered to a critical reflexive approach which permitted contradictions between the selected papers and development of categories most powerful in representing the entire data set. The process included open coding and "line of argument synthesis," a process

linked to primary qualitative research and grounded theory (Dixon-Woods, Cavers et al., 2006. p. 6).

As previously noted, not all studies on the topic are included in the research because the analysis of every existing source on positive emotions is practically unattainable. Thus, only the key papers providing a maximum of information concerning positive and negative feelings are considered. While the literature review was focused largely on recent studies, considering some writings traditionally viewed as foundational in emotional intelligence study was crucial. The critical review initially outlines the origins of positive emotions and then moves to a discussion of the overlooked aspects of positive emotions in mental health interventions and clinical settings, indicating the importance of reflective practice and the potential for adopting a positive psychology as a therapeutic intervention process.

1.2. Literature review

The theme of positive change resulting from human adversity has been with us throughout human history in our philosophies and religions. Nietzsche's (1889) saying: "What doesn't kill me makes me stronger" (as cited in Kaufmann, 1968, p. 35) is a particularly notable example of this. This notion is also set forth by Kierkegaard (1855) and Frankl (1963), who both advocated the innate human potential for growth through meaning (as cited in Wong, 2007). Kierkegaard (as cited in Halling & Nill, 1995, pp. 3-4) introduced despair as a deep level of anxiety that, if properly recognized, can be used as a guide through the process of self-actualization. In other words, he argued that despair is a judgement about choices, behaviours, and experiences that can either promote growth or lead to stasis and withdrawal (Frankl, 1992). Thus, a philosophical presupposition represents one basis of positive psychology.

Psychological research has often ignored the normal healthy functioning of human behaviour and the conditions that foster wellbeing (Seligman, 2002). The positive

psychology movement is founded on humanist theories still influencing counselling and psychotherapy interventions. Positive psychology has roots in humanistic psychology, which is grounded heavily on happiness and fulfilment. The work of several humanistic psychologists include "positive mental health" (Jahoda, 1958), "the nature of motivation and self-actualization theory" (Maslow, 1968), "motivation and personality" (Malsow, 1954), "self-actualizing tendency" (Rogers, 1959), and "the fully functioning person" (Rogers, 1963). These theories and other similar efforts, such as that of William James in 1902 (cited in Gable and Haidt, 2005), which coined the concept of "healthy mindedness," were followed by Allport (1958), which described the positive characteristics of human beings. These sentiments echo Maslow's (1968) optimistic description of human nature as intrinsically good, thus defining *humanness* as having a natural tendency to growth (Maslow, 1962). These are some of the main contributors that facilitated the theoretical origins of empirical research in positive psychological functioning.

Positive psychology and theories provide an umbrella paradigm that reflects a shift of emphasis away from pathology toward resilience and offers a solution to the common deficit-based model used in current mental health practices. Positive psychology is a framework that seeks to provide a complete understanding of the human experience mechanisms that facilitate wellbeing (Csikszentmihalyi, 2009). In this respect, positive psychology integrates prior knowledge into mental illness with knowledge from positive mental health. Consequently, it can create opportunities for an individual to search out his or her potentials and choices. Seligman and Csikszentmihalyi (2000) argued that the field of positive psychology focuses on the "subjective level on wellbeing, contentment, satisfaction with the past, hope and optimism for the future, and flow and happiness in the present . . . on an individual level it focuses on positive traits [such as] the capacity for love and vocation, courage, interpersonal skill, aesthetic

sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent and wisdom" (p. 5). Research by Seligman and Csikszentmihalyi (2000) shows that positive feelings play an important role by enhancing human functioning and reducing suffering. Positive emotions incorporate feelings that are frequently depicted as happy, joyful, transcendent, whole, connected and so on. A number of book chapters and texts on the topic of the positive psychology movement has generated. Seligman and colleagues found many benefits from such positive emotions, including protection from depression (Seligman, Park & Peterson, 2005) and greater life satisfaction (Peterson, Park & Seligman, 2005).

2. The neglect of positive emotions in prior research

The work of Freud, and that of others based on it, dominated both psychology and psychiatry through to the end of the nineteenth century (Korchin, 1976; Barone, Maddux & Snyder, 1997). Psychoanalytic hypothesis, with its accentuation on concealed intrapsychic courses of action and consideration regarding psychopathology, strengthened the illness ideology within the psychological field. Today, the discipline is still steeped in psychopathology, as clear by the way that the language of the medical model remains the language of the therapeutic model (Madux, 2008).

Critics have contended that this psychopathological discourse and medical language disempowers the individual by denying them of control over their own lives and will power or energy to change, which can equally turn into a self-fulfilling prophecy (Salleby 1977). For example, Salleby (1977) noted how a person's life meaning is weakened with the adoptions of medical labels that suggest "the person is the problem or pathology named" (p. 5). Once a person has been given such a label (e.g., having schizophrenia), the person can become defined by that label, and consequently, the entire person's experiences, feelings, and desires become bound within that label.

Challenged as to the generalisability of the conclusions, Robert Spitzer, the chief architect of the *Diagnostic and Statistical Manual of Mental Disorders* (Zimmerman & Spitzer, 2005), outspokenly admitted that a diagnosis of the primary mental disorders is inevitably arbitrary in light of the fact that social dysfunctioning or social weakness under thought could well be a typical response to sociological occasions. Research also reveals that, among humans, even fundamental physiological responses to threat are determined to a large extent by the social awareness that individuals bring to a particular event (Blascovich & Mendes, 2000) or by the quality of their social relationships (Cohen, Doyle, Turrner, Alper & Skoner, 2003). Jacobs (2010) noted that "it is an illusion to hope that research in evolutionary psychology will reveal how people are supposed to react to stressful events and thereby rescue psychiatric diagnosis from the false positive problem" (p. 1).

In terms of research, the current medical model has affected a great part of psychological research in the Western world. This approach is prominent in neuropsychology, where mental dysfunctions or diseases can be understood via brain functioning. Thus, health has been studied as merely the absence of physical or mental dysfunction rather than the increase of positive emotions or wellbeing.

In her review of research on positive emotions, Fredrickson (1998) argued the focus of specific action tendencies is the reason for the lack of attention and limited body of research on positive emotions. Fredrickson (1998) outlined various reasons for that lack of research in this area of positive psychology and noted, by contrast to negative emotions, positive emotions have no unique signal value, thus lack specific facial configurations (Ekman, 1992). Many positive emotions lack autonomic activation and distinguishable autonomic responses (Levenson, Ekman & Friesen 1990). Individuals' self-reports of subjective experience show a certain level of blending in how they are experienced (Ellsworth & Smith, 1988b). Finally, Fredrickson emphasized the impact of

Darwinian natural selection influence. Numerous theorists focused on emotions increasing the odds of ancestors' survival, thus discussing emotions only in terms of situations that include threats rather than opportunities (Nesse, 1990).

2.1. The broaden-and-build theory and positive emotions

The *broaden-and-build theory* developed by Barbara Fredrickson (1998) was an attempt to meaningfully review the effect of positive emotions. The theory argues, that the form and function of positive and negative emotions are both complementary and different. Positive emotions yield nonspecific action tendencies and represent relatively broad thought-action tendencies. Fredrickson (1998) asserts that previous emotion models assumed that an emotion results in physical action, which she calls *specific action tendencies (p.306)*.

Compared to specific action tendencies, Fredrickson (1998, 2000) observed that positive emotions may be recognized as thought-action tendencies. Fredrickson proposed that positive emotions do not narrow one's thought-action response but, rather, widen it. Additionally, she claimed that the experience of positive emotions has got the potential to expand one's perspective and choices of focus. As an example, while positive emotions mightnot consistently evoke a particular reaction, as with negative emotions (i.e., rage = assault), they have the ability to generate more equivocal and creative responses. Particularly, the encounter with the feeling of joy, was shown to evoke satisfaction with inactivity, directionless activation, and focused interest (Frijda, 1986). Fredrickson's (1998, 2001) broaden-and-build theory also posits that negative emotions (e.g., anxiety, rage, and sadness) narrow an individual's momentary thought-action repertoire towards particular activities which serve the ancestral function of survival. An interesting theory akin to the broaden hypothesis is emotional intelligence (EI), which indicates that using both negative and positive emotions and understanding their distinct effects on thought processes is a sort of intellect (Mayer, Salovey & Caruso, 2004).

2.2. Positive psychology and emotional intelligence in therapy and wellbeing

Within a positive therapeutic encounter of an authentic and accepting relationship, the main objective of therapy is to deepen the patient's psychological experience (Greenberg, Rice & Elliott, 1993). Incorporating emotional intelligence into positive psychology means that therapist interventions via the process of experiencing (Rogers1961) as generators of client change (Fitzpatrick & Stalikas, 2005) cause positive emotional changes (Seligman, Steen, Park & Peterson, 2005). Such emotional state's *broadening* (e.g., an open state to contemplate new ideas and creative endeavours) deepens the client's experience (Greenberg, Rice & Elliott, 1993) and leads in an upward spiral of mood via the impact of emotion on reason (Mayer, 2000). For example, the therapist should have an empathic connection and the capacity to capture "the client's private world as if it were your own, but without ever losing the 'as-if' quality" ((Rogers, 1957, p. 99). Such psychological mindedness (Farber and Golden 1997) described in EI Branch 4 (Reflective Regulation of Emotion) evoke a positive elicitation of mood in the client. This sentiment of positive elicitation or euphoria of a mood echoes the broaden-and-build theory (Fredrickson, 1998) of positive emotion and conceptually mirrors the dynamic model of affect (Zautra, Berkhof & Nicolson 2002; Zautra, Reich, Davis, Potter & Nicolson, 2000), which support therapeutic change. The dynamic model of affect postulates, when people are experiencing a calm mood, they process information broadly and generate a balanced and rich evaluation of their context and experiences. Thus, individuals who show enhanced psychological wellbeing, are capable of maintaining a mixture of positive and negative emotion during adversity.

Indeed, evidence from studies by Coifman, Bonanno and Rafaeli (2007) supports that greater resilience to loss emanated from people who exhibit a less intense negative relationship between positive and destructive emotions. A new addition to the field of mixed emotional experience is the findings of Adler and Hersfield (2012). Their research

indicated participants who experienced a <u>coexistent</u> mixture of joy and sadness during therapy had better outcomes in their psychological wellbeing.

