Emotion Regulation in Therapeutic Relationships

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Abstract

In this thesis I explore emotion regulation in therapeutic relationships between occupational therapists/physiotherapists and their patients. I argue that although both intrapersonal emotion regulation (i.e., the regulation of one’s own emotional responses) and interpersonal emotion regulation (i.e., the regulation of other’s emotions) is central to the development and effectiveness of therapeutic relationships between therapist and patient, we know little about their use and development in such relationships. The main aim of this thesis is therefore to understand emotional regulation in therapeutic relationships between therapists and patients.

To address these aims I conducted two studies. In the first study patients and therapists were interviewed regarding their use of emotion regulation during their therapeutic relationships. In the second study, patient/therapist dyads were observed during the course of the therapeutic relationship and then interviewed at the end of the relationship. In both studies, the participants were asked to highlight the turning points, the most significant events that influence each dyadic partner’s ongoing perception of the relationship (Baxter & Bullis, 1986), the emotional consequences of these turning points, and their emotion regulation response.

The key findings from these two studies are therapists and patients use many intrapersonal and interpersonal emotion regulation strategies to address emotions stemming from turning points. They use these strategies both proactively, meaning in anticipation of an affective event and reactively, meaning in response to an affective event. In general, the way they used interpersonal emotion regulation strategies changed as the therapeutic relationship developed. Therapists learn to increasingly tailor their use of interpersonal emotion regulation strategies to suit their patients’ emotional needs and preferences and changed their use of these strategies accordingly. While patients used interpersonal emotion regulation strategies to a lesser degree than therapists, their use of these strategies developed in a similar pattern. There are many factors that influence the dynamic nature of therapists and patients use of emotion regulation strategies. Those that appeared to be particularly important in therapeutic relationships are the perception of prescribed and contextual display rules, the turning points that occur during the relationship, whether the encounters are routine or non-routine, and the perceived quality of the relationship. A theoretical model illustrating how these factors
influence the dynamic nature of how patients and therapists use interpersonal emotion regulation during therapeutic relationships is presented. Theoretical and practical implications are discussed.
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Chapter 1 Introduction

In the late 1970’s and early 1980’s two seminal studies changed our understanding of the work that comprises the healthcare professional’s role. The first of which is Jean Watson’s theory of human caring (1979). The crux of her theory asserts that caring is the essence of nursing practice and is just as important as tasks associated with the curative functions of the nursing role. She defined caring as the actions and choices that nurses make during their interactions with patients that demonstrate respect and value for the patient and are geared towards addressing the patient’s holistic needs. Building positive therapeutic relationships with patients is an essential part of caring. The therapeutic relationship refers to the interpersonal relationship between the healthcare worker and patient (Peplau, 1997). Through these relationships, nurses create a safe space for patients to express their negative and positive emotions and for nurses to receive and attend to these emotions with patience, compassion, and love. It is through this type of human connection that healing can take place, and this exemplifies excellence in nursing practice (Watson, 1979). Although the focus of this study was specific to nursing, it is applicable to all healthcare professionals on the frontlines of patient care, such as occupational therapists and physiotherapists.

The second study was authored by Arlie Hochschild and explored how flight attendants manage their own emotions as a part of their work role. She called this emotional labour (1983). She concluded that flight attendants manage their emotions in two ways, deep acting and surface acting. Deep acting is facilitating a change in actual feelings in order to express organisationally desired emotions (Brotheridge & Lee, 2003). Surface acting is changing emotional expression without facilitating a change in inner emotions (Cheung & Tang, 2009). Hochschild’s work was ground breaking because it emphasised the importance of emotions and managing emotions as part of one’s work role. Later Grandey (2000) reconceptualised emotional labour as emotion regulation done at work. Emotion regulation is the process by which people influence their own and other’s emotions (Gross, 2015). Healthcare organisational environments require a large amount of emotional labour due to the nature of the work, which is helping patients navigate life changing events. In essence, emotional labour is an important part of the caring role (Riley & Weiss, 2016) that Watson (1979) described because healthcare professional’s emotional displays help patients understand the professional’s thoughts, feelings, and intentions (Van Kleef, 2008) and fundamentally whether or not they care.
These two influential studies have illuminated the importance of emotion regulation and therapeutic relationship building in the healthcare professional’s role. Although these two studies have sparked a flurry of research, this research tends to provide only a partial picture of emotion regulation processes in workplace relationships, specifically therapeutic relationships. Research on therapeutic relationships mostly overlooks the role of emotions and emotion regulation in therapeutic relationship dynamics and development. Research on emotion regulation at work tends to focus on the regulation of negative emotions and largely overlooks the regulation of positive emotions. These studies mostly focus on the contribution of the employee and therefore, de-emphasize the customer’s/patient’s contribution within service relationships. These studies also tend to favour intrapersonal emotion regulation, the regulation of one’s own emotions, over interpersonal regulation, the regulation of other’s emotions. Lastly, research on this topic tends to look at episodic use of emotion regulation, rather than how emotion regulation strategies unfold over time within a relationship or series of interactions. Recently, researchers have called for more research that captures the complex and dynamic nature of the use of interpersonal and intrapersonal emotion regulation and how it evolves over time in interpersonal relationships (Niven, 2017; Grandey & Melloy, 2017).

This thesis seeks to provide a more complete picture of emotion regulation processes in social interaction at work by using qualitative methods to understand how therapists and patients use emotion regulation during therapeutic relationships.

