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Emotions: understanding and navigating emotions in healthcare a course for occupational therapists

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Doctoral Project

EMOTIONS:

UNDERSTANDING AND NAVIGATING EMOTIONS IN HEALTHCARE

A COURSE FOR OCCUPATIONAL THERAPISTS

by

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DEDICATION

I would like to dedicate this work to my family and friends, who supported and encouraged me along the way.

ACKNOWLEDGMENTS

First, I would like to acknowledge parents, Yael and Uriel Fischer for the unwavering support, enthusiasm and encouragement. Thank you for being just a (stressed) phone call away, any time of the day. I would also like to thank my siblings Alon and Galya Fischer, for constantly being excited about my journey and my achievements. Next, my peer-mentor Rose Adams, who has become a close friend over the past two years, and always asked what else she can do to support me. Thank you to my friends for (attempting) to keep me sane throughout this process, reading and re-reading my work and for being so supportive. For those who sat with me for endless evenings to discuss complex theoretical constructs and pep talked with me when I was distressed, thank you as well. Thank you to the wonderful BU faculty, for all the knowledge and wisdom that influenced my work. Finally, a giant thank you to my incredibly wonderful academic mentor, Dr. Liat Gafni-Lachter, who encouraged me, guided me, believed in me and my vision and was always available for questions, comments, freakouts and successes. I would not have been able to achieve this without all your support.

EMOTIONS:

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A COURSE FOR OCCUPATIONAL THERAPISTS

TAMAR FISCHER

Boston University, Sargent College of Health and Rehabilitation Sciences, 2022

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ABSTRACT

A therapist's Emotional Competence (EC) is their ability to navigate their own emotions and the emotions of their clients in therapeutic interactions (Brasseur et al., 2013; Wilkinson et al., 2017). EC is defined as a person's skills, confidence, and capacity to navigate emotions in different social situations (Coetzee et al., 2006, Saarni et al., 1997, Brasseur et al., 2013). It is a complex skill that draws from Emotional Intelligence and therapeutic use of self and is linked to one's self-awareness and empathy (Brackett et al., 2021; Perkins, 2018; Perkins & Schmid, 2019; Taylor, 2020). Studies show that effective emotional navigation in healthcare enhances the quality of care by improving client engagement and motivation, therapeutic relationships, and treatment outcomes (Brasseur et al., 2013; Kielhofner, 2009; Kotsou et al., 2011; Park, 2021; Taylor, 2020). Therapists also benefit from increased well-being and protection against burnout and compassion fatigue (Wong, 2016; Taylor, 2020, American Occupational Therapy Association, 2020).

Despite the importance of EC, curriculums for healthcare professionals typically place little emphasis on developing effective emotional-related skills and strategies (Brown, 2018; Grant et al., 2014; Perkins, 2018). Furthermore, many healthcare

organizations lack on-site education to enhance practicing professionals' EC and interpersonal communication skills (Calabrese et al., 2019). All of these may adversely affect the therapist's well-being and the quality of care.

To address this gap in occupational therapy practice, the author created an intervention entitled *EmOTions*. *EmOTions* is a comprehensive, six-week- 30-hour online course for practicing occupational therapists. Its primary purpose is to build and incorporate EC skills into daily therapeutic practice. This theory and evidence-based continuing education course uses key interventional ingredients found in the literature to inform the program's content and structure. The resulting changes in participants' EC and EC's effects on therapeutic relationships and therapist well-being will be evaluated using a pre-post comparative design. Funding for the course will be tuition-based, and the research will be funded using grants to promote quality care. The dissemination plan will be directed towards potential *EmOTions* course participants and organizations providing healthcare services.

In conclusion, emotionally competent occupational therapists will deliver better care and experience improved therapist well-being. It is the author's hope that the *EmOTions* course developed in this OTD project will positively impact the therapists' EC, resulting in improved therapist well-being, quality care, and client outcomes.

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LIST OF ABBREVIATIONS

CF.....Compassion Fatigue

EC .....Emotional Competence

EI.....Emotional Intelligence

IRM.....Intentional Relationship Model

CHAPTER ONE – Introduction

This doctoral project aims to enhance effective therapist emotional competence (EC) within a therapeutic encounter in occupational therapy practice. EC is defined as the demonstration of self-efficacy in emotion-eliciting social transactions (Brasseur et al., 2013). In other words, EC refers to an individual's skills, confidence, and capacity to navigate emotions in different social situations. It includes the identification, expression, understanding, regulation, and use of emotions, both one's own and others' (Brasseur et al., 2013). The application of EC refers to how people strategically apply emotional knowledge and expression in order to adequately respond to others during social and interpersonal exchanges and regulate their own emotional experiences (Coetzee et al., 2016; Saarni, 1997).

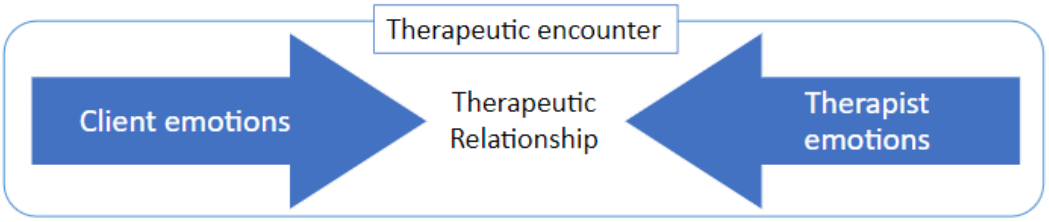
The Role of Emotions in Quality Healthcare

A wide range of factors influences healthcare clinicians' delivery of good-quality care. A recent systematic review compiled a list of 57 clusters of the potential determinants that influence healthcare delivery and strategies to facilitate the delivery of quality care (Flottorp et al., 2013). Some of these clusters and strategies, such as the importance of clinicians' knowledge and skills, and the value of using educational materials, feedback, and reflection in skill-based learning, has received considerable research attention. However, professional interpersonal interactions, representing a substantial portion of the variation in clinicians' care delivery, still remain unexplained (Flottorp et al., 2013; Kolehmainen & McAnuff, 2014).

The premise of this doctoral project is that the healthcare professionals',

specifically occupational therapists', EC largely influences professional interpersonal interactions. EC is an under-researched factor that influences quality care in many healthcare fields. Considering that emotions are known determinants of people's actions in general, it is likely that clinicians' and clients' emotions play a role in the therapeutic interaction (Kolehmainen & McAnuff, 2014). Thus, the need to continue identifying more effective ways to improve healthcare delivery should include addressing therapist and client emotions that arise in the therapeutic interaction in occupational therapy practice. Figure 1.1 illustrates the three different emotion spheres that could arise in the therapeutic interaction, including the therapist's emotions, the client's emotions, and the emotions from the therapeutic relationship.

Figure 1.1. Emotions in therapeutic interactions



Client Emotions

Occupational therapy clients typically face challenges in participating and engaging in meaningful occupations. These challenges are usually connected to the clients' emotional states (American Occupational Therapy Association, 2020). A frustrated parent of a child with Sensory Processing Disorder, a teen experiencing Depression after a traumatic brain injury, or a discouraged older woman with Parkinson's Disease who wants to cook for her grandchildren are only a few examples of the emotional challenges

individuals in need of occupational therapy services face. These occupational challenges and their emotional responses influences the therapeutic interaction.

Therapist Emotions

Occupational therapists also bring an emotional realm into the therapeutic interaction. For example, a study of primary care practitioners identified clinicians' feelings of embarrassment as possible determinants of the clinicians' avoidance of discussion about sexual health with clients. Another study of mental health workers identified that clinicians' feelings of fear and wariness were possible determinants of their reluctance to provide treatment to clients (Kolehmainen & McAnuff, 2014).

Furthermore, a body of research indicates that while working in healthcare can be rewarding, it can sometimes be emotionally draining. Psychological distress, commonly found among healthcare professionals, has been associated with a wide range of stressors, both in relation to their roles as practitioners and the broader organizational context. Managing complex and uncertain situations, lack of control and intensive interactions with service users that evoke strong emotional reactions are found to be particularly challenging (Isidoro et al., 2021; Park, 2021). Over time, these emotional and psychological demands expose clinicians to various stress-related psychological injuries, leading to burnout, compassion fatigue, moral distress, impaired performance, physical illness, and large worker turnover (Isidro et al., 2021; Park, 2021). Park (2021) conducted a meta-analysis that compiled results of 2,430 occupational therapists across 17 peer-reviewed English articles in 12 countries on the topic of occupational therapy and burnout. The study results found psychological exhaustion, leading to burnout, as a critical problem for therapists.

Factors that related to burnout include personal factors, organizational factors and psychological factors. Among the related variables, psychological factors showed a relatively large effect size. These results indicate that a strategy to reduce occupational therapists' burnout that focuses on psychological factors, including therapist emotions, is necessary to assist occupational therapists in practice (Park, 2021).

Emotions from the Therapeutic Relationship

The therapeutic relationship is defined as the collaboration, partnership, communication, and emotional exchange between therapists and clients (Dunleavy, 2017). Establishing and maintaining a therapeutic relationship with the client is essential for building a successful therapist-client partnership and directly impacting client engagement and outcomes in occupational therapy (Perkins & Schmid, 2019; Wong, 2016). The therapeutic relationship can be created in a single encounter or developed over time in longer therapeutic engagements.

Many studies have shown the importance of the therapeutic relationship in occupational therapy. For example, studies show that between 82% and 97% of occupational therapists agree that the therapeutic relationship affects engagement in therapeutic activities and is a key determinant of functional outcomes (Taylor, 2020). Furthermore, Taylor (2020) posits that therapeutic relationships are composed of the communication and reactions of therapists or clients. As with any interpersonal interaction, emotions are likely to arise from the therapeutic relationship (Taylor, 2020).

Emotional Competence and Therapeutic Interactions

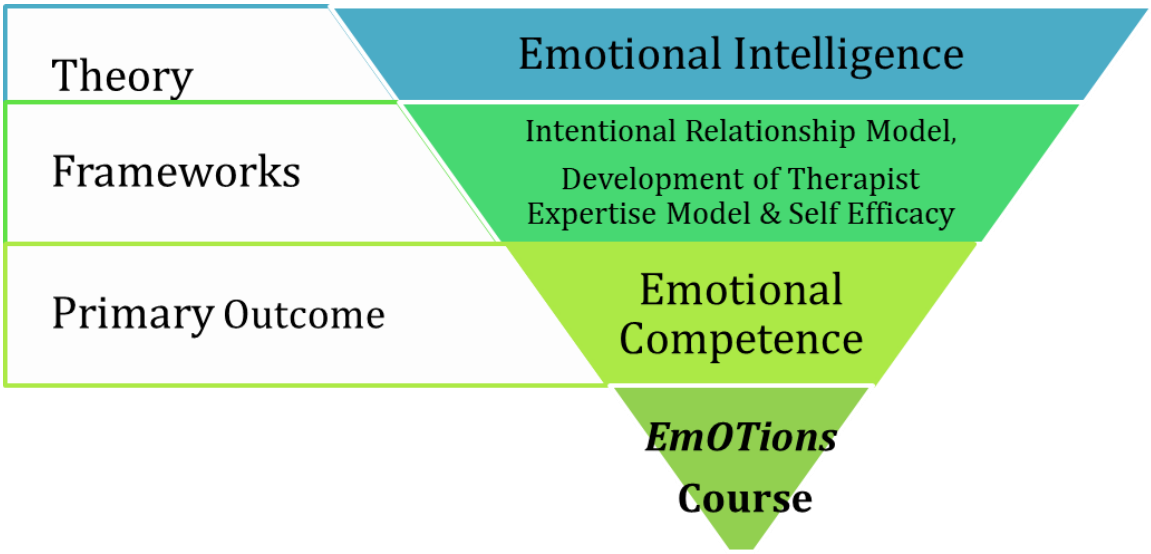
EC provides an essential cornerstone in addressing emotions that arise from the therapist, client and therapeutic relationships. As the therapeutic initiator, it is the therapists' role to recognize these emotions when they occur and respond therapeutically. Emotionally driven therapeutic relationships require the therapist to recognize and address emotions that arise effectively, read and attend to non-verbal cues, and express emotions clearly and genuinely (Wilkinson et al., 2017; Wong, 2016). Therapists require self-knowledge, self-awareness of therapeutic behavior, and the ability to reflect and evaluate their practice to hold interpersonal sensitivity and understanding for their clients (Taylor, 2020). When therapists ignore or do not know how to respond to a client's emotional state, it can threaten the therapists' well-being, as well as the therapeutic relationship and the resulting treatment outcomes. Alternatively, optimally responding to emotional complexities can lead to positive client change, including improved treatment outcomes, and a more solidified therapeutic relationship (Kielhofner, 2009). Thus, occupational therapists must acknowledge the emotions in the therapeutic interaction to foster a positive, empathetic-therapeutic relationship, engage client motivation, protect themselves against therapist emotion-based stress, such as burnout, and create meaningful change (American Occupational Therapy Association, 2020).

Theoretical Base of the Doctoral Project

The theoretical base of this doctoral project draws from the theories and frameworks of Emotional Intelligence (EI), Intentional Relationship Model (IRM), and

Emotional Competence (EC), presented in Figure 1.2. EI theories are used to understand the complexity of the problem and the presented solution (Brackett et al., 2021; Gayathri et al., 2013; Mayer & Salovey, 1997). IRM is used to situate EI within the therapeutic practice and to promote therapeutic relationships and therapeutic use of self (Taylor, 2020). Additional frameworks in the project include the Development of Therapist Expertise Model & Self Efficacy, described in Chapter 4. Finally, EC is used to explain the primary change outcomes in the proposed intervention, *EmOTions* continuing education course for occupational therapists, further described in Chapter 4 (Coetzee et al., 2016; Saarni, 1997). EC also links EI and IRM's concepts and theories. EI, IRM, and EC and their correlations are further explained below and expanded in Chapter 1 and Appendix A.

Figure 1.2. Doctoral project primary theoretical background



Emotional Intelligence Theories

EI is broadly defined as a person's capacity to identify and perceive emotions (both in oneself and in others), regulate emotions, and cope effectively with emotional situations

(Zeidner et al., 2009). It is a relatively new model, coined in 1990 by Salovey and Mayer, whose original framework was created as a response to the lack of terminology and theory concerning the relationship between cognition and emotion (Dhani & Sharma, 2016; Mayer & Salovey, 1997; Mayer & Salovey, 2004). Thus, EI seeks to explore the role of emotions in cognition while increasing recognition of the substantive value of emotions in general (Dhani & Sharma, 2016; Mayer & Salovey, 1997).

EI appears to be distinct from but positively related to other types of intelligence, such as logical-mathematical, spatial, kinesthetic, and linguistic intelligences. Like other types of intelligence, EI is a universal skill found in every person with differing ability levels. It also presents differently in each individual, develops over a person's life span, and can be enhanced through training. The differences in individual behaviors, or skill levels, spur from differences in emotional upbringing, education, culture, age, and experiences (Brackett et al., 2021; Mayer & Salovey, 2016).

EI as a concept is based on extensive scientific and research evidence. Over the years, several theories have been formed explaining EI and its different components. Unfortunately, many of these theories utilize overlapping concepts for EI, and no general census has been reached on its operationalization. Today, three predominant EI models have separate elements and domains. These models are the Ability Model, Mixed Model, and Trait Model. Appendix A compares these three models and presents similarities and differences in the theoretical basis of EI.

Intentional Relationship Model and Development of Therapist Expertise Model & Self Efficacy Frameworks

The IRM was created by Taylor (2008) as a conceptual practice model intended to be used in conjunction with other models in occupational therapy practice. The IRM explains the therapeutic use of self within the practice to promote therapeutic relationships to facilitate occupational engagement (Taylor, 2020). Therapeutic use of self is defined as the therapist's conscious efforts to optimize interactions with clients, as the therapist consciously works with the interpersonal side of the therapeutic relationship to facilitate client outcomes (Anderson & Halbakken, 2020). The theory is further elaborated in Appendix A.

Therapeutic use of self is critical to occupational therapy practice as the ability to develop and manage therapeutic relationships with clients through professional reasoning, empathy, and a client-centered, collaborative approach is integral to facilitating client occupational engagement and effective service delivery (American Occupational Therapy Association, 2020; Taylor, 2020). Literature also supports the importance of therapeutic use of self as an essential element in creating therapeutic relationships, maximizing the client's occupational engagement across many populations and therapeutic goals, and is considered one of the strongest tools used by occupational therapists (Anderson & Halbakken, 2020; Andonian, 2017; Chaffey et al., 2012; Myers, 2014; Perkins & Schmid, 2019, Wong, 2016). Therapeutic use of self is a learned concept in formal occupational therapy training (ACOTE, 2018). However, mastering the therapeutic use of self requires an ongoing process of intentional introspection and learning through practice (Taylor,

2020).

An explanation of the Development of Therapist Expertise Model & Self Efficacy Frameworks is detailed in Chapter 4.

Emotional Competence: The Primary Outcome

As previously stated, EC is defined as an individual's skills, confidence, and capacity to navigate through emotions in different social situations. It includes identifying, expressing, understanding, regulating, and using one's and others' emotions (Brasseur et al., 2013).

The concept of EC was initially conceived from the study of EI and is based on the Mixed Model of EI, which defines EI as an ability with some social behaviors, traits, and competencies. Today, EC and EI are sometimes used interchangeably in the literature. However, there are significant differences in the focus and practical applications between the two terms. While EI relates to traits, abilities, and attributes of emotional functioning, EC describes the skills, knowledge, and capabilities to apply emotional information in the workplace (Coetzee et al., 2006). In other words, EC can be seen as the practical application or response capabilities of a person's EI. For example, while an EI measure might show a person's general emotional skills, an EC assessment measures how well the person can apply their emotional skills in different social situations. The application of EC refers to how people strategically apply emotional knowledge and expression to respond to others in the face of changing social environments to navigate interpersonal exchanges and regulate their own emotional experiences (Coetzee et al., 2016; Saarni, 1997). The concept of EC is used in organizational and workplace applications where individual learning,

development, and performance are emphasized (Coetzee et al., 2006). Studies show that EC can be learned through training and improved among adults through education and experience. They also found significant improvements in EC associated with decreased perceived and objective stress, decreased somatic complaints, and improved quality of social relationships. These findings have important implications, both theoretically and practically. On a theoretical level, the results confirm that a person's ECs can be improved through well-designed interventions. On a practical level, the results show that it is possible to influence people's psychological well-being, subjective physical health, and relationship quality by improving their EC, with lasting effects. These studies show promising results in enhancing emotional knowledge and functioning, even into adulthood (Brasseur et al., 2013; Lenneville, 2014; Mikolajczak et al., 2015; Kotsou et al., 2011; Taylor, 2020;). In this doctoral project, EC serves as the primary change outcome and is further elaborated in Appendix A.

Barriers to Implementing Emotional Competence and Emotional Intelligence in Occupational Therapy

Over the last 20 years, the concepts of EC and EI have been broadly accepted in many fields. EC and EI concepts have set the foundation for multiple studies on the effects of EI and EC in healthcare, management, education, psychology and leadership. However, to this date, EI and EC have been relatively neglected in occupational therapy, and the emotional demands of occupational therapy practice have not been well explored. As illustrated in the above sections, emotions in therapy arise from the client, the therapist, and the therapeutic relationship. Despite the fundamental role of emotions in therapeutic

interaction, the curriculum for healthcare professionals tends to place little emphasis on developing effective emotional-related skills and strategies to protect their personal and professional well-being (Brown, 2018; Grant & Kinman, 2014). According to Perkins (2018), a therapist's education and training do not include or focus on scientific insights into emotions and an individual's emotional architecture, including EC and EI. Although EI components are woven into courses within the occupational therapy curriculum in some programs, they are seldom comprehensively addressed (Calabrese et al., 2019). Moreover, a methodological review of database searches showed that EI training was seldom part of the standard curriculum in other healthcare or medical programs (Perkins, 2018).

Furthermore, a thorough literature search demonstrates that the opportunities to develop EC for practicing professionals are also sparse. Many healthcare organizations lack on-site education to enhance employees' EI, EC and interpersonal communication skills. Many health organizations lack on-site education to enhance employees' EI and interpersonal communication skills. Lastly, while there is some EC and EI research within occupational therapy and the medical fields, studies exploring interventional approaches relating to EI and EC are minimal. Without advancing the evidence within the occupational therapy profession, there is little impetus to add a specific EC curriculum to occupational therapy programs for students and practitioners (Perkins, 2018). Thus, implementing EI and EC knowledge, skills, and research within occupational therapy will facilitate effective emotional navigation development within the profession.

The Proposed Innovation

The *EmOTions* program was developed to improve therapists' EC and therapeutic use of self within the therapeutic setting. The course draws upon various professional and adult learning theories and the latest empirical evidence. It emphasizes the importance of self-reflection and emotional knowledge as a basis for therapeutic relationships and therapist well-being in therapeutic interactions.

The *EmOTions* is a 30-hour, six-week, online continuing education course designed for practicing occupational therapists with varied experience levels in all practice settings who wish to develop their emotional knowledge and skills. The course is designed to improve therapists' EC in daily therapeutic encounters, cultivating and promoting knowledge and skills from the classroom into practice through active and meaningful learning. The sessions include lectures, in-class, and out-of-class activities for an interactive learning experience and include topics such as self-awareness, emotional perception, emotional understanding, empathetic listening, emotional regulation, and emotional management. It also includes one-on-one peer mentoring dyads to promote personal reflection, growth, and professional confidence (Doyle et al., 2019).

Additionally, a complete program protocol, called the *EmOTions Facilitator Manual*, will be published following the pilot testing for the *EmOTions* course. This manual will be the authoritative guide for the *EmOTions* program, providing summaries of the relevant theory, research, and the program's unique pedagogy. When published, this manual will aid other facilitators implement the course in their regions and disseminate the program. It is important to note that the guide is not intended to replace formal training for

teaching the *EmOTions* program.

Summary

This chapter presented the background and rationale for developing the *EmOTions* course and facilitator manual, as well as a glimpse at the program. The following chapters will elaborate on the theories and evidence prompting the creation and implementation of the *EmOTions* course and manual. Chapter 2 presents the theoretical frameworks that informed the explanatory model of the problem. It also provides a thorough literature review supporting the processes presented in the model. Chapter 3 thoroughly evaluates and synthesizes the literature on existing methods for addressing EC and EI in healthcare and provides the foundation for the rationale, design, and methods for the proposed response to the problem, presented in Chapter 4. Chapter 4 also details the *EmOTions* course and facilitator manual and provides a syllabus for the course itself. Chapter 5 then presents a detailed evaluation plan for a three-tier evaluation study, aiming to establish the connection between the course and the expected outcomes. Next, Chapter 6 outlines the planned actions and activities for disseminating the proposed program. Chapter 7 presents the funding plan for the *EmOTions* program and includes a detailed table describing the expected costs of the intervention. Finally, Chapter 8 summarizes the doctoral paper and conclusions for implementing the program with future considerations.

CHAPTER TWO – Project Theoretical and Evidence Base

Introduction

The main objective of this doctoral project is to enhance effective therapist emotional competence (EC) within the therapeutic encounter in occupational therapy practice. EC, defined as an individual's skills, confidence, and capacity to navigate emotions in different social situations, is further elaborated in Chapter 1 and Appendix A (Coetzee et al., 2016; Saarni, 1997). The proposed intervention, detailed in Chapter 4, focuses on EC as the primary outcome measure. Emotional Intelligence (EI) theories, often correlated with EC, assist in explaining the complexity of the problem and the potential solutions and will thus be the focus of this chapter. EI is defined as a person's ability to perceive, identify, regulate and effectively cope with emotions (both in oneself and others) (Zeidner et al., 2009). EI is also further explained in Chapter 1 and Appendix A.

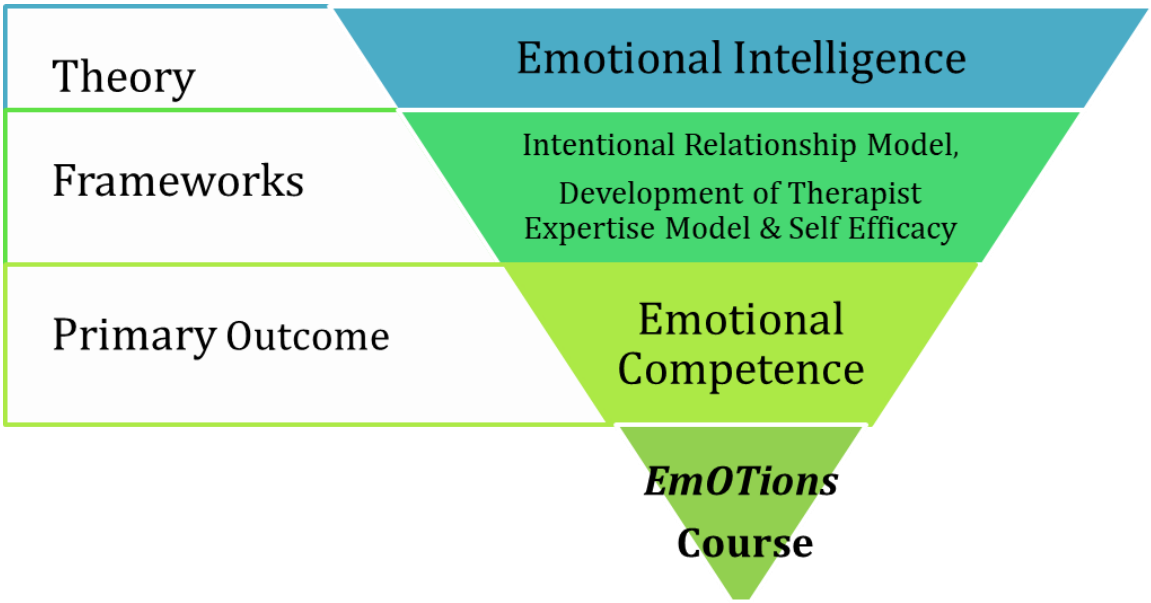
This chapter aims to determine the factors involved in the relationship between therapist EI, EC, therapist well-being, and quality of therapeutic relationships. First, this chapter will present the theoretical base for the doctoral project. Then, it will explain the explanatory model of the problem. Finally, a comprehensive review of evidence will support the associations presented in the model. The theoretical background, explanatory model, and literature review provide the foundation for the proposed intervention's rationale, focus, and aims, presented in Chapter 4.

Theoretical Base of the Doctoral Project

As illustrated in Chapter 1, the theoretical base of this doctoral project draws from

the theories and frameworks of Emotional Intelligence (EI), Intentional Relationship Model (IRM), and Emotional Competence (EC), presented in Figure 1.2. EI theories are used to understand the complexity of the problem and the presented solution (Brackett et al., 2021; Gayathri et al., 2013; Mayer & Salovey, 1997). IRM is used to situate EI within the therapeutic practice and to promote therapeutic relationships and therapeutic use of self (Taylor, 2020). Additional frameworks in the project include the Development of Therapist Expertise Model & Self Efficacy, described in Chapter 4. Finally, EC is used to explain the primary change outcomes in the proposed intervention, *EmOTions* continuing education course for occupational therapists, further described in Chapter 4 (Coetzee et al., 2016; Saarni, 1997). EC also links EI and IRM's concepts and theories. EI, IRM, and EC and their correlations are further explained below and expanded in Chapter 1 and Appendix A.

Figure 1.2. Doctoral project primary theoretical background



Emotional Intelligence

Emotional intelligence (EI) is broadly defined as a person's capacity to identify and perceive emotions (both in oneself and in others), regulate emotions, and cope effectively with emotional situations (Zeidner et al., 2009). EI is a universal skill found in every person with differing ability levels. It also presents differently in each individual, develops over a person's life span, and can be enhanced through training. The differences in individual behaviors, or skill levels, spur from differences in emotional upbringing, education, culture, age, and experiences (Brackett et al., 2021; Mayer & Salovey, 2016). However, studies have found several key findings that provide a broad picture of EI's core critical properties (Coetzee et al., 2006). There are currently three predominant models of EI. Appendix A compares the three models to show similarities and differences in EI's theoretical base.

Intentional Relationship Model, Development of Therapist Expertise Model & Self Efficacy Frameworks

The IRM is a conceptual practice model that explains the therapeutic use of self within practice to promote therapeutic relationships, as a means to facilitate occupational engagement (Taylor, 2020). Therapeutic use of self is defined as the therapists' conscious efforts to optimize interactions with clients, as the therapist consciously works with the interpersonal side of the therapeutic relationship to facilitate client outcomes (Anderson & Halbakken, 2020). The theory is further elaborated in Chapter 1 and Appendix A. Lastly, an explanation of the Development of Therapist Expertise Model & Self Efficacy Frameworks is detailed in Chapter 4.

Emotional Competence

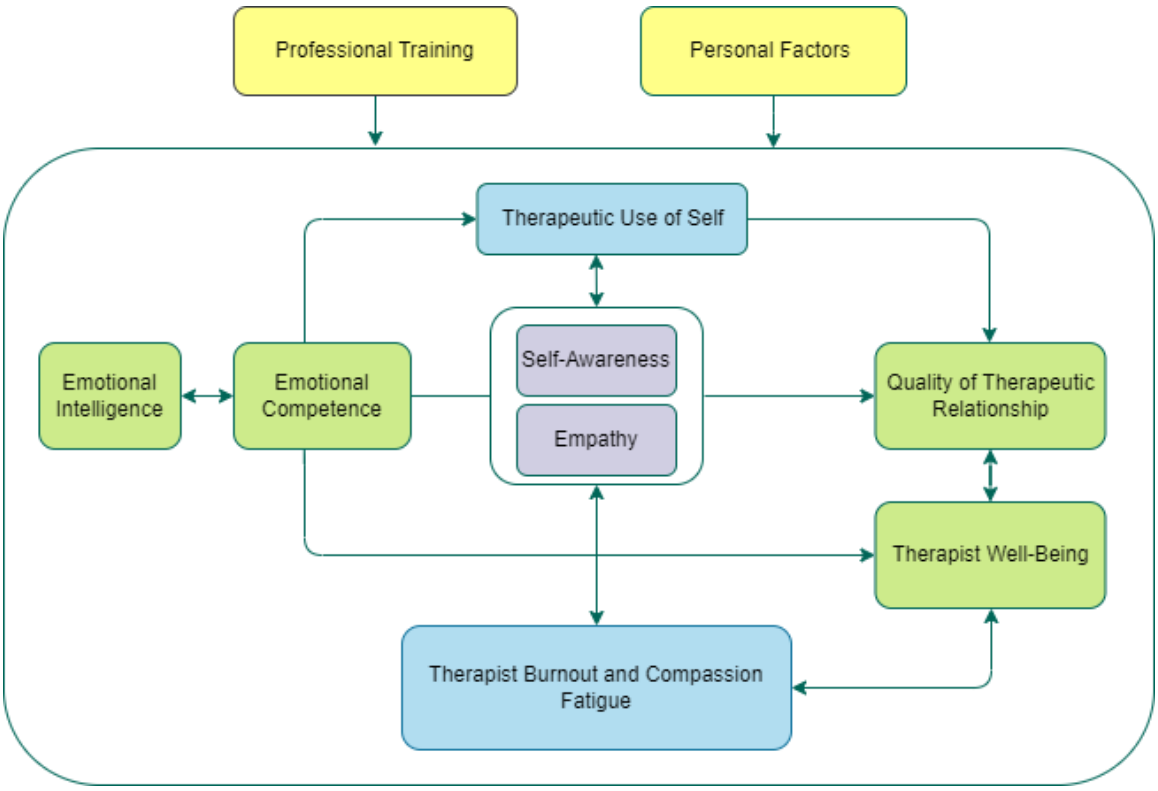
EC is defined as an individual's skills, confidence, and capacity to navigate through emotions in different social situations. It includes the identification, expression, understanding, regulation, and use of emotions (both one's own and others') (Brasseur et al., 2013). The concept of EC is used in organizational and workplace applications where individual learning, development, and performance are emphasized. The application of EC refers to how people strategically apply emotional knowledge and expression to respond to others in the face of changing social environments to navigate through interpersonal exchanges and regulate their own emotional experiences (Coetzee et al., 2016; Saarni, 1997). In this doctoral project, EC serves as the primary change outcome and is further elaborated in Appendix A.

Explanatory Model of the Problem

Figure 2.1 presents a visual explanatory model of the problem developed for this doctoral project. The model depicts the relationships between the therapist's EI and EC, the quality of therapeutic relationship, and the well-being partially mediated therapist's by self-awareness and empathy. Additional components include factors that influence EI and EC and factors influencing self-awareness and empathy. Therapist burnout and compassion fatigue (CF) as well as therapeutic use of self intercorrelate with the therapist's self-awareness and empathy. Therapist burnout and CF are also correlated with the therapist's well-being. Furthermore, EI and EC influence therapeutic use of self, which influences the quality of the therapeutic relationship. The quality of the therapeutic relationship and the therapist's well-being are also inter-correlated. Finally, professional training and personal

factors influence all the factors in the model. Each correlational relationship is supported by evidence in the following sections of this analysis.

Figure 2.1. Visual explanatory model of the problem: The influence of EI and EC on the quality of therapeutic relationship and therapist well-being



Evaluative Evidence Summary of the Explanatory Model of the Problem

The following sections will present evidence of correlations between the different causal factors. First, this section will describe the core relationship between EI, EC quality of therapeutic relationships and therapist's well-being. Next, it will review the correlations of empathy and self-awareness as moderators and therapeutic use of self and therapist burnout and CF as causal factors. Finally, the section will examine evidence to support the influence of individual professional and personal factors on other factors in the model.

Literature Search

A literature search was conducted using the electronic databases Google Scholar, PsychINFO, PubMed, and CINHAL for peer-reviewed articles published between 2011 and 2022 in academic journals. Furthermore, doctoral dissertations and book chapters were also searched for evidence using a similar search strategy. Evidence was also examined from the references list of relevant sources. Keywords were used in various combinations, including occupational therapist, occupational therapy, nursing, psychology, counseling, speech therapy, physical therapy, medicine, healthcare professionals, healthcare personnel, medical personnel, emotional competence, emotional intelligence, empathy, self-awareness, therapeutic relationship, burnout, compassion fatigue, and therapeutic use of self, and therapist well- being. When limited to meta-analysis and systematic reviews, fewer than ten articles were found.

After reviewing the relevant evidence, the search was modified for each correlational pair. For example, keywords such as Emotional Intelligence AND empathy AND occupational therapy were used for each pair. The articles found were then filtered according to rigor and prevalence to include the best evidence-based studies. Two chapters, one occupational therapy capstone, three doctoral dissertations, four systematic reviews/meta-analysis and 11 relevant articles were selected, and their findings are summarized below. A more detailed description of the articles is found in Appendix B.

Correlation Between Emotional Competence and Emotional Intelligence

The concept of EC was initially conceived from the study of EI and is based on the Mixed Model of EI, which defines EI as an ability with some social behaviors, traits, and

competencies. EC and EI are found to be correlated and are sometimes used interchangeably in the literature. However, there are significant differences in the focus and practical applications between the two terms. While EI relates to traits, abilities, and attributes of emotional functioning, EC describes the skills, knowledge, and capabilities to apply emotional information in the workplace (Coetzee et al., 2006). In other words, EC can be seen as the practical application or response capabilities of a person's EI. For example, while an EI measure might show a person's general emotional skills, an EC assessment measures how well the person can apply their emotional skills in different social situations. The application of EC refers to how people strategically apply emotional knowledge and expression to respond to others in the face of changing social environments to navigate interpersonal exchanges and regulate their own emotional experiences (Coetzee et al., 2016; Saarni, 1997).

Influence of Emotional Intelligence and Emotional Competence on Quality of Therapeutic Relationships and Therapist's Well-Being

Evidence shows a correlation between therapist EI and EC and the quality of therapeutic relationships with clients in healthcare (Perkins & Schmid, 2019). An important element for building a successful therapist-client partnership is forming a connection between healthcare professionals and clients, termed therapeutic relationship (Perkins & Schmid, 2019). The therapeutic relationship is defined as the collaboration, partnership, communication, and emotional exchange between therapists and clients (Dunleavy, 2017). The ultimate function of the therapeutic relationship in occupational therapy is to impact client engagement in therapy (Wong, 2016). In order to establish and maintain this

relationship effectively, there must be a level of trust between the client and healthcare provider, which calls for active engagement from both parties. As the relationship initiator, therapists should be cognizant of how emotions can impact the therapeutic encounter, emotionally engage with their clients to enhance the interaction, build trust, and address the client's emotional challenges in therapy to support participation (Wilkinson et al., 2017; Wong, 2016). Therefore, to create a successful therapeutic relationship, clinicians need to know their own and others' emotions to effectively communicate and empathize with their clients and regulate their own and others' affective states (Chaffy et al., 2012).