Through such momentary enhanced positive moods and emotional experience, individuals can buffer the harmful physiological effects of anxiety (Folkman & Moskowitz, 2000). Burton and King (2004) contents that writing about positive emotional experiences was connected with better positive mood. Within these positive moods lies a benevolent connection and empathy (Rogers, 1980). Emotional intelligence (EI) calls for the adaptive utilization of emotions (Salovey & Mayer, 1990). When creating this theory of EI in the 1990's, Salovey and Mayer, made the ambitious claim of a pioneer breakthrough in understanding emotions, using emotions in cognitive processes and managing emotions. Nevertheless, an overlap between EI and positive emotions coexist. A number of parallels exist among positive psychology, positive emotions, and EI, for example, a conceptual overlap with EI branches (e.g., Branch 1 Emotion-Perception and Branch 2 Emotion-Integration). Then therapist and client broaden the collection of actions and potential thoughts that come to mind. Therefore, positive emotions, what the theory pertains to as *broadening*, expand the client's focus to allow information into consciousness. These processes coincide with EI Branch 3–Emotion-understanding and Branch 4–Emotion Management. Emotion management relates to an array of tactics, people use to sustain adaptive functioning and their wellbeing (Mayer & Salovey, 1997). Noticeable, for instance, is the failure to handle emotion that is unfavourable or aggressive (emotional dysregulation) spawning a number of clinical problems, such as anxiety and mood disorders (Gross, 1998).

The broaden-and-build theory proposes that positive emotions and broadening incite one another, in which there appears to be a considerable conceptual overlap with EI emotion-understanding and effective emotion-management strategies (Mayer and Salovey, 1997) or Petride and Furnhma's (2001) TEIQue branches of trait EI emotionality

and self-control. This overlap can bear fruitful therapeutic interventions for trait EI as an integral part of positive psychology (Bar-On, 2010). First, therapists have unique competencies and experience that can facilitate individual growth and, thus, represent a fertile context for positive emotion, positive psychology, EI, and therapeutic relationship outcomes. For example, in practical/ therapeutic implications, the therapist explores clients' individual differences in the ability to use positive emotions intelligently as a means of guiding and understanding their behaviours and experiences (Tugade & Fredrickson, 2006). Successful affect-management strategies promote human strength and increase wellbeing (Lalande, 2004), a primary goal in therapy, and lead to building resources that support therapy. Therapists should assist clients in a positive therapeutic relationship to contain negative sides of life (Gable & Haidt, 2005) and focus on positive emotions by using EI strategies that foster resilience and strength while recognising that suffering and anxiety are also components of human experience (Larsen & McGraw, 2011; D'raven & Pasha-Zaidi, 2014). As noted by Fromm (1947), "If [man] faces the truth without panic, he will recognize that there is no meaning in life except the meaning man gives his life by the unfolding of his powers by living productively." (p. 53). Consequently, a mixture of negative and positive feelings could be best for wellbeing (Larsen & MaGraw, 2011).

Positive psychology and EI in therapy share some core therapeutic benefits for greater professional flexibility (Guse, 2010), reflective practice, and mixed emotional-experience management skills, along with areas in need of further professional development (Kaslow et al., 2008). In addition, the habitual experience of positive emotion is associated with a broad coping style that leads to general healthy adaptation in response to both significant and routine stressors (Fredrickson et al., 2003).

2.3. Positive psychology and positive emotions

Although research on positive psychology is increasing, the field is still unfamiliar to many. Plenty of people are familiar with human negative emotions (e.g., fear, disgust, anger), why such emotions exist (e.g., to secure personal safety or survival), and their potential effects (e.g., increased stress levels, narrowed responses for action). However, fewer know about the types, explanations, and effects of positive emotions, such as hope, happiness, pride, contentment, and love. Fredrickson (2001) suggested that resilient individuals are considered to experience positive emotions in the face of difficult occasions, thereby allowing them to prosper and benefit from positive outcomes. The following section is focused on some of these emotions and how they are presented in prior research.

2.3.1. Happiness, joy, and pride

Lazarus and Lazarus (1994) described happiness as an emotion or as an estimate of wellbeing. More specifically, these researchers noted that "when we ask people how happy they are, the answer does not really refer to the acute emotion of feeling happy, but about their general wellbeing" (p. 89). Joy, which is often used interchangeably with happiness (Lazarus, 1991), is often derived from contexts deemed as secure and familiar (Izard, 1977) and, in some situations, by events perceived as achievements or progress toward the objectives or aims of an individual (Izard, 1977; Lazarus, 1991). King and Pennebaker (1998) recognized that, not only is "meaning in life" a feature of a good life, but the action of discovering such meaning is also associated with happiness.

Lazarus and Lazarus (1994) noted the following:

[T]he plot of happiness, its provocation, is a bit of good news about our lives, which we interpret as indicating that we are making progress towards attaining immediate and long term goals. This progress is the fundamental personal meaning that underlies feeling happy. (p. 96)

Feeling happy is often conjoined with feeling proud, but the two emotions are different. Hume (1957) suggested that pride confirms or enhances one's sense of self-efficacy rather than just happiness. Thus, the personal meaning of pride fosters social status and identity as an individual. Therefore, this emotion makes the individual, as well as others, think of himself or herself as special.

Seligman, Steen, Park and Peterson (2005) cited the efficacy of several positive psychology interventions aimed at increasing individual *happiness*. These researchers first noted the need to better define happiness, which they later define as an emotion consisting of at least the following three distinct aspects or dimensions (Seligman, 2005): "(a) positive emotion and pleasure (the pleasant life); (b) engagement (the engaged life); and (c) meaning (the meaningful life)" (p. 413). In addition, Peterson, Park and Seligman (2005) found that the most satisfied people are those who pursue all three distinct aspects, with engagement and meaning, carrying the most weight.

2.3.2. Hope and optimism

Scheier and Carver (1985, 1987) highlighted in their theory that *optimism* involves a goal-based approach, as well as considerable value being attached to a perceived outcome. Eloquently, Scheier and Carver (1985) emphasized optimism as a stable predisposition to "believe that good rather than bad things will happen" (p. 219). Optimism presents a positive reinterpretation as a style of coping or, as reported by Scheier, Carver, and Bridges (1994), is about "putting problems in the best possible light and searching for hidden benefits and meaning when difficulties arise" (p. 1072).

According to Seligman (1989), optimism promotes better health outcomes. In particular, optimism prevents helplessness in explanatory styles. Explanatory styles is the way in which we describe the events that occur to us in our own lives, either positive or negative (Seligman 1989). Optimism enable people to maintain a positive attitude and have the motivation and willpower to make a difference in their own lives. Moreover,

optimists have less negative life events and a more supporting social environment since instead of isolating themselves in retreat they engage in more social interactions (Scheier and Carver, 1985). Related to the notion of optimism and sharing some of the same conceptual features (Snyder, Sympson, Michael & Cheavens, 2001) is the concept of hope. Hope is characterized by imagined outcomes that have sufficient importance to demand mental attention. Snyder, Irving and Anderson (1991) defined *hope* as "a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)" (p. 287). Harvey and Miller (1998) defined hope as a belief system through which positive emotions can be created through a positive outlook and confidence. In addition, Harvey and Miller (1998) postulated that finding meaning is a crucial agent in finding hope, thus, hope emanates from meaning. Further, Morgante (2000) made the claim that hope is essential because it provides humans with precognition and a sense of control over one's life.

3. Empirical support of positive emotions and resilience

Davis, Zautra and Smith (2004) noted that a key to resilience is the "ability to maintain affective complexity in the face of life's inevitable difficulties" (p. 1155). Edward and Warelow (2005) open a new field addressing the importance of resilience as an emotional intelligence competency. The authors regarded that recovery or psychological healing is often accomplished when individuals find or rediscover their individual strengths and skills, thereby enabling them to "grow or move beyond the symptomatology that deems them to have a mental illness in the first place" (Edward & Warelow, 2005, p. 101). There is evidence showing that positive emotions safeguard humans from distress and adversity (Fredrickson, 2004). As such, positive emotions may help with *psychological resilience*. Psychological resilience has been characterized "by the ability to bounce back from negative emotional experiences and by flexible adaptation to the changing demands of stressful experiences" (Tugade & Fredrickson, 2004, p. 320).

Thus, resilience is an effective adaptation and coping mechanism when faced with adversity (Tugade & Fredrickson, 2004). There is a remarkable advantage by positive emotionality. Lazarus (1993) shows that resilient individuals can evaluate a stressful situation as less hostile and be more effective. This finding of experiencing positive emotions has proved to be key elements of improving individual's psychological broadening. "The psychological broadening sparked by one positive emotion can increase an individual's receptiveness to subsequent pleasant or meaningful events, increasing the odds that the individual will find positive meaning in these subsequent events and experience additional positive emotions" (Fredrickson, 2000, p.16). The repeated broadening perspective that comes about through eliciting the experience of positive emotions, improves resilience and empowers people (Fredrickson, 1998, 2001). This powerful enlightening experience, consequently triggers people's emotional wellbeing at a physical, emotional, intellectual, and social level (Fredrickson, 2003).

As a part of a broader research in the field of human adversity, trauma and resilience, Haidi (2006) suggests the possibility that stress and trauma can actually be good for people. In a cautionary review, studies with combat veterans (Elder & Clipp, 1989) rape survivors (Burt & Katz, 1987), bereaved adults (Edmonds & Hooker, 1992), and male heart patients (Affleck, Tennen, Croog & Levine, 1987), have suggested positive changes. These studies raises questions about these positive changes, as well as changing of meaning and its impact on self-identity. Charmaz (1993) provides a commentary on the impact of self-identity, entailing a reexamination and reconstruction of identity when patients begin to see themselves in new roles that have meaning; in other words, they find new strength "because of" or "in spite of" the traumatic event or illness. Consistent gains have been demonstrated on the basis that positive moods influence people to feel that life is meaningful (King, Hicks, Krull & Del Gaiso, 2006). For

example, King et al. (2006) noted that "positive affect is related to biological responses in the laboratory and everyday life that may be health protective" (p. 56).

A number of studies are increasingly revealing the positive effects of health and the importance of a sense of coherence (Antonovsky, 1987), optimism (Scheier & Carver, 1985; Scheier, Matthews & Owens, 1985), and posttraumatic growth (Tedeschi & Calhoun, 1985). The term *sense of coherence* refers to internal coping resources of confidence that an individual's environment and world view is comprehensive, manageable and meaningful (Antonovsky, 1987). Therefore, the magnitude of the relations among the dynamic feelings of confidence, resilience, and posttraumatic growth all lead to the "light at the end of the tunnel" (Almedom, 2005, p. 253).

Tedeschi and Calhoun's (2004) defined posttraumatic growth (PTG) as "positive psychological change experienced as the result of the struggle with highly challenging life circumstances" (p. 1). PTG is more than simple survival or a traumatic encounter; it is transformational change beyond pre-trauma levels, often representing a change in perception of self, adapt in the encounters of relationships with others, and/or change in one's general attitude of life (Tedeschi & Calhoun, 1996). Recognizing these psychological changes Neimeyer (2006) stated that PTG is a function that helps people to make meaning of the ways in which they have suffered. Ultimately, crafting a narrative out of PTG experiences in order to make sense of them and integrate a less naïve sense of self, a new sense of self, a more vulnerable, (Calhoun & Tedeschi, 2006). Given these significant outcomes, little is well known about how individuals "balance" their emotions within their everyday lives.

4. Cognition and positive emotions

A considerable array of data derived from cross-sectional survey reveals that individuals who are happy have the apparent tendency to function more optimally in life in comparison to individuals who are less happy (Diener, 2000). Social psychology, on

an experimental basis, has many instances indicating that positive emotional encounters are beneficial to the perception and interpretation of social behaviours and the initiation of social interactions (Forgas, 2001; Isen, 1987). Furthermore, Forgas (2002) and Sedikides (1995) also offered some persuasive conclusions, which are generally taken to show that individuals encountering positive emotions, perceive themselves and other people more positively; show higher levels of lenient attributions; and act with higher expressions of confidence, with optimistic and generous modes in interpersonal scenarios (Forgas, 2002; Sedikides, 1995).

Thus, the experimental studies concerning induced emotional states indicate happiness or other positive moods tend to have a direct effect on cognitive functions, cognitive appraisal, and social interactions. These findings reinforce the broaden-and-build theory of Fredrickson concerning positive moods and indicate frequent encounters of positive emotions widen cognitive functions and develop enduring coping tools, leading to future survival (Fredrickson, 200). Further, the results indicate that positive emotions contribute positively in cognitions, attitudes, and elevated cognitive capability. Thus, positive cognition, attitudes, and abilities consequentially enhance positive emotions (Fredrickson & Joiner, 2002).

Positive thinking or positive mental attitude is traditionally referred to as the concept of existential therapy (Wong, 2010); however, it can also be applied to the person-centered approach. Defined as "meaning therapy" (Wong, 2010), the specified approach will give the patient an opportunity to navigate the emotional environment of daily life and focus on positive thinking in the situation, leading to a rapid decrease in stress and negative emotions.

4.1.Emotion regulation

In the past two decades, psychological research has begun to focus on the relative merits of emotion regulation. There are a number of general reviews on emotion regulation and inconsistent definitions. Any discussion of emotion regulation presupposes an understanding of what emotion is. In this section, emotions are considered flexible response sequences (Buck, 1994) utilized whenever a person judges a situation as offering important opportunities or challenges (Tooby & Cosmides, 1990). Moreover, as Lang (1995) noted, these emotional reaction predispositions are short lived and involve changes in the behavioural, autonomic, experiential, and neuroendocrine systems. Certainly emotions are not like any other experiences, as their primary purpose is to facilitate people to respond adaptively to environmental adversities and opportunities accordingly (Frijda, 1988).

"Emotion regulation refers to individuals using a wide range of strategies to exert considerable control over and to influence their emotions and determine when they have them" (Gross & John, 1998, p. 170). It has been asserted that emotional regulation has a core ability to reduce negative emotional responses and represents a key mechanism in the development of mood disruptions (Cole, Martin & Dennis, 2004). Based on this view of emotional regulation, Gross (1999) proposed five regulation strategies: situation selection, situation modification, attentional deployment, cognitive change, and response modulation. These theoretical assertions suggest there are two basic strategies to regulate negative emotions, reappraisal and suppression (Gross 1999). Reappraisal functions as a mechanism of positive interpretation to decrease any emotional turmoil. Whilst suppression is where the external indications of internal feelings are inhibited. Gross (2002) noted that only reappraisal decreases emotional experience and hence these two strategies have different outcomes. While greater use of reappraisal results in an improvement to interpersonal functioning and psychological adjustment a converse effect

was seen in the greater use of suppression (Gross, 2002; Gross & John, 2003). Further support for this came from Nezlek and Kuppens (2008) as they also associated reappraisal with positive outcomes and suppression with certain negative outcomes.

In particular, reappraisal of positive emotions plays a vital role in supporting and maintaining psychological adjustment, self-esteem and positive affect. In contrast, suppressing positive emotions, increases negative emotions and has negative outcomes on self-esteem, positive emotion, psychological adjustment (Nezlek & Kuppens, 2008).

The notion that these emotional response tendencies can be regulated and may shape an individual's emotional response is important (Gross, 1998). According to Gross and John (1995) individual differences in expressivity, emphasized in their eyes, negative expressivity, positive expressivity, and impulse strength were major emotional tendencies. In addition, they noted, "Unmistakable individual differences in expressivity suggest that people differ in the emotional tendencies they have. These differences are important to understand because they influence a wide range of intra- and interpersonal processes" (p. 555).

Proponents of emotion regulation theory posit that positive and negative emotional expression and experience may be regulated (Gross, 1998). Wang, Zhang, Li and Liu, (2007) found that individuals who effectively regulate emotion via cognitive reappraisal strategies benefit in their social adaptation and mental health. Furthermore, they found that the use of cognitive reappraisal strategies was related to higher levels of confidence and subjective wellbeing. Campbell-Sills and Barlow (2007) found a correlation between improper emotion regulation strategies and negative consequences in mental health. Furthermore, adopting inhibition as a regulation method, could expedite and increase the risk of cancer, or the acceleration of existing cancers.

Much of the original research interest focusing on emotion regulation, emanated in developmental psychology (Gaensbauer, 1982). However, emotional regulation, is

currently and successfully applied to children's and adult literature (Campos, Campos & Barrett, 1989; Gross, 1998). Gross (1998) concurs the huge challenge in regulating emotions and noted, "[O]ur theoretical and empirical grasp of emotion regulation is still quite uncertain, and the details of how such an integration of reason and emotion might be achieved remain obscure" (p. 18).

5. The negative side of positive psychology

In contrast to the positive psychology movement, Held (2002a) argued that Western culture has become obsessed with being positive and optimistic, resulting in people having difficulty being in the company of someone who is in a negative mood. Held (2002a) asserted that vociferous optimism in therapeutic interventions poses imbalance risks, conversely sensitising therapists to the possibility of clients feeling guilty or inadequate for lacking the necessary (positive) attitude (in order to learn optimism) when they cannot overcome adversities. Despite the research evidence that positivity and optimism are associated with longevity and good health while negativity and pessimism have the opposite effect, counter evidence indicates that defensive pessimism can be as effective as optimism, at least in some situations (Norem 1987; Hammontree & Ronan 1992). *Defensive pessimism* refers to a strategy anxious individuals may exhibit when they have inadequate perceptual skills prior to undertaking a task (Norem & Cantor, 1986b). For instance, Norem (1987) found that optimists generate fewer alternative plans and choices when presented with a variety of problem-solving situations. In this respect, Valle and Pedro (2008) noted the dispositional-pessimism group demonstrated resilience in the counterfactuals generated based on the mood caused.

Norem and Chang (2002), offer an apparently more complex approach than the traditional "optimism is good" and "pessimism is bad" stance (p. 993). They discuss the dangers and untold costs of optimism or positive thinking by ignoring the crucial warnings that could indicate an ambivalent truth of "negative self-views" (p. 997). Norem

and Chang (2002) stated that "threatened egoism" (p. 998) takes the wisdom to improve one's self and the possibility of harming others, which is antithetical to moral responsibility and self-actualization. Against this backdrop and relevant to therapeutic implications is the increased ability of therapists' clients to tolerate negative affect and self-view and enable them to broaden their coping strategies and self-grow.

Larsen, Hemenover, Norries and Cacioppo (2003), attest a third strategy with a model which indicates that, during adversity, a balance of positive and negative emotions may be ideal for wellbeing. Larsen and MaGraw (2011) describe how one would deal with difficult times by confronting adversity and allowing an emotionally challenging situation to ultimately provide meaning to and insight into life. For example, when a client is encountering bereavement issues, allowing positive memories to be experienced by exploring them along with the meaning of loss, sadness, and bereavement could enable a healthier therapeutic outcome (Folkman & Moskowitz, 2000).

6. Positive emotions and EI

Emotional intelligence is linked directly to the feeling of happiness (Hansenne, 2012, p. 68); more to the point, EI defines one's wellbeing to a considerable extent (Hansenne, 2012, p. 68). As research has shown, the people who are capable of controlling their emotions handle stressful situations in a much better way than those who cannot (Hansenne, 2012, p. 68). More importantly, people with high rates of EI are capable of reaching satisfaction much faster and much more often, disregarding the type of activity they are engaged in (Hansenne, 2012, p. 68). However, claiming that EI leads solely to happiness would be quite a stretch. Research has shown that EI may trigger such negative effects as anxiety (Hansenne, 2012, p. 68). Nevertheless, EI correlates positively with such a crucial part of human wellbeing and emotional stability as self-esteem (Hansenne, 2012, p. 68). Therefore, the means to enhance EI in patients must be sought as the key to successful therapy.

The genetic disposition of emotional stages also predetermines the feeling of happiness experienced by people to a considerable extent. Sprangers et al. (2010) attribute the lack of attention to the issue of happiness and emotional wellbeing on a household level to the fact that people often take happiness for granted. The emotions traditionally defined as the feeling of happiness have the tendency to be replaced with such negative feelings as the feeling of stress and even depression, and vice versa (Sprangers et al., 2010).

The concept of emotional wellbeing is just as complicated as that of happiness, though not nearly as vague (Ryan & Deci, 2001). Introduced in the late 20th century, the concept of emotional wellbeing is viewed as opposed to such phenomena as stress, anxiety, depression, and so on (Sprangers et al., 2010). Represented by hedonic (attaining pleasure and avoiding pain; Ryan & Deci, 2001, p. 141) and eudemonic (the joy of self-realization; Ryan & Deci, 2001, p. 141) characteristics, *wellbeing*—the phenomenon in question—is traditionally identified as a "subjective state that reflects the overall situation: social, physical and material, of an individual in her/his environment" (Ahmed & Chwdhury, 2001, p. 1962). Therefore, the phenomenon is highly subjective, calling for applying a specific measure for its evaluation in the course of the study. Sufficient evidence exists concerning the lack of connection between financial and emotional wellbeing (Kahneman & Deaton, 2010); however, dismissing the financial aspect from the evaluation is unreasonable because the Maslow hierarchy identifies the bare necessities as the basic human needs (Gorman, 2010).

Numerous researchers indicate that, while having an obviously adverse effect on a patient when experienced in large amounts, negative emotions obviously serve to help patients create a specific "shield" to protect them from suffering a more bitter negative experience or a severe shock. More to the point, researchers show that, when aging,

people do not show the tendency to be more depressed, even though their meter of negative emotions is clearly much higher than those of younger people:

> However, although negative life events tend to become more frequent and cognitive function and health tend to decline as people get older, emotional wellbeing does not appear to be compromised by the aging process. In fact, accumulating evidence indicates that healthy emotional aging – characterized by an overall enhancement of emotional experience across the life span—is part of normal human development. (Kryla-Lighthall & Mather, 2008, p. 323)

Though positive emotions are regarded as something to strive for on a regular basis, an "overdose" of positive feelings may, in fact, be as hazardous as the lack thereof (Dogan, Totan & Sapmaz, 2012). Studies have shown that the term *positive emotion* is not only basically indefinable but also extremely vague. Dogan, Totan and Sapmaz (2012) asserted there is no agreement on what constitutes either a positive or a negative emotional experience. According to recent studies, for the most part, a positive emotion is something that can be related to a subjective experience (Dogan, Totan & Sapmaz, 2012). Researchers also warn that, because of obvious problems in their definition, emotions are often confused with affect (Dogan, Totan & Sapmaz, 2012). Conversely, this confusion accentuates the importance of the ability to use positive emotions intelligently as a means of guiding and understanding one's behaviour and experience (Tugade & Fredrickson, 2006).