Furthermore, elements of EI, such as empathy, active listening, and compassion, positively influence higher-quality care for clients (Jiménez-Picón et al., 2021). Therapists who can personalize their responses and are aware of their communication styles can better establish a therapeutic relationship. Oppositely, there may be a detrimental negative impact on the therapeutic relationship if therapists are not conscious of the effects of emotions in treatment, are unaware of their own emotions, reactions, and biases, or disregard client emotions in the therapeutic encounter (Perkins & Schmid, 2019).

Evidence also shows a correlation between EI, EC, and the therapist's well-being. EI and EC have been shown to positively influence healthcare professionals' bio-psycho-social welfare, increasing their job performance and satisfaction, reducing stress, increasing individual resilience, perception of social support, and empathy (Jimenez- Picon et al., 2021; Perkins, 2018; Perkins & Schmid, 2019). EI also influences effective clinical decision-making, reduces burnout in the work environment, and increase work engagement (Jimenez- Picon et al., 2021). Finally, EI and EC training have been shown to lead to

improvement in several health indicators, well-being, and decreased levels of stress (Jimenez- Picon et al., 2021; Perkins, 2018; Perkins & Schmid, 2019).

Empathy and Self-Awareness As Partial Moderating Factors

Empathy.

Empathy holds substantial value for the field of occupational therapy and is studied and cited by numerous scholars (Taylor, 2020). Empathy is defined as the emotional exchange between client and practitioner, or the ability to perceive, imagine, feel, understand and respond to the emotional states of others (Crepeau & Garren, 2011; Taylor, 2020). Empathy allows therapists to create and maintain a trusting connection and rapport with the client established through collaboration, communication, and mutual respect (Crepeau & Garren, 2011; Taylor, 2020). Studies show that therapists who show empathy have more positive, effective therapeutic relationships (Beauvais et al., 2017; Taylor, 2020).

Neurophysiology and psychology studies over the past decade have found that empathic reactions are cognitively controlled through activating neural pathways associated with maintaining a compassionate “other” perspective that stimulates empathic concern and the appropriate actions to alleviate the suffering of another (Brown, 2018). There is emerging evidence to support the role the physiological mechanisms play in activating neural pathways that physiologically recreates the emotional experience of the other in the therapist. In other words, clinicians experience the same autonomic nervous system state as their clients. Thus, clinicians empathize by automatically recreating in themselves the physiological, emotional experiences of others via the unconscious

activation of mirroring neural circuits. This results in structural changes in the brain and other organ systems that are unique to compassion and empathy. The more empathetically in tune healthcare professionals are to the emotions of others, the greater the level of neural activation and shared emotions they experience. This mechanism makes empathy a double-edged sword. While empathy can promote the therapeutic relationship, it can also lead to clinicians' suffering if they are exposed to clients' suffering over time. To balance the amount of empathy, clinicians need to experience an executive or conscious response consisting of cognitive processes that regulate empathic responses. These result in deliberately controlled actions, including self-other awareness, perspective taking, and emotional reappraisal. Clinicians may experience considerable emotional pain when insufficient executive responses are elicited. As such, though empathy is an essential quality in healthcare professionals, as it allows for open communication and aids the therapist's connection to the client on an emotional level, too much empathy or insufficient executive responses can result in various stress-related conditions for the healthcare professionals themselves (Brown, 2018).

EI and EC serve as a foundation for empathy, as empathy involves the ability to understand emotions (Beauvais et al., 2017). To empathize with clients, therapists need to appraise their and others' emotions through EI. Furthermore, EI and EC aid therapists to 1. Perceive what the client is feeling, 2. Understand oneself and one's own emotions, 3. Remain interested in understanding the client, 4. Effectively communicate, even while giving unwanted messages, and 5. Develop trusting and rewarding relationships, solve problems, think creatively, and resolve disagreements (Beauvais et al., 2017). Moreover,

EI and EC include the ability to manage emotions, a skill that is essential to utilizing empathy positively while protecting the clinician from unwanted emotional distress (Brackett et al., 2021).

Self-Awareness.

Self-awareness is a skill that can assist occupational therapists in developing the ability to connect with clients emotionally and empathetically (Perkins & Schmid, 2019). Therapists need to possess self-awareness skills to be cognizant of their interpersonal patterns of behavior and verbal communication. Without accurate and critical self-awareness, the therapist will not be able to know their strengths and weaknesses and which aspects of interpersonal skills require development (Wong, 2016). In addition, therapists must constantly exercise critical self-awareness and attenuate their responses to all types of clients with the appropriate level of empathy and understanding (Taylor, 2020).

As such, self-awareness is associated with EI and EC, and when combined, they influence effective interpersonal skills and communication (Perkins & Schmid, 2019). According to Perkins & Schmid (2019), enhanced self-awareness increases EI skills, improving therapeutic rapport, communication, and collaboration skills. EI and self-awareness skills are also critical for developing positive client-therapist relationships and are often predictive of professional success (Perkins, 2018). A literature review demonstrates that self-awareness skills can increase throughout life and can be developed through educational training (Perkins, 2018). It is also shown that increased self-awareness is associated with greater quality relationships, improved communications, and greater well-being. Oppositely, when therapists' emotions are left unacknowledged, they are likely

to build up over time, leading therapists to perform and communicate in ways that might not be beneficial for themselves or their clients. This lack of communication could lead to an empathetic break in the client-therapist relationship (Dunleavy, 2017; Taylor, 2020).

Therapeutic Use of Self As An Additional Causal Factor

Therapeutic use of self is defined as a practitioner's conscious efforts to optimize client interactions. It is the planned use of the therapist's authentic characteristics, such as personality, intuition, personal experiences, perceptions, and responses to work with the client as part of the therapeutic process (AOTA, 2020; Taylor, 2020; Wong, 2016). Occupational therapists employ therapeutic use of self in client-centered practice to develop trust and understanding with clients during the therapeutic encounter (Andonian, 2017). Literature supports the importance of therapeutic use of self as an essential element in creating therapeutic relationships, maximizing the client's occupational engagement across populations and therapeutic goals, and is considered one of the strongest tools used by occupational therapists (Anderson & Halbakken, 2020; Andonian, 2017; Chaffey et al., 2012; Myers, 2014; Perkins & Schmid, 2019, Price, 2018; Wong, 2016). The selection of which strategies to use in the therapeutic intervention is based on and results from EI and EC and clinical reasoning skills (Myers, 2014).

In a study that surveyed 568 occupational therapists on their attitudes regarding therapeutic use of self and its importance in clinical reasoning, 87% viewed it as the most important skill in their practice (Myers, 2014). As a response to occupational therapists' clinical need for an explicit and integrated approach to understanding therapeutic use of self, Taylor (2020) developed the International Relationship Model (IRM). The IRM is a

conceptual practice model unique to occupational therapy that details how therapeutic use of self relates to occupational engagement (Wong, 2016). According to Taylor (2020), empathy and self-awareness are vital elements of the therapeutic use of self. These two elements, along with other interpersonal skills such as flexibility, humor, compassion, humility, and honesty, are essential to selecting the most appropriate ways of responding to a client in the therapeutic encounter (Dunleavy, 2017; Taylor, 2020).

Successful therapeutic use of self is also correlated with therapist EI and EC. Therapeutic use of self and EI share several common skills, such as self-control, reading and interpreting social cues, and self-awareness (Andonian, 2017). The two theories focus on relating to others but differ in their conceptualization. Therapeutic use of self is essentially using "self as a tool" to advance client functional performance. Therapeutic use of self and being client-centered are transactional and are enacted in relationships with others. Conversely, EI is situated within the therapist and indirectly influences relationships with others. Unlike therapeutic use of self, EI does not directly relate to occupational engagement in approach or theory. However, EI, found within the therapist, can inform the therapeutic use of self and what the therapist brings to the therapeutic relationship to further client engagement. Thus, increasing awareness of the interplay between therapeutic use of self and EI in clinical situations could be an asset to occupational therapy (Andonian, 2017).

EI theory supports the therapeutic use of self in occupational therapy in several distinct methods. First, the focus on EI theory on how emotions influence thinking supports the interactive reasoning process as part of the therapeutic use of self. This reasoning process

relies on self-perception and awareness, which inform clinical reasoning, collaboration, and decision-making (Andonian, 2017). Therapeutic use of self also calls for the ability to actively select appropriate modes of interaction and methods of delivery that are most suitable for the clients' needs. It also requires therapists to empathetically provide a therapeutic response to a client by being emotionally vigilant and responding in a regulated way. This response is especially important when a client behaves in a challenging manner in therapy that triggers unexpected or adverse reactions within the therapist. For example, when a therapist changes activity and a client reacts by accusing the therapist of being too demanding, the therapist could respond in a disciplined manner, such as acknowledging the client's doubts or fatigue and empathizing with the client's feelings, rather than responding in an undisciplined manner, such as avoiding presenting future challenges or losing patience with the client (Wong, 2016). EI skills, self-awareness, empathy, and knowledge aid occupational therapists perceive the client's relational needs accurately, understand the interactions, and choose the proper response more precisely. Similarly to EI, therapeutic use of self as a skill must be developed, reinforced, refined, and regularly monitored (Taylor, 2020).

Therapist Burnout and Compassion Fatigue As Additional Causal Factors

Evidence shows a correlation between self-awareness and empathy with therapist burnout and CF. Burnout is a psycho-social phenomenon categorized by physical and mental exhaustion caused by long-standing exposure to occupational stress (Vlachou et al., 2016). Comparably, CF is defined as an extreme state of distress resulting from exposure to a traumatized individual rather than from direct exposure to the trauma itself. CF is also

described as the development of emotional, physical and spiritual fatigue or exhaustion that results from repeated exposure to witnessing and absorbing the suffering of others (Brown, 2018). Literature shows that CF can be transferred from clients to healthcare professionals through their emphatic listening. CF is also cumulative over time and with experience. CF is characterized by reduced ability to feel empathy, along with feeling powerlessness, exhaustion, anger, irritability, affective numbness, experience sleep disturbances, intrusive thoughts and images, negative coping behaviors, diminished sense of enjoyment or satisfaction, and impaired ability to care for clients (Ariapooran, 2014; Cavanagh et al., 2020; Cococker & Joss, 2016). The feeling of prolonged emotional and physical exhaustion has negative consequences on professionals' mental health, quality of care clients receive and therapeutic relationships, worse job performance and efficiency of care, and increased conflicts among healthcare professionals and clients (Jiménez-Picón et al., 2021). According to Figley, who conducted seminal work on the topic, CF is more prevalent in persons who possess a strong empathetic orientation, are unable to distance themselves from clients psychologically, have difficulty saying no, or possess an unassertive conflict management style, such as avoiding, withdrawing, appeasing, or suppressing conflict at the expense of one's own interests. Low compassion satisfaction is also a predictor of CF. Conversely, high compassion satisfaction, or the positive aspect of helping others and being able to do one's job well, is protective against CF (Brown, 2018). Finally, the literature suggests that being new to a profession is a predictor of CF, probably due to simply having less experience or a lower sense of self-efficacy (Brown, 2018).

Healthcare clinicians have a high prevalence of burnout, CF and other negative

emotional states. According to a study on occupational therapists in Ontario, 34.8% reported high emotional exhaustion, 43.5% high levels of cynicism, and 24.6% low levels of professional efficacy (Gupta et al., 2012).

Although evidence supports an association between burnout and empathy, the findings relating to the direction and nature of the relationship are conflicting and inconclusive, with empirical evidence demonstrating both positive and negative correlations between high burnout scores and empathy (Wilkinson et al., 2017). Wilkinson and colleagues' (2017) study found three main conclusions regarding empathy and burnout: 1. Burnout reduces the ability of clinicians to respond empathically, 2. Having empathic skills draws significantly on personal resources and thus may lead to burnout and 3. Being empathic also protects clinicians from burnout (Vlachou et al., 2016; Wilkinson et al., 2017). Thus empathy, which in some studies is shown to be a positive therapeutic skill, can create vulnerability for stress-related conditions such as burnout or CF. For example, too little connection with the clients' negative emotions might result in a lack of caring and loss of therapeutic connection. In contrast, too much connection with client suffering might result in empathic over-arousal and eventually burnout (Beauvais et al., 2017). Furthermore, the overreliance on empathy can be difficult for the therapist, leading to an inappropriate level of client dependence, emotional overinvolvement, and guilt over therapeutic limits, which could lead to burnout. Due to daily emotional challenges, therapists need to find a balance in empathetic modes and emotional investment in their clients according to the therapist's personal, empathetic capabilities (Anderson & Halbakken, 2020; Perkins & Schmid, 2019). This balance can allow clinicians to

effectively respond to both demands of their jobs and their clients' therapeutic and emotional needs in the therapeutic encounter (Jiménez-Picón et al., 2021).

Clinicians could become more resilient to emotional demands by developing EI and EC-related skills, such as emotional management, empathy, and self-awareness (Jiménez-Picón et al., 2021). In a study conducted by Beauvais and colleagues (2017), EI was positively correlated with compassion satisfaction and negatively correlated with compassion fatigue and burnout in nurses. These findings support previous literature results positing that EI influences nurses' burnout and affects nurses' perceived job stress and well-being.

Professional Training, Practice Setting, Therapist Burnout, and Compassion Fatigue

Literature shows that professional training and practice settings influence therapist burnout and CF. Studies showed that the degree of burnout reported by clinicians differed significantly depending on work settings. For example, Lent and colleagues (2012) found that counselors working in community mental health outpatient settings reported more burnout than those in private practice and inpatient settings. Many specific environmental or organizational characteristics might contribute to the level of burnout and CF. Several key characteristics include work overload, lack of influence on the job, organizational inefficiency, fast-paced environment, compliance with a wide range of guidelines, and lack of supervisory supports. Therefore, interventions that positively impact the work setting may influence healthcare professionals' risk of burnout. Some examples include receiving support from colleagues and mentors, normalizing burnout-related experiences, mentoring others, social support from co-workers, supervisors, and family, and perceived

organizational support (Ariapooran, 2014; Lent et al., 2012).

Therapist Burnout, Compassion Fatigue, and Therapist's Well-Being

Evidence shows a bi-directional correlation between therapist burnout and CF and therapist's well-being. Literature shows that both CF and burnout have harmful effects on healthcare professionals' emotional and physical well-being (Ariapooran, 2014). CF and burnout can lead to emotional exhaustion, a gradual reduction of positive emotions and fatigue, depersonalization, negative or cynical attitudes toward clients, and reduced personal accomplishments, especially regarding services or professional achievements (Vlachou et al., 2016). CocCocker and Joss (2016) found that interventions promoting individual resilience and educating at-risk workers about effective coping strategies in response to those adverse job hazards are likely to have significant health benefits and reduce CF and burnout.

Therapeutic Use of Self and Quality of Therapeutic Relationships

Evidence shows a correlation between therapeutic use of self and the quality of therapeutic relationships. As a part of the doctoral dissertation, Myers (2014) found that when occupational therapists are able to utilize sensitivity, honesty, empathy, and genuineness with a client as part of the therapeutic use of self, they have greater confidence in creating therapeutic relationships and achieve better outcomes with their clients (Myers, 2014).

Quality of Therapeutic Relationship and Therapist's Well-Being

Surprisingly, a comprehensive literature search did not yield evidence of a direct

association between these two outcomes. However, the author asserts that positive therapeutic relationships lead to better treatment outcomes, therapist satisfaction, and work-related well-being.

The Influence of Personal Factors and Professional Training on the Model's Factors

Personal and professional factors influence all factors discussed above. Salovey and Mayer (1997) explain that variance in EI is moderated by individual cultural backgrounds and emotional knowledge base. An individual's emotional knowledge base is defined as the amount of EI they develop over time. It is influenced by many factors, such as the amount and quality of opportunities for learning and developing emotional understanding, emotional upbringing, education, age, and personal experiences. From these factors, individuals can become more emotionally intelligent naturally or through education (Mayer & Salovey, 2016; Salovey & Mayer, 1997;). These differences can be observed in how individuals recognize, understand, and express their emotions with differences in processing abilities and styles with various success levels.

Evidence also supports that EI and EC can be developed through education and training and that individuals can develop and increase EI and EC skills throughout their lifespan (Perkins, 2018). However, there is a lack of consensus on the best EI training structure, duration, and skill transfer into the clinical practice for occupational therapists. Approaches that were found effective included a formal curriculum that addresses professionalism and EI-based models, supervision that focuses on understanding and using emotions within the practice, and reflection time in personally tailored EI training (Chaffey et al., 2012; Kotsou et al., 2011; Perkins, 2018). More prolonged exposure to materials and

opportunities to self-reflect increased competency and retention of EI and EC skills (Kotsou et al., 2011; Perkins, 2018). Similarly, therapeutic use of self is an occupational therapy skill that must be developed, supported, monitored, and refined through training (Taylor, 2020). A thorough review of evidence on approaches to enhance EI and EC via professional training is presented in Chapter 3.

Summary

The objective of this chapter was to provide the theoretical underpinnings of the *EmOTions* course and explain how therapists' EI and EC influence their well-being and therapeutic relationships, as well as the variety of factors participating in this process. These factors included therapeutic use of self, empathy, self-awareness, burnout, and CF, along with the therapists' personal factors and professional training. The relationships between the factors are explained through an explanatory model of the problem. Lastly, a comprehensive review of the evidence was presented to substantiate the associations presented in the model. The next chapter will evaluate and synthesize relevant literature on existing methods for addressing EI and EC in healthcare.

CHAPTER THREE – Overview of Current Approaches and Methods

Introduction

The main objective of this doctoral project is to enhance effective therapist emotional competence (EC) within the therapeutic encounter in occupational therapy practice. EC, defined as an individual's skills, confidence, and capacity to navigate emotions in different social situations, is further elaborated in Chapters 1 and 2 and Appendix A (Coetzee et al., 2016; Saarni, 1997). Moreover, EC's relationship with Emotional Intelligence (EI) is also described in both Chapter 2 and Appendix A. EI is defined as a person's competence to perceive, identify, regulate and cope effectively with emotions (both in oneself and others) (Zeidner et al., 2009). Although the proposed intervention, detailed in Chapter 4, focuses on EC as the primary measured outcome, EI theories assist in explaining the complexity of the problem and potential solutions in the literature. Thus, this chapter will focus on both EI and EC as key factors. EI and EC's effects on therapists' therapeutic relationships and their therapeutic well-being will be examined. This chapter aims to thoroughly evaluate and synthesize the literature on existing methods for addressing healthcare professionals' EI and EC to improve their therapeutic relationships and therapist well-being. This literature review provides the foundation for the rationale, design, and methods for the proposed response to the problem, presented in Chapter 4.

Evaluative Summary

Literature Search

A literature search was conducted using the electronic databases Google Scholar, PsychINFO, PubMed, and CINHAL for peer-reviewed articles published between 2011 and 2022 in academic journals. Evidence was also disclosed from the references list of relevant articles. Keywords were used in various combinations, including occupational therapy, occupational therapist, nursing, psychology, counseling, speech therapy, physical therapy, medicine, healthcare professionals, healthcare personnel, medical personnel, emotional intelligence, and emotional competence. Most studies about EI and EC found were correlational, comparing EI or EC to a multitude of different factors, such as burnout, stress management, communication skills, job satisfaction, and empathy. When limited to interventional studies, utilizing the additional search terms of training, education, and intervention, less than thirty studies were found. The search was narrowed by removing articles that did not include practitioner-based outcomes and were not experimental or literature review studies. The articles found were then filtered according to rigor and prevalence to include the best evidence-based studies. Seventeen relevant articles were selected, of which sixteen pertained to EI, and one to EC and their findings are summarized below. For more details on the included evidence, see Appendix C.

Overview- Emotional Intelligence

Type of Report.

Several studies evaluating EI training were found in the literature review, with

varying research approaches and designs. These studies included two qualitative and mixed methods reviews (Grant et al., 2014; Gribble et al., 2019) and one literature review study (Foster et al., 2015). Four randomized control trial (RCT) studies (Erkayiran et al., 2018; Gorgas et al., 2015; Meng et al., 2018; Shahbazi et al., 2018) and six cohort studies (Abe et al., 2013; Calabrese et al., 2019; Dugan et al., 2014; Grant et al., 2014; Polonio-López et al., 2019; Vishavdeep et al., 2016) were also found. In addition, one article summarized a poster presentation that compared first and second-year masters of occupational therapy students (Perkins et al., 2020). Finally, three articles found were either non-randomized control trials (Gribble et al., 2017) or control trials comparing different groups (Bamberger et al., 2017; Pearson et al., 2017).

Study Participants and Study Locations.

Studies conducted on EI training covered a wide range of participants and study locations. Of the sixteen articles, five studies examined practicing healthcare professionals and not students (Bamberger et al., 2017; Dugan et al., 2014; Gorgas et al., 2015; Pearson et al., 2017; Perkins et al., 2020). In addition, five studies examined nurses and nursing students (Erkayiran et al., 2018; Foster et al., 2015; Meng et al., 2018; Shahbazi et al., 2018; Vishavdeep et al., 2016), five studies examined occupational therapy students (Calabrese et al., 2019; Gribble et al., 2017; Gribble et al., 2019; Perkins et al., 2020; Polonio-López et al., 2019), and three examined medical students and medical residents (Abe et al., 2013; Gorgas et al., 2015; Dugan et al., 2014). The rest of the articles reported on students and professionals in social work, pediatric teams, physiotherapy, speech pathology, and counseling (Bamberger et al., 2017; Grant et al., 2014; Gribble et al., 2017;

Gribble et al., 2019; Pearson et al., 2017). The quantity of participants ranged from 17 to 376 (Grant et al., 2014; Gribble et al., 2017), and collectively were 1,776 participants in the 16 studies on EI.

The intervention sites were most frequently hospitals and universities, with one study conducted in an International Federation of Medical Students' Association, Asia Pacific Regional Meeting (Abe et al., 2013). However, the articles also varied in location, as there were studies conducted in India (Vishavdeep et al., 2016), China (Meng et al., 2018), Iran (Shahbazi et al., 2018), Spain (Polonio-López et al., 2019), Turkey (Erkayiran et al., 2018), Israel (Bamberger et al., 2017), United Kingdom (Grant et al., 2014; Pearson et al., 2017), United States (Calabrese et al., 2019; Dugan et al., 2014; Gorgas et al., 2015; Perkins et al., 2020), Australia (Gribble et al., 2017; Gribble et al., 2019), and Asia-Pacific (Abe et al., 2013), showing the global extent of the importance of EI in healthcare.

Results by Key Topics.

Outcome Measures and Their Corresponding Theoretical Models.

The literature showed various EI outcome measures. The three main outcome measures included the Trait Emotional Intelligence Questionnaire (TEIQue) (Abe et al., 2013; Perkins et al., 2020), the Schutte Self-Report Emotional Intelligence Test (SSEIT) (Grant et al., 2014; Meng et al., 2018), and the Bar-On's Emotional Quotient Inventory (EQ-i) (Bamberger et al., 2017; Dugan et al., 2014; Erkayiran et al., 2018; Gribble et al., 2017; Shahbazi et al., 2018). Interestingly, each of the three primary outcome measures stems from different theoretical models of EI. The TEIQue is a measure based on

Goleman's EI Performance Model or the mixed model. The SSEIT is based on the ability-based EI model, while the EQ-i is based on the trait model (Foster et al., 2015). Descriptions of predominant EI models are found in Appendix A. Other assessments in the studies included the Hay 360 Emotional Competence Inventory (ECI), Emotional Intelligence Self-Assessment Questionnaire (EISAQ), Trait Meta-Mood Scale (TMMS-24), Emotional Intelligence Test (EIT), non-standardized self-reported surveys created by the study authors, and qualitative measures such as half-structured interviews (Calabrese et al., 2019; Grant et al., 2014; Gribble et al., 2019; Gorgas et al., 2015; Pearson et al., 2017; Polonio-López et al., 2019; Vishavdeep et al., 2016). These remaining assessments, excluding the non-standardized and qualitative measures, all assess EI through the trait-based EI theoretical model lens.

All seven standardized measures used were self-reported questionnaires. Thus, all the outcomes described self-reported changes in perceptions of EI and not necessarily objective changes in a person's EI. Although potentially more challenging to measure, there is a need to conduct further research utilizing performance assessments to measure the behavioral change in EI correlating to the intervention provided.

Intervention Approaches.

The literature outlined several interventional approaches for increasing EI capacities. The most frequently cited intervention was a workshop, with nine out of the sixteen studies employing a form of workshop in their approach (Abe et al., 2013; Bamberger et al., 2017; Dugan et al., 2014; Erkayiran et al., 2018; Gorgas et al., 2015; Grant et al., 2014; Meng et al., 2018; Shahbazi et al., 2018; Vishavdeep et al., 2016). The

workshop duration varied in each study and ranged from one half-day workshop (Abe et al., 2013) to seven years of a repeated eight-hour training program (Dugan et al., 2014). In addition, some workshops had one meeting (Abe et al., 2013, Gorgas et al., 2015; Grant et al., 2014), while others included multiple sessions (Bamberger et al., 2017; Dugan et al., 2014; Erkayiran et al., 2018; Meng et al., 2018; Pearson et al., 2017; Shahbazi et al., 2018; Vishavdeep et al., 2016). The main themes regarding the workshop's content and method of administration are summarized in the two tables below (see Table 3.1 and Table 3.2).

Table 3.1. Main themes of content in workshops

Main Themes of Content in Workshops	Referenced Articles
A personal story from an experienced colleague	Abe et al., 2013 Dugan et al., 2014 Grant et al., 2014 Vishavdeep et al., 2016
Teaching one or more elements of EI theory	Bamberger et al., 2017 Dugan et al., 2014 Erkayiran et al., 2018 Gorgas et al., 2015 Grant et al., 2014 Meng et al., 2018
Connection of EI theory to the professional realm	Bamberger et al., 2017 Dugan et al., 2014 Gorgas et al., 2015 Pearson et al., 2017 Vishavdeep et al., 2016
Description of the benefits of EI training activities (explicitly explaining the rationale)	Gorgas et al., 2015

Table 3.2. Main themes of delivery approach in workshops

Main Themes of Delivery Approach in Workshops	Referenced Articles
Group discussions (either in large or small groups)	Abe et al., 2013 Bamberger et al., 2017 Gorgas et al., 2015 Grant et al., 2014 Meng et al., 2018 Pearson et al., 2017 Shahbazi et al., 2018
Reflective activities	Abe et al., 2013 Dugan et al., 2014 (reflection with faculty input) Grant et al., 2014 Pearson et al., 2017
Role-play simulations	Bamberger et al., 2017 Dugan et al., 2014 Pearson et al., 2017
Dissection of case studies	Bamberger et al., 2017 Gorgas et al., 2015
Preparation and presentation of EI topics/reflections to others	Bamberger et al., 2017 Gorgas et al., 2015
Feedback of performance/ score during the intervention	Dugan et al., 2014 (Comparison of personal EI scores with scores of others) Pearson et al., 2017 (Feedback from skill-based practice from peers and tutors)

The two tables summarize the main themes seen in the articles regarding the main content and administration methods of the EI workshops. Teaching about one or more elements of EI theory was the most frequently found activity in the workshops, while group discussions were the most common method of administration. The size of the group discussions differed for the different studies, ranging from large to small groups. The number of people in each group was not explicitly mentioned in the studies. Interestingly,

four studies did not directly teach EI terms or other concepts relating to EI in their interventional workshops (Abe et al., 2013; Perkins et al., 2020; Polonio-López et al., 2019; Shahbazi et al., 2018).

The categorization process for Tables 3.1 and 3.2 was based on the articles' described interventional approaches. One outlier was Pearson and colleagues' (2017) article, which was included in the role-play simulations method, even though the authors described using "skill-based practice" (p. 615) and not simulations. In addition, in the category of feedback on performance/score during the intervention, Dugan and colleagues (2014) and Pearson and colleagues (2017) utilized different feedback modes. Dugan and colleagues (2014) described comparing personal EI scores from prior assessments with scores of others to provide performance feedback, while Pearson and colleagues (2017) provided feedback through both peers and tutors throughout the workshop.

Although most articles described workshops as their primary interventional approach to improving EI, other articles described additional types of interventions. Calabrese and colleagues (2019) developed a series of asynchronous online interventions that included teaching elements of EI theory. Dugan and colleagues (2014) utilized mentoring modeling in clinics. Four studies utilized written reflective methods, such as reflective journaling (Grant et al., 2014; Pearson et al., 2017; Perkins et al., 2020) and structured reflective activities (Calabrese et al., 2019). There were some differences between the articles regarding the timing of the journals. Grant and colleagues (2014) explicitly described requiring journals to be written throughout the fieldwork experience, Pearson and colleagues (2017) encouraged journaling throughout the intervention period, and Perkins

and colleagues (2014) did not describe when the journaling took place. Four studies described utilizing fieldwork experience in varying lengths for EI improvement (Gribble et al., 2017; Gribble et al., 2019; Pearson et al., 2017; Polonio-López et al., 2019). Other intervention methods included visual aids such as training pamphlets and posters (Meng et al., 2018) and high-risk/high-stress simulations in the training program (Dugan et al., 2014). Lastly, three articles did not detail their intervention explicitly (Erkayiran et al., 2018; Vishavdeep et al., 2016; Pearson et al., 2017).

Evaluation of Results/ Effectiveness.

Study Results Comparison.

Due to the vast diversity in the studies' interventions, it is difficult to compare and determine which program content or delivery approach was most effective. However, all the studies found pointed to positive changes in EI post-interventions. The main evaluation results are summarized in Table 3.3.

Table 3.3. Main interventional studies evaluation results

Main Interventional Studies Evaluation Results	Referenced Articles
Changes in a range of EI skills	Erkayiran et al., 2018 Gribble et al., 2017 Meng et al., 2018 Pearson et al., 2017 Perkins et al., 2020 Polonio-López et al., 2019 Vishavdeep et al., 2016
Specific improvements in the five Bar-On dimensions of EI	Bamberger et al., 2017 Dugan et al., 2014 Gribble et al., 2019 Shahbazi et al., 2018
Changes in attentive listening Changes in confidence in managing emotional challenges	Abe et al., 2013
Sustained improvement post-intervention ranging from two months to a year	Dugan et al., 2014 Shahbazi et al., 2018
Application of training in practice	Dugan et al., 2014
Improved knowledge of key components of EI Increased self-perception of EI skills	Calabrese et al., 2019
Improved interpersonal relationship styles	Erkayiran et al., 2018
Increased level of reflective ability and empathy	Grant et al., 2014
Decrease perceived stress Increased communication skills, with significant benefits on tension, verbal skills, audible skills, and feedback skills	Meng et al., 2018

In multiple studies, results differed according to nationality (Abe et al., 2013), gender (Abe et al., 2013; Polonio-López et al., 2019), fieldwork practice area (Polonio-López et al., 2019), participants' profession (Bamberger et al., 2017), and level of education (undergraduate versus postgraduate levels) (Pearson et al., 2017).

Although most of the evidence demonstrated the studies' effectiveness, few studies reported a few ineffective or adverse effects on their participants. For example, along with significant positive increases in EI scores on the Bar-On assessment, Gribble and colleagues (2019) found declining scores in emotional expression, assertiveness, self-

expression, and stress tolerance after the intervention. As the study utilized students and the intervention consisted of a set of clinical fieldwork interventions, this score decline could be explained by many factors. Some factors include a difference in environments, roles, and stressors in the healthcare workplace compared to life as a university student. Furthermore, this gap might also correlate to inadequate quality student supervision in clinical placements, which could negatively impact the students' performance and EI competencies (Gribble et al., 2019). Gorgas and colleagues' (2015) study found no significant improvement in EI scores immediately following their brief intervention, which focused on social perspective taking (SPT). However, when testing six months post-intervention, the intervention group's EI scores significantly improved, whereas the control group's scores had not (Gorgas et al., 2015). This study highlights the importance of allowing time for changes to occur after the intervention while also questioning the sensitivity of the assessment in capturing short-term changes.

Overview- Emotional Competence

Kotsou and colleagues (2011) conducted a literature review to find the key determinants of success in creating an intervention for EC in healthcare. They found several critical findings. First, effective interventions must be rigorous, scientifically derived, and valid programs. Secondly, a coherent, content, and process-based rationale is critical. The process-based model should include tools that allow participants to be more specific about their emotional experiences, fostering their self-efficacy over time. Thirdly, the intervention should include experiential, behavioral, and pragmatic training. Participants should have the opportunity to practice their newly-acquired tools in relevant

contexts, which will help them develop models and references for competencies needed in the future. Fourthly, the intervention should include a learning context that fosters emotional self-awareness. As one becomes more aware of their emotional habits and tendencies, they will have an easier time regulating their own emotions and developing behavior flexibility. Finally, the last key ingredient is following up with the participants. Change does not typically occur immediately, as effort and time are necessary. As such, follow-up via the internet is cost-effective and can be highly efficient and straightforward to access and complete, assuming the intervention fosters a dynamic motivational environment. It also serves as a reminder for the participants to continue applying the different skills taught in the intervention and maintain their motivation for change (Kotsou et al., 2011).

Active Ingredients of Effective Emotional Intelligence and Emotional Competence Training

The evidence presented in this chapter was collected from the 17 articles that present rigorous studies of EI and EC training effectiveness. The training was beneficial to diverse groups, including healthcare professionals, healthcare students, academic institutions, teaching hospitals, and supervisors to healthcare students.

The key interventional ingredients found in the studies included the training content, the delivery approach, and specific learning activities. The key ingredients in the workshop structure included using personal stories from an experienced colleague, educating on the elements of EI or EC, connecting the EI theory to the professional realm, explicitly explaining the benefits of EI and EC training activities, allowing the participants

to practice EC and EI tools in relevant contexts, and emphasizing the development of emotional self-awareness (See Table 3.1 and the Overview-Emotional Competence section for details). The content delivery approach in the workshops was found to be most effective when it consisted of experiential, behavioral, or pragmatic activities, using group discussions, reflective activities, role-play simulations, dissection of case studies, preparation and presentation of EI or EC topics/reflections to others, and feedback on performance/ score during the intervention (Table 3.2 and the Overview-EC section). Finally, utilizing high-risk/high-stress simulations in the training program (Dugan et al., 2014) and following up with participants (Kotsou et al., 2011) were also influential.

Additional valuable learning activities included asynchronous online interventions that included teaching EI theory (Calabrese et al., 2019), modeling mentors in clinics (Dugan et al., 2014), written reflective methods (Calabrese et al., 2019), reflective journaling (Grant et al., 2014; Pearson et al., 2017; Perkins et al., 2020), fieldwork experiences (Gribble et al., 2017; Gribble et al., 2019; Pearson et al., 2017; Polonio-López et al., 2019), and visual aids such as training pamphlets and posters (Meng et al., 2018).

Summary

This chapter assessed and synthesized the key ingredients found in the literature on existing methods for addressing EI and EC for healthcare professionals to improve therapist well-being and the therapeutic relationship. The literature review, including the key ingredients found, provides the rationale, design, and methods in the proposed intervention to the problem presented in Chapter 4.

CHAPTER FOUR – Description of the Proposed Program

Introduction

The main objective of this doctoral project is to enhance effective therapist emotional competence (EC) within the therapeutic encounter in occupational therapy practice. EC, defined as an individual's skills, confidence, and capacity to navigate emotions in different social situations, is further elaborated in Chapters 1 and 2 and Appendix A (Coetzee et al., 2016; Saarni, 1997). Moreover, EC's relationship with Emotional Intelligence (EI) is also described in both Chapter 2 and Appendix A. EI is defined as a person's competence to perceive, identify, regulate and cope effectively with emotions (both in oneself and others) (Zeidner et al., 2009). This chapter aims to describe the proposed response to the problem that was presented in Chapters 1 and 2. First, the chapter will provide a program overview. Then it will illustrate and deconstruct the program logic model, defining the theoretical base of the program, the participants and resources, interventions and activities, and outputs and outcomes of the program. Finally, anticipated barriers and challenges will be presented.