In addition to the positive emotions of the client, the emotional experiences of the therapist must be addressed. Though it is traditionally assumed in every single therapy that two agents are usually involved in the healing process—the therapist and the client—, the significance of the former's emotional journey is often overlooked. The engagement of the EI-related skills of the therapist, however, is crucial from the beginning of the intervention; specifically, the emotional experiences of the doctor have a direct relation

to the therapy results. People are used to seeing doctors only as part of the treatment process and, therefore, rarely consider the emotional strain an average therapist has to go through on a daily basis. A therapist must engage emotionally in the concerns of every single client, possibly leading to emotional draining and the following unwillingness to be emotionally invested in a patient's wellbeing at all. Consequently, it is reasonable to assume that for a therapist experiencing positive emotions is also essential; the positive emotions that the therapist has in the process of communicating with the patient have a direct effect on the level of trust established between the two, as well as on the positive thinking of the patient. Concerning the approaches that can be adopted to promote positive thinking and experiencing positive emotions among therapists, creating a specific strategy is quite difficult.

7. **Positive psychology and mental health practicing**

Saleeby (2002) noted that adolescents who continue to receive psychotherapeutic support are more prone to be stigmatized than cured, have disbelief instilled rather than hope, and instigate avoidance rather than enthusiasm. If psychologists are to alter the paradigm, they should acknowledge that "much of the best work that [they] already do in the counseling room is to amplify strengths rather than repair the weaknesses of their clients" (Seligman & Csikszentmihalyi, 2000, p. 23). Rogers' understanding of person-centered therapy (1957), for any therapeutic progress, advocates' empathy, genuineness and unconditional positive regard. The unique therapeutic encounter as experienced in the therapeutic relationship between a client towards his therapist and vice versa.

De Shazer (1991) and Watkins (2001) reviewed the solution-focused therapies, and noted that therapeutic interventions effectiveness involves clients insight development into their coping abilities. Thus, these therapeutic interventions encompasses Aaron Antonovsky (1987) theory of salutogenesis, which focuses on the creation of wellbeing via a process of successful strategies to promote health rather than

curing illness. The implication for therapists is to view clients as moving toward a healthy end of the continuum by supporting clients' sense of coherence.

From the field of social work, Saleebey (1997, 2002) advocated a strength-based approach by encouraging clients to cultivate strategies of resilience from resources within to cope with life's issues. Saleebey suggested "the stimulation of a strengths discourse involves a vocabulary of strengths (in the language of the client), mirroring—providing a positive reflection of the client's abilities and accomplishments, and helping the client to find other positive mirrors in the environment" (p. 55). Thus, acknowledging that clients possess strengths, attributes, and resources can facilitate resilience and growth.

8. Summary and Conclusion

This chapter reviewed relevant literature concerning the effect of positive emotional states but also the positive psychology of negative thinking on mental health and wellbeing. A comprehensive investigation of related prior research indicates that positive moods can promote mental and physical wellbeing. Fredrickson (2000); Schultz, Izard, and Bear (2004); and Lazarus (2001) also found that joy in humans may yield sustainable survival benefits. Contrary to positive psychology is the notion of optimism and pessimism (Norem & Chang 2002). Positive psychology needs to encompass more than simply positive thinking and optimism. The therapeutic implications from the critical review indicate a more balanced approach is needed in positive psychology to avoid a state of delusion in clients. A balance is needed to include the diversity of ways in which therapists and clients achieve change and self-growth. These sentiments echo the concepts of the broaden-and-build model (Fredrickson, 2006) and EI that could lead to upward spirals of growth, wellbeing, and functioning. Therapists who use a positive empathetic and balanced approach with their clients can recognize the potential costs and benefits of both pessimism and optimism.

A reflective practice under the aforementioned conditions in which clients may be enabled to broaden their coping strategies and EI can increase their ability to tolerate a negative self-view and work toward resilience and growth. These findings indicate, in building a positive clinical psychology field, researchers should not only adopt a new approach and value set but also a new language for talking about positive psychology. Further, more studies need to be conducted on the clinical application of positive emotional states in therapy to support novel and expert therapists in developing positive moments in therapeutic encounter, thus facilitating experiential competencies, reflective awareness, and therapeutic change.

Throughout my clinical experience working with children, adolescents, and adults, I have been privileged to witness the growth of some people and come to understand the stagnation in others. I have deeply reflected upon and appreciated many theoretical approaches and the evidence-based value in practice. Based on my observations, clients struggle for change and seek therapists' assistance to place their often chaotic mental states into an organized and meaningful understanding. This struggle occurs on a different level of emotional processing. This level refers to EI and empathetic balance strategies aimed to manage and facilitate experiences of positive emotions. Thus, cultivating positive emotions is especially vital for building resilience to stressful events (Tugade and Fredrickson, 2006). There may be a message here for EI techniques within the humanistic psychotherapies as a powerful experiential motivator for patients' own positive emotions. Research awaits the development of therapeutic interventions and experiential training which can merge with the empirical evidence underpinning of the humanistic tradition. To conclude, EI is an integral part of positive psychology and therapeutic intervention, but it is still in its infancy. Future research in the field of EI, positive emotions, positive psychology, and the therapeutic relationship needs should be based on empirical evidence.

References

Adler, A. (1956). *The individual psychology of Alfred Adler*. New York: Basic Books.

Adler, J., & Hershfield, H. (2012). Mixed Emotional Experience Is Associated with and Precedes Improvements in Psychological Well-Being. *Public Library Of Science*, *7*(4). doi:10.1371/journal.pone.0035633

Ainsworth, M., & Bell, S. (1970). Attachment, Exploration, and Separation: Illustrated by the Behavior of One-Year-Olds in a Strange Situation. *Child Development*, *41*(1), 49. doi:10.2307/1127388

Ahmed, S. M. & Chwdhury, M. (2001). Micro-credit and emotional well-being: experience of poor rural women from Matlab, Bangladesh. *World Development, 29*(11), 1957–1966.

Arnheim, R. (1974). *Art and visual perception*. Berkeley: University of California Press.

Arsenio, W., Cooperman, S., & Lover, A. (2000). Affective predictors of preschoolers' aggression and peer acceptance: Direct and indirect effects. *Developmental Psychology*, *36*(4), 438-448. doi:10.1037//0012-1649.36.4.438

Barkow, J., Cosmides, L., & Tooby, J. (1992). *The Adapted mind*. New York: Oxford University Press.

Bar-On, R. (2010). Emotional Intelligence: An Integral Part of Positive Psychology. *South African Journal Of Psychology*, *40*(1), 54-62. doi:10.1177/008124631004000106

Barone, D., Maddux, J., & Snyder, C. (1997). *Social cognitive psychology*. New York: Plenum Press.

Beck, A. (1979). *Cognitive therapy and the emotional disorders*. London: Penguin.

Blascovich, J., & Mendes, W. (2000). Challenge and threat appraisals: The role of affective cues. In J. Forgas, *Feeling and Thinking: The Role of Affect in Social Cognition* (1st ed., pp. 59-82). Cambridge: Cambridge University Press.

Bless, H., Bohner, G., Schwarz, N., & Strack, F. (1990). Mood and Persuasion: A

Cognitive Response Analysis. *Personality And Social Psychology Bulletin*, *16*(2), 331-345. doi:10.1177/0146167290162013

Bonanno, G., & Keltner, D. (1997). Facial expressions of emotion and the course of conjugal bereavement. *Journal Of Abnormal Psychology*, *106*(1), 126-137. doi:10.1037//0021-843x.106.1.126

Boulton, M., & Smith, P. (1992). The social nature of play fighting and play chasing: mechanisms and strategies underlying cooperation and compromise. In J. Barkow, L. Cosmides & J. Tooby, *The adapted mind: evolutionary psychology and the generation of culture* (1st ed., pp. 429-444). New York: Oxford University Press.

Bowlby, J. (1969). *Attachment and loss, Vol 1. Attachment*. Harmondsworth: Penguin.

Bowlby, J. (1973). *Attachment and loss, Vol 2. Separation, Anxiety and Anger*. London: Hogarth Press.

Bowlby, J. (1980). *Attachment and loss, Vol 3. Loss sadness and depression*. London: Hogarth Press.

Bradburn, N., & Noll, C. (1969). *The structure of psychological well-being*. Chicago: Aldine Pub. Co.

Brake, W., Zhang, T., Diorio, J., Meaney, M., & Gratton, A. (2004). Influence of early postnatal rearing conditions on mesocorticolimbic dopamine and behavioural responses to psychostimulants and stressors in adult rats. *Eur J Neurosci*, *19*(7), 1863-1874. doi:10.1111/j.1460-9568.2004.03286.x

Bredy, T., Zhang, T., Grant, R., Diorio, J., & Meaney, M. (2004). Peripubertal environmental enrichment reverses the effects of maternal care on hippocampal development and glutamate receptor subunit expression. *Eur J Neurosci*, *20*(5), 1355-1362. doi:10.1111/j.1460-9568.2004.03599.x

Brunstein, J., Schultheiss, O., & Gr√§ssman, R. (1998). Personal goals and emotional well-being: The moderating role of motive dispositions. *Journal Of Personality And Social Psychology*, *75*(2), 494-508. doi:10.1037//0022-3514.75.2.494

Buck, R. (1985). Prime theory: An integrated view of motivation and emotion. *Psychological Review*, *92*(3), 389-413. doi:10.1037//0033-295x.92.3.389

Burton, C., & King, L. (2004). The health benefits of writing about intensely positive

experiences. *Journal Of Research In Personality*, *38*(2), 150-163. doi:10.1016/s0092-6566(03)00058-8

Charles, S., & Carstensen, L. (2010). Social and Emotional Aging. *Annu. Rev. Psychol.*, *61*(1), 383-409. doi:10.1146/annurev.psych.093008.100448

Clore, G., Schwarz, N., & Conway, M. (1994). Affective causes and consequences of social information processing. In R. Wyer & T. Srull, *The handbook of social cognition* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

Cohen, S., Doyle, W., Turner, R., Alper, C., & Skoner, D. (2003). Sociability and Susceptibility to the Common Cold. *Psychological Science*, *14*(5), 389-395. doi:10.1111/1467-9280.01452

Coifman, K., Bonanno, G., & Rafaeli, E. (2006). Affect dynamics, bereavement and resilience to loss. *Journal Of Happiness Studies*, *8*(3), 371-392. doi:10.1007/s10902-006-9014-5

Crane, T. (2005). The problem of perception. In *The Stanford Encyclopedia of Philosophy*. Zalta: Macmillan.

Csikszentmihalyi, M. (1990). *Flow*. New York: Harper & Row.

Damasio, A. (1994). *Descartes' error*. New York: Putnam.

Danner, D., Snowdon, D., & Friesen, W. (2001). Positive emotions in early life and longevity: Findings from the nun study. *Journal Of Personality And Social Psychology*, *80*(5), 804-813. doi:10.1037//0022-3514.80.5.804

Davidson, R. (1992). Emotion and affective style: Hemispheric substrates. *Psychological Science*, *3*(1), 39-43. doi:10.1111/j.1467-9280.1992.tb00254.x

Davidson, R. (2005). Well-being and affective style: neural substrates and biobehavioral correlates. In F. Huppert, N. Baylis & B. Keverne, *The Science of Well-being* (1st ed.). Oxford: Oxford University Press.

Davidson, R., Chapman, J., Chapman, L., & Henriques, J. (1990). Asymmetrical Brain Electrical Activity Discriminates Between Psychometrically-Matched Verbal and Spatial Cognitive Tasks. *Psychophysiology*, *27*(5), 528-543. doi:10.1111/j.1469-8986.1990.tb01970.x

Davidson, R., Coe, C., Dolski, I., & Donzella, B. (1999). Individual Differences in Prefrontal Activation Asymmetry Predict Natural Killer Cell Activity at Rest and in Response to Challenge. *Brain, Behavior, And Immunity*, *13*(2), 93-108. doi:10.1006/brbi.1999.0557

Davidson, R., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., & Santorelli, S. et al. (2003). Alterations in Brain and Immune Function Produced by Mindfulness Meditation. *Psychosomatic Medicine*, *65*(4), 564-570. doi:10.1097/01.psy.0000077505.67574.e3

Davis, M., Zautra, A., & Smith, B. (2004). Chronic Pain, Stress, and the Dynamics of Affective Differentiation. *Journal Of Personality*, *72*(6), 1133-1160. doi:10.1111/j.1467-6494.2004.00293.x

Dawson, G., Ashman, S., & Carver, L. (2000). The role of early experience in shaping behavioral and brain development and its implications for social policy. *Develop. Psychopathol.*, *12*(4), 695-712. doi:10.1017/s0954579400004089

de Rivera, J., Possell, L., Verette, J., & Weiner, B. (1989). Distinguishing elation, gladness, and joy. *Journal Of Personality And Social Psychology*, *57*(6), 1015-1023. doi:10.1037//0022-3514.57.6.1015

Deci, E., & Ryan, R. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum.

del Valle, C., & Mateos, P. (2008). Dispositional pessimism, defensive pessimism and optimism: The effect of induced mood on prefactual and counterfactual thinking and performance. *Cognition & Emotion*, *22*(8), 1600-1612. doi:10.1080/02699930801940289

Descartes, R., Cottingham, J., & Williams, B. (1996). *Meditations on first philosophy*. New York: Cambridge University Press.

Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, *95*, 542-575.

Diener, E., & Lucas, R. (2000). Explaining Differences in Societal Levels of Happiness: Relative Standards, Need Fulfillment, Culture, and Evaluation Theory. *Journal Of Happiness Studies*, *1*(1), 41-78. doi:10.1023/a:1010076127199

Diener, E., Suh, E., Lucas, R., & Smith, H. (1999). Subjective well-being: Three

decades of progress. *Psychological Bulletin*, *125*(2), 276-302. doi:10.1037//0033-2909.125.2.276

Dimberg, U., & Thell, S. (1988). Facial electromyography, fear relevance and the experience of stimuli. *Journal Of Psychophysiology*, *2*, 213-219.

Dimberg, U., Thunberg, M., & Elmehed, K. (2000). Unconscious Facial Reactions to Emotional Facial Expressions. *Psychological Science*, *11*(1), 86-89. doi:10.1111/1467-9280.00221

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D., Miller, T., & Sutton, A. et al. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, *6*(1), 27-44. doi:10.1177/1468794106058867

Dogan, T., Totan, T., & Sapmaz, F. (2012). The role of self-esteem, psychological well-being, emotional self-efficacy, and affect balance on happiness: A path model. *European Scientific Journal*, *9*(20), 31-42.

Dolhinow, P., & Bishop, N. (1970). The development of motor skills and social relationships among primates through play. In J. Hill, *Minnesota symposia on child psychology, Vol. 4* (1st ed., pp. 141-198). Minneapolis: University of Minnesota Press.

Donovan, N., & Halpern, D. (2002). *Life satisfaction: The state of knowledge and implications for Government. Prime Minister‚Äôs Strategy Unit*. http://www.strategy.gov.uk/2001/futures/attachments/ls/paper.pdf.

Edward, K. (2005). Resilience: When Coping Is Emotionally Intelligent. *Journal Of The American Psychiatric Nurses Association*, *11*(2), 101-102. doi:10.1177/1078390305277526

Ehrenreich, B. (2009). *Bright-sided*. New York: Metropolitan Books.

Ekman, P. (1992). An argument for basic emotions. *Cognition & Emotion*, *6*(3), 169-200. doi:10.1080/02699939208411068

Ekman, P. (1994). Are these basic emotions?. In P. Ekman & R. Davidson, *The nature of emotions: Fundamental questions* (1st ed.). Oxford: Oxford University Press.

Ekman, P., Friesen, W., O'Sullivan, M., Chan, A., Diacoyanni-Tarlatzis, J., Heider, K., & Sroufe, L. (1992). Predicting peer competence and peer relationships in

childhood from early parent-child relationships. In R. Parke & G. Ladd, *Family-peer relationships: Modes of linkage* (1st ed., pp. 77-106). New Jersey: Erlbaum.

Elliot, A., Sheldon, K., & Church, M. (1997). Avoidance Personal Goals and Subjective Well-Being. *Personality And Social Psychology Bulletin*, *23*(9), 915-927. doi:10.1177/0146167297239001

Ellsworth, P., & Smith, C. (1988). From appraisal to emotion: Differences among unpleasant feelings. *Motivation And Emotion*, *12*(3), 271-302. doi:10.1007/bf00993115

Ellsworth, P., & Smith, C. (1988). Shades of Joy: Patterns of Appraisal Differentiating Pleasant Emotions. *Cognition & Emotion*, *2*(4), 301-331. doi:10.1080/02699938808412702

Farber, B., & Golden, V. (1997). Psychological mindedness in psychotherapists. In M. McCallum & W. Piper, *Psychological Mindedness. Contemporary Understanding* (1st ed.). Mahwah, NJ: Erlbaum.

Fiedler, K., Asbeck, J., & Nickel, S. (1991). Mood and constructive memory effects on social judgement. *Cognition & Emotion*, *5*(5-6), 363-378. doi:10.1080/02699939108411048

Fitzpatrick, M., & Stalikas, A. (2008). Positive emotions as generators of therapeutic change. *Journal Of Psychotherapy Integration*, *18*(2), 137-154. doi:10.1037/1053-0479.18.2.137

Folkman, S., & Moskowitz, J. (2000). Stress, Positive Emotion, and Coping. *Current Directions In Psychological Science*, *9*(4), 115-118. doi:10.1111/1467-8721.00073

Folkman, S., & Moskowitz, J. (2000). Stress, Positive Emotion, and Coping. *Current Directions In Psychological Science*, *9*(4), 115-118. doi:10.1111/1467-8721.00073

Forgas, J. (1999). On feeling good and being rude: Affective influences on language use and request formulations. *Journal Of Personality And Social Psychology*, *76*(6), 928-939. doi:10.1037//0022-3514.76.6.928

Forgas, J. (2001). *Handbook of affect and social cognition*. Mahwah, N.J.: L. Erlbaum Associates.

Forgas, J. (2002). Feeling and Doing: Affective Influences on Interpersonal Behavior.

Psychological Inquiry, *13*(1), 1-28. doi:10.1207/s15327965pli1301_01

Forgas, J., Laham, S., & Vargas, P. (2005). Mood effects on eyewitness memory: Affective influences on susceptibility to misinformation. *Journal Of Experimental Social Psychology*, *41*(6), 574-588. doi:10.1016/j.jesp.2004.11.005

Francis, D., Plotsky, P., & Meaney, M. (2002). Environmental enrichment reverses the effects of maternal separation on stress reactivity. *Journal Of Neuroscience*, *22*(18), 840-843.

Fredrickson, B. (1998). What good are positive emotions?. *Review Of General Psychology*, *2*(3), 300-319. doi:10.1037//1089-2680.2.3.300

Fredrickson, B. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist*, *56*(3), 218-226. doi:10.1037/0003-066x.56.3.218

Fredrickson, B. (2002). Cultivating positive emotions to optimize health and well-being. *Prevention & Treatment*, *3*(1). doi:10.1037//1522-3736.3.1.31a

Fredrickson, B. (2004). Gratitude, like other positive emotions, broadens and builds. In R. Emmons & M. McCullough, *The psychology of gratitude* (1st ed., pp. 145-166). New York: Oxford University Press.

Fredrickson, B., & Branigan, C. (2005). Positive emotions broaden the scope of attention and thought‚Äêaction repertoires. *Cognition & Emotion*, *19*(3), 313-332. doi:10.1080/02699930441000238

Fredrickson, B., & Joiner, T. (2002). Positive Emotions Trigger Upward Spirals Toward Emotional Well-Being. *Psychological Science*, *13*(2), 172-175. doi:10.1111/1467-9280.00431

Fredrickson, B., Tugade, M., Waugh, C., & Larkin, G. (2003). What good are positive emotions in crisis? A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001. *Journal Of Personality & Social Psychology*, *84*(2), 365-376. doi:10.1037//0022-3514.84.2.365

Frijda, N. (1986). *The emotions*. Cambridge: Cambridge University Press.

Frijda, N., Kuipers, P., & ter Schure, E. (1989). Relations among emotion, appraisal,

and emotional action readiness. *Journal Of Personality And Social Psychology*, *57*(2), 212-228. doi:10.1037/0022-3514.57.2.212

Fromm, E. (1950). *Psychoanalysis and religion*. New Haven: Yale University Press.

Fromm, E. (1990). *Man for himself*. New York: H. Holt.

Gable, S., & Haidt, J. (2005). What (and why) is positive psychology?. *Review Of General Psychology*, *9*(2), 103-110. doi:10.1037/1089-2680.9.2.103

Gallie, R. (1989). *Thomas Reid and "the way of ideas"*. Dordrecht, Netherlands: Kluwer Academic.

Gasper, K., & Clore, G. (2000). Do You have to Pay Attention to Your Feelings to be Influenced by Them?. *Personality And Social Psychology Bulletin*, *26*(6), 698-711. doi:10.1177/0146167200268005

Gasper, K., & Clore, G. (2002). Attending to the Big Picture: Mood and Global Versus Local Processing of Visual Information. *Psychological Science*, *13*(1), 34-40. doi:10.1111/1467-9280.00406

Gendlin, E. (1981). *Focusing*. New York: Bantam Books.

Gendlin, E. (1996). *Focusing-oriented psychotherapy*. New York: Guilford Press.

Gibson, J. (1986). *The ecological approach to visual perception*. Hillsdale, N.J.: Lawrence Erlbaum Associates.