Program Overview

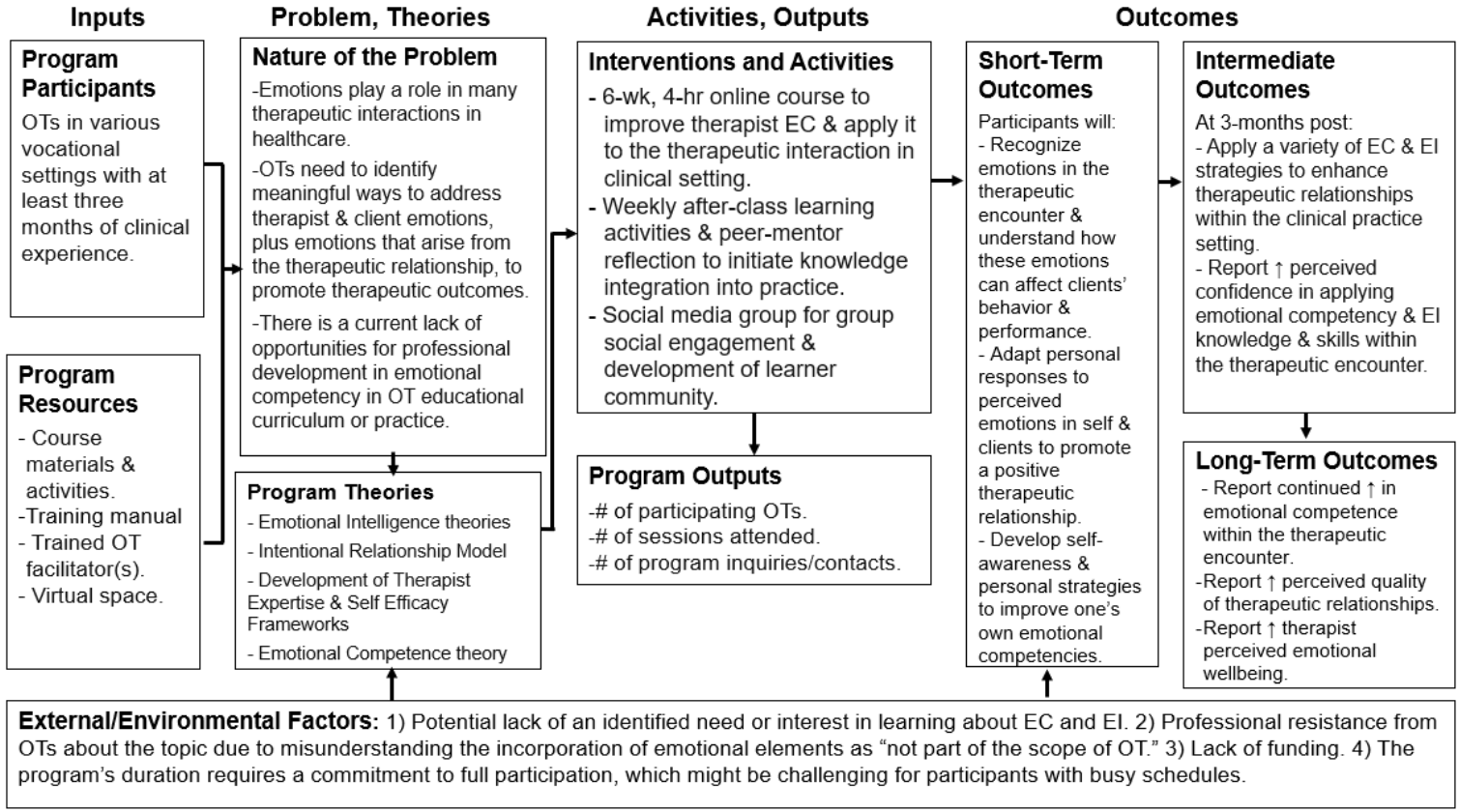
The *EmOTions* program is a comprehensive six-week, 30-hour online continuing education course for practicing occupational therapists. Its primary purpose is to effectively build and incorporate EC skills into daily therapeutic practice. The course draws upon various professional and adult learning theories as well as the latest empirical evidence and emphasizes the importance of self-reflection and emotional knowledge as a basis for therapeutic relationships and therapist well-being in treatment.

The *EmOTions* course is designed for occupational therapists with varied experience levels in all practice settings who wish to develop their emotional knowledge and skills. The course is created for working clinicians and supports cultivating and promoting knowledge and skills from the classroom into practice through active and meaningful learning. The lessons are live for an interactive learning experience. The topics covered include self-awareness, emotional perception, emotional understanding, empathetic listening, emotional regulation, emotional management, therapeutic use of self, emotional competence, and emotional intelligence. The course also includes one-on-one peer mentoring dyads to promote personal reflection, growth, and professional confidence (Doyle et al., 2019).

Additionally, a complete program protocol, called the *EmOTions Facilitator Manual*, will be published following the pilot testing for the *EmOTions* course. This manual will be the authoritative guide for the *EmOTions* program, providing summaries of the relevant theory, research, and the program's unique pedagogy. When published, this manual will aid other facilitators implement the course in their regions and disseminate the program. It is important to note that the guide is not intended to replace formal training for teaching the *EmOTions* program.

Figure 4.1 provides a logic model illustrating the conceptual blueprint of the *EmOTions* program. It outlines the program's key inputs and resources, theories explaining the nature of the problem and interventions, external and environmental factors, intervention activities, and expected outcomes. The following sections in this chapter will elaborate on each element described in the logic model below.

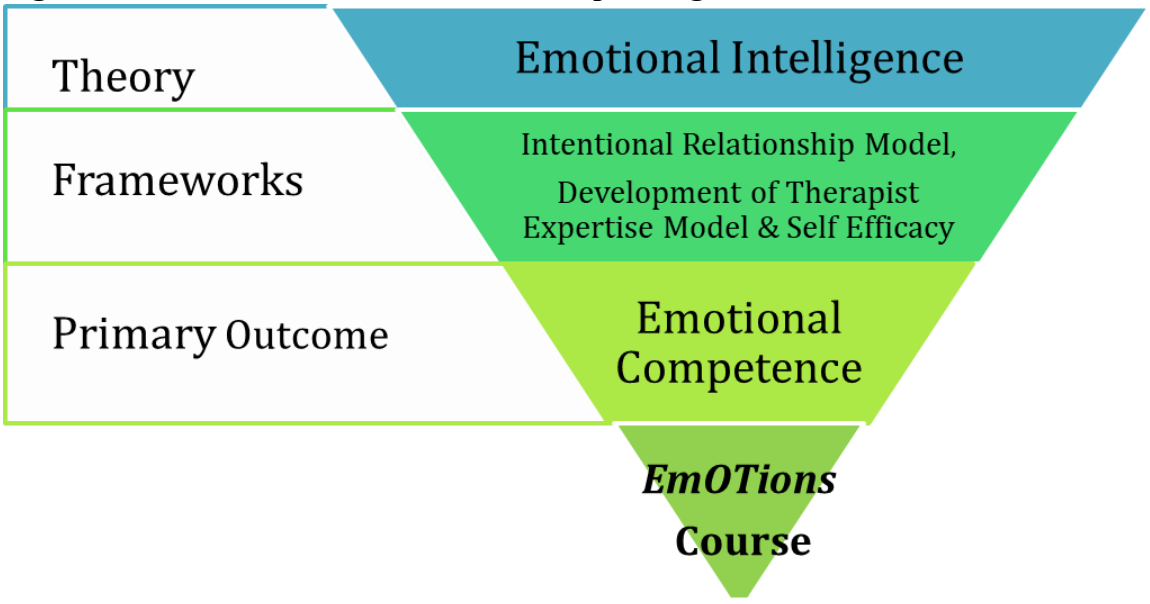
Figure 4.1. *EmOTions* program logic model



Theoretical Base of the EmOTions Program

The *EmOTions* program is based on EI, IRM, professional development, and EC theories and frameworks, presented in Figure 1.2. The primary theoretical base is EI theories (Brackett et al., 2021; Gayathri et al., 2013; Mayer & Salovey, 1997). Specific clinical application strategies are drawn from Taylor's IRM Framework for therapeutic use of self (Taylor, 2020). The course delivery approach is designed according to the Development of Therapist Expertise Model and Framework (King, 2009) and includes an element of Self-Efficacy Theory (Bandura, 1986). These theories were chosen based on studies highlighting the importance of actively integrating adult learning principles in teaching and facilitating knowledge application into practice to improve student learning in healthcare professional development (Mukhalalati & Taylor, 2019). Finally, EC explains the key mediating concept, representing the primary change outcome in the proposed intervention (Coetzee et al., 2016; Saarni, 1997).

Figure 1.2. *EmOTions* intervention's corresponding models/theories



Emotional Intelligence Theory.

Emotional Intelligence (EI) is broadly defined as a person's capacity to identify and perceive emotions (both in oneself and in others), regulate emotions, and cope effectively with emotional situations (Zeidner et al., 2009). It is a relatively new model, coined in 1990 by Salovey and Mayer, and seeks to explore the role of emotions in cognition while increasing recognition of the substantive value of emotions in general (Dhani & Sharma, 2016; Mayer & Salovey, 1997; Mayer & Salovey, 2004). EI considers how individuals can recognize, understand, process, manage, monitor, and utilize emotional information (McKenna, 2013). EI is a universal skill found in every person with differing ability levels and also presents differently in each individual, develops over a person's life span, and can be enhanced through training. The differences in individual behaviors, or skill levels, arise from differences in emotional upbringing, education, culture, age, and experiences (Brackett et al., 2021; Mayer & Salovey, 2016).

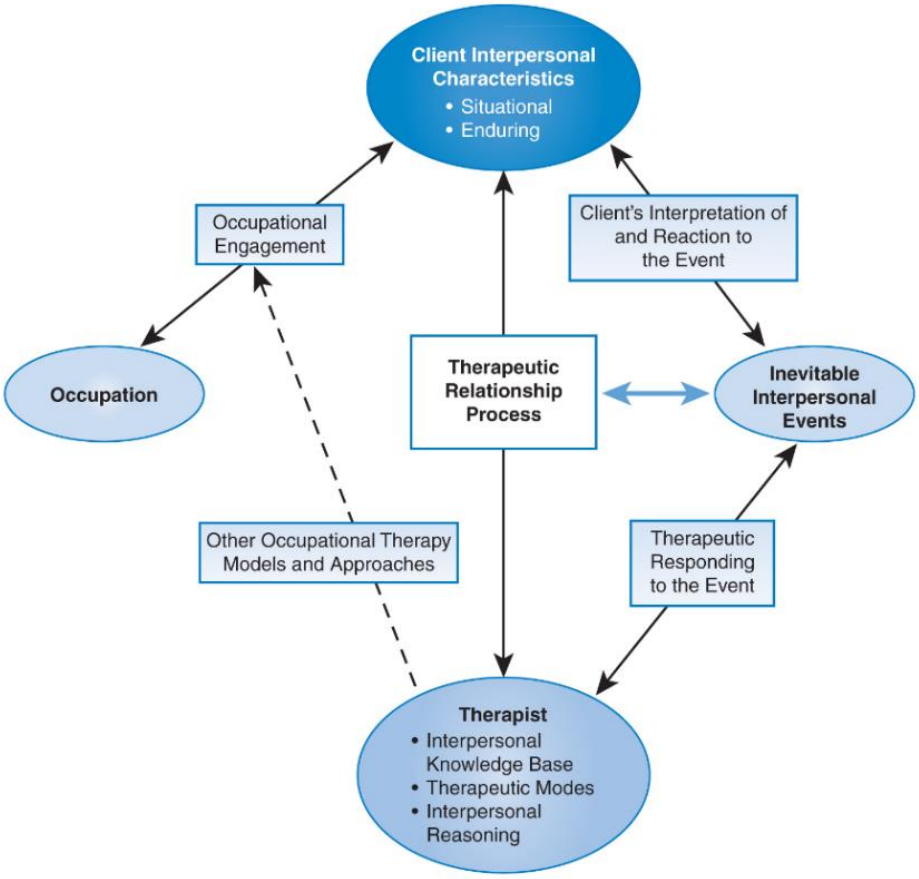
EI as a concept is based on extensive scientific and research evidence. Over the years, several theories have been formed explaining EI and its different components. Unfortunately, many of these theories utilize overlapping concepts for EI, and no general census has been reached on its operationalization. Today, three predominant EI models have separate elements and domains. These models are the Ability Model, Mixed Model, and Trait Model. Appendix A compares these three models and presents similarities and differences in the theoretical basis of EI.

Intentional Relationship Model.

The IRM was created by Taylor (2008) as a conceptual practice model intended to be used in conjunction with other models in occupational therapy practice. The IRM explains the therapeutic use of self within the practice to promote therapeutic relationships to facilitate occupational engagement (Taylor, 2020). Therapeutic use of self is defined as the therapist's conscious efforts to optimize interactions with clients, as the therapist consciously works with the interpersonal side of the therapeutic relationship to facilitate client outcomes (Anderson & Halbakken, 2020).

The IRM consists of four central elements: the client, interpersonal events in therapy, the therapist, and the occupation. The client is the focal point in the intervention, with the therapist responsible for developing a positive relationship with the client (Anderson & Halbakken, 2020). Each client has interpersonal characteristics that are either situational or enduring that influence the therapeutic relationship. Finally, the therapist, trained in interpersonal skills, interpersonal reasoning, and the ability to use therapeutic modes, can influence the inevitable interpersonal events that occur in practice, enhance the therapeutic relationship, and improve the client's occupational engagement (Taylor, 2020). Figure 4.2 illustrates the components of the IRM model. Additionally, the IRM model is expanded in Appendix A.

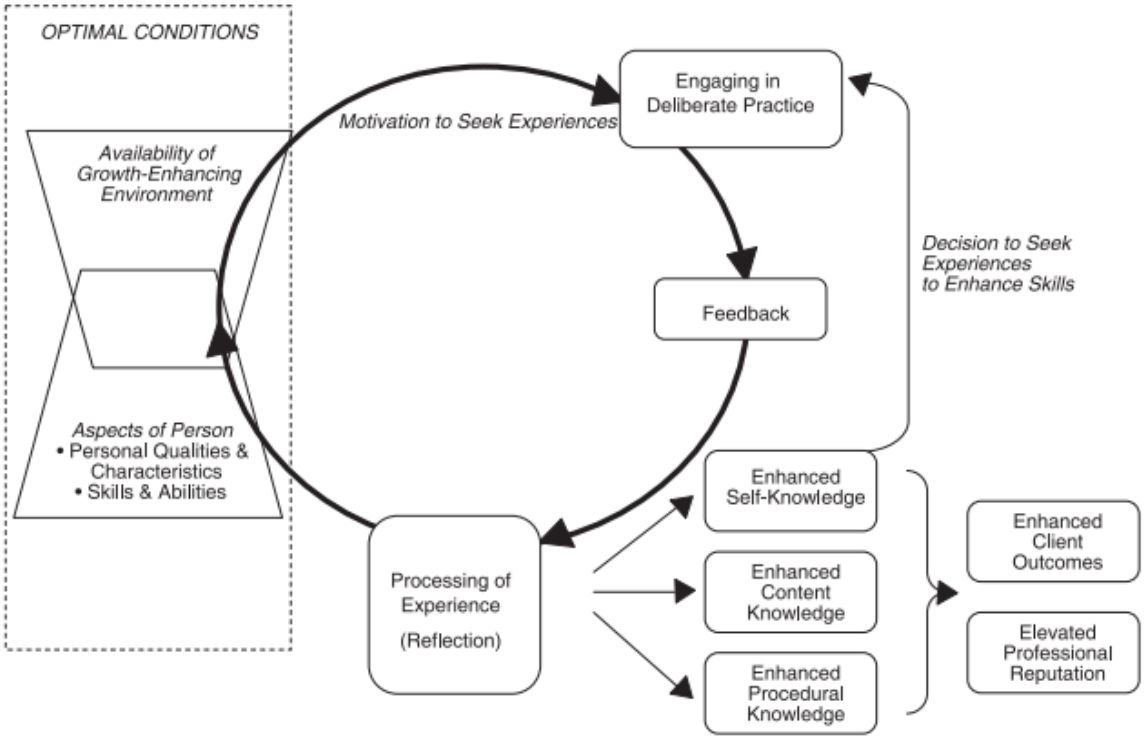
Figure 4.2. Taylor's (2020) Intentional relationship model.



Development of Therapist Expertise Model and Framework.

King (2009) created a model of expertise development and a framework for personal and environmental learning-based strategies to foster therapist expertise. The model of expertise development depicts the development of clinical expertise as an ongoing process that requires individual motivation to seek experiences, engage in deliberate practice, receive feedback, and process the experience through reflection. It also includes optimal personal capacities and recommends an environmental context that offers support, opportunities, and resources for optimal experiences for professional development (King, 2009; Gafni-Lachter, 2015). Figure 4.3 presents the model in its entirety.

Figure 4.3. King's (2009) model of factors and processes in the development of professional experience



In addition, King (2009) expanded on the model by providing 21 learning-based strategies for the development of therapist expertise. These include personal level strategies, personal experiences, supports and resources, and workplace opportunities to promote professional growth. The model's key ingredients for developing professional expertise are combining instructional, experiential, and observational learning with support from individualized feedback and reflection (Gafni-Lachter, 2020; King, 2009). These ingredients inform the *EmOTion* program and are incorporated as central learning mechanisms throughout the course.

Bandura's Self-Efficacy Theory.

Bandura (1986) defined self-efficacy as task-specific confidence or self-judgment of one's ability to perform a specific action required in a particular situation. Self-efficacy has been studied in many fields and was found to mediate learning and performance in various tasks (Gafni-Lachter, 2015). Individuals with high self-efficacy in a specific area of function are more likely to develop effective task strategies, problem-solve and respond positively to negative feedback than those with low self-efficacy (Gafni-Lachter, 2015). Evidence shows that self-efficacy is contingent on self-observation, evaluation and responsiveness to environmental feedback and personal perceived success and failures. Self-efficacy beliefs related to clinical abilities influence healthcare providers' clinical behaviors (Clemons, 2017). Moreover, substantial evidence shows that when clinical self-efficacy is lacking, the implementation of clinical knowledge becomes limited (Gafni-Lachter, 2020). Clinicians must acquire both knowledge and skills and the confidence to utilize them. Therefore, it is vital to address self-efficacy in the *EmOTion* course content to enhance professional capabilities and practices.

Emotional Competence Theory.

As previously stated, EC is defined as an individual's skills, confidence, and capacity to navigate through emotions in different social situations. It includes the identification, expression, understanding, regulation, and use of emotions (both one's own and others') (Brasseur et al., 2013). The application of EC refers to how people strategically apply emotional knowledge and expression to respond to others in the face of changing

social environments to navigate through interpersonal exchanges and regulate their own emotional experiences (Coetzee et al., 2016; Saarni, 1997). EC is essential in establishing empathetic therapeutic relationships (Lenneville, 2014). EC is further elaborated in Appendix A. In the *EmOTions* program, EC serves as the primary change outcome, as studies show that when EC is enhanced through training, psychological, social, and work adjustments improve in both statistically and practically meaningful ways (Mikolajczak et al., 2015).

Program Participants and Resources

Program participants will include occupational therapy practitioners from various vocational settings with varying clinical experience. Each course cohort will include 20-25 participants. The program will be offered online through Zoom, with materials posted using the Google Classroom learning platform. Participants will need a computer with a camera and internet access to participate in the program. Necessary resources include hard-copy and digital versions of materials and activities to implement the course.

The primary facilitator will be the course developer, an occupational therapist with EI and EC expertise. A second facilitator will be added if necessary to help promote small group interactions for high student-facilitator interactions. Other personnel includes an administrative assistant and an IT support consultant. Table 4.1 shows the different personnel involved in the program facilitation and their respective roles.

Table 4.1. Personnel and roles in *EmOTions* program

Title	Role	Description of Duties
Occupational Therapist	Lead Facilitator	Teach classes in the course. Gather, and disperse resources.
Other Healthcare Clinicians (occupational therapist, Counsellor, Social Worker, Psychologist)	Co-Facilitator (in case of large class signup)	Co-teach classes in the course. Gather and disperse resources concurrently.
Administrative Assistant	Administrative	Manage enrolment, facilitate communications, support scheduling, oversee and maintain electronic media and advocacy.
IT Support	Consultant	Assist with electronic media as needed.

Intervention and Activities

The *EmOTions* program activities promote active and meaningful learning to increase EC knowledge, skills, and application to the therapeutic encounter. As previously stated, the *EmOTions* program will be offered online. The program format will consist of six modules, split into two live weekly lessons. Lesson 1 will be 90 minutes long, while lesson 2 will be two hours long. There will be a 30-minute break between the lessons for participant convenience. The lessons will consist of an interactive lecture introducing the weekly content, followed by in-class activities and follow-up activities in the practice setting. The course lessons include an introduction & course overview, emotional perception, emotional facilitation and understanding, emotional management, advanced skills, and summary & evaluation.

The following sections provide insight into the content and structure of the

EmOTions course. Furthermore, Table 4.2 provides the expanded syllabus for the program. Before beginning the program, each participant completes a learner profile that influences the pace and emphasis of the course.

Learner Profile/Self-Assessment.

Before the course, each participant receives and completes an online learner profile questionnaire (see Appendix D), which details the following elements: 1. Professional background, 2. Previous EI and EC knowledge and experience, 3. Personal learning needs and goals, 4. Areas of strength and limitations, and 5. Description of clinical situations requiring EC the participants found challenging in their practice. The course facilitator utilizes these responses to tailor the course to meet the participant's needs. The instructor includes and addresses examples from the learner profiles in the frontal lectures to increase relevancy, engagement, and knowledge application.

Live Lectures.

Frontal lectures provide the baseline for EC, EI, and IRM knowledge and skills. Each week, the facilitator introduces a new topic, explains it, and links it to the program’s primary goals.

In-Class Activities.

After the lectures, experiential in-class activities apply learning, combined with immediate peer and facilitator feedback. Different learning modalities are used, including whole class, small group, and individual learning of case studies, discussions, skill practice,

and more. Participants have the opportunity to deconstruct theories and practice each step, learn from each other, receive positive reinforcement, learn to use past successes and reflect on personal strengths and weaknesses in a positive learning environment.

Reflective Writing.

Each week, out-of-class homework is assigned. The assignment includes reflecting on clinical situations through the lens of the material learned in class. In addition, each participant discusses their reflections with a peer on Zoom throughout the week in a follow-up peer mentoring meeting.

Peer-Mentoring.

Participants are paired into peer mentoring dyads for the course duration. The participants discuss their reflective writing weekly in a Zoom meeting before the next class. These weekly peer meetings should be around 30 minutes in length. At the end of the meeting, the pair fills out a form to be delivered to the instructor. The form asks the couple to summarize their two reflective clinical situations concerning the central EC and EI concepts, explain the significant takeaways from the discussion, and write down any questions they might have for the instructor or the class. The instructor reads these forms and addresses them at the beginning of the next lesson. The goals of peer mentoring in the *EmOTion* course are to (1) practice EC and EI skills in a personalized, safe interaction, (2) increase self-reflection and self-efficacy regarding EC and EI skills and practice, and (3) facilitate skill utilization in the clinical setting.

Peer mentoring is integrated into the *EmOTion* program based on evidence showing

the positive effects of mentoring as a mechanism that promotes practitioner expertise (Doyle et al., 2019; Gafni-Lachter & Ruland, 2018; King, 2009). In recent studies, peer-mentoring programs have reported several positive effects on the participants, such as improved career choices, increased self-esteem, perseverance, well-being, self-management, communication and interpersonal skills, compassion, networking, leadership skills, enhanced personal and professional competence, and satisfaction. In addition, studies show that mentoring others often leads to personal reflection on one's assumptions and knowledge (Doyle et al., 2019; Gafni-Lachter, 2020, Hall & Jaugietis, 2011).

Social media group.

A social media group (WhatsApp or Facebook group) facilitates a platform for participants to share dilemmas, engage with each other, and create a community of learners during and after the course.

Table 4.2. *EmOTions* program expanded syllabus

Class	Topic & Learning Objectives	In-Class Learning Activities	After-Class Learning Activities	Peer Mentoring
1	Intro & Course Overview – Understand the course's structure & content. – Assess personal EC & therapeutic use of self. – Identify the four main components of EI & the main elements of the IRM. – Identify personal goals & motivations for the course. – Apply one strategy for emotional self-awareness.	<u>Lesson 1</u> – Group introduction & icebreaker. – Review course goals, modules & course requirements. – Conduct group agreement. – EC & therapeutic use of self assessments. --- Break--- <u>Lesson 2</u> – Icebreaker. – Lecture on EI overview (concept, main elements & history) & IRM (concept & main elements) – Share assigned peer mentors with the group. – Peer mentor dyad discussion on personal goals for course/ personal motivation to develop EC. – Whole group summary and assignment of after-class learning activities.	<u>Reflective writing:</u> Journal entry about a therapeutic interaction with a client of their choosing. Optional: Bring a clip of 2-3 minutes of treatment, with video and audio. Written informed consent must be obtained from the client or faculty prior to recording.	<u>Discussion:</u> Share the journal entries in peer mentors, highlight the emotional words throughout and compile an emotions word bank.
2	Emotional Perception – Summarize & explain emotional perception in self & others. – Assess emotional awareness of self & others. – Apply five strategies for emotional perception in self & others.	<u>Lesson 1</u> – Icebreaker. – Review questions from previous material or peer-mentoring reflection. - Lecture on emotional perception, interoception, & emotional perception through mindfulness. - Group activity- Technique 1: breaths exercise & discussion. - Group activity- Technique 2: body scanning exercise (Body-Heart- Mind) & discussion. - Discuss personal self-perception in small groups.	<u>Reflective writing:</u> Choose one mindfulness technique to practice 5 minutes at least three times before the next session, with perceptive writing before and after the practice.	<u>Discussion:</u> Discuss importance of self- awareness, strategies for improvement, and personal strengths & limitations.

	– Integrate skills learned in EI with therapeutic use of self. – Apply EI perception concept into the clinical setting.	--- Break--- <u>Lesson 2</u> – Icebreaker. – Lecture on IRM- emotional identification in others. – Emotional table & physical feeling table in small groups. – Identify emotions in clinical video clips. Watch first with only video, then only audio, and compare in small groups. – Whole group summary & assignment of after-class learning activities.	Option 1: Breathing exercise Option 2: Body scanning exercise.	
3	Emotional Facilitation & Understanding – Summarize & explain emotional facilitation & understanding in self. – Summarize & explain emotional facilitation & understanding in others though empathy. – Assess emotional facilitation & understanding in self & others. – Apply three strategies for emotional facilitation & understanding of self & others – Apply EI facilitation & understanding concepts to the clinical setting.	<u>Lesson 1</u> – Icebreaker activity. – Review questions from previous material or peer-mentoring reflection. – Lecture on emotional facilitation & understanding. – Introduction of Feelings wheel & individual feelings quilt activity. – Discussion on the quilt in small groups. – Mood Meter activity in whole group. --- Break--- <u>Lesson 2</u> - Icebreaker. - Group discussion on facilitation & understanding emotions. - Lecture on facilitation & understanding emotions through empathy. - Emphatic listening activity in small groups. - Emphatic listening chart in pairs. - Discussion of activity as a whole group. - Whole group summary & assignment of after-class learning activities.	<u>Reflective writing:</u> Pick one client and practice empathetic listening using the Perspectrum Chart. Write 1 page describing how the activity was for you, how it felt, and what you learned from the practice.	<u>Discussion:</u> Review the written reflection & discuss personal strengths and challenges regarding empathetic listening.

4	Emotional management – Summarize & explain emotional management in self & others. – Assess personal emotional management in self & others. – Apply three strategies for emotional management in self & others. – Integrate skills learned in EI with therapeutic use of self. – Apply EI management concepts to clinical settings.	<u>Lesson 1</u> - Icebreaker activity. - Review questions from previous material or peer-mentoring reflection. - Lecture on emotional management: expression & regulation - Small group discussion of emotional management in the clinical setting. - Emotional management chart in small groups & large group. --- Break--- <u>Lesson 2</u> - Icebreaker. - Lecture on IRM & therapeutic modes. - Therapist mode flashcard activity. - Case study analysis with therapeutic modes in small groups. - Whole and small group discussions on therapeutic modes. - Whole group summary & assignment of after-class learning activities.	<u>Reflective writing:</u> Part I: Self-assessment of therapeutic modes. Part II: Write a 1-page case study from your clinical setting for class analysis.	<u>Discussion:</u> Discuss the assessment results.
5	Advanced Skills – Integrate skills learned in EI with therapeutic use of self. – Apply two EI & therapeutic use of self strategies – Apply EI & IRM concepts to the clinical setting.	<u>Lesson 1</u> - Icebreaker activity. - Review questions from previous material or peer-mentoring reflection. - Lecture on the emotional blueprint. - Emotional blueprint small & large group activities. - Analyze videos with emotional blueprint. - Group discussion on analysis. --- Break--- <u>Lesson 2</u> - Icebreaker.	<u>Reflective writing:</u> Apply the Emotional Blueprint or the Six Steps of Interpersonal Reasoning to one clinical situation this week. Write a short reflection about the interaction.	<u>Discussion:</u> Share the reflective writing with your peer and discuss.

		- Lecture on interpersonal events & six steps of interpersonal reasoning. - Discussion on interpersonal events in whole groups. - Role playing activity in pairs. - Whole group reflection on the role play activity. - Whole group summary & assignment of after-class learning activities.		
6	Summary and Evaluation – Integrate skills learned in EI with therapeutic use of self. – Summarize learned concepts, strategies, & skills. – Reflect on personal & professional growth during the course. – Reassess personal EC. – Apply EI & IRM concepts to the clinical setting.	<u>Lesson 1</u> - Icebreaker activity. - Review questions from previous material or peer-mentoring reflection. - Discuss EC barriers in clinical settings in small groups. - Lecture on barriers in applying EC in healthcare settings. - Discussion on how to remove the barriers. - Establish an individual self-care toolbox. - Whole group discussion on improving EC after the end of the course. --- Break--- <u>Lesson 2</u> – Icebreaker. – Summary of course topics. – Group reflection. – EC reassessment . – Final summary & course evaluation feedback	No Assignments.	

Outputs and Outcomes

Expected Outputs

The *EmOTions* program outputs consist of: (1) the number of participants completing the program, (2) the number of sessions attended by each participant, and (3) the number of program inquiries/ contacts from each mode of marketing.

Expected Outcomes

Short-Term Outcomes.

At the completion of the program, the participants will:

- Recognize emotions in the therapeutic encounter and understand how these emotions can affect clients' and therapists' behavior and performance.
- Adapt personal responses to perceived emotions in self and clients to promote a positive therapeutic relationship.
- Develop self-awareness and personal strategies to improve one's own emotional competencies.

Intermediate Outcomes.

At 3-6 months post-program completion, the participants will:

- Apply a variety of EC and EI strategies to enhance therapeutic relationships within the clinical practice setting.

- Report increased perceived confidence in applying emotional competency and EI knowledge and skills within the therapeutic encounter.

Long-Term Outcomes.

At one-year post-program completion, the participants will:

- Report continued growth in emotional competence within the therapeutic encounter.
- Report enhanced perceived quality of therapeutic relationships.
- Report increased therapist perceived emotional wellbeing.

Anticipated Barriers and Challenges

The potential program implementation barriers and possibilities for their mitigation are detailed in Table 4.3.

Table 4.3. Potential barriers and mitigation

Barriers	Mitigation
Potential lack of identified need or interest in learning about EC and EI. Professional resistance to the topic due to misunderstanding the incorporation of emotional elements as "not part of the scope of *occupational therapy*."	Spearheading marketing efforts that provide evidence of the contribution of EC and EI to therapist well-being and improved therapeutic relationships can raise interest and recognition of the need for this intervention. Adapting the program to the participants' interests, relevant challenges, and personal goals of professional development. These adaptations should help enhance motivation for learning and application of the material in practice.
Lack of funding	Online courses can reduce costs for facilitators and participants compared to in-person facilitation. Secondly, applying for continuing education credit

	approval will promote employer funding of the course. Lastly, applying for grant funding for the evaluation stage of the course (pilot stage) will also reduce participant costs.
The program's duration requires commitment and full participation, which might be challenging for participants with busy schedules.	Keeping in mind the practice realities, the course is designed to maximize accessibilities and minimize inconveniences to providers. Participation will be communicated upfront before beginning the course. Participants will also know the dates before committing to the course to plan their schedules accordingly. Furthermore, the online format of the program may assist participants balance their time and other commitments. Finally, if participants have exceptional circumstances in which they cannot participate, the participants will be given asynchronous activities to perform in place of the synchronous activities.

Summary

The objective of this chapter was to present the *EmOTions* course as a continuing education program for enhancing EC for occupational therapists within the therapeutic encounter. First, the program overview was presented via a logic model, the theoretical base of the program was explained, and program participants and resources were outlined. Furthermore, the *EmOTions* program intervention and activities were described, followed by expected outputs and outcomes. Lastly, anticipated barriers and challenges, with possibilities for mitigation, were described. Chapter 5 will present a program evaluation plan for the *EmOTions* course.

CHAPTER FIVE – Program Evaluation Research Plan

Introduction

The main objective of this doctoral project is to enhance effective therapist emotional competence (EC) within the therapeutic encounter in occupational therapy practice. EC, defined as an individual's skills, confidence, and capacity to navigate emotions in different social situations, is further elaborated in Chapters 1 and 2 and Appendix A (Coetzee et al., 2016; Saarni, 1997). Moreover, EC's relationship with Emotional Intelligence (EI) is also described in both Chapter 1 and Appendix A. EI is defined as a person's competence to perceive, identify, regulate and cope effectively with emotions (both in oneself and others) (Zeidner et al., 2009). This chapter will present a detailed plan for a three-tier evaluation study for the intervention program proposed in Chapter 4, aiming to establish the connection between the *EmOTions* course and its expected outcomes.

Program

The *EmOTions* program is a 6-week online continuing education course for practicing occupational therapists. Its primary purpose is to build and incorporate EC skills into daily therapeutic practice. The course draws upon various professional and adult learning theories as well as the latest empirical evidence and emphasizes the importance of self-reflection and emotional knowledge as a basis for therapeutic relationships and therapist well-being in treatment.

Additionally, a complete program protocol, called the *EmOTions Facilitator*

Manual, will be published following the pilot testing for the *EmOTions* course. This manual will be the authoritative guide for the *EmOTions* program, providing summaries of the relevant theory, research, and the program's unique pedagogy. When published, this manual will aid other facilitators implement the course in their regions and disseminate the program. It is important to note that the guide is not intended to replace formal training for teaching the *EmOTions* program.

The *EmOTions* course is designed for occupational therapists with varied experience levels in all practice settings who wish to develop their emotional knowledge and skills. The course is created for working clinicians and supports cultivating and promoting knowledge and skills from the classroom into practice through active and meaningful learning. The lessons are live for an interactive learning experience. The topics covered include self-awareness, emotional perception, emotional understanding, empathetic listening, emotional regulation, emotional management, therapeutic use of self, emotional competence, and emotional intelligence. The course also includes one-on-one peer mentoring dyads to promote personal reflection, growth, and professional confidence (Doyle et al., 2019). A program soft launch/pilot program will precede a full program launch. Evaluation of the pilot program will provide the author with formative and summative feedback to improve the program before its full launch.

Description of the Problem

The premise of this doctoral project is that professional interactions are largely influenced by the professional's emotional competency. Considering that emotions are known determinants of people's actions in general, it is likely that clinicians' and clients'

emotions play a role in the therapeutic interaction (Kolehmainen & McAnuff, 2014). Therefore, the need to identify more effective ways to improve healthcare delivery should include addressing therapist and client emotions, as well as the emotions from the therapeutic relationship that influence the therapeutic interaction.

EC is an essential cornerstone in addressing emotions arising in therapeutic interactions. As the therapeutic initiator, it is the therapists' role to recognize emotions when they occur and respond therapeutically. When therapists ignore or do not know how to respond to a client's emotional state, it can threaten the therapist's well-being, as well as the therapeutic relationship and the resulting treatment outcomes. Alternatively, optimally responding to emotional complexities can lead to positive client change, including improved treatment outcomes and a more solidified therapeutic relationship (Kielhofner, 2009). Thus, occupational therapists must acknowledge the emotions in the therapeutic interaction to foster a positive, empathetic-therapeutic relationship, engage client motivation, protect themselves against therapist emotion-based stress, such as burnout, and create meaningful change (American Occupational Therapy Association, 2020).

Recent findings have shown that EC can be taught and learned through education and experience even in adulthood, showing promise in enhancing emotional knowledge and functioning into adulthood (Brasseur et al., 2013; Lenneville, 2014; Taylor, 2020). Yet, despite a potential for improvement and the fundamental role of emotions in the therapeutic interaction, the curriculum for healthcare professionals tends to place little emphasis on developing effective emotional-related skills and strategies to protect their personal and professional wellbeing (Brown, 2018; Grant & Kinman, 2014). Furthermore, a thorough

literature search demonstrates that the opportunities to develop EC for practicing professionals are also sparse. Thus, implementing EC knowledge and skills within occupational therapy will facilitate emotional effective emotional navigation development within the profession.

Purpose

The study described in this chapter aims to examine the efficiency of the *EmOTions* course in enhancing occupational therapists' EC in the therapeutic encounter. The researchers will conduct formative assessments to gather information about the program's delivery and evaluate the course's key ingredients to determine effective strategies for promoting EC skills and maximizing program performance. They will also conduct a summative evaluation to determine changes in EC and therapeutic use of self, both quantitatively and qualitatively. First, the researchers will assess quantitative pre-post changes in EC and therapeutic use of self through assessment scores. Finally, they will measure change qualitatively through interviews and open-ended questionnaires post-course and three months post-course to determine if gains were maintained over time.

The research findings will contribute to the EC body of knowledge in occupational therapy. This knowledge will help therapists form more effective therapeutic relationships and promote therapeutic outcomes. In addition, findings will influence the structure and content of the *EmOTions* program, inform policies on professional education, and improve occupational therapists' understanding of how to address emotions in therapeutic encounters. Finally, results from the program could lead to its adoption by facilities or organizations, locally, nationally, or globally and serve as a basis for change in current

practice.

Research Questions

- At the completion of the course, did the participants understand the concepts and techniques of EC, EI, and IRM theories and their role in occupational therapy clinical encounters?
- At the completion of the course, did the participant recognize interpersonal therapeutic situations that could profit from applying EC, EI, and IRM knowledge and skills?
- At the completion of the course, did the participants report increased perceived confidence in applying EC, EI, and IRM knowledge and skills in clinical settings?
- At the completion of the course, did the participants improve EC, as reflected by higher scores on the EC assessment?

Stakeholder Involvement

EmOTions's evaluation research is part of an entrepreneurial initiative that benefits occupational therapists. Therefore, it is highly recommended that program stakeholders actively contribute their knowledge, funding, and involvement in the program's development, implementation, and analysis making stakeholder buy-in imperative for its success.

Methods

Participants

Each *EmOTions* cohort will include 20–25 occupational therapy practitioners from various vocational settings with varying clinical experience. Inclusion criteria will consist of more than three months of clinical experience and at least a basic level of interest in the topic presented. Exclusion criteria will consist of no current employment as an occupational therapist, no direct involvement with clients, and prior inability to participate in all the sessions. No previous EC training is required. Participants will be offered a substantial discount if they agree to participate in the study and complete pre-post questionnaires and interviews. Participants will be required to register for the program online.

Design

The *EmOTions* continuing education program's research plan will have three stages. Table 5.1 will illustrate this plan.

Table 5.1. Stages of the *EmOTions* research plan

Stage	Goal	Design	Participants	Facilitator	Instruments
Stage I	Evaluation of course effectiveness	1-group pilot	Occupational therapy practitioners	Program developer	Course facilitation instruments
Stage II	Evaluation of cause-effect relation through program participation	2-group RCT	Occupational therapy practitioners	Program developer or external facilitators	Course facilitation instruments
Stage III	Analysis of facilitator experience with *EmOTions* Program.	Cohort qualitative	Program facilitators	Program developer or external facilitators	In-depth interviews

Stage I: Pilot.

The purpose of Stage I is to examine the *EmOTions* course's effect on enhancing EC and EC's effect on the participants' therapeutic relationships and therapist well-being. The study will have a pilot one-group repeated-measures design. The data compilation will be multitiered and involve both formative and summative data collection methods. Furthermore, the data gathered in the pilot study will enable program enhancements before conducting Stages II and III.

After the completion of Stage I, a facilitator manual will be edited and published. This manual, called the *EmOTions Facilitation Manual*, is an authoritative guide for the *EmOTions* program. The manual reviews relevant theory and research and describes the program's unique pedagogy. Readers are taken step by step through facilitating each of the course's six modules, including detailed descriptions of the lessons, activities, and assessments to operate the course successfully. It is important to note that the guide is not

intended to replace formal training for teaching the *EmOTions* program. Through this manual, the *EmOTions* course can expand beyond the scope of one facilitator and can be implemented globally. Stage I will be the focus of this chapter.

Data Collection.

Stage I will include four data collection checkpoints. The combination of the checkpoints will provide the author with both formative and summative, qualitative and quantitative information. Thus, the author will identify the extent to which the program met its intended outcomes, assess its strengths and weaknesses, and determine improvement methods for future program iterations. Table 5.2 and the following sections describe each information-gathering checkpoint in detail.

Table 5.2. Data collection checkpoints and measures in the pilot program

Checkpoint	Instruments
Pre-Course	Needs-based assessment- Learner Profile PEC pre-test SETUS pre-test ProQOL
Throughout the Course	Weekly learning activities: homework and peer mentoring logs
Post-Course	PEC SETUS ProQOL Mixed-method formative questionnaire
Three-Months Post-Course	Individual interviews PEC SETUS ProQOL

Pre-Course Checkpoints.

Needs-Based Assessment.

Before the course, each participant will receive and complete an online Learner Profile questionnaire (see Appendix D), which details the following elements: 1. Professional background, 2. Previous knowledge and experience in EC, 3. Personal learning needs and goals, 4. Areas of strength and limitations, and 5. Description of clinical situations requiring EC the participants found challenging in their practice.

The course facilitator will use these responses to assess the level of knowledge and support each participant will require during the course and tailor the course to meet the needs of the participants. The facilitator will also include examples from the Learner Profiles in the lectures on EC elements to increase participant relevancy and engagement.

Standardized Assessments.

The second assessment method will include delivering two standardized assessments before program initiation, immediately following program completion and three months post-program completion. The assessments will all be completed digitally. The two assessments are described below.

Profile of Emotional Competence (PEC). The PEC assesses EC and its five core emotional competencies related to one's own and others' emotions. The assessment is composed of 50 items with a 5-point response (1 "Strongly disagree" to 5 "Strongly agree"). It provides two global scores, an intrapersonal and an interpersonal score and a total score. Scores are calculated by the mean response to each item of the corresponding

component. Higher scores indicate a higher perceived use of EC in daily life. The PEC is found to have strong internal consistency, with high convergent validity to the TEIQue assessment of EI (Brasseur et al., 2013).

Self-efficacy for Therapeutic Use of Self Questionnaire (SETUS). The SETUS measures therapeutic use of self and was developed based on the IRM. The questionnaire consists of three parts. In part I, respondents rate their confidence level in skills required for using each of the six therapeutic modes. In part II, respondents rate their level of confidence in recognizing the client's interpersonal characteristics in therapeutic encounters. Finally, in part III, the respondents rate their level of confidence that they possess the required skills to manage interpersonal challenges that may occur in therapeutic encounters. The SETUS was found to have strong internal consistency between items. Each assessment part was measured separately, finding Cronbach's α ranging from 0.82-0.94 (Yazdani et al., 2021).

Professional Quality of Life (ProQOL). The ProQOL assessment is a 30-item self-report questionnaire designed to measure compassion fatigue, work satisfaction, and burnout in helping professionals. Helping professionals are defined broadly as individuals working in healthcare settings, including social service workers, teachers, and first responders. It was found as a valuable assessment for workers who perform emotional labor and professionals exposed to traumatic situations. The assessment measures three aspects of professional quality of life: compassion satisfaction, burnout, and secondary traumatic stress. The ProQOL is the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events.

The measure is shown to have high validity, with Cronbach's α ranging from .75-.88, and inter-scale correlation showing low variance (Stamm, 2010). For this project, EC will be compared to the compassion satisfaction portion to assess if the changes in EC correlate to changes in satisfaction at work.

During-Course Checkpoints.

Homework Assignments.

During the course, weekly homework is assigned, which includes reflection and peer-mentoring components. These assignments allow participants to reflect on the learned material and integrate it into daily practice. In addition, each week, the participants are asked to submit a peer mentoring log, which highlights the topics discussed, significant takeaways from the discussions, and questions for the facilitator. These logs will be treated as official program records that provide the course instructor informal feedback on the course pace, participant understanding, and individual learning supports and needs.

Post-Course Checkpoints.

Standardized Assessments.

PEC, SETUS, and ProQOL will be readministered at the end of the program. Results will be compared to the pre-course assessment scores.

Mixed-Methods Formative Survey.

A researcher-developed electronic survey is administered in the final lesson of the course to gather qualitative and quantitative information about the participants' experiences in the course, attitudes regarding the program's execution, and suggestions for

improvement. The survey includes ten qualitative, Likert scale, closed questions combined with four open-ended qualitative questions. Questions in the survey focus on the effectiveness of the course's format, including the length of the lessons and modules, the number of modules, the use of technology, and the inclusion of case studies, videos, and small group discussions.

Three-Months Post-Course Checkpoints.

Data will also be collected three-month post-course to determine if gains were maintained over time.

Standardized Assessments.

PEC, SETUS, and ProQOL will be readministered three months after the end of the program. Results will be compared to the pre-and post-course assessment scores.

Individual Interviews.

One-on-one in-depth interviews will be conducted three months after the end of the course, as evidence shows that prolonged exposure to EC materials and opportunities to self-reflect have increased competency and retention of EC and EI skills (Perkins, 2018). Three months after completing the course, a final email will be sent to the participants as a reminder to participate in a follow-up semi-structured interview. These one-on-one interviews will be conducted on Zoom with the course facilitator. The primary goals of the interviews will be to assess how occupational therapists are integrating EC into their clinical settings, how suitable the course was to their practice, and how the course can be improved to serve future occupational therapy participants better.

Ethical Conduct

As dictated by IRB regulation, participant confidentiality is a high priority in this study, and thus the researcher will take various steps to ensure participant confidentiality in the research. All the course participants will be asked to sign a consent form before participating in the program. Each participant will be assigned a code designation used throughout data analysis. This code will consist of a combination of numbers and will have no participant identifying information. The master spreadsheet containing the names and code information will be stored separately in a locked, secure location. Only the author will have the key to this location. Computers used for data storage will be password protected, and access to the technology will be limited only to the author.

Data Management

The survey questions will be compiled using the data analysis software found in Qualtrics and then transferred to Microsoft Excel. To ensure confidentiality, the surveys will remain anonymous. The online copies will be downloaded and saved on a digital, secure hard drive, while hard copy files will be held in a secure, locked location. In addition, the analytic rigor and trustworthiness of the open-ended survey findings will be enhanced through the triangulation of the qualitative information by multiple sources, such as requesting confirmation from peers familiar with the study to review the findings. Data analysis will be discussed in a later section of this document.

The standardized assessment results will be electronically entered into a secure computer from Qualtrics. Qualtrics will be used to create and manage the questionnaires as well. Data will be double-checked for lack of errors by the author and confirmed by

peers familiar with the study who reviewed the findings. An external hard drive or cloud software will also be necessary to back up the collected data.

Each interview will be recorded, and transcripts will be generated for analysis through computer voice-to-transcript applications on Zoom. The author will also read through the transcripts to ensure the voice-to-transcripts were correct throughout the transcription. Transcript corrections will be made if necessary. Confidentiality will be assured by replacing the student's name with numbers in the transcripts. The original recording will be saved in a secure, external hard drive stored in a locked location. The analytic rigor will be enhanced for the interviews by ensuring enough time with each participant in the virtual interviews. Finally, the interview participants will be asked for verbal consent for future contact to verify or double-check anything they stated during the interview if necessary.

Data Analysis

Quantitative data will be analyzed using SPSS software. Inferential statistics will follow descriptive statistics tests to describe the sample to test for pre- to post-test changes. Calculations will include repeated MANOVA tests, comparing the reports on the PEC, SETUS, and ProQOL at the three checkpoints (e.g., pre-test, post-test, and three-month post-test). These findings would provide indications of causation between the course and the outcomes obtained.

Qualitative data from the open-ended survey questions and the in-depth interviews will be organized and analyzed using NVivo software. The findings will be analyzed by this researcher or trained partners for themes using hermeneutics methods. Furthermore,

possible alternative explanations will be examined via triangulation to limit potential biases.

Stage II

Stage II aims to evaluate the *EmOTions* program's effectiveness on a broader scale. The design will consist of an RCT comparing intervention and waitlist control groups.

Stage III

With the publication of the *EmOTions* Facilitator Guide, new facilitators will be trained in implementing the program. Stage III aims to study the program's effectiveness as administered by different facilitators and evaluate the facilitator's experiences conducting the *EmOTions* course. Stage III will then include repeating the effective study design from Stage I with other facilitators and cohorts. The study will also assess external facilitators' qualitative instruction experience. The data collected from the large sample will contribute to the EC knowledge base in healthcare.

Summary

This chapter described the three-stage evaluation plan for the *EmOTions* continuing education program. First, the chapter introduced the *EmOTions* program design and illustrated the study's purpose and research questions. Then, the participants were described, along with the evaluation design, including the designs for Stages I, II, and III. Next, Stage I was expanded with detailed descriptions of the data collection, ethical conduct, data management, and data analysis stages. Finally, Stages II and III were described. The next chapter outlines the planned actions and activities for disseminating

the proposed program.

CHAPTER SIX – Dissemination Plan

Introduction

The main objective of this doctoral project is to enhance effective therapist emotional competence (EC) within the therapeutic encounter in occupational therapy practice. EC, defined as an individual's skills, confidence, and capacity to navigate emotions in different social situations, is further elaborated in Chapter 1 and Appendix A (Coetzee et al., 2016; Saarni, 1997). Studies show that occupational therapists' work is influenced by their EC within the therapeutic encounter (McKenna & Mellson 2013).

This doctoral project aims to enhance occupational therapists' EC to promote therapeutic relationships necessary for quality care. To reach this goal, the author developed *EmOTions*: a continuing education training course for occupational therapists. This six-week, 30-hour online course is further elaborated in Chapter 4. The course aims to enhance the participants' knowledge, abilities, and skills to purposefully navigate emotions in daily practice encounters with their clients. The course was designed according to EI, IRM, and EC models to address perceiving, understanding, and managing emotions, empathy, and self-reflection. These skills aid occupational therapists in building trusting relationships with their clients and protecting themselves from emotion-related stress, burnout, and compassion fatigue.

Additionally, a complete program protocol, called the *EmOTions Facilitator Manual*, will be published following the pilot testing for the *EmOTions* course. This manual will be the authoritative guide for the *EmOTions* program, providing summaries of the relevant theory, research, and the program's unique pedagogy. When published, this

manual will aid other facilitators to implement the course in their regions and disseminate the program. It is important to note that the guide is not intended to replace formal training for teaching the *EmOTions* program.

This chapter outlines a comprehensive dissemination plan for the *EmOTions* program, assuming successful results within the pilot implementation and empirical evaluation. First, specific short- and long-term dissemination goals will be presented. Second, the target audience and their unique interests and needs will be discussed, along with key messages and influential spokespeople for each population. Finally, an outline of the dissemination activities and budget will be provided, followed by an evaluation of the dissemination plan.

Dissemination Goals

Long-Term Goal

Within five years, the *EmOTions* course will be recognized as an effective, fundamental evidence-based continuing education course for occupational therapy practitioners' purposeful navigation of emotions and improving EC within the therapeutic encounter, integrated into both private and public facilities.

Short-Term Goals.

- The *EmOTions* course will be implemented and piloted with a group of 20-25 occupational therapists. This pilot course will provide evidence of the program's effectiveness and the importance of implementing EC in therapeutic interactions with clients.

- The pilot and subsequent courses' evaluation outcomes will be disseminated through scholarly healthcare communication methods, such as conference presentations, peer-reviewed articles, professional trade magazines, websites, and social media.
- The course will be offered commercially through different outlets, such as privately, sponsored by continuing education- approved company, and in partnership with different healthcare providers in the United States and Israel.
- Ongoing course evaluations will be conducted to improve the course and monitor outcomes for continued dissemination efforts.

Target Audiences, Key Messages, and Relevant Spokespeople

This dissemination plan is designed to reach two target audiences. The primary audience consists of occupational therapy providers, including practitioners and administrators, who work in occupational therapy services with clients. The secondary audience includes organizations providing healthcare or occupational therapy services.

Primary Audience

The primary target audience for the dissemination efforts will be occupational therapy practitioners and administrators. Dissemination efforts will target this audience in hopes they will register for the course. Due to the course's online nature, these target practitioners can be practicing clinicians worldwide, though initial, direct outreach efforts will be directed to clinicians in Israel and the United States.

Primary Audience Unique Challenges and Needs.

EC provides an essential cornerstone in addressing emotions arising from the therapist, client, and therapeutic relationships. As the therapeutic initiator, it is the therapist's role to recognize these emotions when they occur and respond therapeutically. Emotionally driven-empathetic therapeutic relationships require the therapist to recognize and address emotions that arise effectively, read and attend to non-verbal cues, and express emotions clearly and genuinely (Wilkinson et al., 2017; Wong, 2016). In addition, therapists require self-knowledge, self-awareness of therapeutic behavior, and the ability to reflect and evaluate their practice to hold interpersonal sensitivity and understanding for their clients (Taylor, 2020). When therapists ignore or do not know how to respond to a client's emotional state, it can threaten the therapist's well-being, as well as the therapeutic relationship and the resulting treatment outcomes. Alternatively, optimally responding to emotional complexities can lead to positive client change, including improved treatment outcomes and a more solidified therapeutic relationship (Kielhofner, 2009). Thus, occupational therapists must acknowledge the emotions in the therapeutic interaction to foster a positive, empathetic-therapeutic relationship, engage client motivation, protect themselves against therapist emotion-based stress, such as burnout, and create meaningful change (American Occupational Therapy Association, 2020).

However, despite the fundamental role of emotions in therapeutic interaction, the curriculum for healthcare professionals tends to place little emphasis on developing effective emotional-related skills and strategies to protect their personal and professional well-being (Brown, 2018; Grant & Kinman, 2014). According to Perkins (2018), therapists'

education and training do not include or focus on scientific insights into emotions and an individual's emotional architecture, including EC and EI. Although EI components are woven into courses within the occupational therapy curriculum in some programs, they are seldom comprehensively addressed (Calabrese et al., 2019). Moreover, methodological reviews of databases found that EI or EC training were not typically part of the standard curriculum in other healthcare or medical programs either (Perkins, 2018). Furthermore, a thorough literature search demonstrates that the opportunities to develop EC for practicing professionals are also sparse. Many health organizations lack on-site education to enhance employees' EI and interpersonal communication skills. Lastly, while there is some EC and EI research within occupational therapy and the medical fields, studies exploring interventional approaches relating to EI and EC are minimal. Without advancing the evidence within the occupational therapy profession, there is little impetus to add a specific EC curriculum to occupational therapy programs for students and practitioners (Perkins, 2018). Thus, implementing EI and EC knowledge, skills, and research within occupational therapy will facilitate effective emotional navigation development within the profession.

Key Messages for Primary Audience.

- Do you ever feel emotionally exhausted after working with clients all day? Do you ever feel helpless, powerless or hopeless at the end of the day? Do you feel burnt out after long hours at clinic? Taking care of others is really difficult, but you are not alone and there is a lot to do!
- Many occupational therapists work with people in emotional distress. Negative emotions can sometimes erupt during the therapy session, and you as a medical

professional must know what to do, and how to handle the situation in the best way possible.

- Similarly, in order to give your clients the best care, you must make sure that you, as a clinician, are taken care of as well. Therapeutic professions can be stressful and emotionally draining at times. Constantly pushing your emotions aside for the good of your clients and others around you may lead to burnout and compassion fatigue in the long run.
- As you can see, navigating emotions purposefully, both your own and your clients, is critical in occupational therapy. Yet, frequently, clinicians are not taught the necessary tools to navigate emotions thoughtfully and purposefully to best help their clients and themselves.
- This is where *EmOTions* comes in! *EmOTions* is a 6-week online course where you will get the tools to improve your knowledge, abilities, skills and confidence to purposefully navigate emotions in your daily practice. We aim to help you become a better clinician to your clients while taking care of your well-being in the process.

Spokesperson for Primary Audience.

Credible spokespeople for this audience are previous *EmOTions* course participants. Testimonies from past participants on the course's personal and professional benefits and satisfaction level with the content, structure, and instruction will be influential for occupational therapists considering taking the course. Thus, collecting such testimonials throughout the pilot phase and the following courses will be necessary.

Secondary Audience

The secondary target audience is organizations providing occupational therapy or healthcare services. This audience can influence and encourage occupational therapists to participate in the course and create partnerships with the program to include the *EmOTions* course in their workplace. Similarly to the primary audience, due to the course's online nature, these target organizations can be worldwide, though initial, direct outreach efforts will be directed to organizations in Israel and the United States. Examples include large hospitals, NGOs, and non-profits that employ several occupational therapists.

Secondary Audience Unique Challenges and Needs.

Workplace factors significantly impact the development of clinicians' expertise and clinical skills, including the implementation of EC skills throughout practice (King et al., 2009). Healthcare organizations often seek opportunities to grow and increase efficiency and profitability in a competitive environment. Many organizations, including therapeutic organizations, recognize the importance of supporting their employees' needs to retain employees and create customer satisfaction. Additionally, current healthcare policies, especially in the U.S., emphasize the importance of improving the quality of care of their clients. Quality care is typically accomplished through improving clients' services and creating educational opportunities for clinicians to improve their skills and expertise. Yet, in the field of EI and navigating emotions in practice, many health institutions lack on-site education to enhance employees' EI and interpersonal communication skills (Perkins, 2018).

Key Messages for Secondary Audience.

- Occupational therapists often navigate many types of emotions when working with their clients daily. Whether these are clients' emotional responses to therapy or the therapists' emotions related to caring for their clients, it is imperative for occupational therapists to have the proper skills to understand and manage the emotions that arise.
- Occupational therapists that acknowledge emotions in the therapeutic interactions help foster a positive, empathetic-therapeutic relationship, engage client motivation, and create meaningful change. Plus, improving clinicians' EC skills can influence clinicians' psychological well-being, subjective physical health, and relationship quality with lasting effects, as well as protect therapists from therapist emotion-based stress, such as burnout (American Occupational Therapy Association, 2020; Brasseur et al., 2013; Lenneville, 2014; Mikolajczak et al., 2015; Kotsou et al., 2011; Taylor, 2020).
- However, many therapists lack the knowledge and confidence to purposefully navigate emotions in the treatment setting.
- *EmOTions* is a six-week course that provides occupational therapists with updated, clinician-centered, evidenced-based knowledge and skills to navigate the complex emotional situations that may arise in the therapeutic interaction. Participating in this course can help clinicians improve client therapeutic outcomes and satisfaction as well as prevent clinician burnout and turnover in the workplace.

Spokesperson for Secondary Audience.

The program developer will contact major HMOs and present the program and research study conducted on the program. Having the author deliver the message will ensure the most accurate delivery of the message and the information. Furthermore, occupational therapists who have previously participated in the course can speak to their supervisors and attest to the positive impact this course had on their daily practice.

Dissemination Activities and Budget

Several dissemination activities consist of spreading awareness of the scope and the importance of the course and its contents on different platforms. These activities include person-to-person contact through phone calls, emails, and social media marketing. The course developer will conduct the activities presented with support from collaborators and local resources. The activities are presented according to the chronological sequence of implementation, though some flexibility and overlap are expected. The dissemination activities for each target population and the budget necessary to implement the activities are detailed in Table 6.1.

Table 6.1. Dissemination Activities and Costs.

Target Audience	Activity	Description	Cost
Primary Audience: Occupational therapy practitioners and administrators	Electronic media	Produce a program website detailing the need for the program, information about the program, and contact information, and distribute a link and advertisements to the program's website to the relevant audiences.	$0
	Person to person	Present in conferences, such as AOTA, ISOT, WFOT, and Virtual Compassion in Action Healthcare Conference.	$4,000 includes two conferences, with expected costs of registration ($450), travel ($500) and accommodations ($1,000 for hotel, transportation and food)
	Person-to-person	Apply for approval and accreditation with continuing education providers with marketing and advertising departments.	$ 700
	Electronic media	Create online content, such as posts, stories, and infographics, to be posted on different social media outlets, such as LinkedIn, Instagram, and Facebook.	$0
	Written information	Design an electronic handout with key messages and promotional content for the course to be mailed to potential participants. The handout will also include a description of the program and registration information.	$0
	Written information	Advertise the *EmOTions* course in a newsletter/ journal published by professional occupational therapy groups.	$1,500

	Written information	Publish an article in a peer-reviewed journal describing the need for the *EmOTions* course and showing the program's findings.	$0
	Person-to-person	Reach out to university professors requesting time to inform students in their final year about the course.	$0
Secondary Audience: Organizations providing occupational therapy or healthcare services	Written information	Develop a fact sheet presenting evidence supporting the *EmOTions* program with testimonies from past participants, providers, and managers.	$0
	Electronic Media	Compose an introductory email presenting the need for the program and requesting a meeting to further explain the program to various hospital/HMO/ healthcare provider settings.	$0
	Person-to-person	Prepare a short promotional "pitch" presentation for the course, including the outline of the course, supportive evidence, and alignment with the organization's strategic plan to present in various hospital/HMO/ healthcare provider settings.	$0
	Written information	Advertise the *EmOTions* course in a newsletter/journal published by professional occupational therapy groups.	$0- price already accounted for the primary audience
	Person-to-person	Reach out to past participants requesting they ask their employers if they are interested in signing up other employees in the course.	$0
	Person-to-person	Network with occupational therapy practitioners to establish relationships with influential key persons in professional associations to spread awareness of the program.	$0
			Total Cost: $6,200

Dissemination Evaluation

The author will determine the dissemination's effectiveness to the primary and secondary audiences by several means. First, the course registration information will indicate successful advertising and explanatory efforts. Such information will also consider individual or group registration orchestrated by a healthcare organization. The author will track which dissemination efforts were most effective by including a section on the registration form for how the participant learned about the course. To determine the most effective dissemination efforts, the author will keep a list of all marketing activities and the number of registrations associated with each marketing activity. Finally, an assessment of the effectiveness of specific dissemination activities is presented in Table 6.2.

Table 6.2. Assessment of the Effectiveness of Specific Dissemination Activities

Dissemination Activities	Assessment of Effectiveness
Conference presentations and articles	Proposals will be accepted for presentation in two conferences, and one article will be accepted by a peer-reviewed journal one year following the *EmOTions* pilot completion.
Brochure/factsheet/ presentation	Audiences will request handouts in presentations and conferences.
Social media marketing strategy	Posts and comments will receive more views and shares from clinicians and providers and develop communication threads in response to the posts.
Networking	Increased number and quality of relationships with key leaders in local and national occupational therapy realms. These relationships will be initiated and maintained through different collaborative projects.

Conclusion

This chapter described the dissemination plan for the *EmOTions* continuing education program and the *EmOTions Facilitator Manual*. First, the short- and long-term

dissemination goals were described. Then, the target audiences were disclosed, and key messages from the doctoral project for each target audience and potential messengers from those audiences were highlighted. Thirdly, dissemination facilitation activities were identified, along with the budget plan. Finally, an evaluation of the dissemination plan was described. The next chapter detailed the funding plan for the EmOTions course.

CHAPTER SEVEN – Funding Plan

Introduction

The main objective of this doctoral project is to enhance effective therapist emotional competence (EC) within the therapeutic encounter in occupational therapy practice. EC, defined as an individual's skills, confidence, and capacity to navigate emotions in different social situations, is further elaborated in Chapter 1 and Appendix A (Coetzee et al., 2016; Saarni, 1997). Studies show that occupational therapists' work is influenced by their EC within the therapeutic encounter (McKenna & Mellson 2013).

This doctoral project aims to enhance occupational therapists' EC to promote therapeutic relationships necessary for quality care. To reach this goal, the author developed *EmOTions*: a continuing education training course for occupational therapists. This six-week, 30-hour online course is further elaborated in Chapter 4. The course aims to enhance the participants' knowledge, abilities, and skills to purposefully navigate emotions in daily practice encounters with their clients. The course was designed according to EI, IRM, and EC models to address perceiving, understanding, and managing emotions, empathy, and self-reflection. These skills aid occupational therapists in building trusting relationships with their clients and protecting themselves from emotion-related stress, burnout, and compassion fatigue.

Additionally, a complete program protocol, called the *EmOTions Facilitator Manual*, will be published following the pilot testing for the *EmOTions* course. This manual will be the authoritative guide for the *EmOTions* program, providing summaries of

the relevant theory, research, and the program's unique pedagogy. When published, this manual will aid other facilitators to implement the course in their regions and disseminate the program. It is important to note that the guide is not intended to replace formal training for teaching the *EmOTions* program. This chapter presents a detailed funding plan for the *EmOTions* program. There are currently two phases for the program funding. Phase 1 includes pilot testing of the course, and phase 2 involves commercializing the *EmOTions Facilitator Manual*.

Available Local Resources

Several local resources will be used to implement the *EmOTions* program and the *EmOTions Facilitator Manual*. Firstly, the program developer is the program facilitator and will administer the program at no cost during the initial pilot study of the program. Secondly, Dr. Liat Gafni-Lachter, Ph.D., OTD, OTR/L, Lihi Savion, BOT, and Sarah B. Harvey, OTR/L, are three occupational therapy experts from different specialty areas who will offer advisement and provide guest lectures. Lastly, Galya Fischer has volunteered to help with the web and graphic design for the course and manual. Her skills and experience in creating intentional design will be a great asset to the visual aesthetics of the program.

Needed Resources- Budget

The costs and expenses of the *EmOTions* program will differ depending on the stage of the program development. The Phase 1 pilot study will require a research assistant to support data input and processing. During the pilot stage, the program developer will administer the program at no fee. The main costs will include a research assistant for data

collection and analysis, consultation for online course development and copy editor for the content, Zoom software licensing, and recruiting strategies, totaling $2,690.00. Participants will be offered a substantial discount for this stage if they agree to participate in the study and complete pre-post questionnaires and interviews.

After completing the pilot program and analyzing the results, the facilitator will continue to provide ongoing courses privately and to organizations interested in improving their clinicians' emotional competencies to improve their clients' quality of care and their clinicians' well-being. Considering the financial investment of this course, the calculated course price will reflect the course's personal and professional value and ensures participants are serious about their intentions when committing to the program. The current price is $525 per participant. The facilitator's salary will be calculated through market research based on the standard rate of adjunct instructors. Due to the short form of this course, a salary of less than an entire semester at the adjunct rate is expected. Currently, a full adjunct rate is about $6,000, and thus a current rate of $5,000 per course was decided. However, future calculation of fees for services will be defined by what the market can bear and may be subject to change according to each setting and location, as is standard with continuing education courses.

In Phase 2, commercializing the *EmOTions Facilitator Manual*, the main expenses include copy editing, material preparation and maintenance, marketing of the manual, and dissemination of the program and the results, totaling $10,200.00, not including facilitator’s salary. The *EmOTions Facilitator Manual* will be finalized and sold for $75 a copy during this phase. Prices may also change, defined by what the market can bear.

A detailed description of the costs and expenses can be seen in the Revenues and Expenses Sheet in Table 7.1. After completing the pilot program stage, the commercialized stage will be implemented. Tuition collected from participants and the *EmOTions Facilitator Manual* will be used to cover course implementation costs. The remaining funds will be used for dissemination and ongoing course development.

Table 7.1. Revenues and expenses sheet

	Explanation	Pilot Program	Commercialized Stage
Facilitator salary	The first program will be a pilot study, and the facilitator will not receive payment. During the commercialized stage, the course instruction, grading, and content development are estimated by what the market can bear and may be subject to change according to each setting and location.	0	Calculated separately depending on the number of courses facilitated and market rate.
Research assistant	The research assistant supporting the pilot study through data collection and analysis will receive an $18 an hour salary. With 30 hours at work, a total of $540 for the pilot program alone.	$18 per hour, $540 for the pilot program.	0
Consultation	Online course development and adaptation to different learning styles will be purchased for $500.00 A copy editor will be hired to review all the course materials to enhance the clarity and quality of the course content and provide additional suggestions for activities; 10 hours at $100.00= $1,000. After the pilot, course changes will be reviewed, and the *EmOTions Facilitator Manual* will be published, costing another $1,000.	$500.00 $1,000.00	0 $1,000.00
Facility rental	The online format does not require rental facilities	0	0
Technology/ equipment	Equipment needed for on-line teaching includes a personal computer and webcam (available to the instructor)	0	0
Software	The free teaching platform, UDEMY teach (https://www.udemy.com/teach/course-84 creation/), will be used for pilot course delivery.	$150.00	0

	Various teaching technologies with no cost will be used, such as google docs, to enhance learning. Communication with course participants will be conducted via email. Zoom license will be purchased at $150 per year.		
Materials preparation and maintenance	No physical supplies are needed for the course. During the commercialized portion, the instructor might need to update course materials to remain up to date on new research and evidence-based practice.	0	$500
Recruiting and Marketing/ social media	Rerouting efforts for participants in the pilot program (advertisements, written posts on social media, networking, etc.) Marketing for the *EmOTions Facilitator Manual* (including advertisements, written posts on social media groups, networking, etc.)	$500	$2,500
Dissemination	Dissemination activities will aim to enhance awareness of EC's scope and the importance of how the *EmOTions* course can promote it. Examples include creation of course website, presentation in conferences, application for accreditation with continuing education providers, online content for social media, and publication of articles in peer-reviewed journals. These activities are further detailed in Chapter 7.		$6,200
Total		$2,690.00	$10,200.00

Potential Funding Sources

The *EmOTions* program is designed as a self-sustainable course, primarily based on participants' tuition. To help fund the pilot testing and research expenses, such as assistance, standardized assessments, and data analysis, the researcher will apply for federal and state grants. Such grants include the Dudley Allen Sargent Research Fund:

Doctoral Student Competition, Israeli Ministry of Health grants for health-related research, and applicable population-specific grants. The Dudley Allen Sargent Research Fund: Doctoral Student Competition gives financial assistance to post-professional doctoral students involved in research. The research fund is open to any student enrolled in the Sargent College post-professional doctoral degree who can apply, with a maximum award of $5,000. The Israeli Ministry of Health offers several annual grants to support health-related research conducted in collaboration with researchers overseas to enhance the quality of care. Partnering with other providers and receiving this grant could be incredibly beneficial to researching and implementing the *EmOTions* course. Finally, the author will apply for grants for clinicians working with specific client populations, such as people with intellectual disabilities or autism spectrum disorder, where the emotional load on the clinician is considerably large. When applying, the facilitator will suggest that the grantmakers use the *EmOTions* program funds to enhance the quality of care by empowering and strengthening the clinicians providing services for these populations. Some local grant providers include Beit Isi Shapira, Ale, Joint Ashalim, Yad Hanadiv, and Keren Rashi.

Finally, it is the author's long-term goal to establish relationships with major healthcare organizations and apply for accreditation from continuing education providers to expand the course's reach and promote EC on a larger scale. Examples of major healthcare organizations include building partnerships with regional hospitals/HMOs/private healthcare providers/healthcare provider associations interested in educating their clinicians on the importance of emotions in healthcare or universities with

healthcare programs. Departments may purchase the course for a group of employees to train their staff and enhance the quality of care in the department. After partnering with a relevant organization, the facilitator will apply for the Health Resources & Services Administration (HRSA) grant. The HRSA provides grants for health and public safety workforce resiliency training programs that promote resilience and mental health among health professional workforce programs. The potential grants that were listed above are summarized in Table 7.2.

Table 7.2. Grants and grant criteria

Grant Title	Grant Criteria
Dudley Allen Sargent Research Fund: Doctoral Student Fund	• Gives financial assistance to post-professional doctoral students involved in research • Any student enrolled in the Sargent College post-professional doctoral degree can apply • Max award: $5,000 • https://www.bu.edu/sargent/research/research-funding-administration/funding-opportunities-for-sargent-faculty-and-students/student-research-grant/
Health Resources & Services Administration (HRSA): Health and Public Safety Workforce Resiliency Training Program/ Promoting Resilience and Mental Health Among Health Professional Workforce Program	• Gives financial assistance to health professions schools, academic health centers, state or local governments, Indian tribes, tribal organizations, or other appropriate public or private nonprofit entities (or consortia of such entities, including entities promoting multidisciplinary approaches. • Funding for planning, developing, operating, or participating in health professions and nursing training activities using evidence-based or evidence-informed strategies, to reduce and address burnout, suicide, mental health conditions, and substance use disorders and promote resiliency among health care professionals, including healthcare students, residents, professionals, paraprofessionals, trainees, public safety officers, and employers of such individuals, collectively known as the "Health Workforce," in rural and medically underserved communities.