Glasersfeld, E. (1996). *Radical constructivism*. London: Routledge.

Goldman, D. (2001). Emotional intelligence: Issues in paradigm building. In C. Cherniss & D. Goldman, *The emotionally intelligent workplace* (1st ed., pp. 13-26). San Francisco: Jossey-Bass.

Gorman, D. (2010). Maslow's hierarchy and social and emotional wellbeing. *Aboriginal And Islander Health Worker Journal*, *33*(5), 27-29.

Grant, V. (1983). Behavior of Hawkmoths on Flowers of Datura meteloides. *Botanical Gazette*, *144*(2), 280. doi:10.1086/337374

Greenberg, L., Rice, L., & Elliott, R. (1993). *Facilitating emotional change*. New York: Guilford Press.

Grinde, B. (2002). *Darwinian happiness*. Princeton, N.J.: Darwin Press.

Gross, J. (1998). The emerging field of emotion regulation: An integrative review. *Review Of General Psychology*, *2*(3), 271-299. doi:10.1037//1089-2680.2.3.271

Guse, T. (2010). Positive psychology and the training of psychologists: Students‚Äô perspectives. *SA Journal Of Industrial Psychology*, *36*(2). doi:10.4102/sajip.v36i2.848

Hammontree, S., & Ronan, G. (1992). *Optimism, pessimism and defensive pessimism: The role of personal problem-solving*. Presentation, 100th Annual Convention of the American Psychological Society. Washington, DC.

Hansen, K., Lloyd, J., & Stough, C. (2009). Clinical perspectives in emotional intelligence. Emotional intelligence, new perspectives and applications. In C. Stough, D. Saklofske & J. Parker, *Assessing Emotional Intelligence: Theory, Research, and Applications* (1st ed.). Springer.

Hatfield, E., & Rapson, R. (1993). Love and attachment processes. In M. Lewis & J. Haviland, *Handbook of emotion* (1st ed., pp. 594-604). New York: Guilford Press.

Held, B. (2002). The tyranny of the positive attitude in America: Observation and speculation. *J. Clin. Psychol.*, *58*(9), 965-991. doi:10.1002/jclp.10093

Helliwell, J. (2003). How's life? Combining individual and national variables to explain subjective well-being. *Economic Modelling*, *20*(2), 331-360. doi:10.1016/s0264-9993(02)00057-3

Helliwell, J., & Putnam, R. (2004). The social context of well-being. *Philosophical Transactions Of The Royal Society Series B*, *359*, 1435-1446.

Helliwell, J., & Putnam, R. (2004). The social context of well-being. In F. Huppert, N. Baylis & B. Keverne, *The science of well-being* (1st ed.). Oxford: Oxford University Press.

Hockly, E., Cordery, P., Woodman, B., Mahal, A., Van Dellen, A., & Blakemore, C. et al. (2002). Environmental enrichment slows disease progression in R6/2 Huntington's disease mice. *Annals Of Neurology*, *51*(2), 235-242. doi:10.1002/ana.10094

Huppert, F. (2005). Positive mental health in individuals and populations. In F.

Huppert, N. Baylis & B. Keverne, *The science of well-being* (1st ed.). Oxford: Oxford University Press.

Huppert, F., & Whittington, J. (2003). Evidence for the independence of positive and negative well-being: Implications for quality of life assessment. *British Journal Of Health Psychology*, *8*(1), 107-122. doi:10.1348/135910703762879246

Huppert, F., Baylis, N., & Keverne, B. (2005). *The science of well-being*. Oxford: Oxford University Press.

Huppert, F., Baylis, N., & Kevernes, B. (2005). Natural selection and the elusiveness of happiness. In *The Science of well-being* (1st ed.). Oxford: Oxford University Press.

Huttenlocher, P. (1990). Morphometric study of human cerebral cortex development. *Neuropsychologia*, *28*(6), 517-527. doi:10.1016/0028-3932(90)90031-i

Isen, A. (1987). Positive affect, cognitive processes and social behaviour. In L. Berkowitz, *Advances in experimental social psychology Vol.20* (1st ed., pp. 203-253). New York: Academic Press.

Izard, C. (1977). *Human emotions*. New York: Plenum Press.

Izard, C. (2001). Emotional intelligence or adaptive emotions?. *Emotion*, *1*(3), 249-257. doi:10.1037//1528-3542.1.3.249

Izard, C., Fine, S., Mostow, A., Trentacosta, C., & Campbell, J. (2002). Emotion processes in normal and abnormal development and preventive intervention. *Develop. Psychopathol.*, *14*(04), 761-787. doi:10.1017/s0954579402004066

Izard, C., Huebner, R., Risser, D., McGinnes, G., & Dougherty, L. (1980). The young infant's ability to produce discrete emotion expressions. *Developmental Psychology*, *16*(2), 132-140. doi:10.1037//0012-1649.16.2.132

Izard, C., Huebner, R., Risser, D., McGinnes, G., & Dougherty, L. (1980). Resting frontal and anterior temporal EEG asymmetry predicts ability to regulate negative emotion. *Developmental Psychology*, *16*, 132-140.

Izard, C., King, K., Trentacosta, C., Morgan, J., Laurenceau, J., Krauthamer-Ewing, E., & Finlon, K. (2008). Accelerating the development of emotion competence in Head Start children: Effects on adaptive and maladaptive behavior. *Develop. Psychopathol.*, *20*(01). doi:10.1017/s0954579408000175

Jackson, D., Mueller, C., Dolski, I., Dalton, K., Nitschke, J., & Urry, H. et al. (2003). Now you feel it, now you don't: frontal brain electrical asymmetry and individual differences in emotion regulation. *Psychological Science*, *14*(6), 612-617. doi:10.1046/j.0956-7976.2003.psci_1473.x

Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.

Judge, T., Thoresen, C., Bono, J., & Patton, G. (2001). The job satisfaction-job performance relationship: A qualitative and quantitative review. *Psychological Bulletin*, *127*(3), 376-407. doi:10.1037//0033-2909.127.3.376

Kahneman, D., & Deaton, A. (2010). High income improves evaluation of life but not emotional well-being. *Proceedings Of The National Academy Of Sciences*, *107*(38), 16489-16493. doi:10.1073/pnas.1011492107

Kaplan, S. (1992). Environmental preference in a knowledge-seeking, knowledge-using organism. In J. Barkow, L. Cosmides & J. Tooby, *The adapted mind: Evolutionary psychology and the generation of culture* (1st ed., pp. 581-598). New York: Oxford University Press.

Karimi, L., Leggat, S., Donohue, L., Farrell, G., & Couper, G. (2014). Emotional rescue: the role of emotional intelligence and emotional labour on well-being and job-stress among community nurses. *J Adv Nurs*, *70*(1), 176-186. doi:10.1111/jan.12185

Kaslow, N. (2004). Competencies in Professional Psychology. *American Psychologist*, *59*(8), 774-781. doi:10.1037/0003-066x.59.8.774

Kasser, T., & Ryan, R. (1996). Further Examining the American Dream: Differential Correlates of Intrinsic and Extrinsic Goals. *Personality And Social Psychology Bulletin*, *22*(3), 280-287. doi:10.1177/0146167296223006

Keverne, E. (2004). Understanding well-being in the evolutionary context of brain development. *Philosophical Transactions Of The Royal Society B: Biological Sciences*, *359*(1449), 1349-1358. doi:10.1098/rstb.2004.1517

Keyes, C., & Haidt, J. (2003). *Flourishing*. Washington, DC: American Psychological Association.

Kierkegaard, S., & Kierkegaard, S. (1954). *Fear and trembling*. Garden City, N.Y.:

Doubleday.

Kihlstrom, J. (1987). Response: The Cognitive Unconscious. *Science*, *238*(4834), 1638-1638. doi:10.1126/science.238.4834.1638-b

Kihlstrom, J. (1990). The cognitive unconscious. In L. Pervin, *Handbook of personality: Theory & Research* (1st ed., p. 445). New York: Guiford Press.

Korchin, S. (1976). *Modern clinical psychology*. New York: Basic Books.

Kryla-Lighthall, N., & Mather, M. (2008). The role of cognitive control in older adults‚Äô emotional well-being. In V. Berngtson, D. Gans, N. Putney & M. Silverstein, *Handbook of theories of aging* (2nd ed., pp. 323-344). New York: Springer Publishing.

Lalande, V. (2004). Counselling psychology: A Canadian perspective. *Counselling Psychology Quarterly*, *17*(3), 273-286. doi:10.1080/09515070412331317576

Lambert D'raven, L., & Pasha-Zaidi, N. (2014). Positive Psychology Interventions: A Review for Counselling Practitioners. *Canadian Journal Of Counselling And Psychotherapy / Revue Canadienne De Counseling Et De Psychoth√©rapie*, *48*(4), 383-408. Retrieved from http://cjc-rcc.ucalgary.ca/cjc/index.php/rcc/article/view/2720

Larsen, J., & McGraw, A. (2011). Further evidence for mixed emotions. *Journal Of Personality And Social Psychology*, *100*(6), 1095-1110. doi:10.1037/a0021846

Larsen, J., Hemenover, S., Norris, C., & Cacioppo, J. (2003). Turning adversity to advantage: On the virtues of the coactivation of positive and negative emotions. In L. Aspinwall & U. Staudinger, *A psychology of human strengths: Perspectives on an emerging field* (1st ed., pp. 211-216). Washington, D.C.: American Psychological Association.

Lazarus, R. (1991). *Emotion and adaptation*. New York: Oxford University Press.

Lazarus, R. (1993). From psychological stress to the emotions: A history of changing outlooks. In M. Rosenzweig & L. Porter, *Annual review of psychology* (1st ed., pp. 1-21). Palo Alto: Annual Reviews.

Lazarus, R. (2003). Does the Positive Psychology Movement Have Legs?. *Psychological Inquiry*, *14*(2), 93-109. doi:10.1207/s15327965pli1402_02

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer Pub. Co.

Lazarus, R., & Smith, C. (1988). Knowledge and Appraisal in the Cognition‚ÄîEmotion Relationship. *Cognition & Emotion*, *2*(4), 281-300. doi:10.1080/02699938808412701

Lazarus, R., Kanner, A., & Folkman, S. (1980). Emotions: A cognitive phenomenological analysis. In R. Plutchik & H. Kellerman, *Emotion: Theory, research and experience: Vol. 1. Theories of emotion* (1st ed., pp. 189-217). New York: Academic Press.

Lazarus. R. S.,. *Does the positive psychology movement have legs?*. Psychological Inquiry, 2003, Vol. 14 No. 2, pp. 93-109.

Lecy, J., Harris, J., & Beatty, K. (2011). *Mapping your field without going crazy: A new software and approach to citation network data sampling and collection using Google Scholar*. Presentation, International Network for Social Network Analysis Annual Meeting, St. Pete‚Äôs Beach.