	• https://bhw.hrsa.gov/funding/health-workforce-resiliency-awards
The Israeli Ministry of Health	• The Israeli Ministry of Health offers several annual grants to support health related research conducted in collaboration with researchers overseas to enhance the quality of care. • http://www.health.gov.il/Subjects/Research/Pages/Research-Foundation.aspx.
Grants for specific populations	• Grants for clinicians working with specific client populations, such as people with intellectual disabilities or autism spectrum disorder, where the emotional load on the clinician is considerably large. • When applying, the facilitator will suggest that the grantmakers use the *EmOTions* program funds to enhance the quality of care by empowering and strengthening the clinicians providing services for these populations. • Some local grant providers include Beit Isi Shapira, Ale, Joint Ashalim, Yad Hanadiv, and Keren Rashi.

Conclusion

This chapter described the funding plan for the *EmOTions* continuing education program and the *EmOTions Facilitator Manual*. First, available local resources were described. Then, the needed resources, including the budget, were disclosed, and a three-year projected revenue plan. Finally, potential funding sources were identified. The next chapter summarizes and concludes the doctoral paper.

CHAPTER EIGHT – Conclusion

The central premise of this academic paper is that the effectiveness of occupational therapists' work correlates with the degree of their Emotional Competence (EC) within the therapeutic encounter (McKenna & Mellson, 2013). An individual's EC is a person's skills, confidence, and capacity to navigate emotions in different social situations and is related to Emotional Intelligence (EI) (Coetzee et al., 2016; Saarni, 1997).

Occupational therapists must know how to work with emotions to connect with and treat their clients. Studies show that effectively navigating emotions in the therapeutic interaction influences many factors critical to occupational therapy practice, such as client engagement and motivation, the therapeutic relationship between therapist and client, treatment outcomes, and therapists' psychological well-being, protecting from emotion-based stress, burnout or compassion fatigue (Brasseur et al., 2013; Kielhofner, 2009; Kotsou et al., 2011; Park, 2021; Taylor, 2020;).

Despite the importance of EC, research cited in this academic paper consistently demonstrated multiple gaps in the application to practice. First, healthcare professionals' curriculums typically emphasize developing practical emotional-related skills and strategies (Brown, 2018; Grant et al., 2014; Perkins, 2018). Furthermore, many healthcare organizations lack on-site education to enhance practicing professionals' EC and interpersonal communication skills (Calabrese et al., 2019). All of these may adversely affect the therapist's well-being and the quality of care.

To address this gap in occupational therapy practice, the author created an intervention entitled *EmOTions. EmOTions* is a comprehensive, six-week- 30-hour online

continuing education course for practicing occupational therapists. Its primary purpose is to build and incorporate EC skills into daily therapeutic practice. This theory and evidence-based course uses key interventional ingredients found in the literature to inform the program's content and structure. Detailed plans were developed for the program's evaluation, funding, and dissemination.

Limitations of the *EmOTions* program and research study include the lack of testing of its applicability to other healthcare professionals from different cultural and geographic backgrounds. Moreover, the program is yet to be piloted to demonstrate its effectiveness in practice. Further directions for program development include expanding it to a multi-discipline, culturally diverse population and conducting a pilot program evaluation.

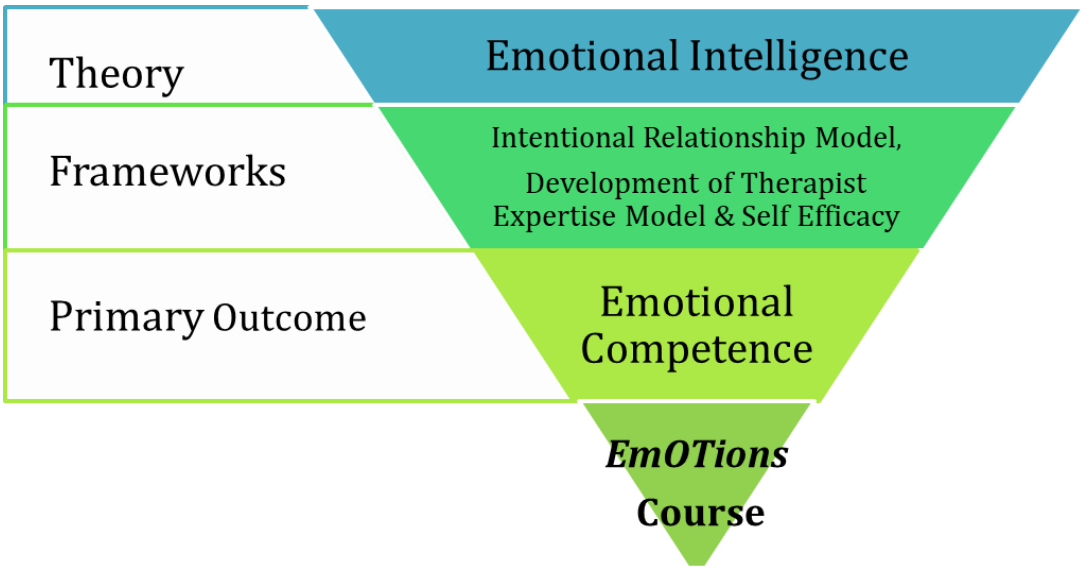
On a personal note, developing this doctoral work has been illuminating and gratifying. My own experiences inspired the project as an occupational therapist in a mental health domain, where I recognized the importance of emotions in the therapeutic realm. I began my OTD journey with an aspiration to improve the therapist's emotional understanding and well-being within themselves and with their clients. It has been a long process to identify the most accurate terms and knowledge bases. I learned that EC is an under-researched and underutilized skill that needs to be brought to the forefront of occupational therapy practice. It has vast effects on the therapist, therapeutic interactions, and treatment outcomes. The endless potential of emotional understanding and the exploration of emotions in occupational therapy can lead to both personal and professional development. I hope the *EmOTions* program will be broadly used to help many occupational therapists leverage the benefits of EC into daily practice, resulting in

improved therapist well-being, client outcomes, and quality care.

APPENDIX A – Theoretical Background of Doctoral Project

The theoretical base of this doctoral project draws from the theories and frameworks of Emotional Intelligence (EI), the Intentional Relationship Model (IRM), and Emotional Competence, presented in Figure 1.2. EI theories are used to understand the complexity of the problem and the potential solutions (Brackett et al., 2021; Gayathri et al., 2013; Mayer & Salovey, 1997). The IRM is used to situate EI within the therapeutic practice and to promote therapeutic relationships and therapeutic use of self (Taylor, 2020). Additional frameworks in the project also include the Development of Therapist Expertise Model & Self Efficacy, described in Chapter 4. Finally, Emotional Competence (EC) is used to explain the primary change outcomes in the proposed intervention, *EmOTions* continuing education course, which is further described in Chapter 4 (Coetzee et al., 2016; Saarni, 1997). EC also links EI and IRM's concepts and theories. EI, IRM, and EC and their correlations are illustrated in Figure 1.2, further explained below.

Figure 1.2. Doctoral project primary theoretical background



Emotional Intelligence Theory

EI is broadly defined as a person's ability to identify, perceive, understand and regulate emotions in oneself and others and manage or cope effectively with emotive situations (Zeidner et al., 2009). It also considers the extent to which individuals can recognize, understand, process, manage, monitor and utilize emotional information (McKenna, 2013). EI is a relatively new model, established in 1990 by Salovey and Mayer. The EI concept primarily focuses on the complex tapestry of emotional reasoning in everyday life. It rests on the assumption that emotions convey knowledge about a person's relationships with the world and taps into the extent to which people's cognitive capabilities are informed by emotions, along with the extent to which emotions are managed cognitively (Coetzee et al., 2006). It also increases the recognition of the substantive value of emotions in general (Dhani & Sharma, 2016; Mayer & Salovey, 1997).

EI appears to be distinct from but positively related to other types of intelligence, such as logical-mathematical, spatial, kinesthetic, and linguistic intelligence. Like other types of intelligence, EI is a universal skill found in every person with differing ability levels. It also presents differently in each individual, develops over a person's life span, and can be enhanced through training. The differences in individual behaviors, or skill levels, spur from differences in emotional upbringing, education, culture, age, and experiences (Brackett et al., 2021; Mayer & Salovey, 2016).

EI as a concept is based on extensive scientific and research evidence. Over the years, several theories have been formed explaining EI and its different components. Unfortunately, many of these theories utilize overlapping concepts for EI, and no general

census has been reached on its operationalization. This overlap makes it difficult to understand and apply EI. However, studies have found several key findings that provide a broad picture of EI's core critical properties (Coetzee et al., 2006).

Prominent Models of Emotional Intelligence

There are currently three predominant models of EI that operationalize and construct EI into different elements and domains. These models are the Ability Model, Mixed Model, and Trait Model. Figure A.1 illustrates those models and describes their defining characteristics, as well as their strengths and limitations.

Table A.1. Comparison of the three prominent EI theories

Model	Founders	Defining Characteristics	Strengths & Limitations
Ability Model or Performance-Based Model	Salovey and Mayer (1990)	EI is comprised of a hierarchy of branches, organized from most basic to most complex: (1) perception or expression of emotions (2) access and generate emotions to facilitate thinking (3) understand emotions and emotional knowledge (4) manage and reflectively regulate emotions in oneself and others to promote emotional and intellectual growth. Each branch is composed of areas of reasoning, ranged hierarchically as well. Behavior change occurs when an individual can progress from a fundamental skill to a more complex one and thus exhibit more integrated, mature, emotionally intelligent behavior. EI is a universal skill found in every person with differing ability levels. The differences in individual behaviors, or skill levels, spur from differences in emotional upbringing, education, culture, age, and experiences. EI is an ability, not a trait (a consistent behavior over time), that can increase with experience, knowledge and training.	One of the most prominent EI models currently used. EI is defined narrowly, with constructs sharing minimal overlap with other existing measures for assessing other elements of personality. Ability EI has the purest correlation between emotion and intelligence. EI relates specifically to interactions between emotions and cognitions, using emotion to enhance thinking and using thought to regulate emotion. Model holds a considerable body of research. Abilities are measured through objective tests akin to IQ tests, where problems are scored on a right-or-wrong basis, with sound psychometric properties. These assessments include (1) Multi-factor Emotional Intelligence Scale (MEIS) and (2) the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT). However, assessments are expensive and relatively inaccessible.

Mixed Models	Emotional Social Intelligence	Bar-On (1997)	Provides a broader conception of EI, which incorporates both abilities and other qualities such as personality and motivational traits that assist the person in using EI in real life. Five non-sequential dimensions with 15 components: (1) Intrapersonal skills- self-regard, emotional self-awareness, assertiveness, self-actualization, and independence. (2) Interpersonal skills - empathy, interpersonal relationship, and social responsibility. (3) Adaptability dimension- problem-solving, flexibility, and reality testing. (4) Stress management- stress tolerance and impulse control. (5) General mood- Happiness, optimism. Compared to Goleman's Mixed Model, this model is more theoretical in nature.	Both Bar-On and Golemans' Mixed models have low discriminant validity with personality measures that measure personality traits and adaptive functioning. Each model is slightly different in defining the elements of EI and which qualities it incorporates. Typically measured through questionnaires, which provide a straightforward, economical, and accessible way to measure individual differences in emotional functioning. These questionnaires were created under the assumption that people have sufficient insights into their own emotions and real-life functioning for self-reports to be valid. Such an assumption is sometimes questioned in its validity. Also, the questionnaire assessments tend to overlap with standard personality traits such as extroversion and emotional stability. Example of prominent assessments: (1) BarOn Emotional Quotient Inventory (EQ-i), and (2) Emotional Intelligence Self-Assessment Questionnaire (EISAQ).

	Competency Model	Goleman (1995)	EI is a set of learned skills that may translate directly into success in various social domains. It is designed specifically for workplace applications. It is comprised of four non-sequential abilities with 20 competencies: (1) <u>Self-awareness</u> (combination of personal competence and recognition) - emotional self-awareness, accurate self-assessment, confidence. (2) <u>Self-Management</u> (combination of personal competence and regulation)- emotional self-control, trustworthiness, consciousnesses, adaptability, achievement drive, initiative. (3) <u>Social Awareness</u> (combination of social competence and recognition)- empathy, service orientation, organizational awareness. (4) <u>Relationship Management</u> (combination of social competence and regulation)- developing others, influence, communication, conflict management, visionary leadership, catalysing change, building bonds, teamwork, and collaboration.	The model is more practical in nature and application but is less empirically based. It also involves a combination of many traits and abilities in broad strokes and is less specific in its operationalized definition. Thus, it is not purely measure EI, as it is more focused on adaptive functioning skills such as social skills, coping with stress, and motivation, all of which are less likely to be categorised as either emotion or intelligence. The qualities listed are defined as emotional competencies- they may be seen as learned capabilities based on EI that result in changes in performance at work and in other domains of life. Assessments include: (1) 360-degree feedback program- measures managerial performance in human resources which assess the employee in totality, (2) Emotional Competency Inventory (ECI) -an EI self-report assessment.

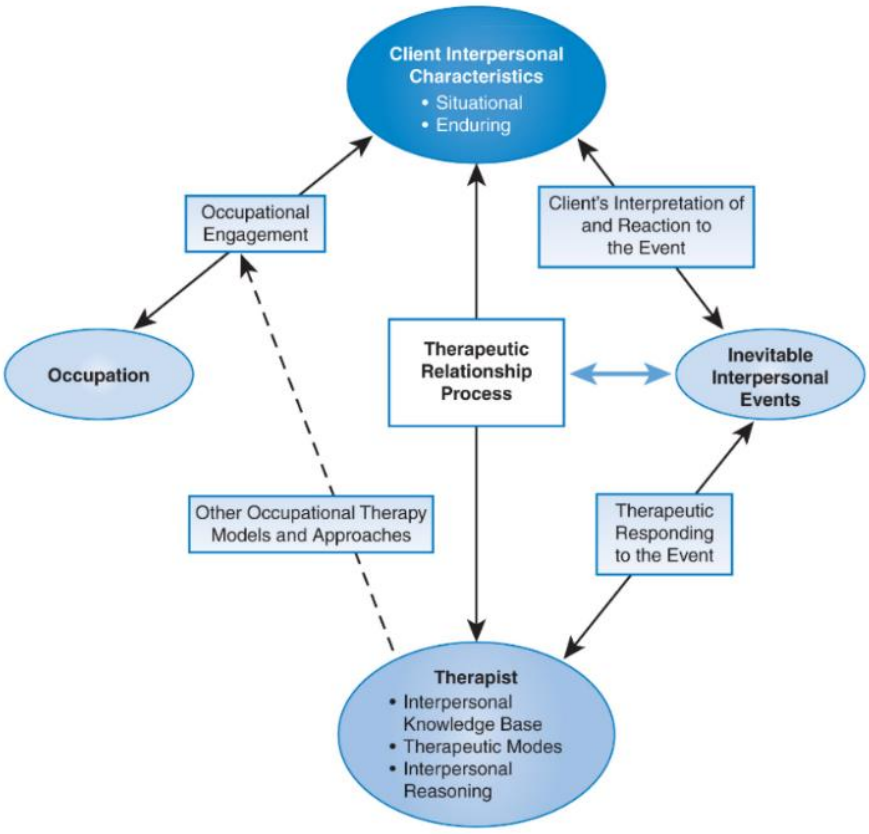
Trait Model or Trait Emotional Self-Efficacy	Petrides and Furnham (2000)	Examines personality traits that relate directly to emotional functioning and emotional self-confidence. Represents a qualitative style of behavior and experience that is adaptive in some contexts but not in others. Comprised of fifteen emotion-related facets scattered across personality dimensions and clustered under six factors: (1) Well-being- trait happiness, trait optimism, self-esteem. (2) Self-control- emotional regulation, impulsiveness (low), stress management. (3) Emotionality- emotional perception, emotion expression, relationships. (4) Sociability- emotional management, assertiveness, social awareness. (5) Adaptability. (6) Self-Motivation.	EI is intertwined with the self-perceived ability and tendency to behave. EI is located at the lower levels of personality. Therefore, stable dispositions influence emotional, cognitive and behavioral functioning in a range of different contexts or situations and do not change easily.

Internal Relationship Model

The Internal Relationship Model (IRM) was created by Taylor (2008) as a conceptual practice model intended to be used in conjunction with other models in occupational therapy practice. It explains the therapeutic use of self within the practice to promote therapeutic relationships and facilitate occupational engagement (Taylor, 2020). Therapeutic use of self is defined as the therapist's conscious efforts to optimize interactions with clients, as the therapist consciously works with the interpersonal side of the therapeutic relationship to facilitate client outcomes (Anderson & Halbakken, 2020).

The IRM consists of four central elements: the client, interpersonal events in therapy, the therapist, and the occupation. The client is the focal point in the intervention, with the therapist responsible for developing a positive relationship with the client (Anderson & Halbakken, 2020). Each client has interpersonal characteristics that are either situational or enduring that influence the therapeutic relationship. The therapist, trained in interpersonal skills, interpersonal reasoning, and the ability to use therapeutic modes, can influence the inevitable interpersonal events that occur in practice, enhance the therapeutic relationship, and improve the client's occupational engagement (Taylor, 2020). Figure 1 illustrates the components of the IRM model.

Figure A.1. Taylor's (2020) Internal relationship model.



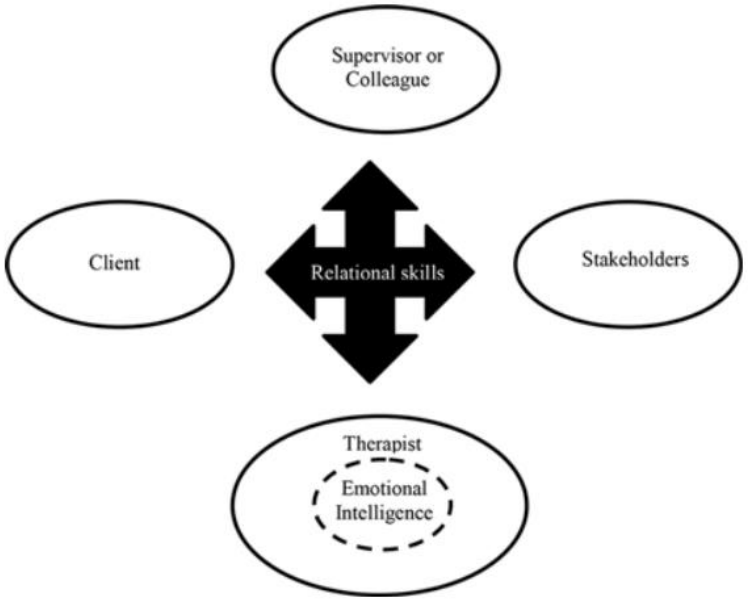
Therapeutic use of self is the ability to develop and manage therapeutic relationships with clients by using professional reasoning, empathy, and a client-centered, collaborative approach to facilitate client occupational engagement (American Occupational Therapy Association, 2020; Taylor, 2020). Literature supports the importance of therapeutic use of self as an essential element in creating therapeutic relationships, maximizing the client's occupational engagement and therapeutic goals across populations, and is considered one of the strongest tools used by occupational therapists (Anderson & Halbakken, 2020; Andonian, 2017; Chaffey et al., 2012; Myers, 2014; Perkins & Schmid, 2019, Wong, 2016). To utilize therapeutic use of self to forge and maintain a positive therapeutic relationship, therapists must use EI and EC to understand and navigate the emotions that arise within the therapeutic intervention (Myers, 2014).

The Relationship Between Emotional Intelligence and Therapeutic Use of Self

The therapeutic use of self and EI are distinct yet related concepts. Both concepts share common skills, such as self-control, reading and interoperating social cues, and self-awareness. The two theories share a foundation in relating to others, yet they differ in how they are conceptualized. Occupational therapy describes therapeutic use of self as using the "self as a tool" to advance client functional performance. The concepts of therapeutic use of self and client-centered practice are transactional in nature and are enacted in relationships with others. In contrast, EI is situated within the therapist and indirectly influences relationships with others. Unlike therapeutic use of self, EI does not directly relate to occupational engagement in its theory or approach. Instead, EI refers to

occupational therapists' inherent and developed skills, which then inform what the therapist brings to the client-therapist relationship (Andonian, 2017). Figure A.2 illustrates the relationship between therapeutic use of self and EI.

Figure A.2. Andonian's (2017) illustration of the relationship between therapeutic use of self and Emotional Intelligence



EI theory strengthens the application of therapeutic use of self in occupational therapy. EI theory describes how emotions influence thinking, supporting the interactive reasoning process inherent in therapeutic use of self, which heavily relies on self-awareness and perception, informing clinical reasoning, collaboration, and decision-making. EI theories describe how emotions influence thinking as well as relationships, as feelings influence judgment, memory, reasoning, and good decision-making. Thus, implementing EI knowledge, skills, and research within occupational therapy will facilitate effective emotional navigation development within the profession. Moreover, increased awareness

of the interplay between EI and therapeutic use of self in clinical situations would also be an asset to the profession (Andonian, 2017).

Emotional Competence

Emotional Competence (EC) is defined as the demonstration of self-efficacy in emotion-eliciting social transactions. In other words, EC refers to an individual's skills, confidence, and capacity to navigate emotions in different social situations. It includes identifying, expressing, understanding, regulating, and using emotions (both one's own and others') (Brasseur et al., 2013). The application of EC refers to how people strategically apply emotional knowledge and expression to respond to others in the face of changing social environments to navigate through interpersonal exchanges and regulate their own emotional experiences (Coetzee et al., 2016; Saarni, 1997). EC is an essential cornerstone in establishing empathetic therapeutic relationships between clients and occupational therapists (Lenneville, 2014). Table A.3 shows the dimensions of EC, as measured by the Profile of Emotional Competence (PEC), the measure of EC (Brasseur et al., 2013).

Table A.3. Brasseur and Colleagues' (2013) Dimensions of EC

Dimensions	Self	Other
Identification	Identify my emotions	Identify others' emotions
Understanding	Understand my emotions	Understand others' emotions
Expression	Express my emotions	Listen to others' emotions
Regulation	Regulate my emotions	Regulate others' emotions
Use	Use my emotions	Use others' emotions
	Intrapersonal EI	**Interpersonal EI**
	Global EI	

The concept of EC was conceived from the study of EI. The conceptualization of EC is historically based on the EI Mixed model, which defines EI as an ability mixed with social behaviors, traits, and competencies (Coetzee et al., 2006). EC is comprised of three hierarchical levels. The first level is knowledge of emotion. The focus is on what people know about emotions and how to deal with emotions, with all their complexity. The second level is the emotional ability, or the ability to apply emotional knowledge in an emotional situation and how well to implement a given strategy. The last level is emotional traits or the individual's tendency to behave a certain way in emotional situations. Again, the focus is on what people essentially do, not what they know or can do theoretically. All three levels are loosely connected, as knowledge does not always translate into abilities which in turn do not always translate into usual behaviors (Kotzou et al., 2011).

EC is linked with an individual's experiences, EI skills and knowledge base, cultural context, and biological predispositions. Additionally, people behave differently when in relationships with others. Relationships with others provide diversity in an individual's emotional experience, emotional coping challenges, and variations in how they communicate their emotional experience to others. Thus, relationships influence individuals' emotions, and their emotions reciprocally influence their relationships (Coetzee et al., 2006).

Today, in many studies, EC and EI are used interchangeably. However, there are significant differences in the focus and practical applications of the two terms. While EI relates to traits, abilities, and attributes of emotional functioning, EC describes emotional information's skills, knowledge, capabilities, and workplace application (Coetzee et al., 2006). In other words, EC can be seen as the practical application or response capabilities of a person's EI. The concept of EC is used in organizational and workplace applications where individual learning, development, and performance are emphasized (Coetzee et al., 2006).

Summary

This chapter presented the theoretical underpinnings for the *EmOTions* course and *EmOTions Facilitator Manual*. First, the theories of EI, IRM, with therapeutic use of self as one of the primary factors, and EC were presented and explained. Lastly, the theories were linked to each other and to occupational therapy practice.

APPENDIX B- Evaluative Evidence of the Explanatory Model of the Problem

Reference	Report Type	Participants	Study Site	Definition & Measures	Intervention Procedures	Purpose & Key findings	Application to OTD project
Anderson, J. and Halbakken, H. (2020). Therapeutic use of self: Continuing education for occupational therapy practitioners and students. Occupational Therapy Capstones. 431. https://commons.und.edu/ot-grad/431	Capstone project	None	None	According to AOTA (2014), empathy is an important part of therapeutic use of self, and it is an emotional exchange that takes place between practitioners and clients. Empathy allows for open communication and allows practitioners to connect with clients at an emotional level so that practitioners can better assist clients with his or her current life situations. Importance of creating an atmosphere of empathy in order to understand the client and establish a meaningful therapeutic relationship. When occupational therapy practitioners possess the qualities of empathy, it has been shown to lead to a positive therapeutic relationship. Taylor (2008) identified that using the empathizing mode consists of witnessing, validating, actively listening, and understanding a client's experiences in order to gain perspective of their difficulties. This allows opportunity for clients to learn to empathize with themselves, self-reflect, and gain insight. In addition, empathy is fundamental to resolving conflicts and misunderstandings during therapy. Therapeutic use of self is a crucial skill for occupational therapy practitioners to possess when providing treatment to clients. Currently, occupational therapy practitioners have expressed concern about feeling incompetent and lack of confidence in therapeutic use of self and interpersonal skills due to the limited education and training provided in schools and continued	None	Fan and Taylor (2018) discovered when occupational therapy practitioners use the emphasizing mode, clients had the highest participation and adherence to therapy, as compared to the other therapeutic modes. The empathizing mode was significantly correlated with a client's motivation toward occupation and participation in therapy. Clients felt more comfortable and shared more thoughts with the occupational therapy practitioner, leading to higher participation in treatment Techniques to implement empathy into conversations with clients include the following: listen to the client, encourage the client to share story from his or her perspective, and restate the client's words to validate emotions and/or feelings. It is important to restate the client's phrases rather than rephase statements because the information may be misinterpreted from original meaning . Fan and Taylor (2018) concluded that the empathizing mode can be viewed as the foundation for building a strong therapeutic relationship with clients as well as increasing client participation in the therapy process.	Importance of empathy in therapeutic use of self and in occupational therapy in general- incorporate into intervention. Also include the problems with over-reliance on empathetic mode.

				education. The feelings of inadequacy and lack of training are problematic as it may limit occupational therapy practitioners' therapeutic engagement with clients. When occupational therapy practitioners are competent in therapeutic use of self, they are able to form a stronger therapeutic relationship with clients, which leads to higher outcomes and results in therapy. In addition, current healthcare trends have made it increasingly difficult for occupational therapy practitioners to form relationships with their clients and to appropriately use the IRM model and modes to guide their interactions with clients.		Despite the importance of the empathizing mode, Taylor (2008) described that overreliance on this mode can place too high of an emphasis on emotions during the therapeutic process, which can lead to clients feeling uncomfortable if their emotions are being reflected back to them. In addition, it can encourage an inappropriate level of dependence, emotional overinvolvement, and guilt over the limits of therapy, which can lead to burnout . Therefore, there are reported benefits of using empathy as a foundation to establish the therapeutic relationship and to improve outcomes of therapy; however, practitioners must also be aware of the cautions of over-reliance on this mode. It is recommended that there are more opportunities for occupational therapy practitioners to receive further training on therapeutic use of self in order to enhance therapy services and the therapeutic relationship between practitioner and client.	
Andonian, L. (2017) Emotional intelligence: An opportunity for occupational therapy, Occupational Therapy in Mental Health, 33:4, 299-307, DOI:	Theore-tical article	None	None	EI theory fucuses on how emotions influence thinking supports the interactive reasoning process inherent in the therapeutic use of self. That reasoning process relies on self-awareness and perception, which inform clinical reasoning, collaboration, and decision making. EI theory describes how emotions influence thinking as well as relationships. This is an important addition to interactive reasoning. Generally, thinking and feeling	None	Both EI theory and occupational therapy address relationship building skills that support the development of rapport and connection with others. Occupational therapists employ therapeutic use of self in client-centered practice to develop understanding and trust with clients during therapy sessions	Highlights the correlation of EI, therapeutic use of self and occupational therapy, which can be used in the intervention. Implementing EI knowledge,

10.1080/0164212X.2017.1328649				are regarded as two separate and unrelated aspects of expression; however, in EI theory, feelings influence judgment, memory, and reasoning and foster good decision making. There are currently no measures of therapists' ability to use the therapeutic use of self or client-centeredness. EI theory provides a valid, reliable, and standardized measure of the therapist's foundational relational skills and may be used as a tool to help therapists develop specific relationship skills that they may be lacking. EI theory draws upon a wealth of research from business, management, and psychology which applies to clinicians and addresses the needs of occupational therapy leaders. Studies indicate that degree of EI is positively related to leadership and management abilities as well as occupational therapy students' fieldwork performance. EI has established EI skill development approaches, which would enhance the existing resources in the profession. Training modules in EI skills have been implemented for diverse groups including faculty, students, clinicians, and managers. Training approaches include EI skill education, self-questioning strategies, coaching, and role play. Modules often begin with participants completing the MSCEIT online and then receiving feedback on their MSCEIT scores in terms of areas to develop, areas of competence, and areas of skill.		The literature supports the importance of therapeutic use of self-skills for occupational therapists across populations and when working with clients with whom they differ in terms of therapy goals. Historically, the therapeutic use of self has been used in occupational therapy to address the therapeutic relationship through encouraging engagement in occupation, fostering client self-awareness, and focusing on collaboration and understanding the client's perspectives during therapy. The therapeutic use of self and EI share some common skills, such as, self-control, reading and interpreting social cues, and self-awareness. The two theories share a focus on relating to others, yet they differ in terms of how they are conceptualized. Occupational therapy describes therapeutic use of self as using the "self as tool" to advance patient functional performance. The therapeutic use of self and being client-centered are transactional in nature and are enacted in relationship to others. In contrast to the relational nature of the therapeutic use of self, EI is situated within the person themselves, and indirectly influences relationships with others. Unlike the therapeutic use of self, EI does not directly relate to occupational engagement in its theory and approach. EI refers to	measures, and skills within occupational therapy will facilitate relationship skill knowledge, measurement, and development within the profession. EI skill development focuses on relationships with others generally, not only client relationships, and as such, it has the potential to benefit the occupational therapy profession in education, advocacy, and practice.

						the inherent and developed EI skills of the occupational therapist, which then informs what the therapist brings to the client–therapist relationship, as well as to relationships with their colleagues. Increased awareness of the interplay between therapeutic use of self and EI in clinical situations would be an asset to the profession. EI theory supports the use of therapeutic use of self in occupational therapy through four distinct methods.	
Ariapooran S. (2014). Compassion fatigue and burnout in Iranian nurses: The role of perceived social support. Iranian Journal of Nursing and Midwifery Research, 19(3), 279–284.	Correla-tional descript-ive survey research design	173 participants among the nurses working in public hospitals of Malayer, Iran.	Malayer , Iran	The symptoms of CF are feelings of powerlessness, depression and affective numbness, sleep disturbances and nightmares, autonomic arousal, memory gaps, dissociation, rumination, and intrusive thoughts and images. Joinson (1992) who coined the term "CF" found that nurses were at a greater risk for CF, and it could be harmful to the emotional and physical well-being of the nurse. Professional Quality of Life (CF and burnout subscales) and Multidimensional Scale of Perceived Social Support (MSPSS) were used for collecting the data.		Based on the obtained results, some nurses (especially emergency nurses) are at risk for CF and burnout and social support negatively correlated to CF and burnout in Iranian nurses . Higher levels of support from co-workers were correlated to lower levels of emotional exhaustion in nurses, and higher stressor scores were related to higher levels of depersonalization for staff reporting high levels of social support, but not for those reporting low levels of support. Perceived organizational support is related to nurses' health and job satisfaction. Social support (supervisory support and family support) was negatively related to burnout and secondary traumatic stress (STS). There was a statistically significant relationship between social support and burnout of Iranian nurses .	It is necessary to develop support systems for clinicians at risk for CF and Burnout

Beauvais, A., Andreychik, M., & Henkel, L. A. (2017). The role of emotional intelligence and empathy in compassionate nursing care. Mindfulness & Compassion, 2(2), 92-100.	cross-sectional study used a descrip-tive, correla-tional design	100 participants - working nurses	United States	EI can help clinicians to empathize with the patients they care for. Empathy: an affective response that stems from the apprehension or comprehension of another's emotional state or condition, and which is identical or very similar to what the other person is feeling or would be expected to feel. Empathy- has been shown to enhance the therapeutic effeteness of the client-patient relationship. EI is a basis for empathy and caring, as individuals need to appraise others emotions to develop those abilities. EI serves as a foundation for empathy as it helps people to (1) appreciate what is truly worring other individuals (2) understand oneself and one's own emotions, (3) remain interested in understanding another individual (4) effectively communicate, even while giving undesirable messages and (5) develop trusting and rewarding relationships, solve problems, think creatively and resolve disagreements. Importantly, although some past research has examined relations between emotional intelligence and empathy as well as personal and professional outcomes among clinicians, this work has largely focused on empathy for others' negative emotions (e.g., pain, sadness, anxiety). This focus is logical especially in healthcare settings where clinicians are likely to encounter individuals struggling with negative emotions. In such settings, the extent to which clinicians ''feel along with'' such negative emotions is likely to be quite consequential. For example, too little	online recruitment site	The significant relationship between emotional intelligence (total and branch scores) and positive empathy supports statements in the literature that empathy is a key component of emotional intelligence as empathy involves the ability to understand another's emotion The findings support the developing view that empathy is more than just connecting with others' emotions broadly speaking, and that different styles or types of empathy exist. Positive empathy (relating to patient's positive emotions such as happiness and optimism) was found to be related to emotional intelligence in the study's sample of nursing professionals, but negative empathy (relating to patient's negative emotions such as sadness and pain) for the most part was not related to emotional intelligence. In different contexts, different styles of empathy can be beneficial, and it appears that nurses higher in emotional intelligence tend to engage in positive empathy as part of their healthcare practice. For example, the emotionally intelligent nurse might perceive joy in a patient who has just given birth. The nurse may empathize and feel that joy as well. The nurse might use that emotional information to facilitate thinking and manage the	Importance of EI and empathy-include in intervention

				connection with a patient's suffering might result in a lack of caring, whereas too much connection with the patient's suffering might result in empathic over-arousal and, eventually, burnout . Building on recent work demonstrating that empathy for others' negative emotions and empathy for others' positive emotions are distinct from one another, it can be argued that such positive empathy may have a beneficial effect for clinicians. For example, clinicians who are particularly likely to connect with their patients' positive emotions (e.g., hopefulness, optimism) seem likely to draw greater enjoyment from the experience of emotional connection, which may help to buffer the effects of other ob-related stresses and, perhaps, make them better able to effectively empathize with the negative emotions that their patients will inevitably experience Emotional intelligence was measured by the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT), Positive and negative empathy were measured with the Positive and Negative Empathy Scales (PaNES) The ProQOL5		situation to help the mother bond with the baby. The flip side of this is nurses who tend to empathize too much with patients' negative emotions (their pain, their fears, their distress) may be inadvertently engaging in unhealthy styles of empathy in this context. In general, emotional intelligence and negative empathy were not related (except for branch 3, managing emotions). For example, the emotionally intelligent nurse might recognize from a patient's expression that he is anxious. Although the nurse might understand this emotion and recognize that it is related to an upcoming surgery in which the patient worries about the lack of control and fears the unknown, this does not mean that the nurse is empathizing with that negative emotion or feeling the same emotion. Most likely the nurse recognizes that the surgery will help the patient and chooses to focus on the hope the surgery will provide. The emotionally intelligent nurse can help the patient manage the anxiety with relaxation techniques, and when the patient's anxiety decreases the nurse can offer education to decrease the fear of the unknown. Interestingly, the one correlation between emotional intelligence and negative empathy was with	

						the branch of emotional intelligence that deals with managing emotions. In healthcare, ignoring negative emotions can be perceived as being cold or uninvolved, and thus skills at managing negative emotions may be especially valuable and something that people with experience with these sorts of situations might either develop out of necessity or might be something that draws people to the profession in the first place Emotional intelligence (total and branch scores) was positively correlated with compassion satisfaction. Emotional intelligence (total and branch scores except branch 3: understanding emotion) was negatively correlated with both compassion fatigue and burnout. These findings support previous findings in the literature that emotional intelligence influences burnout and caring of nurses and that emotional intelligence effects nurses' well-being and perceived job stress These findings suggest that the more nurses connect with their patients' positive emotions, the more positive and the less emotionally-draining is the emotional support aspect of their work.	

Cavanagh, N., Cockett, G., Heinrich, C., Doig, L., Fiest, K., Guichon, J. R, Page, S., Mitchell, I., & Doig, C.J. (2020). Compassion fatigue in healthcare providers: A systematic review and meta-analysis. Nursing Ethics, 27(3), 639–665. https://doi.org/10.1177/0969733019889400	Systematic review and meta-analysis	37 articles pertained exclusively to nursing professionals and physicians or medical trainees . Although most studies from North America (41/71), there were articles worldwide.	71 articles describe and summarize the prevalence of compassion fatigue in healthcare practitioners using narrative synthesis and meta-analytic methods .	Compassion fatigue- healthcare practitioner's diminished capacity to care as a consequence of repeated exposure to the suffering of patients and from the knowledge of their patient's traumatic experiences. It is a result of providing patient care for individual patients or events. It may develop from the trauma of patients as well as other factors. Compassion fatigue is triggered by the continual use of empathy and emotional energy, previous exposure to trauma, prolonged exposure to secondary trauma (a consequence of being witness to the trauma of others, and being in a position of having to care for those who are suffering, rather than being the primary subject of the trauma themselves), and the work environment. Burnout is defined as a "psychological syndrome that involves a prolonged response to stressors in the workplace." Specifically, burnout involves the chronic strain that results from an incongruence, or misfit, between the worker and the job. Considering that burnout develops largely due to organizational and structural stressors (i.e. related to working environment), changes in the work environment may potentially mitigate negative impacts to patients and be relatively easier to implement. However, Burnout may also be related to personal characteristics or a disrupted care provider that is more difficult to address such as inter-personal conflicts in or outside the work place, or personal financial stresses. Although Burnout and other distress may affect providers, compassion fatigue may	Systematic review	Compassion fatigue exists across diverse practitioner groups and specialties. Compassion fatigue's relationship to demographic, personal, and professional characteristics is unclear, as demonstrated by the variability in studies reviewed. The burnout subscale had the highest mean value (and therefore potentially most significant impact on compassion fatigue) across studies. This was also the subscale that had the highest number of studies with heterogeneous results with 10 studies significantly above the pooled mean. Results demonstrate an association between personal factors such as an existing diagnosis of anxiety or depression and prior negative life events and increased levels of compassion fatigue. Although the subscale scores for Burnout and compassion fatigue were correlated, it was not as clear how factors related to the work environment such as shift time and length, and the type of caring work being done, explicitly impacted compassion fatigue levels. This evidence of compassion fatigue and the effect on providers and patient care raises an important question on what strategies and programs health systems should consider to prevent or mitigate its effect. There are programs in existence, which include general wellness programs	Illustrates the importance of compassion fatigue and burnout, and why they should be addressed in the intervention.

				more severely affects patients as it is the direct effect of a healthcare provider's diminished capacity to care that results from repeated exposure to the suffering of their patients, as well as from the knowledge of their patient's traumatic experiences. CF-often reflected in outcomes of emotional distress, pain, and suffering, and may manifest in increased rates of absenteeism, reduced service quality, low levels of efficiency, and high attrition rates and eventually, workforce dropout. Professional Quality of Life scale- prevalence and predicted risk of compassion fatigue. Measures both the positive and negative elements experienced by persons who act as professional helpers. Three subscales- Compassion satisfaction, burnout and secondary traumatic stress/compassion fatigue. Each score is scored separately and compared to each other to gain insight into compassion fatigue.		that encourage self-care, and increased social and managerial support. Education to practitioners, from students to the most experienced, about the existence and impact of compassion fatigue could assist with identification of the condition, and also mitigate stigma in practitioners about the prevalence and impact of psychological distress in health professions. Prior to the implementation of any treatment or mitigation program, organizations should attempt to understand issues that affect their practitioners, and implement programs tailored to meet specific mitigating causes and concerns. This may be one specific benefit of a measurement tool such as the ProQOL as the effect of different domains can be measured, and more focused interventions considered.	
Chaffey, L., Unsworth, C. A., & Fossey, E. (2012). Relationship between intuition and emotional intelligence in occupational therapists in mental health practice. American Journal of Occupational	Clinical reasoning studies	134 practicing occupational therapists in mental health registered to the Australian Occupational Therapy Association.	Austra-lia	Intuition measure: CSI- 38 item questionnaire designed specifically for professionals. It measures respondents' preference for an intuitive versus an analytical cognitive style. The developers defined intuitive style as use of immediate judgments based on feelings and a global understanding of a situation and analytical style as use of judgments based on reasoning and a focus on detail. EI measure: SUEIT- which measures five areas of emotional competency:	Survey design- self reported data.	Suggested that clinicians need to have knowledge of their own emotions and those of others to effectively empathize and communicate with their clients and regulate their own and others' affective states . EI as an element of therapeutic use of self (concept in OT literature)- defined as "practitioner's planned use of his or her personality, insights, perceptions and judgment as part of the therapeutic process. Also described as a highly	Reflective practice, focused on exploring emotions, could be incorporated into the intervention format for occupational therapists

Therapy, 66(1), 88-96.				1. Emotional Recognition and Expression refers to the ability to identify and express one's own emotions. 2. Understanding Emotions, External, refers to the ability to perceive and understand the emotions of others. 3. Emotions Direct Cognition refers to the extent to which one incorporates emotions into one's decision making and problem solving. 4. Emotional Management refers to the ability to repair negative moods and maintain positive moods in both oneself and others. Emotional Control refers to the ability to control strong emotional states such as anger and frustration.		personal and subjective decision-making process that may be intuition driven but also grounded in rational and interpersonal guidelines. Findings suggest that exploring emotions through reflective practice could enhance intuitive aspects of clinical reasoning. Developing abilities associated with EI, either individually or in supervision, could enhance practice by encouraging occupational therapists to make effective use of intuition within clinical reasoning. It may also contribute to the therapeutic use of self. Supervision for occupational therapists could be enhanced if it focused not only on practice issues but also on understanding and using emotions within practice . Including education on EI in occupational therapy course curricula could be beneficial because novice therapists could develop improved skills more quickly by analyzing and articulating their intuitions	
CocCocker, F., & Joss, N. (2016). Compassion fatigue among healthcare, emergency and community service workers:	Systema-tic review	Thirteen studies-majority nurses (10)	11 studies from the US, one from Austra-lia, and one	CF is the convergence of secondary traumatic stress (STS) and Burnout, a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment. Exposure to patients or clients experiencing trauma or distress can negatively impact professional's mental	Eleven studies described single-faceted interventions focusing on yoga,	Effectiveness of interventions to reduce CF in healthcare, emergency, and community service workers Seven studies revealed a significant difference post-intervention in burnout or STS. The review revealed that evidence	Interventions that promote individual resilience and educate at-risk workers about effective coping strategies in

A systematic review. International Journal of Environmental Research and Public Health, 13(6), 618. https://doi.org/10.3390/ijerph13060618			from Israel.	and physical health, safety, and well-being, as well as that of their families, the people they care for, and their employing organizations. The term CF was coined to describe the phenomenon of stress resulting from exposure to a traumatized individual rather than from exposure to the trauma itself. An often extreme state of tension and preoccupation with the emotional pain and/or physical distress of those being helped can create secondary traumatic stress (STS) for the caregiver, and, when converged with cumulative burnout, a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment, CF results. CF is characterized by exhaustion, anger and irritability, negative coping behaviors including alcohol and drug abuse, reduced ability to feel sympathy and empathy, a diminished sense of enjoyment or satisfaction with work, increased absenteeism, and an impaired ability to make decisions and care for patients and/or clients. The adverse effects of providing care are aggravated by the severity of the traumatic material to which the caregiver is exposed, such as direct contact with victims, mainly when the exposure is of a graphic nature. CF can impact standards of patient care, relationships with colleagues or lead to more serious mental health conditions such as PTSD, anxiety, or depression. Emotional, cognitive, and physical consequences of providing professional services to trauma victims and survivors have been addressed in the literature. Several conceptual models have been	mindfulness, meditation, music therapy, resilience and coping, or transcranial magnetic stimulation. In contrast, Berger et al. and Flarity et al. described more complex interventions involving multiple, interactive sessions focused on promoting professional self-efficacy, improving theoretical knowledge, and assigning homework tasks, and individual and group exercises, guided imagery, take-home materials including print-outs, DVDs, and	of the efficiency of CF interventions in at-risk health and social care professions is relatively recent. Interventions that promote individual resilience and educate at-risk workers about effective coping strategies in response to these adverse job exposers are equally important and likely to have significant health and economic benefits, as they reduce not only STS, burnout , and CF but also the risk of more serious mental health disorders such as anxiety and depression, the quality of life and productivity consequences of which are well documented. The thirteen included studies in the search demonstrated mixed or no effects. The most promising trend was for the effectiveness of interventions involving an element focused on teaching and/or bolstering resilience, all of which showed improvement in burnout . Two of which demonstrated a reduction in STS and burnout and an improvement in CS. These findings are encouraging, as they suggest that workers in at-risk occupational groups can be taught to cope with the known risk factors for the development of CF,	response to these adverse job exposers

				developed to explain them. However, the majority of research to date has focused on identifying the prevalence and predictors of CF in a unique occupational group such as nurses, therapists, community service workers, and healthcare professionals in hospital emergency departments or intensive care units. Examine and interrogate the quality of these preventive measures. These include workload intensity, inadequate rest periods between shifts, task repetitiveness, low control, and low job satisfaction, poor resilience, lack of meaningful recognition, and poor managerial support Professional Quality of Life (ProQoL) scale- measures CF.	music CDs, and access to educational resources and publications, respectively. Each had follow-up intervals ranging from three weeks (immediately post-intervention) to six months.	which are also, unfortunately, unavoidable parts of their job. Accelerated Program for Compassion Fatigue (ARP), developed by Gentry et al., is a five-session model for treating the deleterious effects caregivers experience due to their caregiving work through the promotion of resilience and self-efficacy. Participants in the ARP not only report a reduction in CF symptoms, but they also feel more empowered, more energetic, and have a stronger sense of self-worth. Designed to reduce the intensity, frequency, and duration of symptoms associated with Compassion Fatigue, ARP aims to help at-risk workers identify symptoms of CF, recognize CF triggers, identify and utilize existing available resources, review personal and professional history to the present day to identify those at increased risk, master arousal reduction methods, resolve any impediments to efficacy, initiate conflict resolution, and initiate a supportive aftercare plan-in collaboration with their employer or supervisor. The ARP also advocates the promotion of self-compassion to encourage individuals to challenge a negative internal dialogue and focus on shifting their automatic	

						thoughts and beliefs to reflect a more positive outlook. The program promotes: (i) self-care and revitalization; (ii) connection and support; (iii) intentionality, or eradicating stress and shifting from reactive to intentional behavior ; (iv) self-regulation, which involves developing the ability to intentionally control the activity and lessen the energy of the Autonomic Nervous System while engaged in the activities of daily living. For some, this may prove as simple as relaxing the muscles while encountering the myriad of perceived threats that emerge throughout each workday; and (v) perceptual maturation, which is a cognitive skill and involves maturing the perceptions of self towards resiliency and the perceptions of the workplace, to render them less toxic. Eight (61.5%) of included studies reported a significant difference post-intervention in either CF or one of the ProQoL subscales burnout , CS, or STS. More specifically, five studies (38.5%) reported significantly reduced burnout and STS, risk factors for CF, and three studies (23.1%) reported significantly increased CS, a protective factor in the development of CF. Secondly, participants were given multimedia resources such as	

						printed seminar handouts, a guided imagery CD, access to a website with CF, CS, and resiliency educational resources and publications, and DVD, which informed them of Gentry's five elements above. This is, by far, the most comprehensive intervention evaluated by the included studies and, not surprisingly, has the most significant, positive outcomes. Unlike the other twelve interventions evaluated, this intervention focuses on teaching participants: (i) about CF; (ii) how to recognize and actively prevent and treat CF in themselves and their colleagues; and (iii) provides them with tools and resources to consolidate these learnings which is likely to increase the probability of these positive outcomes remaining a long term. However, this is yet to be determined.	
Crepeau, E. B.; Garren, K. R. (2011). I looked to her as a guide: The therapeutic relationship in hand therapy. Disability and Rehabilitation, 33(10), 872–881. doi:10.3109/09638288.2010.511419	Instrumental case study of stories told by an occupa-tional therapist and patient about their therapy experi-ence.	one hand therapist and a patient	USA	The therapeutic relationship as exemplified by mutual engagement, helping and caring has been an essential component of occupational therapy practice since the founding of the profession. It is an optimal form of interpersonal experience in which there is mutual attentiveness, deep and effortless concentration, and mutual satisfaction and enjoyment. The therapeutic relationship helps to establish a working alliance with the patient in order to achieve mutually conceived goals. Cole and McLean define the therapeutic relationship as 'a trusting connection and rapport established through collaboration, communication, therapist empathy, and mutual respect' (p. 49, emphasis theirs).	The analysis focuses on the stories they each told about their experiences from the time of the patient's evaluation by the hand therapist until discharge approximately 3 months	Findings from this study suggest that when the technical knowledge and skills of hand therapy are combined with the occupational therapy principle of collaboration between therapists and patients, both patient and therapist can find meaning in the therapy experience Therapy is not a one-way flow from the therapist to the patient but a mutual exchange between equals. Copley et al. emphasized the importance of the iterative nature of the therapists evolving understanding of the patient's perspective, providing	It is important to highlight the critical nature of the therapeutic relationship in OT.

				Price asserted that empathy and presence was necessary on the therapists' part to help clients 'through a process that the clients did not bargain for and might not be able to work through alone' (p. 328) . Common elements in this description are mutual commitment, collaboration, and attention leading to agreed-upon methods and goals. What sets the therapeutic relationship apart from other friendships or partnerships is the need for competence on the part of the therapist. Caring is insufficient in itself to provide the medical or technical skills that is necessary for the patient to achieve his/her goals. Furthermore, the capacity to respond to patients within the ongoing stream of therapy or what Schön called 'reflection-in-action', develops through experience working with patients. The therapeutic relationship is not easily achieved but results from a complex interplay of technical skill, communicative competence and the reflective capacity of the therapist to respond to the patient in the moment of therapy. The lack of communicative competence is likely to lead to an inability to understand the patient's perspective and may result in conflicts over what interventions are most important resulting in less than optimal outcomes. Consequently, if therapists are to create therapeutic relationships with patients, they need to be able to communicate in a way that allows them to enter into that person's experience, connect with their feelings, and be willing to change their own perspective in order to respond to the patient's needs	later. The authors selected aspects of the interviews that pertained specifically to the therapeutic relationship for narrative analysis. This selection process enabled them to focus most closely on the stories related to the therapeutic relationship that developed between the occupational therapist certified in hand therapy and a patient.	information, and working toward common goals.	

Dunleavy, L. (2017). Behavior modification and the intentional relationship: Combining perspectives for managing challenging behaviors. SIS Quarterly Practice Connections, 2(4), 7–9.	Theore-tical article	None	None	Therapeutic use of self- three main components: interpersonal skill base, therapeutic modes and capacity for interpersonal reasoning. Interpersonal skills base refers to the skills of effective therapeutic communication, and skills in self-awareness, self-discipline, and flexibility in adapting therapeutic modes when managing challenging behavior, empathetic breaks	None	After analyzing the antecedent and the function of the behavior, the therapist examines what occurred immediately after the behavior that could increase or decrease future occurrences. Did the therapist respond to the challenging behavior with an appropriate therapeutic mode? Failure to do so could result in an empathetic break, resulting in challenging behavior related directly to the client feeling hurt or offended The therapeutic relationship is commonly described in terms of communication, emotional exchange, collaboration, and partnership between therapists and clients	Therapists' conscious efforts to optimize their actions with clients are referred to as therapeutic use of self
Gupta, S., Paterson, M. L., Lysaght, R. M., & von Zweck, C. M. (2012). Experiences of burnout and coping strategies utilized by occupational therapists. Canadian Journal of Occupational Therapy, 79, 86-95. doi: 10.2182/cjot.2012.79.2.458	mixed methods study	63 occupational therapists who were members of the Ontario Society of Occupational Therapists (OSOT)	Online - Canada	Maslach Burnout Inventory–General Survey (MBI-GS), a widely used burnout measure. Areas of Worklife Survey (AWS) - six subscales on workload, control, reward, community, fairness, and values	Quantitative data were collected through an online questionnaire. The first section requested demographic information such as their work setting, their level of education, and years of experience. Section 2 of the survey was comprised of	The purpose of the interviews was to explore the lived experiences of participants relative to burnout and to build an understanding of how Ontario therapists cope, successfully and unsuccessfully, with contemporary practice demands Burnout amongst occupational therapists is a complex issue, central features of which are unmanageable workload, lack of autonomy, lack of respect, and conflict in the values of therapists and their employers. Use of coping strategies, such as maintaining workhome boundaries, staying in touch with colleagues and friends,	Teaching burnout coping strategies, such as the ones in this article, would be helpful for the intervention.

					the MBI-GS and Qualitative data were gathered using hermeneutics methodology through semi-structured interviews and focus groups. Focus groups and interviews (with those therapists who could not make the focus group times due to other constraints) were conducted by teleconfer-ence.	maintaining self-awareness, and focusing on satisfying aspects of the job can help ameliorate job stress. Clinicians, educators, administrators, and policy makers need to take note so that they can create health care environments that promote worker engagement and resiliency.	
Jiménez-Picón, N., Romero-Martín, M., Ponce-Blandón, J. A., Ramirez-Baena, L., Palomo-Lara, J. C., & Gómez-Salgado, J. (2021). The relationship	Systematic review from 10 studies	6/10 focused on nurses and 6/10 practitioners (versus students). One study was on OTs (fourth largest	4/10 studies used the Trait Emo-tional Intelli-gence Questio nnaire, while	The World Health Organization considers EI to be one of the ten life skills that support people to act in an adaptable and positive manner. As professionals who show a combination of technical skills and high levels of EI can provide more humanized health care.	Systematic review search of four databases, with the following MESH terms: ("em otional intelligence"	In the context of healthcare, EI has been shown to positively influence healthcare professionals' bio-psycho-social welfare, increasing their individual resilience, their perception of social support, empathy, job performance and satisfaction, and reducing stress. Training in EI increases the bio-psycho-social welfare of healthcare professionals, as well as	Justifying EI as a bio-psycho-social phenomenon-shows a need for an intervention for healthcare. Importance of including emotional

between mindfulness and emotional intelligence as a protective factor for healthcare professionals: Systematic review. International Journal of Environmental Research and Public Health, 18(10), 5491. https://doi.org/10.3390/ijerph18105491		population-427 OTPs)	the rest varied.		OR "emotional regulation" OR "emotional expression") AND (mindfulness OR meditation) AND (health professionals OR nurses OR physicians). The search was limited to studies published from 2010 to 2020 as recent scientific publications render others previously published obsolete.	benefitting their clinical practice, the satisfaction of patients, and the institution for which they work. The ability to manage emotions is a fundamental skill that should be developed by healthcare professionals as their work environment often entails a significant emotional burden. Specifically, there is evidence linking EI with effective clinical decision-making, the occurrence or reduction of stress and burnout in a work environment, work engagement and, by extension, with the institution's general productivity, turnover rate, work absenteeism and patient satisfaction. Moreover, there is ample evidence showing the benefits of health professionals' EI while undertaking daily tasks and on the physical and emotional care patients receive. EI has been identified as a predictor of professional success. Similarly, patients also perceive that professionals with EI provide higher quality care, recognizing empathy, active listening and compassion as aptitudes related to EI . The nature of healthcare professionals' work entails a marked emotional intensity that can lead to emotional exhaustion. This is a feeling of prolonged physical and emotional	management as a fundamental skill in the intervention. Importance of addressing emotional exhaustion in the intervention Justification for EI training for healthcare, as it leads to promising positive results.

						exhaustion, due to stress, overload and the challenging emotional job demands of care itself. Healthcare professionals with emotional exhaustion have lower energy levels, struggle to face the tasks their job demands and have fewer opportunities for positive experiences in their work. The emotional exhaustion has negative consequences on both the professionals' mental health and the quality of the care their patients receive, as the exhaustion is reflected in worse job performance and efficiency of care they provide. Furthermore, emotional exhaustion has been linked to increased turnover intentions and conflicts both among healthcare professionals and towards patients. Emotional exhaustion is in part due to the intense emotional demands of caring, therefore professionals could become more resilient to such demands by developing skills such as EI. Many studies emphasize the importance of offering education in EI both to students and professionals, highlighting that the best moments for EI training are in childhood, higher education and adult life, as a part of continuous professional development. The satisfactory experiences of EI training for healthcare	

						professionals have taken place in a wide range of contexts, ranging from intensive care to long-term care in nursing homes, including clinical areas. Indeed, EI training has not only increased these skills in healthcare professionals but has also been associated with the patients' quality of life, professionals' job performance and job retention, their perceived state of health and patient satisfaction. Healthcare professionals face highly intense emotional challenges on a daily basis, as they witness human suffering and deal with patients' anxiety and negative feelings; in addition to their work overload and interpersonal conflicts within their team. The inherent duties of health professionals, such as managing pain, loss, emotional discomfort, end-of-life care and supporting family members, contribute to their emotional burden. Because of these daily emotional challenges, they need to find a balance between their emotional investment in patients and detachment, which allows them to effectively respond to both the demands of the organization as well as the patients' needs.	
Lent, J., & Schwartz, R. C. (2012). The impact of work setting,	Empirical study	national sample of professional counselors (N = 340) -	USA-Midwestern state counsel-	International Personality Item Pool Big Five.	national online survey	The degrees of burnout reported differed significantly depending on work setting. Specifically, counselors working in community mental health outpatient settings	Importance to mention the variability in burnout based

demographic characteristics, and personality factors related to burnout among professional counselors. Journal of Mental Health Counseling, 34(4), 355-372.		counselors who worked in inpatient settings (including partial hospitalization and residential treatment settings); community mental health outpatient settings; and private practice outpatient settings.	ing association			reported more burnout of every type than those in private practice, and more burnout related to emotional exhaustion than counselors in inpatient settings. These findings support previous studies showing that community mental health settings may result in more professional burnout. It is possible that specific organizational or environmental characteristics either unique to, or heightened in, community settings may have contributed to these findings. For example, Sullivan (1989) showed that work overload, lack of influence on the job, organizational inefficiency, and lack of supervisory support were key factors related to burnout for a range of psychiatric center staff. These factors may be more extreme in fast-paced, overburdened public mental health centers that must comply with a wide range of accreditation and compliance guidelines while simultaneously competing for funding and balancing annual budgets. Although we did not investigate the underlying causes of burnout within each setting, it is important to note that results of the present study show that counselors evidence trends consistent with other mental health professionals. The findings of this study support the need for interventions that positively impact the work setting	on settings, and personal factors.

						because certain work environments seem to put professional counselors at greater risk for burnout. Recognizing the effects of work settings, counselors can advocate for a work environment that is more conducive to both productivity and their own mental health. Skovholt, Grier, and Hanson (2001) suggested several strategies for creating this kind of environment. First, cultivating organizational leadership willing to promote a healthy other-care/self-care balance is important. While recognizing that all counseling settings are businesses with overhead costs and revenue expectations, counselors should advocate for more concern for professional effectiveness and client welfare than for organizational profit. Citing ethical codes and counselor laws as part of advocacy efforts (Wheeler & Bertram, 2008) may be helpful with administrators. Second, receiving support from colleagues and mentors can aid with both catharsis and normalization of burnout-related experiences (Q6). If counselors attempt to repress or ignore burnout symptoms, it is likely that additional symptoms could manifest (e.g., depersonalization). Although admitting to experiences of burnout can seem embarrassing,	

						counselors can be assured that these experiences are common enough to be accepted by colleagues. Finally, mentoring others can bring renewed enthusiasm for one's own work.. Mentoring often leads the mentor to rise above workplace dilemmas in order to model effective behaviors for others. Similarly, mentoring usually results in introspection because of the need to consider different aspects of the mentee and one's own professional life (Schwartz & Kaelber, 2007). Ultimately, it is important for counselors to take an active role in creating a desirable environment rather than waiting for the organization to meet all of their needs. Results of this study also showed that workplace factors are only one contributor to burnout. Personal characteristics such as race, gender, experience as a counselor, and personality characteristics can also affect the degree of burnout. Although demographic variables are not easily changed, awareness of being at higher risk could lead to preventive strategies that could benefit both counselors themselves and the work environment. By becoming more self-aware, counseling professionals can help to prevent professional stagnation	

						and burnout. Introspection allows counselors to become more self-aware, increase personal maturity, and enhance professional effectiveness.	
Mayer, J. D., Caruso, D. R., & Salovey, P. (2016). The ability model of emotional intelligence: Principles and updates. Emotion Review, 8(4), 290-300.	Theoretical article	None	None	Emotional Intelligence (EI), as defined by Salovey, Mayer & Caruso, describes EI as the ability to perceive emotions, facilitate thought using emotions, understand emotions and manage emotions in oneself and others. It includes the reasoning capacity to understand emotions and problem solve using emotions. By using the principles developed in EI to understand how people solve problems in the area of emotions, we can improve education in the subject matter.	None	Define EI and expand on the 1997 definition with new concepts and structures.	Incorporate EI theory into the intervention.
Mayer, J. D., & Salovey, P. (1997). "What is emotional intelligence?," in Emotional Development and Emotional Intelligence: Implications for Educators, eds P. Salovey and D. Sluyter (New York, NY: Basic Books), 3–31.	Theoretical article	None	None	Understanding the concept of EI requires exploring the two component terms-emotions and intelligence. The original concept of EI primarily focused on the complex, potentially intelligent tapestry of emotional reasoning in everyday life. For most healthy individuals, we assume that emotions convey knowledge about a person's relationships with the world. Definition: EI involves the ability to perceive accurately, appraise and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotions and emotional knowledge and the ability to regulate emotions to promote emotional and intellectual growth.	None	Define EI, and expand on the original 1990 definition. EI is expected to be involved in the home, in school, in work and other settings. Most skills improve through education, beginning at home with good parent-child interactions. Parents help children identify and label their emotions, to respect their feelings and to begin to connect them to social situations. This is considered their emotional knowledge base. Opportunities for learning emotional skills are not always equal. Psychotherapists can aid also, as well as schools.	Incorporate EI theory into the intervention.
Myers, E. J. (2014). Fieldwork quality of life: Addressing the	Doctoral Dissertation	None	None	The Intentional Relationship Model provides an operational definition of the therapeutic use of self (TUOS), which is	None	Taylor et al. (2009) surveyed OT's attitudes regarding TUOS and its importance in clinical reasoning. Of 568 respondents, 87% viewed	Importance of including the IRM into the intervention and

occupational therapy Level II field work student/ supervisor relationship (Doc-toral dissertation, Boston University).				considered one of the strongest tools used by occupational therapy. The Occupational Therapy Practice Framework defines TUOS as, "An occupational therapy practitioner's planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process." While broad concepts of TUOS have been explored in the literature, there are no examples of an approach occupational therapy could use to evaluate the effectiveness of TUOS in everyday practice. In Taylor et al. 's survey (2009), 51% of respondents felt that they received inadequate training on TUOS in their academic programs. In addition, surveys reveal that while OTs use TUOS frequently in their practice, they have difficulty defining what TUOS is and how they personally use TUOS in their interventions . The Intentional Relationship Model (IRM) was developed out of the need to better define the therapeutic relationship and give a vocabulary to the different phenomena that occurs during the intervention process. The model explains TUOS and its role in occupational therapy treatment, how interpersonal reasoning is defined when challenges occur within the therapeutic relationship, and how to best develop these therapeutic relationships within the scope of OT practice.		TUOS as the most important skill in their practice. In establishing a therapeutic relationship, occupational therapists use TUOS to select aspects of their personality, attitudes, values, or responses they feel are relevant to situations as well as suppress those behaviors not appropriate to the benefit of the situation. The selection of which aspects to use in therapeutic interventions are not random but rather follow clinical reasoning and are for the benefit of maintaining a client-centered focus. Aspects important to establishing legitimacy in a therapeutic relationship include sensitivity, honesty, empathy, and genuineness with the client. The literature shows that OTs who master these skills tend to have greater confidence in creating therapeutic relationships and achieve better outcomes with their clients.	theoretical background.
Perkins, N. A. (2018). Therapeut ic professional self-awareness: an educational mobile application to	Doctoral Disserta-tion	None	None	While studies have demonstrated a clear need for EI training in medical professions there is a lack of consensus on how best to address this need. It is generally recommended that the training be incorporated into curriculum at medical schools and OT programs as EI is	None	The literature did reflect that EI and self-awareness skills can be developed through educational training and individuals are able to develop and increase skills throughout life.	Importance of including self-awareness as part of EI skills training in the intervention.

develop emotional intelligence (Doctoral dissertation, Boston University).				considered “the most important competency associated with success and lacking EI as being more closely associated with performance shortfalls” (Taylor, Farver, & Stoller, 2011, p. 1552). These authors recommend a formal EI curriculum in medical schools that addresses professionalism and EI-based models. In the context of occupational therapy it was concluded that there is a need to develop EI skills, specifically in the areas of professional behavior, communication, and managing emotions in order to facilitate the transition from student to fulltime OT. Increasing self-awareness and the ability to manage relationships will translate into improved occupational success and satisfaction. Increasing self-awareness leads to improved rapport, communication, collaboration, and removes any potential blockages between healthcare providers and clients.		Training should correspond to the developmental phase of one’s profession. For example, social awareness and self-management skills would correlate with teamwork and collaboration areas of education. EI and self-awareness skills are critical for the development of positive client-provider relationships and is often predictive of success within one’s profession. EI training has been shown to lead to improvement in health indicators, well-being and decreased levels of stress. EI had a strong correlation with the ability to create a positive work environment. Review of literature demonstrates that self-awareness skills can be developed through educational training and individuals are able to develop and increase skills throughout life. It is also shown that increased self-awareness is associated with greater well-being, improved communication, and better quality relationships. EI training needs to allow for the process of learning and often times participants initially over-estimate EI skills. This means that participants must have time to reflect and move through the cyclic process of learning. Learning situations need to be created in a way that leads to personal change and individuals	EI and self-awareness training is proven to be effective and to endure after the initial training is provided. There is a compelling and demonstrated need for EI and self-awareness training for occupational therapy students as well as for other healthcare students and professionals, in order to improve clinical performance, self-awareness, and overall EI skills.

						must be allowed to move at a desired pace. Despite strongly recommending training to develop EI and self-awareness each study struggles to define the duration of training needed and how to account for varying 21 demographics. It has been demonstrated that longer exposure to material and opportunities to self-reflect increase competency and retention of skills.	
Perkins, N. A., & Schmid, A. A. (2019). Increasing emotional intelligence through self-reflection journals: Implications for occupational therapy students as emerging clinicians. Journal of Occupational Therapy Education, 3 (3). https://doi.org/10.26681/jote.2019.030305	Non-equivalent group design study	Experimental group- first year MOT students Control- second year MOT students	Colo-rado State Univer-sity USA	Self-awareness assists healthcare providers in developing the ability to emotionally connect with clients. Building a connection may increase therapeutic rapport, which is important for successful therapist-client partnerships. Effective communication and interpersonal skills are built upon self-awareness and are also associated with emotional intelligence. Effective communication, interpersonal skills, and EI are vital for occupational therapists. As clinicians, occupational therapy practitioners have an almost equal impact on the emotional and physical wellbeing of clients and their families, as the relationship between therapists and clients is foundational to successful outcomes. Moreover, the focus of occupational therapist-client partnerships is often to help the client restore participation in meaningful life activities. However, like all individuals, not all occupational	Experimental group received and completed monthly self-reflection journal during the spring academic semester, and completed pre- and post assessments. Second year- did not receive intervention, just pre-post assessments The journals consisted of 3-4 short answer open-ended questions.	The increase in the TEIQue scores in the first-year students indicates that use of self-reflection journals may contribute to improving overall trait EI scores. The first year MOT students demonstrated an overall increase in the four areas that are addressed using self-reflection journals (Table 4). The students improved in the following trait EI areas: adaptability, relationships, impulse control, and stress management. This is important, because, individuals with higher impulse control are more likely to be reflective and less likely to act upon their urges. Further analysis of the data demonstrated that the facets of relationships and adaptability had a significant increase in scores among the intervention group. Higher EI skills have been correlated with greater individual	

				therapists have effective communication skills or abilities that comprise EI. <u>Measures:</u> TEIQue full form (EI)	Online self-reflection journals were developed for occupational therapy students to use throughout the academic semester. Using the background, theories, and literature reviews, the researchers developed the questions for the self-reflection journals. The following are examples of some of the journal questions: 1. How do your behaviors and actions support what you say and do? 2. Discuss a time when what you said or did had a positive impact on a	performance in task and relational skills that is above and beyond that which are associated with one's general intelligence. Relational skills are an important component of clinical competence for healthcare professionals who have meaningful interactions with clients. Implementation of EI programming in the higher education setting has been recommended. Johnson (2015) suggested that EI training should be integrated into the professional curriculum and give students opportunities to practice the skills, and not delivered as an additional course. Integrating EI training into the occupational therapy curriculum could be both practical and beneficial as it would be an asset to the occupational therapy profession if there was increased awareness of the interplay between EI skills and therapeutic use of self in terms of the impact these interpersonal skills have on client outcomes However, therapists' education and training often does not include or focus on scientific insights into emotions and an individual's emotional architecture, which can result in biases or miscommunication between the provider and the client. When healthcare providers are unaware	

					fellow student or co-worker. 3. Describe how you impact the occupation choices of those around you. Reflect on what was said, how each person responded, and the feelings involved. 4. Discuss a time you were distracted or preoccupied by something. How did you know? What impact did it have on your performance? What impact did it have on others? Another component of self-reflection is the ability to recognize emotional responses.	of personal biases it may impact the therapeutic relationship By learning to develop new emotional responses with clients, occupational therapy practitioners and students can become more interpersonally effective. In order to build new communication or interaction skills occupational therapy practitioners and students need to increase self-awareness and apply strategies to improve EI Self-awareness is one of many components under the umbrella of EI. Effective communication is built upon self-awareness Moreover, personal and social skills are associated with EI and the ability to be self-aware Being self-aware includes being aware of feelings and emotions that may arise during the day. Oftentimes emotions are evoked about a personally sensitive topic. Awareness of non-verbal reactions is another key component of self-awareness Therapeutic relationships demand a level of honesty and trust between client and healthcare provider. It is imperative that healthcare providers be self-aware in order to prevent a breakdown in trust. Providers need to be cognizant of how their own personal emotions can impact a treatment session. Therapists who are able to personalize responses	

					Understanding and recognizing how one's emotions impact others is a central component of self-awareness. Positive reflection can lead to learning self-awareness and also facilitate personal accountability. The following are example questions addressing emotional responses: 1. Describe a time when your emotions were triggered by the actions of another. 2. Did you recognize your emotional trigger in the moment or later? 3. How	and who are aware of their communication style are better able to establish rapport The relationship between these two factors are supported by the assumption that increased self-awareness which is (a component of EI), will increase EI skills which in turn will improve therapeutic rapport, communication skills, and collaboration skills Through self-reflection, one begins to identify areas of strength and need, and can identify emotional responses. The process of reflection may improve personal performance and encourage continued self-awareness over time. Emotional intelligence training has also been shown to lead to improvement in health indicators, well-being and decreased levels of stress	

					could you respond differently next time?		
Price, P. (2018). The Therapeutic relationship In Wolters Kluwer Health (13th Eds.). Schell, B., & Gillen, G. Willard and Spackman's occupational therapy	Book chapter	None	None	The therapeutic relationship in OT is the central aspect of the therapeutic process of occupational therapy and one catalyst for change. Empathic competence is defined as the therapist's emotional ability to accurately perceive and respond to clients and their experiences in order to fine-tune the therapy process. The researchers provided empirical evidence that empathic competence is an important feature of professional competence and professional knowledge Experienced therapists who have reflected on their processes are likely to have more highly developed interactive skills than are novice therapists. Occupational therapy students and new practitioners are encouraged to focus on developing their interactive, interpersonal, and communicative skills as much as they would focus on developing their manual muscle testing skills.	None	An individual's process of recovery and adaptation requires professional expertise but also an empathic partner who is willing to feel the individual's fear, uncertainty, or despair and to provide support, encouragement, and hope. The degree to which the occupational therapist is able to understand the fears, hopes, priorities, and desires of the client and family will influence collaborative goal setting, intervention plans and activities, and the entire therapy process. The interactive aspects of the therapeutic relationship require interpersonal and communicative skills that an occupational therapist can learn and develop through reflective practice. The interactive, interpersonal, and communication skills cannot be learned and applied in practice as a list of procedures and techniques; rather, therapeutic relationships emerge out of real care, from dynamic and responsive interactions, and from both tacit and explicit reasoning as the therapist and client work together toward a common desired outcome. Therefore, truly understanding and caring about clients and their experiences, hopes, and dreams are essential to this emotional aspect of practice	Important to incorporate self-awareness, reflection and development of interactive, interpersonal and communication skills into intervention.