Ledoux, J. (1989). Cognitive-Emotional Interactions in the Brain. *Cognition & Emotion*, *3*(4), 267-289. doi:10.1080/02699938908412709

Leverich, G., Perez, S., Luckenbaugh, D., & Post, R. (2002). Early psychosocial stressors: relationship to suicidality and course of bipolar illness. *Clinical Neuroscience Research*, *2*(3-4), 161-170. doi:10.1016/s1566-2772(02)00041-5

Levine, L., & Burgess, S. (1997). Beyond General Arousal: Effects of Specific Emotions on Memory. *Social Cognition*, *15*(3), 157-181. doi:10.1521/soco.1997.15.3.157

Levy, B., Hausdorff, J., Hencke, R., & Wei, J. (2000). Reducing Cardiovascular Stress With Positive Self-Stereotypes of Aging. *The Journals Of Gerontology Series B: Psychological Sciences And Social Sciences*, *55*(4), P205-P213. doi:10.1093/geronb/55.4.p205

Lewis, M., Haviland-Jones, J., & Barrett, L. (2000). *Handbook of emotions*. New York: Guilford Press.

Liu, D., Diorio, J., Day, J., Francis, D., & Meaney, M. (2000). Maternal care,

hippocampal synaptogenesis and cognitive development in rats. *Nature And Neuroscience*, *3*(8), 799-806.

Loftus, E. (1979). *Eyewitness testimony*. Cambridge, Mass.: Harvard University Press.

Lykken, D. (2000). *Happiness*. New York: St. Martin's Griffin.

Lykken, D., & Tellegen, A. (1996). Happiness is a stochastic phenomenon. *Psychological Science*, *7*(3), 186-189. doi:10.1111/j.1467-9280.1996.tb00355.x

Lyubomirsky, S., & Ross, L. (1999). Changes in attractiveness of elected, rejected, and precluded alternatives: A comparison of happy and unhappy individuals. *Journal Of Personality And Social Psychology*, *76*(6), 988-1007. doi:10.1037//0022-3514.76.6.988

Lyubomirsky, S., & Tucker, K. (2014). Implications of individual differences in subjective happiness for perceiving, interpreting and thinking about life events. *Motivation And Emotion*, *22*, 155-186.

Maccoby, E., & Martin, J. (1983). Socialization in the context of the family: parent child interaction. In P. Mussen & E. Hetherington, *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (1st ed.). New York: Wiley.

Maddi, S. (2006). Hardiness: The courage to grow from stresses. *The Journal Of Positive Psychology*, *1*(3), 160-168. doi:10.1080/17439760600619609

Maddux, J. (2008). Positive Psychology and the Illness Ideology: Toward a Positive Clinical Psychology. *Applied Psychology*, *57*(s1), 54-70. doi:10.1111/j.1464-0597.2008.00354.x

Maslow, A. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370-396. doi:10.1037/h0054346

Maslow, A. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370-396. doi:10.1037/h0054346

Maslow, A. (1968). *Toward a psychology of being*. New York: Van Nostrand.

Maslow, A. (1970). *Motivation and personality*. New York: Harper & Row.

Maslow, A. (1978). *Motivation and personality*. New York: Harper & Row.

Mastekaasa, A. (1992). Marriage and Psychological Well-Being: Some Evidence on Selection into Marriage. *Journal Of Marriage And The Family*, *54*(4), 901. doi:10.2307/353171

Masud Ahmed, S., Chowdhury, M., & Bhuiya, A. (2001). Micro-Credit and Emotional Well-Being: Experience of Poor Rural Women from Matlab, Bangladesh. *World Development*, *29*(11), 1957-1966. doi:10.1016/s0305-750x(01)00069-9

Matas, L., Arend, R., & Sroufe, L. (1978). Continuity of Adaptation in the Second Year: The Relationship between Quality of Attachment and Later Competence. *Child Development*, *49*(3), 547-556. doi:10.1111/j.1467-8624.1978.tb02354.x

May, R. (1953). *Man's search for himself*. New York: Norton.

May, R. (1961). *Existential psychology*. New York: Random House.

May, R., Angel, E., & Ellenberger, H. (1958). *Existence. A new dimension in psychiatry and psychology*. New York: Basic Books.

Mayer, J., & Gaschke, Y. (1988). The experience and meta-experience of mood. *Journal Of Personality And Social Psychology*, *55*(1), 102-111. doi:10.1037//0022-3514.55.1.102

Mayer, J., & Salovey, P. (1997). What is emotional intelligence?. In P. Salovey & D. Sluyter, *Emotional Development and Emotional Intelligence: Educational Implications* (1st ed., pp. 3-31). New York: Basic Books.

Mayer, J., Gaschke, Y., Braverman, D., & Evans, T. (1992). Mood-congruent judgment is a general effect. *Journal Of Personality And Social Psychology*, *63*(1), 119-132. doi:10.1037/0022-3514.63.1.119

Mayer, J., Salovey, P., Gomberg-Kaufman, S., & Blainey, K. (1991). A broader conception of mood experience. *Journal Of Personality And Social Psychology*, *60*(1), 100-111. doi:10.1037//0022-3514.60.1.100

McGuire, T. (1993). Emotion and behavior genetics in vertebrates and invertebrates. In M. Lewis & J. Haviland, *The Handbook of Emotion* (1st ed., pp. 155-166). New York: Guilford Press.

Meaney, M. (2001). Maternal care, gene expression, and the transmission of individual differences in stress reactivity across generations. *Annual Reviews Of Neuroscienc*,

21, 1161-1192.

Messinger, D., Fogel, A., & Dickson, K. (2001). All smiles are positive, but some smiles are more positive than others. *Developmental Psychology*, *37*(5), 642-653. doi:10.1037//0012-1649.37.5.642

Miller, S., Brody, D., & Summerton, J. (1988). Styles of coping with threat: Implications for health. *Journal Of Personality And Social Psychology*, *54*(1), 142-148. doi:10.1037/0022-3514.54.1.142

Murray, N., Sujan, H., Hirt, E., & Sujan, M. (1990). The influence of mood on categorization: A cognitive flexibility interpretation. *Journal Of Personality And Social Psychology*, *59*(3), 411-425. doi:10.1037/0022-3514.59.3.411

Nesse, R. (2004). Natural selection and the elusiveness of well-being. *Philosophical Transactions Of The Royal Society B: Biological Sciences*, *359*(1449), 1333-1347. doi:10.1098/rstb.2004.1511

Nesse, R. (2005). Natural selection and the elusiveness of happiness. In F. Huppert, N. Baylis & B. Kevernes, *The Science of well-being* (1st ed.). Oxford: Oxford University Press.

Nietzsche, F., Hollingdale, R., & Nietzsche, F. (1990). *Twilight of the idols ; and, the Anti-Christ*. London, England: Penguin Books.

Norem, J., & Cantor, N. (1986). Anticipatory and post hoc cushioning strategies: Optimism and defensive pessimism in ?risky? situations. *Cognitive Therapy And Research*, *10*(3), 347-362. doi:10.1007/bf01173471

Norem, J., & Cantor, N. (1986). Defensive pessimism: ‚Äò‚ÄòHarnessing‚Äô‚Äô anxiety as motivation. *Journal Of Personality And Social Psychology*, *52*, 1208-1217.

Norem, J., & Chang, E. (2002). The positive psychology of negative thinking. *J. Clin. Psychol.*, *58*(9), 993-1001. doi:10.1002/jclp.10094

Noruzi, A. (2005). Google Scholar: The New Generation of Citation Indexes. *Libri*, *55*(4). doi:10.1515/libr.2005.170

Oatley, K. (1996). Blackwell of emotion. In R. Wyer & T. Srull, *Handbook of social cognition* (1st ed., pp. 323‚Äì418). Hillsdale, NJ: Erlbaum.

Oatley, K., & Jenkins, J. (1996). *Understanding emotions*. Cambridge, Mass.: Blackwell Publishers.

Ostir, G., Markides, K., Peek, M., & Goodwin, J. (2001). The Association Between Emotional Well-Being and the Incidence of Stroke in Older Adults. *Psychosomatic Medicine*, *63*(2), 210-215. doi:10.1097/00006842-200103000-00003

Otta, E., Abrosio, F., & Hoshino, R. (1996). Reading a smiling face: Messages conveyed by various forms of smiling. *Perceptual And Motor Skills*, *82*(3c), 1111-1121. doi:10.2466/pms.1996.82.3c.1111

Panagariya, A. (2011). Living longer living happier: My journey from clinical neurology to complexities of brain. *Ann Indian Acad Neurol*, *14*(4), 232. doi:10.4103/0972-2327.91931

Panksepp, J. (2000). The Riddle of Laughter: Neural and Psychoevolutionary Underpinningsof Joy. *Current Directions In Psychological Science*, *9*(6), 183-186. doi:10.1111/1467-8721.00090

Panksepp, P. (2000). Emotions as natural kinds within the mammalian brain. In J. Haviland-Jones, *Handbook of emotions* (2nd ed., pp. 137-156). New York: Guilford Press.

Plutchik, R. (1994). *The psychobiology of emotions*. New York: Harper Collins.

Poerksen, B. (2004). *The certainty of uncertainty*. Exeter: Imprint Academic.

Poole, T. (1997). Happy animals make good science. *Laboratory Animals*, *31*(2), 116-124. doi:10.1258/002367797780600198

Pressman, S., & Cohen, S. (2005). Does Positive Affect Influence Health?. *Psychological Bulletin*, *131*(6), 925-971. doi:10.1037/0033-2909.131.6.925

Putnam, R. (2000). *Bowling alone*. New York: Simon & Schuster.

Reverberi, C., Lavaroni, A., Gigli, G., Skrap, M., & Shallice, T. (2005). Specific impairments of rule induction in different frontal lobe subgroups. *Neuropsychologia*, *43*(3), 460-472. doi:10.1016/j.neuropsychologia.2004.06.008

Rim√©, B., Philippot, P., & Cisamolo, D. (1990). Social schemata of peripheral changes in emotion. *Journal Of Personality And Social Psychology*, *59*(1), 38-49.

doi:10.1037//0022-3514.59.1.38

Rogers, C. (1951). *Client-centered therapy*. Boston: Houghton Mifflin Co.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal Of Consulting Psychology*, *21*(2), 95-103. doi:10.1037/h0045357

Rogers, C. (1959). A Theory of Therapy, Personality and Interpersonal Relationships as Developed in the Client-centered Framework. In S. Koch & J. Haviland, *Psychology: A Study of a Science. Vol. 3* (1st ed.). Mcgraw-Hill Book Company, Inc.

Rogers, C. (1963). The concept of the fully functioning person. *Psychotherapy: Theory, Research & Practice*, *1*(1), 17-26. doi:10.1037/h0088567

Rogers, C. (1995). *On becoming a person*. Boston: Houghton Mifflin.