						and require a personal commitment to self-awareness, reflection, and development of interactive, interpersonal, and communication skills.	
Taylor, R. R. (2020). Therapeutic use of self in occupational therapy: The importance of empathy and intentionality In FA Davis (Eds.), The intentional relationship: Occupational therapy and use of self (pp. 2-24).	Book Chapter	None	None	therapeutic relationship as a manifestation of artistry because it reflected a capacity to establish rapport, to empathize, and to guide clients to actualize their potential as participants within a wider social network. therapeutic use of self is defined as a product of the extent to which one applies empathy and intentionality to an interpersonal knowledge base and corresponding skill set that can be applied thoughtfully to resolve evocative interpersonal events in practice therapeutic use of self as comprising understanding, empathy, and caring. Effective use of self was defined as remaining neutral but engaged, accepting the client as the client is, being tolerant and interested in the client's painful emotions, and being able to interpret the client's expectations of therapy accurately Therapeutic use of self involves prioritizing one's attempts to cultivate an empathic understanding of one's client and applying a knowledge base and interpersonal skill set thoughtfully to common interpersonal events, such as when a client is not engaging in therapy appropriately. Accordingly, therapeutic use of self is an occupational therapy skill that must be developed, reinforced, monitored, and refined Some therapists prioritize teaching, demonstrating, and utilizing a range of activity-based therapeutic approaches, leaving other aspects of humanity, such as empathy, respect, trust, and mutuality, as	None	If we are able to harness our conscious awareness of any of these feelings as an asset, we can learn to use them in a disciplined way to inform our interpersonal reasoning in therapy. However, if these thoughts or feelings are left unacknowledged, they are likely to build up through time, leading us to perform and communicate in ways that may not be best for ourselves and our clients . Today, empathy continues to serve as a strong value for the field of occupational therapy, and it is studied and cited by numerous scholars A conscious use of self represents an ability to deliberately use one's own responses to clients as a part of therapy. To select the appropriate ways of responding to a client, the therapist had to possess self-awareness, empathy, flexibility, humor, honesty, compassion, and humility Therapists who desire a more personal or emotional connection with their clients will have to exercise critical self-awareness and attenuate their preferences in order to respond to these types of clients with an appropriate level of empathy and understanding	Importance of therapeutic use of self within the therapeutic relationship- add to intervention

				implicit assumptions within the relationship. Empathy is one of the most important prerequisites for a positive therapeutic relationship			
Vlachou, E. M., Damigos, D., Lyrakos, G., Chanopoulos, K., Kosmidis, G., & Karavis, M. (2016). The relationship between burnout syndrome and emotional intelligence in healthcare professionals. He alth Science Journal, 10(5), 1-9. doi:http://dx.doi.org/10.4172/1791-809X.1000100502	Clinical study	Doctors, nurses, physiothera-pists, speech therapists, occupational therapists, and psychologists (OT – around 5%)	Multiple rehabi-litation sites in Greece	Burnout syndrome is the result of the workers' long-standing exposure to occupational stress. It is considered a psycho-social phenomenon that is categorized by physical and mental exhaustion. Professional loss of interest in his colleagues, including physical exhaustion and emotional exhaustion where the professional no longer has positive, warm feelings or respect for his patients.. Most researchers describe burnout as a process or situation of a dynamic interaction between individual and environment. Maslach's three-dimensional model: 1. emotional exhaustion- gradual reduction of positive emotions, physical and mental fatigue, 2. Depersonalization- negative and often cynical attitude of a worker towards client or patients, 3. Reduce personal accomplishment- evaluate themselves in a negative light, especially regarding his services or professional achievements.. Maslach burnout inventory- 22 self-assessment questions that investigate the three dimensions of the syndrome Trait emotional intelligence que-short form	Data collection	In general, the regression analysis results showed that trait emotional intelligence q short form could influence and predict the Maslach burnout inventory scores. Furthermore, it was found that the higher the trait emotional intelligence q short form was, the lower the score for the burnout inventory, with the most critical factors being Emotionality, Self-control, well-being, and sociability. Past studies are consistent with most of these findings since EI among workers is considered to act protectively against developing burnout syndrome. This process includes initially identifying occupational stress and the associated negative emotions through Emotionality, and afterward their management, with the help of self-control, well-being, and sociability. It is also necessary to point out the predictive role of the trait EI q short form- increased 1 point caused a decrease of burnout by 18 points.	
Wilkinson, H., Whittington, R., Perry, L., & Eames, C. (2017). Examining the	Systemati c review	Nursing, or medical professional background, doctors	Develop ed countrie s and three	Empathy and burnout are concepts have been cited in the literature as fundamental to quality of healthcare. Burnout is a psychological syndrome involving physical depletion, feelings of	Five electronic databases-10 studies	Prevalence of burnout in western countries within the general working population ranges from 13% to 27%. However, healthcare professionals are referred to as	It is important to note in the intervention about the correlation

relationship between burnout and empathy in healthcare professionals: A systematic review. Burnout Research, 6, 18–29. https://doi.org/10.1016/j.burn.2017.06.003		No students, no allied healthcare professionals (psychologists, therapists and social workers). Studies published for, 1990-2017	studies in the USA	helplessness, negative self-concept, and negative attitudes towards work, life, and others. It is an internal reaction to external stressors <u>Maslach Burnout inventory (MBI)</u> is the gold standard for measuring burnout in empirical research. It measures three dimensions of burnout: 1. emotional exhaustion (state of emotional and physical depletion, feeling over-extended and unable to offer emotional support to others. This is the central manifestation), 2. depersonalization (unfeeling and impersonal response towards recipients of one's care- coping mechanism) 3. personal accomplishment (negative view of oneself, particularly in relation to one's work with service users) <u>Empathy</u>- ability of the clinician to sense the service user's private world as if it were their own, without losing the "as if" hypothetical quality. There are four key dimensions: emotive, cognitive, behavioral and moral. Emotive and cognitive components relate to clinicians' ability to experience and share in another person's feelings and intellectually identify and understand another person's feelings from an objective stance. Behavioral dimension refers to the clinician's ability to communicate their understanding of another person's perspective. Moral dimension as an internal altruistic motivation to be empathetic towards others		being at increased risk of suffering burnout. Studies have shown how, despite being an important component in providing effective care, empathy also creates vulnerability for stress related conditions such as compassion fatigue and professional emotional exhaustion. However, findings have been inconclusive in establishing the direction and nature of the relationship, with empirical evidence demonstrating both a negative and positive correlation between high burnout scores and empathy. Three hypotheses for the relationship between burnout and empathy: (1) burnout reduces the ability of clinicians to respond empathically; (2) being empathic draws significantly on personal resources and thus causes burnout; and (3) being empathic protects clinicians from burnout. Results: all studies supported an association between burnout and empathy. Findings relating to the direction (positive/negative) of the relationship between burnout and empathy were not unanimous. The current review found the strongest evidence, with eight out of 10 articles, for the first hypothesis that burnout and empathy were negatively correlated, inferring that as the presence of one	between burnout and empathy: (1) burnout reduces the ability of clinicians to respond empathically; (2) being empathic draws significantly on personal resources and thus causes burnout; and (3) being empathic protects clinicians from burnout.

				(this element is not proven in literature support). Engagement on a solely cognitive level could lead to empathic statements appearing superficial, therefore emotional engagement is necessary to enhance the interaction, building trust within the therapeutic relationship. Here the focus is on the importance of the cognitive and emotional dimensions. Conversely, service users have reported that a clinician's ability to firstly, understand them (cognitive dimension) and secondly, express this understanding (behavioral dimension), is a key aspect in the therapeutic relationship. Improved clinical outcomes have also been linked to increased clinician empathy and a good therapeutic relationship.		construct increases the other decreases.	
Wong, S. R.. (2016). Therapeutic Use of Self in Occupational Therapy: Applying the Intentional Relationship Model (Version 1). University of Illinois at Chicago. https://hdl.handle.net/10027/21339	Thesis	Occupational therapists were recruited if they were working in National University Hospital for at least 6 months in their specialty area, regardless of whether they work in an inpatient or outpatient setting. Clients were	National University Hospital	Effective therapeutic use of self, which is "a product of the extent to which one possesses the knowledge base and interpersonal skills that can be applied thoughtfully to common interpersonal events in practice" . Therapeutic use of self has been described as both a skill and an art as it requires certain intrapersonal and interpersonal skills in intentionality and selectivity, while being authentic in therapist characteristics (such as personality, intuition and personal experience) in order to create a therapeutic relationship. Taylor (2008) developed the Intentional Relationship Model (IRM), which is a model unique to occupational therapy that details how therapeutic use of self relates to occupational engagement. This conceptual practice model was created in response to a need in the occupational	Three sub-studies were conducted using descriptive and correlational analyses. The first and second sub-study quantitatively describes the therapeutic modes (therapeutic communication styles) from the perspective	First, it is important for the therapist to be highly self-aware of one's own interpersonal patterns of behavior and verbal communication. Without accurate and critical self-awareness, the therapist will not be able to know one's strengths and weaknesses and know what aspects of interpersonal skills require development. Second, interpersonal self-discipline is critical to therapeutic use of self. It is the ability to empathically provide what is most therapeutic to a client by being emotionally vigilant and responding in a self-disciplined manner. This is especially important when the way a client	Highlights the importance of therapeutic use of self in treatment- an important element of the intervention.

		recruited if they were medically stable for rehabilitation, referred for therapy services, above 21 years old, and English speaking.		therapy profession for an integrated and explicit approach to understanding therapeutic use of self. IRM has four main attributes: 1) the client, 2) the therapist, 3) interpersonal events that occur during therapy and 4) occupation. Based on the study's literature review within occupational therapy as well as related disciplines, the IRM stands out as the only comprehensive model that focuses solely and strictly on therapeutic use of self and the therapeutic relationship in the occupational therapy profession. The client-therapist relationship has been one of the focal points of occupational therapy literature on therapeutic use of self. The therapeutic relationship has mainly been examined from the therapist perspective. In a statewide survey, 96.5% of the occupational therapists perceived that the therapeutic relationship was critical to functional outcomes. Specifically, therapists identified rapport (100%), open communication (98%) and empathy (99%) as components of the therapeutic relationship that positively affected outcomes. Similarly, Taylor and colleagues (2009) reported that 82.3% of occupational therapists surveyed agreed that the therapeutic relationship key determinant of outcomes and 95.9% agreed that the relationship affects engagement in therapeutic activities. Other qualitative studies have described the importance of the therapeutic relationship in various client populations, such as clients with brain and spinal cord injury, in the military and civilian settings, and in home-based therapy. The therapeutic relationship has also been examined from a client perspective.	of therapist and client populations respectively. In the third sub-study, the association between therapist and client perceptions of therapeutic mode use, therapeutic relationship and client participation were examined between matched therapist-client dyads.	behaves or interacts in a challenging or demanding way that triggers negative or unexpected reactions within the therapist. The third principle of putting one's "head before heart" emphasizes that one should not react by default or automatically to interpersonal situations. Next, mindful empathy describes the ability to locate the source of one's interpersonal reasoning with the client so that one is making a continual effort to understand the client's ever-changing experience from the ever-changing perspective of the client. The sixth principle emphasizes the need to communicate in flexible and pure manner. Communicating flexibly means being able to changing therapeutic modes as necessary. Therefore, a therapist needs to continually strive to have a deeper and wider understanding of each of the therapeutic modes. Pure use of modes can be achieved best if a therapist remains in a therapeutic mode as long as required instead of mixing modes so that the intended message is not confusing. The seventh principle emphasizes that as the client defines the effectiveness of the relationship, it is not only important for the therapist to communicate in a flexible and pure manner but also	

				In IRM, it is the responsibility of the therapist to facilitate the positive therapeutic relationship. That implies unequal responsibility between the therapist and client in terms of upholding and maintaining the relationship. This also reinforces that the therapeutic relationship is also conceptually distinct from therapeutic use of self. IRM describes the therapeutic relationship as being both socially defined and personally perceived by both therapist and client. Therefore, although the therapeutic relationship is socially understood as a professional relationship in which the therapist is the service provider and the client is receiving the service, the therapeutic relationship is uniquely personal to both therapist and client. On the other hand, therapeutic use of self is the therapist applying oneself responsibly in facilitating the therapeutic relationship. According to IRM, if the therapist was effective in all mode use, the therapeutic relationship would still be strengthened even if there were shifts in mode use (Taylor, 2008). The results support that this therapist was generally effective in mode use, as that overall and individual mode use were positive association with all aspects of the therapeutic relationship. According to the IRM, therapeutic modes are said to be effective if 1) they are perceived by clients as therapeutic and 2) result in the strengthening of the therapeutic relationship		important that the client perceives it as such. Next, the therapist not only needs to select appropriate modes but also to select ways of delivering the modes that are most suitable for the needs of the client. It is important to constantly reassessing and balancing the use of activity and interpersonal focusing strategies for each client as the need for verbal interaction and emotional intensity varies not only between clients but also across therapy situations. Finally, the last two principles emphasize the importance of ethical and professional boundaries as well as increasing in cultural competence Results: instructing mode was found to be most positively associated with all three aspects of the therapeutic relationship. It also appeared that the empathizing mode was moderately to strongly associated with the goal and task aspects, while the problem solving mode was moderately to strongly associated with the bond and task aspects of the relationship. It may be interpreted that this therapist is most effective in the instructing mode, followed by the problem solving and empathizing modes. The agreement on goals and tasks were more critical than the emotional bond in facilitating client participation.	

						Therapeutic relationship has a social component (i.e. it is primarily a professional helping relationship) as well as a personal component (i.e. it is grounded in subjective experience). In this particular case, successful occupational engagement was related to the mutual agreement on the purposes and 'doing' aspects of therapy, rather than the 'feeling' of emotional closeness. It would be interesting to examine if the phenomenon is consistent across different therapists, or unique to this therapist. Results: clients' experiences of mode use were mostly moderately to strongly related to strengthening of the therapeutic relationship. In particular, the modes were most strongly related to improving agreement on therapeutic tasks more than strengthening the affective bond with their therapist. This may reflect a stronger desire for the relationship to be more focused on the occupational aspect of therapy rather than primarily on the emotional connection. This does not imply that the bond aspect is unimportant. Instead, the stronger association with tasks is consistent with the ultimate purpose of occupational therapy (i.e. occupational engagement).	

APPENDIX C- Evaluative Evidence of the Effective Professional Interventions

Reference	Type of Report	Participant characteristics & selection	Site/context of study	Definition & Measures	Procedures of the Intervention	Purpose and Key findings	Application to OTD project
Abe, K., Evans, P., Austin, E. J, Suzuki, Y., Fujisaki, K., Niwa, M., & Aomatsu, M. (2013). Expressing one's feelings and listening to others increases emotional intelligence: A pilot study of Asian medical students. B MC Medical Education, 13(1), 82.	Cohort study	183 international undergraduate medical students of Asian nationality: Japanese, Taiwanese, Thais, Indonesian	The 5th International Federation of Medical Students' Association, Asia Pacific Regional Meeting, about Mental Health and Well-being	EI as a set of skills hypothesized to contribute to the accurate appraisal and expression of emotion in oneself and in others, the effective regulation of emotion in self and others, and the use of feelings to motivate, plan, and achieve in one's life. Also refers to an individual's awareness on his or her own emotions, together with an awareness of the emotions in others and the ability to manage them and act appropriately. The trait EI is measured through self-reported questionnaires, whereas ability EI should be measured through maximum performance tests with correct and incorrect answers. Trait Emotional Intelligence Questionnaire (TEIQue- SF) is 15-item assessment composed of four factors (well-being, self-control, emotionality and sociability). It is suitable for the rapid assessment of global trait EI 20 items PT (Personality Trait) scale The participants completed a self-reported measure of EI on three occasions, pre- and post-workshop, and a 1-year follow-up. The participants were also asked	Half-day workshop (WS) about mental-health and well-being. The format began with a short lecture about mental health and impaired healers. Two physician facilitators disclosed their own painful experiences, such as a junior resident's sudden death. With these stories as an introduction, students worked in groups of 6 to disclose an experience in their own lives that was distressing, but not deeply personal. Self-introduction game followed by pairs of students working on issues of grief and loss. Emphasis was placed upon the importance of listening to and expressing feelings. Consideration was given to the emotional aspects of the experience under discussion, as a way of focusing upon the individual's emotional intelligence. **does not seem to directly mention EI or teach concepts about EI**	Strong correlations between the TEIQue-SF and personality traits. Significant positive changes after the WS for all students. 80% of the students reported that they were more attentive listeners, and 60% agreed that they were more confident in dealing with emotional issues, both within themselves and in others, as a result of the workshop. The mental health workshop was helpful to develop medical students' EI but showed different results for gender and nationality. The immediate impact on the emotional awareness of individuals was particularly significant for male students and the non-Japanese group. The impact over the long term was notable for the significant increase in EI for females and Japanese. Japanese female students were more conscious about emotionality. Emotion-driven communication exercises might strongly	-Trait Emotional Intelligence Questionnaire (TEIQue-SF) as a viable measure for the intervention. -one time workshop as an idea for improving IE.

				four questions to assess an effect of the workshop.		influence the development of students' EI over a year.	
Bamberger, E., Genizi, J., Kerem, N., Reuven-Lalung, A., Dolev, N., Srugo, I., & Rofe, A. (2017). A pilot study of an emotional intelligence training intervention for a paediatric team. Archives of Disease in Childhood, 102(2), 159-164.	Prospective (pre-training/post-training) experimental design	Control group consisted of 17 physicians and 10 nurses. 11 physicians who did not undergo the intervention served as controls.	Israel Department of pediatrics a large metropolitan teaching hospital in Northern Israel	(EI) as the individual's ability to perceive, understand and manage emotion and to understand and relate effectively to others. Also defined as a cross-section of interrelated emotional and social competencies, skills and facilitators that determine how effectively we understand and express ourselves, understand others and relate with them and cope with daily demands" Bar-On's emotional quotient inventory (EQ-i)- 133 items covering what Bar-On describes as the five main dimension of EI, namely intrapersonal EI, interpersonal EI, adaptability, stress management and general mood	Data was collected before and after the 18 month intervention. One week later, all study participants met individually with an EI specialist to review their score on the EI questionnaire, after which those assigned to the intervention group began an 18-month EI training program. The training program comprised 10 sessions that met every month for 90–120 min and was divided into two steps. The initial sessions consisted of the core topics of EI, where an EI specialist outlined the meaning of EI, its centrality to patient-focused medicine and its impact on the quality of medical care. In the following sessions, tailored to the departmental needs, the intervention group members participated in role plays and simulations, small group discussions and case study analyses and were responsible for preparing and then making presentations on selected EI topics, including care-provider stress, burnout and well-being; intergenerational relationships; managing patient relations; effective communication and relaying 'difficult' information (eg, death, malignancy or poor prognosis); effective listening skills and acknowledging medical errors. For each topic, small group discussions were held following the staff member presentation, the aim of which	Findings show that following the EI training intervention was associated with general improvement in the overall and dimension-specific EI of the participating medical staff compared with controls who did not undergo the training. Among those participating in the training intervention, the improvement in EI was more robust among physicians than nurses.	

					was to allow each participant to relate the topic to his or her own experience as a medical professional.		
Calabrese, J., Lape, J. E., & Delbert, T. (2019). Use of online educational modules to improve occupational therapy students' knowledge and perceptions of their emotional intelligence skills: An evidence-based pilot study. Journal of Occupational Therapy Education, 3 (3). https://doi.org/10.26681/jote.2019.030312.	Evidence based study	28 second-year graduate occupational therapy students.	Online modules	EI as a combination of four elements: 1. self-awareness 2. self-management 3. social-awareness 4. relationship-management. The outcome was measured by comparing pre-and post-EI self-reported survey scores that measured the participants' perceived knowledge and EI level before and after the modules	The intervention procedure was a six- and a half week intervention, consisting of six asynchronous, narrated online learning modules and five reflective online activities centered around EI. The program was completed through the Blackboard Learning Management System, with each module and corresponding activities lasting approximately 30-45 minutes. The modules and activities had a one-time release, allowing the participants to complete each assignment at an individually set pace and in any order.	After completion of the intervention, the participants reported increased knowledge of the key components of emotional intelligence and improved perceptions of their own EI skills. The changes included: increased self-awareness (+14.1%) and social awareness (+12.2%), relationship management (+10.0%) and self-management (+8.3%). The open-ended questions allowed for identification of perceived benefits of improved EI as leading to future success in the classroom and clinical fieldwork affiliations. Results of this study align with transformational learning theory, where changes are expected in awareness and understanding prior to behavior change	-online modules could be beneficial to increasing EI -the outcome self-questionnaire is attached in this article. - -important to remember that the short six-week timeframe and the exclusively online delivery format of the emotional intelligence education may have limited participants' abilities to move beyond understanding the concepts to apply the content learned. Interactive or face-to-face activities using real life situations with patients in the classroom and clinical fieldwork placements may be helpful to demonstrate synthesis of emotional intelligence knowledge and allow students to practice managing their own behaviors.
Dugan, J. W, Weatherly, R. A, Girod, D. A, Barber, C. E, & Tsue, T. T. (2014). A longitudinal	Prospective longitudinal, cohort study	28 residents and 19 faculty members from the surgical specialty, otolaryngology.	Department of Otolaryngology, University of Kansas Medical Center	EI as a set of skills that facilitates self-awareness, understanding, and management of how our emotions affect self, others, and our performance. Emotional Quotient Inventory (EQ-i)- administered 20 days before and then one year after the training.	Three levels of interventions included: 4 years of repeated EI assessment, 7 years of highly interactive EI training with high-risk/high-stress simulations in an 8-hour off site training program, that sets the stage for reflection on and development of EI skills, and ongoing modeling and mentoring of EI skills by faculty	Participants demonstrated improvement in mean EQ-i scores from 102.19 (baseline/pretraining) to 107.29 (post-training and assessment 1 year later; change, 6.71; This increase was sustained in successive years, and these results were	-perhaps consider a program that is cyclical (once a month/ once a year) rather than a "crash course".

study of emotional intelligence training for otolaryngology residents and faculty. JAMA Otolaryngology-- Head & Neck Surgery, 140 (8), 720-726.					in the clinic, at bedside and in the operating room. 8-hour program: individual test results are distributed; individuals compare their results with the total department group's score and benchmark their individual results to star performers in other fields. The faculty/leaders describe the added value of EI skills, and examples of emotional disconnect in medicine, sports, and businesses are highlighted. A key ingredient is that the residents and faculty view a video or participate in high-risk/high-stress simulations (e.g., giving bad news, talking to a family about a medical error, responding to a leader who is perceived as autocratic, or dealing with a blocked airway in the operating room where everything goes wrong) In the discussion during the simulations and in the debriefing after them, residents are encouraged to think out loud and reflect on their comments, and faculty are encouraged to offer suggestions and share tacit knowledge about managing emotions in difficult situations. The highly interactive style of the debriefings fosters a collaborative culture and supportive learning environment where feedback and practice of EI skills are encouraged. Integral to this developing EI culture is the strong and ongoing participation of faculty, which supports, facilitates, and models	supported with linear growth curve analysis. A comparison between the pretraining and post-training periods showed that a faculty-led and mentored interactive training program using high-risk/high-stress simulations enhanced participants' recognition, understanding, and management of emotions; participants enjoyed the training, found applications to their practice, and changed their behavior, and these changes were reflected in increased patient satisfaction with their physicians. Effective in increasing the EQ-i of the majority of residents and almost half the faculty members The largest increase in EQ-i scores for faculty and residents occurred from the first time they took the EQ-i (baseline) to the second time they took it 1 year later.	

					the positive role of EI in delivering patient care. The program was facilitated by program directors and psychologist trained in EI		
Erkayiran, O., & Demirkiran, F. (2018). The impact of improving emotional intelligence skills training on nursing students' interpersonal relationship styles: A quasi-experimental study. International Journal of Caring Sciences, 11 (3).	Quasi-experimental study with pre-test – post-test control groups and randomized control	72 nursing students- 36 of whom were in the training group and 36 of whom were in the control group.	freshmen nursing students studying at Adnan Menderes University, Aydin School of Health in western Turkey	Bar-On Emotional Quotient Inventory Interpersonal Style Inventory	Intervention group received an Emotional Intelligence Development Training, which included 10-session emotional intelligence training with interactive content, each of which lasted 60–75 minutes. The content of the teaching material was based upon the 5 dimensions in Bar-On Emotional Quotient Inventory, communication skills, body language and the use of emotions in social relationships. The 1st and 10th sessions included filling out the questionnaires. In each session, a warm-up activity was conducted before the training. Warm-up activities were related with the training of the day and were designed in order to prepare for the training. Warm-up activities were performed by means of role-play, group work, and self-report. methods, and the methods and materials varied according to the content of each warm-up activity. After the warm-up activity, basic theoretical information was presented about session topics. During the presentation, the students were told the topic of the training by means of question-answer and discussions. Following the topics, activities related with the	The results of this study revealed that the training provided using structured emotional intelligence skills improvement material was an effective method for increasing the nursing students' emotional intelligence and interpersonal relationship styles scores. Improving emotional intelligence skills training positively affected the improvement of emotional intelligence and interpersonal relationship styles of nursing students. Significant difference between the post-training emotional intelligence mean scores of training. Post-training interpersonal relationship style mean scores of training group students were higher when compared to pre-training. It was revealed that post-training emotional intelligence mean scores of training group students were higher when compared to pre-training and that this difference was statistically significant.	

					topic to improve emotional intelligence skills were conducted. With the activity, it was aimed to practically reinforce the information provided theoretically. After each session, the session was evaluated.		
Foster, K., McCloughen, A., Delgado, C., Kefalas, C., & Harkness, E. (2015). Emotional intelligence education in pre-registration nursing programmes: An integrative review. Nurse Education Today, 35(3), 510-517.	Integrative literature review	17 articles about EI in pre-registration nurse education literature.		two main EI conceptual models; one based on abilities, the other on personality traits. The ability-based model views EI as a form of information-processing and is considered the most conceptually and empirically valid. Their four factor or branch model involves a hierarchy of abilities starting with emotional perception (accurately perceiving emotions in self and others); emotional facilitation (using emotions to facilitate tasks); emotional understanding (understanding the relationship between emotions and situations); and emotional management (regulation of own and others' emotions). The trait-based EI model- a mix of competencies and personality traits such as assertiveness, stress management, self-awareness, and social awareness. This model works with self-report measures based on these conceptual underpinnings. model encompasses a range of emotional skills and personality traits and includes two types of competencies: emotional and personal. Emotional competencies include self-awareness, self-regulation and motivation, whereas social competencies	CINAHL, Medline, Scopus, ERIC, and Web of Knowledge electronic databases were searched. Peer-reviewed research or discussion papers focusing on education for EI in the context of pre-registration nursing programmes, published in English between 1992 and 2014, were included. Literature reviews and grey literature were excluded. Papers that addressed EI education for postgraduate nursing or registered nurses, or did not have EI as the central focus, were excluded. Empirical research investigating or measuring nursing students' emotional intelligence (EI) were also excluded as the focus of the review was on how students were being educated for EI, rather than on students' levels of EI.	Three categories were identified: Constructs of emotional intelligence; emotional intelligence curricula components; and strategies for emotional intelligence education. A wide range of emotional intelligence constructs were found, with a predominance of trait-based constructs. A variety of strategies to enhance students' emotional intelligence skills were identified, but limited curricula components and frameworks reported in the literature. An ability-based model for curricula and learning and teaching approaches is recommended. Strategies for EI education in pre-registration curricula were highlighted in all papers, with many referring to multiple strategies. These included EI self-assessment, reflection activities, modelling of EI behaviours and development of empathy. Three papers outlined programmes with strategies that had been designed and implemented to enhance EI skills. These	-should consider utilizing an “ability-based model for curricula and learning and teaching approaches Emotional intelligence education strategies proposed for curricula: -Reflective learning/ enquiry-based learning -Reflection activities/ support/personal growth/counselling -Assessment of EI/ self-assessment & feedback -Teachers to model EI skills Experiential/role play/theatre/ art/poetry -Service user involvement -Transparency of EI skills expectations”

				comprise of empathy and social skills. Theories: -Goleman Personal competence: Motivation, Self-awareness, Self-regulation. Social Competence: Empathy, Social skills, Emotional competence -Salovey & Mayer Intelligence: Ability to perceive emotion, Understand emotions, Use emotion to facilitate cognition, Manage, regulate and reflect upon emotions - Bar-On Intrapersonal Interpersonal: Adaptability, Stress-management, General mood/motivation		all drew heavily on Goleman's EI model. As a way forward for EI nurse education, the article recommends that EI be explicitly included as a construct on which to scaffold EI theory and abilities throughout pre-registration programmes, and as a core ability outcome expectation for pre-registration nursing students. We contend that emotional intelligence and emotional labour can be understood as threshold concepts, or learning thresholds, which form the basis for mastery of personal and interpersonal emotion management in nursing practice, and provide an opportunity for students to develop new ways of thinking about and practising effective interpersonal communication. From a theoretical standpoint the EI ability construct can be used as an organising heuristic or framework which includes personal and interpersonal skills relating to emotion work and provides a validated conceptual basis from which to develop and scaffold curricula components, and to subsequently measure students' EI ability. There are a range of developed EI resources and components relating to healthcare,	

						including those reported in this review. Table 5- Summary recommendations for emotional intelligence nurse education.	
Gorgas, D. L, Greenberger, S., Bahner, D. P, & Way, D. P. (2015). Teaching emotional intelligence: A control group study of a brief educational intervention for emergency medicine residents. The Western Journal of Emergency Medicine, 16(6), 899-906.	randomized control group design	Thirty-three Emergency Medicine Residents, randomized to either EI intervention or control groups.	large urban Emergency Medical residency program- Ohio	EI as an ability to perceive another's emotional state combined with an ability to modify one's own. EI as a fluid construct, susceptible to improvement or decline. This article focused on one sub-skill from one of the primary EI skills, social awareness, which encompasses the sub-skills of empathy, organizational awareness, and social perspective taking (SPT). SPT is a skill related to understanding another individual's viewpoint. 10-item sample of the Hay 360 Emotional Competence Inventory to measure EI at three time points for the training group: before (pre) and after (post) training, and at six-months post training (follow up); and at two time points for the control group: pre- and follow up.	The intervention was a two-hour session focused on improving the skill of social perspective taking (SPT), a skill related to social awareness and compassion. The session was introduced with a lecture covering basic EI vocabulary and concepts, a description of environmental stressors common to EM residents, and then a brief description about the intended benefits of EI training activities. A video of an interview with Daniel Goleman a leading authority on the topic of EI, and a video of a TED-Talk lecture delivered by Daniel Goleman on the topic of compassion were interspersed into the introductory lecture. The lecture was followed by a series of four case scenarios, each involving a person in distress. The cases included a list of suggested actions that an external observer might take, including the reasons why they might take that action. The first two cases were presented and discussed with the entire intervention group. Participants were asked questions about the cases to guide them to identify the source of distress, the cause of the distress, potential environmental factors, and how the perspective one takes might impact their	No significant improvement in EI scores immediately following the brief intervention. However, at testing six months post-intervention, the intervention group's EI scores significantly improved after the intervention involving SPT, whereas the control group's scores had not.	-important to check the improvement also a few months post intervention, and also after being able to implement it in practice.

					response to the situation. Two subsequent cases were discussed in facilitated small groups. At the end of the session, each small group presented their case analysis, their response, and a defense of their response. The session concluded with a debriefing in which the "best" responses to each case were identified along with explanations.		
Grant, L., Kinman, G., & Alexander, K. (2014). What's all this talk about emotion? Developing emotional intelligence in social work students. So cial Work Education, 3 3(7), 874-889.	mixed-methods two-stage study	17 first-year undergraduate social work students	University of Bedfordshire, UK	EI as 'the ability to perceive emotions; to access and generate emotions so as to assist thought; to understand emotions and emotional knowledge; and to effectively regulate emotion so as to promote emotional and intellectual growth'. It encompasses four abilities: to perceive feelings in oneself and others; to use emotions mindfully to facilitate problem solving and creative thinking; to appreciate the causes and effects of specific emotions and appreciate their complexity; and finally, to manage emotions effectively through reflection and self/other awareness Measures: online survey questionnaires and reflective logs pre- and post-intervention (Times 1 and 2 (at two months post intervention, and towards the end of their practice placements)) Questionnaires: -33-item scale developed by Schutte et al. (1998) to measure emotional intelligence - scale developed by Aukes, Geerstsma, Cohen-Schotanus,	A series of questionnaires were completed and a reflective log submitted at Time 1 (before the intervention and the reflective diaries and log had been started) and Time 2 (two months after the intervention, towards the end of their practice placement) (1) Students attended a workshop prior to their initial placement which comprised a series of activities designed to address the four themes of emotional intelligence identified by Salovey et al. (2008) (Table 1 holds detailed description of the workshop content). (2) Students were asked to keep reflective diaries during their three-month placement which identified emotional reactions to practice situations preferably on a daily basis where emotions were used to facilitate judgements and decision making. They were also required to provide examples where they demonstrated insight into their own emotional experiences and those of others in the practice situation. Students were then asked to write reflective logs using a structured reflective writing template which	Levels of reflective ability and empathy increased significantly between Times 1 and 2 and psychological distress decreased. Content analysis of reflective logs found evidence that reflective ability, empathy and emotional intelligence were enhanced following the interventions.	-reflective logs can be added to the intervention

				Zwierstra, and Slaets (2007) measured reflective ability. -Davis' (1983) scale to measure empathy. -General Health Questionnaire (GHQ-12: Goldberg & Williams, 1988) to measure psychological distress. Qualitative measures -Structured reflective log based on their reflective diaries that explored situations encountered during previous mandatory work experience and/or an initial in-class exercises that had generated strong emotional reactions (time 1). Students were then required to keep reflective diaries following the intervention (Time 2) during their initial three-month placement which identified emotional reactions to their training experiences and practice, situations where emotions were used to facilitate judgements and decision making, as well as examples where they demonstrated understanding of the emotional experiences of themselves and others in the practice situation. They were then asked to select one structured reflective log, based on Gibbs' (1988) reflective cycle, extracted from their diaries that explored situations that they found emotionally challenging (Time 2).	is part of their placement portfolio. They were then asked to submit the log which they felt was the most reflective. Topic of workshop: 1. Perceiving emotions- After a general introduction about the emotional nature of social work practice, students reflected upon their most recent work experience in social care and share any emotions that this had engendered. 2. Using emotions to facilitate thought- students were asked to consider the implications of emotions on their practice: for example, 'negative' emotions such as fear, anxiety and sadness, and 'positive' emotions such as satisfaction, joy and happiness. It should be noted, that some students were initially reluctant to disclose that they felt upset, angry or fearful as they felt this was unprofessional and unsafe 3. Understanding emotion in self and others- Three social workers from a range of cultural backgrounds, levels of experience and social work specialisms spoke to students about practice situations which had provoked strong emotional reactions in them. They were asked to reflect upon the emotions that the service users might have experienced and the emotions that this evoked in them. The implications for professional practice were also discussed. The scenarios included working with a man with serious mental health		

					problems with a history of violence, a case of serious child neglect and a situation where parents were accused of injuring their child. A subsequent group discussion explored these emotional reactions and discussed why insight into personal emotional reactions and those of others was important. The ways in which unacknowledged emotions can adversely affect professional practice were also explored 4. Managing emotion-The three social workers discussed the ways in which they managed their emotions in practice. They highlighted the effectiveness of supervision and reflective discussions with peers and managers, as well as maintaining a healthy work–life balance. Reflective writing and journaling were introduced as key mechanisms to help foster emotional intelligence, empathy, reflective ability and psychological wellbeing		
Gribble, N., Ladyshewsky, R. K., & Parsons, R. (2017). Strategies for interprofessional facilitators and clinical supervisors that may enhance the emotional	qualitative phase of a longitudinal, retrospective mixed methods design	24 healthcare professional students (third-year undergraduate occupational therapy, physiotherapy, and speech pathology students).	four Australian Universities.	EI as both ability-based, mixed- and trait-based models: - The ability based model (Mayer and Salovey)- emotions as significant sources of information to assist the individual to make sense of and navigate the social environment. The ability-based model purports that individuals vary in their capacity to process information of an emotional nature. four types of abilities: perception of emotion in oneself and in others, assimilation of emotion to facilitate thought,	reports the findings from an analysis of interviews with therapy students (n = 24) to determine the aspects of clinical placements that therapy students perceived as influencing the changes in EI scores. In order to be selected into this part of the study (PART II- part 1 is also detailed in this chart)- analysis of participant EI results showed a positive or negative change of eight points or more in four or more EI scores.	95% agreed that clinical placements had a significant impact on a range of EI skills with changes being both positive and negative. EI skills had changed because of the following aspects of clinical placements: student supervisor interactions, student interactions with patients in emotional distress and being encouraged to reflect and	interprofessional facilitators and profession-specific supervisors are recommended - The key influences on EI skills during clinical placements were the student–supervisor interactions, students working with patients experiencing emotional distress, pain or loss, and students receiving

intelligence of therapy students. Journal of Interprofessional Care, 31(5), 593-603.				understanding of emotion, and managing and regulating emotion in self and others - mixed model (Bar-On)- Model of Emotional-Social Intelligence - emotionally and socially intelligent means to effectively manage personal, social and environmental change by realistically and flexibly coping with the immediate situation, solving problems and making decisions. To do this, we need to manage emotions so that they work for us and not against us - Trait-based EI- array of emotional self-perceptions, such as adaptability, assertiveness, emotion management, relationships, and self-motivation, which operationalize the affective aspects of personality <u>Measure:</u> semi-structured interviews to investigate the perceived impact that clinical placements had on EI scores.	Interviews were conducted by the researcher either face-to-face (n = 18) or over the phone (n = 6). The same researcher conducted all 24 interviews. Interviews ranged from 30 to 75 minutes. Interviewees were read the MultiHealth Systems (2011) definition of EI, and then, the interviewer provided a description of the model of emotional– social intelligence. Interviewees were provided with a printout of their 22 EI scores at the three timepoints. For each interviewee, the researcher had highlighted four to six EI scores that had increased or decreased by eight points or more. For each EI score, the interviewee was provided with the definition for that EI domain (from MultiHealth Systems, 2011). The interviewee was then asked, "Do you agree that this EI score has increased (or decreased) over the last 16 months?" This question was included to clarify if the interviewee perceived that the specific EI ability had changed, and if so, in the direction indicated. If the interviewee responded positively, the researcher then asked, "Do you think the change was due to your clinical placements, personal factors or a combination of the clinical placements and personal factors?" If the interviewee agreed the change in EI score was due to clinical placements, they were asked, "What occurred during your clinical placements	hear feedback on their EI skills. Supervisors and facilitators should be emotionally in-tune with students and trust students to work autonomously with patients experiencing emotional distress, pain and loss, especially those with complex needs. Importantly, interprofessional facilitators and direct supervisors should encourage students to reflect on their EI skills both individually and as a group. Supervisors should frequently evaluate and provide feedback to students on their EI skills, at the same time as providing feedback on their practical and clinical reasoning skills. Interviewees frequently described supervisors and interprofessional facilitators as skillful mentors and educators who set up a safe learning environment that resulted in student's reporting improving EI skills. However, students also described supervisory styles that hindered the development and, in some cases, crushed the student's perceived EI skills. The role of creating a positive learning environment where students can observe, practice, and gain feedback on their EI skills should fall equally on both the interprofessional facilitator and profession-specific	feedback and reflecting on their EI skills.

					that may have influenced this change in this EI score?"	supervisor. Supervisors need to be particularly cognizant of the fluctuating nature of student's EI abilities in the first week of so of placements where students are reporting feeling vulnerable and underconfident. Facilitating interprofessional education and clinical placements for healthcare students is challenging and demanding for the interprofessional facilitator and profession-specific supervisor.	
Gribble, N., Ladyshewsky, R. K., & Parsons, R. (2019). The impact of clinical placements on the emotional intelligence of occupational therapy, physiotherapy, speech pathology, and business students: a longitudinal study. BMC Medical Education, 19(1), 1-10.	longitudinal, retrospective mixed methods design	283 3rd year undergraduate therapy students (occupational therapy, physiotherapy, and speech pathology students) and 93 2nd year business students (control group who do not have clinical placements) before, during and after they completed their final clinical placements enrolled at four Australian universities.	Australia OTs in Australia are scheduled to participate in three or more full time practice placements of four weeks during their 4th year. All three programs scaffold practice placements through the course with parttime, shorter placements (for example, 1 day per week; 1 or 2 week placements)	EI as a mixed model (Bar-on/Multi-health system's model of emotional intelligence). EI is comprised of: 1. Self-perception (self-regard, self-actualization and emotional self-awareness), 2. Self-expression (emotional expression, assertiveness, and independence), 3. Interpersonal (interpersonal relationships, empathy, and social responsibility), 4. Decision making (problem solving, reality testing, impulse control), and 5. Stress management (flexibility, stress tolerance and optimism). Emotional Quotient Inventory (EQ-i)- 133 item self-report tool used to measure self-perception of EI. The measure has standard scores	Emotional Quotient Inventory (EQ-i) measured the students at three points in time over a 16-month period (online questionnaire)- before first placement, the following year after the student completed one or more clinical placements, and after completion of all mandatory placements. The intervention group had clinical placement (therapy students) compared to control group of business school students (without clinical placements)	Analysis of the therapy students showed significant increases in Total EI score, as well as nine other EI skills. However, large percentages of students reported . Emotional intelligence in student therapists should be actively fostered during coursework, clinical placements and when first entering the workforce. University educators are encouraged to include EI content through the therapy curricula. Employers are encouraged to provide peer coaching, mentoring and workshops focused on EI skills to recent graduates. -Practice placements contribute to improvements in students' emotional intelligence.	-utilizing clinical placement to foster EI and EI content through the therapy curricula for students -for new clinicians- peer coaching, mentoring and workshops

			early in the program, with three or more placements of 6 weeks or more scheduled in the final year.			-Emotional intelligence is a critical skill for occupational therapy students. -New graduates may present with many well–matured emotional intelligence competencies; however, assertiveness, problem–solving and stress tolerance remain relatively low.	
Kotsou, I., Nelis, D., Grégoire, J., & Mikolajczak, M. (2011). Emotional plasticity: conditions and effects of improving emotional competence in adulthood. Journal of Applied Psychology, 96(4), 827.	Experimental with a between-subject variable and a within-subject variable	132 adult participants	Brussels	Trait Emotional Intelligence Questionnaire- short form- 30 seven point items providing a global score of EC Trait Emotional Intelligence Questionnaire- 360 short form- 15 items, representing one of the 15 facets of the TEIQue-SF Satisfaction with Life Scale- assessing satisfaction with respondent's life in general Perceived Stress Scale- 10- item scale designed to measure the degree to which individuals appraise their life as stressful. Diurnal Profile of Cortisol (AUC)- measured stress. Five different saliva samples and tested at the university of brussels. Pennebaker Inventory of Limbic Languidess- measure of 54 physical symptoms and bodily sensations. Quality of Interpersonal Relationships- 16 item, scored on 5 point scale Quality of Interpersonal Relationships Scale 360- 16 items. The spouse or close friend	Participants were randomly assigned to an EC-enhancing intervention (in group format) or to a control group. Participants in the intervention group underwent a specifically designed a two and a half day program (15-hour) intervention targeting the five core emotional competencies, with a four week email follow up. Participants were asked to complete the measures before intervention, 1 month after the intervention and one year after the intervention. The first two days (12 hr) consisted in intensive raining structured around the acquisition and/or the improvement of five core emotional competencies: (1) the capacity to identify one's own and others' emotions; (2) the capacity to understand emotions, their antecedents, and consequences; (3) the capacity to express emotions in a socially adequate	The level of emotional competencies increased significantly in the intervention group in contrast with the control group. This increase resulted in lower cortisol secretion, enhanced subjective and physical well-being as well as improved quality of social and marital relationships in the intervention group. No significant change occurred in the control groups. Peer reports on EC and quality of relationships confirmed these results. These data suggests that EC can be improved, with effective benefits in personal and interpersonal functioning level lasting for at least a year.	Theoretical and practical implications of these results can be used for the construction and development of effective emotional competency interventions.

				instructed to indicate on a 5-point scale the quality of the relationship the participant had with the informant, with his/her family, and with his/her friends.	manner and to listen to others' emotions; (4) the capacity to manage one's own and others' emotions; (5) the capacity to use emotions to enhance thinking and actions. Reminders and readings were given to the participants at the end of each day. This intensive training was followed by a 1-month Internet follow-up (i.e., participants received an e-mail twice a week, encouraging them to apply a different part of the intervention each time). As an example, the first mail asked participants to pay attention to the next emotion-related situation they would encounter. They were instructed to observe and differentiate the different components of that situation (physiological activation, cognitions, action tendencies, and subjective feeling). Two weeks after the beginning of the program, participants attended a half-day session (3 hr), where they received a reminder of the materials covered during the first two training days. Following this, team discussions, reflections, and feedback within the group were encouraged to gauge the extent to which individuals attempted to use the competencies		
Meng, L., & Qi, J. (2018). The effect of an emotional intelligence	Experimental study	81 nursing students randomized to an emotional	introductory psychology classes at a moderate western	The Perceived Stress Scale (PSS) is a 14-item questionnaire that screens for tension disorder. The Communication Skills Inventory (CSI) examines	Researcher-made and included: training pamphlet, poster, a 4-session general conference program and 6-session in-group program. The training programs were conducted 2 sessions per	Perceived stress decreased in the emotional intelligence group, but not in the control group. Also, communication skills increased in emotional intelligence group but	- The Schutte Self-Report Emotional Intelligence Test (SSEIT) could be a viable measure to look up.

intervention on reducing stress and improving communication skills of nursing students. Neuro-Quantology, 16(1)		intelligence group and control group	Chinese university	communication skills in three levels of verbal, audible and feedback. The Schutte Self-Report Emotional Intelligence Test (SSEIT)- 33 descriptive sentences, consisted of three components, including emotion regulation, evaluation and expression of emotion, and taking advantage of emotion All the nursing students participated in the study first completed measures of stress and communication skills. Participants completed the follow-up assessments approximately 5 weeks following pretest	week (2 hours per session). In these programs, emphasis was placed on 15 subscales of emotional intelligence, particularly anxiety reduction programs. In the training programs, the necessary training was first done on the above, and then they were taught how to think, express emotions, attachments, change their perceptions and judge about their beliefs. They were also taught methods of adaptation to stressors and stressful environment.	remained unchanged in the control group. There were significant benefits of the emotional intelligence intervention on the variables tension, verbal skill, audible skill, feedback skill and perceived emotional intelligence were found in the intervention group compared to the control group.	
Pearson, A., & Weinberg, A.. (2017). The impact of counsellor training on emotional intelligence. British Journal of Guidance & Counselling, 45(5), 610-621.	mixed quasi-experi-mental design	45 undergraduates (in which counselling was a named component, comprising 50% or more of the focus of the degree) and 58 postgraduates in counseling programs in a UK university		EI proposed by Goleman and included items designed to assess self-awareness, self-regulation, motivation, empathy and social skills. Emotional Intelligence Self-Assessment Questionnaire (EISAQ)- global rating of intra- and interpersonal functioning for particular use with university students. Its purpose is to enable individuals pursuing under- and postgraduate studies in psychology and related degree subjects to carry out evaluations of their emotional functioning.	Both undergraduate and postgraduate participants were invited to complete the EISAQ, at the beginning and end of their respective programs. Undergrad: The total hours dedicated to all counselling program components was between 178 and 328 hours depending on whether students pursued a joint or single honors program in counselling; however all undergraduates irrespective of program were exposed to the same counselling skills training and were awarded a certificate in counselling skills. The counselling training took place in class settings in the university and was delivered during 5-hour weekly blocks over a 20-week period, as well as an additional 2-day workshop. Skills training was provided by a team of 6	Using EI as an indication of the development of counselling students' interpersonal and intrapersonal emotional competencies necessary for the professional counsellor, this study investigated the impact of participation in counselling programs, and examined the role of age as a correlate of EI. There was no statistically significant support for differences in EI between under- and postgraduates at the start of their respective counselling program. No significant correlations were found between age and EI scores in the student groups at T1 or T2, whether	

					qualified counsellors; each counsellor facilitated groups of 8– 10 students. Teaching methods focused on providing students with opportunities to work collaboratively with others. This was done through theoretically and skills-oriented groups, varying in size to permit students' experience of working in small groups and pairs. A mix of lectures, seminars and experiential learning were used; in addition, students were encouraged to keep a diary to facilitate reflection on their personal development. Theoretical perspectives focused on Rogers' person-centred approach, including the core conditions for the therapeutic process. Students were encouraged to apply and evaluate relevant theory in relation to their own life situations, before progressing to undertake skills-based practice in peer dyads. Students recorded and received feedback from peers and tutors, on a minimum of three counselling skills sessions, with peers taking the roles of different clients. Satisfactory completion of the counselling skills component of the program involved demonstration of awareness of the impact of counselling techniques and of understanding the choices made within the counselling situation. The range of activities and assessments encouraged interpersonal skills development, including building warmth and rapport, working collaboratively, establishing contracts in helping	considered separately or in combination. statistically significant degree for improvements in EI over the course of the program for both under- and postgraduate groups, where undergraduates' higher EI on completion of their program, suggesting that these were attributable to training which enhanced intra- and interpersonal aspects of emotional functioning. As a group, postgraduates were older than undergraduates, and at the outset of the study, EISAQ scores were comparable; however, at follow-up, undergraduates recorded significantly higher EISAQ scores. Students' EI was not significantly related to their age, and these findings indicate the potential for effective EI-skills training which is unrelated to quantity of life experiences.	

					relationships, maintaining ethical practice, giving and receiving feedback, as well as reflective practice. Postgrad: completed a practice placement within a counselling service during which they completed a minimum of 100 hours of face-to-face client practice, 20 work-based learning hours and 21 hours of supervision. In addition, students attended university for 1 study day per week for 28 weeks (6.5 hours weekly contact time totalling 182 hours). Each study day comprised 2 hours of interactive lectures (whole group), 2 hours of skills and supervision (in groups of 8–10) and a further 1.5 hours in personal development groups (12–15 persons). Skills training was provided by a team of six qualified counsellors. The program utilised a range of interactive learning and teaching methods which focused on small group-work and dyads. In this way, students were encouraged to reflect on the relative strengths of their communication styles in personal and professional settings, on their personal development as individuals and as practitioners, and on the impact of enhancing self-awareness in their lives. Tutors used a range of exercises focused on developing Rogers' core conditions for therapy. These included exposure to art and artefacts aimed at facilitating student engagement in the processes of elucidating thoughts, feelings and		

					perceptions. For example, students were paired for field trips in order to share experiences which were then used in the classroom to enhance unconditional positive regard; similarly discussion of ethical dilemmas was designed to BRITISH JOURNAL OF GUIDANCE & COUNSELLING 615 help exploration of subjective assumptions and biases. Workshops and exercises enabled students to participate in self-exploration on the themes of congruence, belonging and trust in group settings, as well as to further develop capacities for listening and providing and receiving feedback.		
Perkins, N., & Schmid, A. (2020). Increasing emotional intelligence (EI) through self-reflection journals: implications for OT students. American Journal of Occupational Therapy, 74(4_Supplement_1), 7411520501p1-7411520501p1.	Poster presentation non-equivalent group study design	experimental group: 1st year MOT students who completed monthly self-reflection journals during spring academic semester. Control- second year students completed pre- and post assessments but did not complete the journal assignments. OTs in MOT students in Colorado University	USA	TEIQue Full Form: measure trait EI-report inventory comprised of 153 questions that measure trait EI.	Both group (1st years and 2nd years), completed the TEIQue Jan and May 2018. 1st years participated in total of four online self-reflection journals- one every month.	Findings: First-year MOT participants who completed the self-reflection journals improved overall scores in 14/15 facet categories and had an overall increase in the four areas addressed using self-reflection journals. Conclusions: This study's findings add new perspectives and depth to the current research and the evidence supporting the need for EI training in OT curricula. OT students that are trained in the use of self-reflection journals could continue to build upon their skills as they move towards becoming emerging	The interventions should include reflective journaling. A potential measure to assess change: TEIQue Full Form

						clinicians. Developing training that encourages more opportunities for self-reflection provides students with a chance to practice and develop new cognitive strategies and emotional responses.	
Polonio-López, B., Triviño-Juárez, J. M., Corregidor-Sánchez, A. I., Toledano-González, A., Rodríguez-Martínez, M., Cantero-Garlito, P., ... & Romero-Ayuso, D. M. (2019). Improving self-perceived emotional intelligence in Occupational Therapy students through practical training. Frontiers in psychology, 10, 920.https://doi.org/10.3389/fpsyg.2019.00920	Multi-center, quasi-experimental, pre-post study	156 OT undergrad students from two public universities in Spain. Inclusion: first clinical rotation, either year two or year three.	Spain. Areas of practicum for students included: 1. childcare, 2. physical rehabilitation, 3. Mental health, 4. geriatrics and gerontology, 5. non-conventional areas (social exclusion, gender violence, prisons)	EI as the ability to monitor one's own and others' feelings, to discriminate among them and to use this information to guide one's thinking and actions. consists of 1. emotional perception, 2. emotional facilitation, 3. emotional understanding, 4. emotional regulation. Definition 2: EI as as a personality trait. Measure: 1.TMMS-24- self reported measure based on trait meta mood scale (TMMS-48) to determine self-perceived EI- 1. EA-emotional attention, 2. EC-Emotional clarity, 3. ER-Emotional repair. good internal consistency.	Two weeks prior to start of practical training, participants completed the TMMS-24. They underwent 4-6 weeks practical training (fieldwork experience) and then retook the TMMS-24 questionnaire. Finally, they filled out questions about specific areas of training	Purpose: to determine whether performing practical work included in the undergraduate OT program improves students' self-perceived EI, and whether there are any differences depending on the area of practical training. Women showed significant change in EA and EC after practical training, in some practice areas (physical rehab, mental health, geriatrics and gerontology) Women showed significant change in ER in 1. physical rehab, 2. geriatrics and gerontology Significant improvement in all EI dimensions after practical training in the areas of Physical Rehabilitation and Geriatrics and Gerontology. However, in women after practical training in Mental Health, improved EA and EC but not ER.	-Practical training can influence EI for OT students, depending on practice setting and gender (?) -EI as a complementary skill can be improved through practical training. -Potential measure for EI: TMMS-24- self reported measure

Shahbazi, S., Heidari, M., Sureshjani, E. H., & Rezaei, P. (2018). Effects of problem-solving skill training on emotional intelligence of nursing students: An experimental study. Journal of Education and Health Promotion, 7.	Interventional case–control study	43 senior nursing students randomly allocated to either the intervention group or the control group	Hazrat Fatemeh School of Nursing and Midwifery of Shiraz University of Medical Sciences	Emotional Quotient Inventory (EQi)- consists of 133 questions arranged in 15 subscales including emotional self-awareness, assertiveness, independence, self-regard, self-actualization, interpersonal relationship, social responsibility, empathy, problem-solving, reality testing, flexibility, stress tolerance, impulse control, optimism, and happiness. Problem Solving: problem-solving skill questionnaire was completed before and after the intervention, which was a researcher-made self-evaluation checklist, contained 19 items, and was designed based on the model proposed by D'zurilla and Goldfried.	Pretest-posttest design to assess the effects of problem-solving skill education the emotional intelligence of nursing students. The EQ-i and problem-solving skill questionnaire were completed immediately and 2 months after the program. After completing the questionnaire, the intervention group participated in an educational program on problem-solving. The program lasted for 2 months and comprised six 2-h sessions held at Hazrat Fatemeh School of Nursing and Midwifery. Various methods such as group discussions (in groups of four), brainstorming, JIGSAW method, and the application of educational aids (e.g., books, booklets, posters, and video projection) were used during the program. All the sessions were planned and performed based on the six-stage model developed by social problem-solving model developed by D'zurilla and Goldfried. The training was conducted by two university faculty members and with the help of a researcher. The sessions were planned as follows: 1. the ability to identify the problem and accept it as a natural, potentially manageable phenomenon, belief. in the efficacy of the problem-solving framework in dealing with the problem, high perceived self-efficacy in completing all	EQi scores were significantly higher in the intervention group both immediately and 2 months after the intervention.	-intervention does not need to target EI directly to influence EI improvement.

					the stages of the model, and forming the habit of pausing and thinking before taking action to solve a problem 2. Defining and formulating the problem, collecting all available information, discriminating between facts and hypotheses requiring further research, analyzing the problem, and determining real goals 3. Developing alternative solutions, suggesting a variety of possible solutions, and selecting the most effective solution 4. Decision-making and predicting the possible outcomes of each action and the benefits of each outcome 5. Implementing the selected solution 6. Revision and evaluation - Members of both groups also took part in routine programs of the school, i.e., theoretical classes and internship programs. Since most nursing courses involve the problem-solving skill, the control group did not receive any additional education.		
Vishavdeep, S., Das, K., Malhi, P., & Ghai, S. (2016). A pre experimental study to assess the effect of emotional intelligence	pre experimental study	224 nursing students B.Sc.	India, university of Chandigarh.	The conceptual framework of the study was based on Roy's adaptation model and Goleman's model of Emotional Intelligence. Emotional Intelligence Test (EIT)	Pre-test score at baseline before the intervention was assessed and post test score was assessed one month after the intervention. A protocol of EI skill training included seven sessions on: 1. Introduction 2. need of Emotional Intelligence, 3. self awareness, 4. self management, 5. social awareness, 6. relationship management and 7. termination session. Each session	Significant improvement after intervention was found in EI.	

skill training on emotional intelligence of undergraduate nursing students. International Journal of Nursing Education, 8 (2), 203-208.					was of one hour which included teaching, activities and discussion which was validated by the experts from the fields of Nursing, Psychiatry and Psychology.		

APPENDIX D – Learner Profile

Course description

EmOTions continuing education course is designed to cultivate EC knowledge, skills, and application to practice through active and meaningful learning for occupational therapists. This course aims to help clinicians enrich their EC skills to expand therapeutic relationships and therapist well-being for improved therapeutic outcomes.

Instructions	The following questionnaire will help the facilitators in the *EmOTions* course to understand your specific learning needs. By understanding your learning preferences, we can tailor the learning process to support you with understanding and applying the theoretical concepts to your clinical settings. *Please fill out this questionnaire to the best of your ability.*
Learner Characteristics	*Please describe your professional background as an occupational therapist:* 1. Your area of practice: _____ 2. Area(s) of practice and years of experience in each: _____
	Please rank your level of familiarity with each of the following: 1. <u>EI/EC theory</u> 1 2 3 4 5 (no prior knowledge) (Mastery)

	2. <u>Intentional Relationship Model (IRM)/ Therapeutic Use of Self</u> 1 2 3 4 5 (no prior knowledge) (Mastery) 3. <u>Techniques for applying EI/EC & IRM theory and skills into practice</u> 1 2 3 4 5 (no prior knowledge) (Mastery)
	Rank how emotionally aware you feel you are during therapy sessions with clients. 1 2 3 4 5 (Not self-aware) (Very self-aware)
	Rank how confident you feel when using therapeutic use of self in the clinical setting. 1 2 3 4 5 (Not confident) (Very confident)
Learning Goals	*What are you hoping to learn in this program?*

	What are you hoping to improve by the end of the program?
Learning Needs	*Which of the following emotional competency skill(s) would you like to improve?* □ Recognize & identify my emotions. □ Recognize & identify my clients' emotions. □ Understand my emotions. □ Understand my clients' emotions. □ Express my emotions. □ Listen & empathize with my clients. □ Manage & regulate my emotions. □ Support my clients with managing & regulating their emotions. □ Decreasing emotional fatigue and burnout. □ Other_____
Strengths and Limitations	*What are your strengths in the realm of emotional intelligence?*

	What are the areas you would like to improve in the realm of emotional intelligence?
Learning Motivation	*Please mark your reasons for participating in this program (you may mark more than one)* □ The topic looks interesting. □ To learn practical techniques and skills related to EI theory. □ To learn how to apply EI skills to my daily practice. □ I need support with understanding my reactions to clients. □ I need support with understanding my client's reactions to treatment. □ I feel emotionally overwhelmed at work and do not know why. □ I feel emotionally overwhelmed at work and do not know how to manage it. □ I know this area is something I need to work on. □ To meet like-minded clinicians. □ I need the continuing education credits. □ Other _____

Learning Preferences	*Rank your preferred learning style from 1 (least preferred) to 7 (most preferred):* □ Small group discussions □ Formal lectures □ Experiential learning (learning through practice) □ Reflective discussions □ Handouts and visual aids □ Self- study □ Other_____
	Please describe any learning challenges that could help us better understand your learning style(s). In the past, what has helped you to overcome these challenges?
Emotionally Charged Clinical Situations	*Describe two clinical situations where you found navigating emotions (your clients' or your own) challenging. Describe what was challenging about the situation and what you would like to learn to manage it better next time.*

APPENDIX E – Executive Summary

Introduction

The effectiveness of occupational therapists' work correlates with the degree of their emotional competence (EC) within the therapeutic encounter (McKenna & Mellson, 2013). An individual's EC is defined as a person's skills, confidence, and capacity to navigate emotions in different social situations and is related to their Emotional Intelligence (EI) (Coetzee et al., 2016; Saarni, 1997).

Emotions are integral to both the human experience and the therapeutic encounter. In emotionally-driven empathetic therapeutic relationships, therapists should effectively recognize and address emotions that arise, read and attend to non-verbal cues, and express emotions clearly and genuinely (Wilkinson et al., 2017; Wong, 2016). These capacities require self-knowledge, self-awareness of therapeutic behavior, and the ability to reflect and evaluate their practice to hold interpersonal sensitivity and understanding for their clients (Taylor, 2020). When therapists ignore or do not know how to respond to a client's emotional state, it can threaten the therapist's well-being, as well as the therapeutic relationship and the resulting treatment outcomes. Alternatively, optimally responding to emotional complexities can lead to increase client engagement, motivation, and positive client change, including improved treatment outcomes and a more solidified therapeutic relationship (Kielhofner, 2009; Taylor, 2020). Thus, occupational therapists must acknowledge emotions in the therapeutic interaction to foster a positive, empathetic-therapeutic relationship, engage client motivation, protect themselves against therapist

emotion-based stress, such as burnout, and create meaningful change (American Occupational Therapy Association, 2020).

Barriers to Developing Emotional Competence

Despite the fundamental role of emotions in therapeutic interaction, the curriculum for healthcare professionals tends to place little emphasis on developing effective emotional-related skills and strategies to protect their personal and professional well-being (Brown, 2018; Grant & Kinman, 2014). According to Perkins (2018), therapists' education and training do not include or focus enough on scientific insights into emotions and an individual's emotional architecture, including EC and EI. Although EI components are woven into courses within the occupational therapy curriculum in some programs, they are seldom comprehensively addressed (Calabrese et al., 2019). Moreover, in a methodological review of databases, EI training was not typically part of the standard curriculum in other healthcare or medical programs (Perkins, 2018). Furthermore, a thorough literature search demonstrates that the opportunities to develop EC for practicing professionals are sparse. Many health institutions lack on-site education to enhance employees' EI and interpersonal communication skills. Lastly, while there is some EC and EI research within occupational therapy and the medical fields, studies exploring interventional approaches relating to EI and EC are minimal. Without advancing the evidence within the occupational therapy profession, there is little impetus to add a specific EC curriculum to occupational therapy programs for students and practitioners (Perkins, 2018). Thus, implementing EI and EC knowledge, skills, and research within occupational therapy will facilitate effective emotional navigation development within the profession.

Project Overview

This doctoral project aims to enhance occupational therapists' EC to promote therapeutic relationships necessary for quality care. To reach this goal, the author developed *EmOTions*: a continuing education course for occupational therapists. The program's primary focus is on successfully recognizing and managing both clinician and client emotions in practice. The course aims to enhance the participants' knowledge, abilities, and skills to navigate emotions in daily practice with their clients purposefully. In addition, the course focuses on gaining new emotional knowledge and skills and applying them directly to the clinical setting.

The program includes six modules in a six-week, 30-hour online course delivered synchronously for occupational therapists with varied experience levels in all practice settings. The course was designed according to the theories and frameworks of EI, the Intentional Relationship Model, and EC (Brackett et al., 2021; Coetzee et al., 2016; Gayathri et al., 2013; Mayer & Salovey, 1997; Taylor, 2020). In addition, the course delivery approach was constructed according to the Development of Therapist Expertise Model and Framework and includes elements of Self-Efficacy Theory (Bandura, 1986; King, 2009). These theories were chosen based on studies highlighting the importance of actively integrating adult learning principles in teaching and facilitating knowledge application into practice to improve student learning in healthcare professional development (Mukhalalati & Taylor, 2019). Together, the models provide course participants insight into how to perceive, understand, and manage their and clients' emotions and enhance their empathy and self-reflection in practice. These skills can aid

occupational therapists in building trusting relationships with their clients and protecting themselves from emotion-related stress, burnout, and compassion fatigue.

Each of the six-course modules consists of an interactive lecture to introduce the module content, followed by in-class activities and follow-up, out-of-class activities in the participants' therapeutic settings. Finally, one-on-one peer mentoring dyads were designed to promote personal reflection, growth, and professional confidence through active learning.

Once the course is piloted and refined, a full protocol, the *EmOTions Facilitator Manual*, will be published to aid other facilitators in implementing the course in their regions and disseminating the program. The manual is an authoritative guide for the *EmOTions* program. The manual reviews relevant theory and research and describes the program's unique pedagogy. Readers are taken step-by-step by facilitating each course's six modules, including detailed descriptions of the lessons, activities, and assessments to operate the course successfully. It is important to note that the guide is not intended to replace formal training for teaching the *EmOTions* program.

Research and Development

To further solidify the need for this course and measure its results systematically, the developer of *EmOTions* is planning on conducting research in a three-stage design.

Stage I will examine the course's effect on enhancing EC and EC’s effect on the participants' therapeutic relationship and therapist well-being using a pilot one-group repeated-measures design. Formative assessments will gather information about the

program's delivery and evaluate the course's key ingredients to determine effective strategies for promoting EC skills and maximizing program performance. A summative evaluation will determine changes in EC and therapeutic use of self. The quantitative pre-post changes in EC and therapeutic use of self-assessment scores will be measured using assessments. In addition, qualitative changes will be assessed through interviews and open-ended questionnaires post-course and three months post-course to determine if gains were maintained over time.

Stage II will evaluate the *EmOTions* program's effectiveness on a broader scale through RCT design comparing intervention and waitlist control groups.

Stage III will be conducted consecutively with the publication of the *EmOTions Facilitator Guide*. Stage III aims to study the program's effectiveness as administered by different facilitators and evaluate the facilitator's experiences conducting the *EmOTions* course.

The research findings will contribute to the body of knowledge on EC in occupational therapy. In addition, findings will influence the structure and content of the *EmOTions* program, inform policies on professional education, and improve occupational therapists' understanding of addressing emotions in therapeutic encounters. Finally, results from the program could lead to its adoption by facilities or organizations, locally, nationally, or globally and serve as a basis for change in current practice.

Dissemination Plan

The program's dissemination plan is designed to reach two target audiences. The primary audience consists of occupational therapy providers, including practitioners and

administrators. The secondary audience includes organizations providing healthcare or occupational therapy services. The dissemination activities will aim to enhance awareness of EC's scope and the importance of how the *EmOTions* course can promote it. The activities presented below will be primarily conducted by the course developer, with support from collaborators and local resources.

1. Creation of a website explaining the need for the course and contact information.
2. Presentation in conferences, such as the American Occupational Therapy Association, Israeli Society for Occupational Therapy, World Federation of Occupational Therapists, and Virtual Compassion in Action Healthcare Conference.
3. Application for accreditation with continuing education providers with advertising departments.
4. Creation of online content, such as posts, stories, and infographics, to post on different social media outlets, such as LinkedIn, Instagram, Twitter, and Facebook.
5. Publication of articles in peer-reviewed journals describing the need for the *EmOTions* course and pilot findings.
6. Preparation of a promotional "pitch" presentation, including a course outline, supportive evidence, and alignment with the organization's strategic plan to present in various hospital/health maintenance organization/ healthcare provider settings.

Funding Plans

The *EmOTions* program's funding plan is currently separated into two phases: phase 1 includes the course pilot testing, and phase 2 includes the commercialization of the *EmOTions Facilitator Guide*. Although the expenses will differ depending on the stage of

the program development, both will be funded through similar means.

The *EmOTions* program is designed as a self-sustainable course, primarily based on participants' tuition. To help fund the pilot testing and research expenses, such as assistance, standardized assessments, and data analysis, the researcher, will apply for federal and state grants. Finally, the author's long-term goal is to establish relationships with major healthcare organizations and apply for accreditation from continuing education providers to expand the course's reach and promote EC on a larger scale.

Conclusion

In conclusion, *EmOTions* is a theory-driven and evidence-based course helping clinicians improve their emotional competence. Conducting the *EmOTions* course can positively impact the therapists' well-being, influencing quality care and client outcomes. Additional anticipated benefits are reduced therapist burnout and emotional fatigue in the practice setting.

This executive summary provided an overview of the rationale for the *EmOTions* continuing education program's development, including the evaluation, funding, and dissemination plans. The author hopes that the program will be broadly used to empower occupational therapists to harness the power of emotions to promote health and well-being for themselves and their clients.

APPENDIX F – Fact Sheet

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EmOTions

Understanding and navigating emotions in healthcare
A course for occupational therapists

Tamar Fischer, B.O.T, OT

Therapists' ability to navigate their own emotions and the emotions of their clients in therapeutic interaction is tethered to their emotional competence (4,5).

Emotional Competence

A person's skills, confidence, and capacity to navigate emotions in different social situations (2,3,4).

Effective Emotional Navigation Influences:

- Client engagement & motivation
- Therapeutic relationships
- Treatment outcomes
- Therapist well-being, protecting against burnout, compassion fatigue (6,7,8).

Emotions Course

Six weeks, 30-hours online course for practicing occupational therapists.

Goals:

- Improve therapists' emotional competencies in daily therapeutic encounters.
- Gain new emotional knowledge & skills and apply them into directly into the clinical setting.
- Emphasize self-reflection and emotional knowledge as a basis for therapeutic-relationships and therapist well-being in the therapeutic encounter.

Each module will be delivered using interactive lectures, in-class activities, follow-up (out-of-class) activities in individual therapeutic settings, & one-on-one peer mentoring dyads.

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EmOTions

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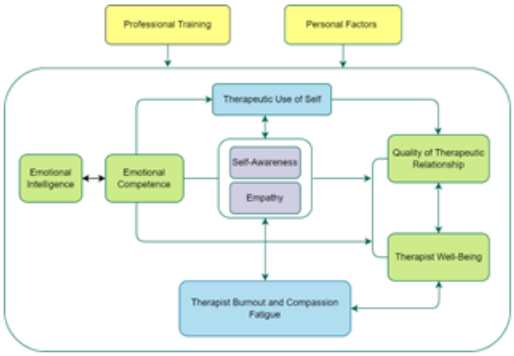
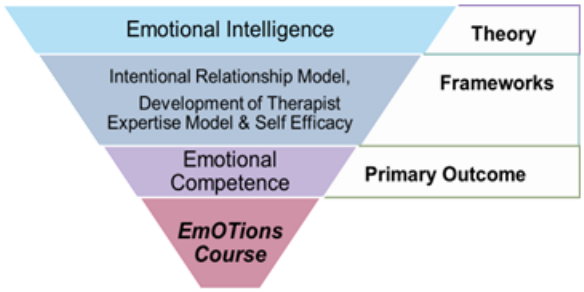
Figure 2. Explanatory model



Evidence

Theory-driven and evidence-based course to purposefully navigate emotions in healthcare can positively impact therapists' well-being & reduce emotional fatigue, improving quality care & client outcomes (1,2,3).

Figure 3. Theoretical foundations



Evaluation Plan:

The program effectiveness will be piloted using a pre-post comparative design to evaluate for changes in participants' emotional competence, and its effect on participants' therapeutic relationships and therapist well-being. The study will collect data through formative and summative assessments, combining standardized assessments and open-ended questionnaires.

Emotionally competent occupational therapists will deliver better care and experience improved well-being.

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