Rosenkranz, M., Jackson, D., Dalton, K., Dolski, I., Ryff, C., & Singer, B. et al. (2003). Affective style and in vivo immune response: Neurobehavioral mechanisms. *Proceedings Of The National Academy Of Sciences*, *100*(19), 11148-11152. doi:10.1073/pnas.1534743100

Rossi, S., Cappa, S., Babiloni, C., Pasqualetti, P., Miniussi, C., & Carducci, F. et al. (2002). Prefontal cortex in long-term memory: an ‚Äúinterference‚Äù approach using magnetic stimulation. *Nature Neuroscience*, *5*(10), 1017-1017. doi:10.1038/nn1002-1017a

Rozelle, R. (2005). *Write great fiction*. Cincinnati, Ohio: Writer's Digest Books.

Ruch, W. (1993). Exhilaration and humor. In M. Lewis & J. Haviland, *Handbook of emotions* (1st ed., pp. 605-616). New York: Guilford Press.

Ryan, R., & Deci, E. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annu. Rev. Psychol.*, *52*(1), 141-166. doi:10.1146/annurev.psych.52.1.141

Ryle, G. (2002). *The concept of mind*. Chicago: University of Chicago Press.

Scheier, M., Matthews, K., Owens, J., Magovern, G., & et al,. (1989). Dispositional optimism and recovery from coronary artery bypass surgery: The beneficial effects on physical and psychological well-being. *Journal Of Personality And Social*

Psychology, *57*(6), 1024-1040. doi:10.1037//0022-3514.57.6.1024

Schultz, D., Izard, C., & Bear, G. (2004). Children's emotion processing: Relations to emotionality and aggression. *Development And Psychopathology*, *16*(02). doi:10.1017/s0954579404044566

Sedikides, C. (1995). Central and peripheral self-conceptions are differentially influenced by mood: Tests of the differential sensitivity hypothesis. *Journal Of Personality And Social Psychology*, *69*(4), 759-777. doi:10.1037/0022-3514.69.4.759

Seligman, M. (2003). *Authentic happiness*. London: Nicholas Brealey.

Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, *55*(1), 5-14. doi:10.1037/0003-066x.55.1.5

Seligman, M., Steen, T., Park, N., & Peterson, C. (2005). Positive Psychology Progress: Empirical Validation of Interventions. *American Psychologist*, *60*(5), 410-421. doi:10.1037/0003-066x.60.5.410

Shallice, T. (2004). The fractionation of supervisory control. In M. Gazzaniga, *The cognitive neurosciences III* (1st ed., pp. 943-956). Cambridge, MA: MIT Press.

Sheldon, K., & Elliot, A. (1999). Goal striving, need satisfaction, and longitudinal well-being: The self-concordance model. *Journal Of Personality And Social Psychology*, *76*(3), 482-497. doi:10.1037/0022-3514.76.3.482

Sheldon, K., & Kasser, T. (1998). Pursuing Personal Goals: Skills Enable Progress, but Not all Progress is Beneficial. *Personality And Social Psychology Bulletin*, *24*(12), 1319-1331. doi:10.1177/01461672982412006

Siegel, S., & David, F. (1957). Nonparametric Statistics for the Behavioral Sciences. *Biometrika*, *44*(3/4), 538. doi:10.2307/2332896

Sprangers, M., Bartels, M., Veenhoven, R., Baas, F., Martin, N., & Mosing, M. et al. (2010). Which patient will feel down, which will be happy? The need to study the genetic disposition of emotional states. *Qual Life Res*, *19*(10), 1429-1437. doi:10.1007/s11136-010-9652-2

Stroop, J. (1935). Studies of interference in serial verbal reactions. *Journal Of Experimental Psychology*, *18*(6), 643-662. doi:10.1037/h0054651

Szasz, T. (1978). The Myth of Psychotherapy. *Psychother Psychosom*, *24*(4-6), 212-221. doi:10.1159/000286736

Szasz, T. (1987). *Insanity*. New York: Wiley.

Tedeschi, R. (1995). *Trauma & transformation*. Thousand Oaks, Calif.: Sage Publications.

Thayer, R. (1991). *The Biopsychology of Mood and Arousal*. New York: Oxford University Press.

Tugade, M., & Fredrickson, B. (2004). Resilient Individuals Use Positive Emotions to Bounce Back From Negative Emotional Experiences. *Journal Of Personality And Social Psychology*, *86*(2), 320-333. doi:10.1037/0022-3514.86.2.320

Tugade, M., & Fredrickson, B. (2006). Regulation of Positive Emotions: Emotion Regulation Strategies that Promote Resilience. *Journal Of Happiness Studies*, *8*(3), 311-333. doi:10.1007/s10902-006-9015-4

Veening, J., Gerrits, P., & Barendregt, H. (2012). Volume transmission of beta-endorphin via the cerebrospinal fluid; a review. *Fluids And Barriers Of The CNS*, *9*(1), 16. doi:10.1186/2045-8118-9-16

Weinberger, D. (1990). The construct validity of the repressive coping style. In J. Singer, *Repression and Dissociation: Implications for personality theory, psychopathology, and health* (1st ed., pp. 337-386). Chicago: University of Chicago Press.

Werner, E., & Smith, R. (1982). *Vulnerable but invincible*. New York: McGraw-Hill.

Willig, C. (2008). *Introducing qualitative research in psychology*. Maidenhead, England: McGraw Hill/Open University Press.

Wong, P. (2009). Meaning Therapy: An Integrative and Positive Existential Psychotherapy. *Journal Of Contemporary Psychotherapy*, *40*(2), 85-93. doi:10.1007/s10879-009-9132-6

Zautra, A., Berkhof, J., & Nicolson, N. (2002). Changes in affect interrelations as a function of stressful events. *Cognition And Emotion*, *16*(2), 309-318. doi:10.1080/02699930143000257

Zautra, A., Reich, J., Davis, M., Potter, P., & Nicolson, N. (2000). The Role of Stressful Events in the Relationship Between Positive and Negative Affects: Evidence From Field and Experimental Studies. *Journal Of Personality*, *68*(5), 927-951. doi:10.1111/1467-6494.00121

Critical Literature Appendices

Appendix 1: Search terms for electronic databases

Positive emotions	&	mental health
Positive emotions	&	psychotherapy outcomes
Positive emotions	&	Clinical outcomes
Positive psychology	&	Positive emotions outcomes
Positive psychology	&	Mental Health
Positive Psychology	&	Emotional intelligence
Positive Psychology	&	Counselling Psychotherapy
Positive Psychology	&	Happiness well being
Positive Psychology	&	Positive mooods
Positive Psychology	&	Clinical outcomes
Positive Psychology	&	Clinical studies
Positive Psychology	&	Empirical validation
Positive Emotions	&	Mental Health
Positive Emotions	&	Emotional Intelligence
Positive Emotions	&	Therapeutic outcomes
Positive Emotions	&	Counselling
Mental Health	&	Positive Psychology
Positive emotions	&	Therapeutic change
Positive Psychology	&	Critics

Appendix 2: Critical interpretive synthesis

CIS is an interpretive research method that consists of "synthetic constructions" (broad theoretical categories) abstracted from the data through a derivation of Glaser and Strauss's (1967) grounded theory techniques. Dixon-Woods et al (2006) developed a programmatic procedure for conducting a CIS analysis encompassing the following steps:

1. Formulating the review question
2. Searching the literature
3. Sampling
4. Determination of quality
5. Data extraction and
6. Interpretive synthesis

Formulating the review question

Dixon-Woods et al (2006) noted that research should begin with broad research questions. For the part D the review question was: "The importance of positive emotions to mental health". This was the subject area but it did not limit the ongoing analytical process since I could also examine other relevant meanings in literature such as positive psychology and mental health.

Searching the literature

When formulated the initial review question I began the search in the literature by collecting all relevant literature. This strategy however yielded an unwieldy initial set of over 9077 hits. As the process revealed to be unmanageable for the purpose and resources of the study, I had to adopt a more manageable sampling frame. I then focused on what Dixon-Woods et al. (2006) advised: "potentially relevant papers to provide a sampling frame" (2006: p.3). The sampling frame encompassed the most recent research trends in the subject area published in academic psychology, counselling and psychotherapy journals. There are, of course a lot of such journals therefore I had to choose the positive psychology and positive emotions and other search terms from well known electronic databases such as EBSCO, PsycINFO, Medline from inceptions in 2010-2014 and classified lists e.g., Willey Periodicals, Journal of Personality and Social Psychology,

American Psychologist and other book popular publications. These strategy and list of publications from journals provided important published abstracts and a manageable sampling frame.

Sampling

Purposive sampling, also know as theoretical sampling, is an iterative method in which the emerging theory dictated sampling decision (Glaser & Straus 1967). At this stage a more manageable sampling frame again proved inadequate as it was providing another unmanageable number of references. A more meaningful purposive sample needed the following strategies.

1. Identify those academic journals dedicated to positive psychology and positive emotions. 200 journals out of 4430 were selected
2. Identify all articles from these journals that present original research, while excluding some reviews articles. (187 research articles were collected and analysed)
3. Sample other more specific articles and books as I was analysing the selected journals from the sampling frame.
4. Conduct targeted searches for recent articles in relevant databases.

Quality

I aimed to prioritise papers that met methodological standards and were relevant to the topic area. The following criteria adopted from Mary Dixon-woods et al, (2006) for appraising the quality:

1. Are the aim and objectives of the research clearly stated ?
2. Is the research design clearly specified and appropriate for the aims and objectives of the research?
3. Do the researcher provide a clear account of the process by which their findings we reproduced?
4. Do the researcher display enough data to support their interpretations and conclusions?
5. Is the method of analysis appropriate and adequately explicated?

Data Extraction

All the data and literature review research was printed and I followed Dixon-Woods et al., (2006) example to capture basic information about each of the journal articles using the grounded theory coding methods (Glaser and Strauss 1967) and a pro-forma for journal data extraction as illustrated bellow:

Element	Description of elements	Example
Record ID	Unique identifier for article (in this case, the initial of the source journal title followed by the number of the article from the issue sampled)	FB1
Year	The Year of publication	2005
First Author	The last name and first initial of the first author listed in the article.	Fredrickson , B
Title	Title of the article	Positive emotions broaden the scope of attention and thought-action repertoires
Journal	The title of the source journal	Cognition and Emotion
Codes	One or more open codes assigned to describe the individual presentation	**Positive emotions broadened the scope of attention and cognition v negative emotions narrowed thought-action repertoire.**
Record ID	Unique identifier for article (in this case, the initial of the source journal title followed by the number of the article from the issue sampled)	FWL
Year	The Year of publication	2003
First Author	The last name and first initial of the first author listed in the article	Fredrickson B
Title	Title of the article	What good are positive emotions in crises? A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001

Journal	The title of the source journal	Journal of Personality and Social Psychology
Codes	One or more open codes assigned to describe the individual presentation	**Resilience and emotions**

The pro-forma method was implemented on printing by printing the articles and on the side of the page margins write one or more open codes assigned to describe the individual presentation as above. The pro-forma enabled the researcher to organize larger quantities of information on search terms as depicted in appendix 1. The critical interpretive synthesis of the literature of positive emotions and positive psychology initially included 187 articles papers but gradually became firmed up and more highly specified as the analysis continued. In addition textbooks were considered as part of journal reading.