Research on emotion regulation in social interaction at work is particularly needed in the healthcare industry as there are many challenges that make emotion regulation difficult for healthcare professionals. Emotional labour is an essential part of healthcare professionals’ job (Bolton, 2000) however, it tends to be undervalued in healthcare organisational contexts (Riley & Weiss, 2016). This is compounded by the fact that there is a need to increase training for healthcare professionals to help them effectively regulate their own and other’s emotions at work (Riley & Weiss, 2016). Also, the healthcare industry’s fast-paced changing landscape, competition, and increasing time and resource pressures widens the gap between what healthcare professionals should do and what they actually do (Watson, 2009). For example, due to time pressures, therapists may spend less time getting to know their patients, even though they know this is required to build therapeutic relationships. It is within this challenging and dynamic context that this thesis presented.

This introductory chapter begins by providing a broad overview of key concepts, theories, and knowledge gaps in research on emotion regulation at work and therapeutic relationships.
This is followed by a brief description of the research design, including the research questions, the rationale, and the research setting. Lastly, the content and structure of the thesis outlined.

1.1 Key Concepts, Theories and Knowledge Gaps: Therapeutic Relationships

This thesis draws on theories and concepts from research on interpersonal relationships, service relationships, and therapeutic relationships. Theories of interpersonal relationships can be understood as relevant to all types of relationships. Service relationships are a type of interpersonal relationship specifically between an employee and a customer/patient. Therapeutic relationships are a sub-category of service relationships specifically between healthcare professionals and patients, where the purpose of the relationship is for the professional to utilise their knowledge and skills to help the patient. Research on interpersonal and service relationships has been integrated to enable the discussion on therapeutic relationships to benefit from conceptual and methodological gains from each respective discipline.

In particular, the idea that emotions play an important role in relationship development and maintenance is borrowed from research on interpersonal and service relationships. The importance of emotion is a common thread amongst theories on interpersonal relationship development including social exchange theory (Hinde, 1979), stage theories of relationship development (Planalp, 2003) and emotions-in-relationships model (ERM) (Berscheid, 1983). Similarly, emotion is considered a central element in service relationships (Oliver, 1997). Emotions can naturally arise from social interactions between employees and customers. Even mundane, brief service encounters may generate affective responses that can influence customer’s evaluations of service (Mattila & Enz, 2002).

Although the importance of emotions in therapeutic relationships is acknowledged (Gard, 2004; Nicholls, 2013; Taylor, 2008), research on therapeutic relationships has mostly overlooked the influence of emotion regulation on relationship development and maintenance, particularly in the context of occupational therapy and physiotherapy. This omission is problematic because if emotions are essential in understanding relationship dynamics, emotion regulation is likely to be vital in understanding therapeutic relationship dynamics.
Another concept borrowed from interpersonal relationship research are turning points. Turning points refer to points in time that dyadic partners perceive as noteworthy moments in their partnership. These points can be subtle or very significant and alter the relationship either negatively or positively (Huston, Surra, Fitzgerald & Cate, 1981). Examples of turning points in therapeutic relationships may be a disagreement between a patient and therapist or a patient regaining the ability to walk with the help of his therapist. These happenings may change the way both dyadic partners view each other and their relationship. Turning point analysis is a method that is commonly used in interpersonal relationship research to understand how relationships develop over time.

In research on therapeutic relationships, researchers often attempt to understand how therapeutic relationships develop by examining one encounter during the relationship, rather than the many encounters that happen throughout the duration of the therapeutic relationship. For this reason, it is not surprising that little is known empirically about how therapeutic relationships develop (de Roten et al, 2004) and what therapists can do, if anything, to improve the quality of their relationships (Gelso & Silberberg, 2016). These are key research questions because therapeutic relationships have an important impact on clinical outcomes (Hall et al, 2010; Martin, Garske & Davis, 2000; Klein et al, 2003; Zuroff & Blatt, 2006) and patient satisfaction (Beattie et al, 2002). The importance of the therapeutic relationship is widely recognised across healthcare professions including nursing (Peplau, 1997), physiotherapists (Hall et al, 2010), physicians (Mack et al, 2009), and psychotherapists (Gaston, 1990; Bordin, 1979). In occupational therapy, a therapist’s ability to develop therapeutic relationships with patients is considered an essential component in the therapeutic process (Kielhofner, 2002; Wright-St Clair 2001; Hinojosa, Sproat, Mankhetwit & Andersen, 2002; Palmadottir, 2006; Cole & McLean, 2003).

1.2 Key Concepts, Theories and Knowledge Gaps: Emotion Regulation

Emotion regulation is the goal-directed process of regulating the occurrence, magnitude, or duration of emotional responses (Gross, Sheppes & Urry, 2011). The regulation of one’s own emotional responses is called intrinsic or intrapersonal emotion regulation. The regulation of other’s emotions is called extrinsic or interpersonal emotion regulation (Gross, 2015). While intrapersonal and interpersonal emotion regulation strategies are distinct categories, they are interrelated (Kappas, 2013) because they are often used simultaneously,
are both influenced by intrapersonal and interpersonal processes (Kappas, 2013), and both influence interpersonal and intrapersonal outcomes (Little, Kluemper, Nelson, & Gooty, 2012). For example, using interpersonal emotion regulation strategies to improve or worsen a target’s emotions, has a similar effect on the agent’s emotions (Niven, Totterdell, Holman & Headley, 2012).

This thesis uses the process model of emotion regulation (Gross, 1998) as an organising framework throughout. This model specifies the sequence of steps involved in the emotion generation cycle and the type of emotion regulation strategies that may be used at each step in the cycle to influence one’s own experience or expression of emotion (Gross, 1998). The model proposes five families of emotion regulation strategies distinguished by the point in the emotion-generative process at which they have their primary impact. Antecedent-focused strategies primarily occur prior to the experience of an emotion. Response-focused strategies typically occur after the experience of an emotion. The model identifies four antecedent-focused strategies; situation selection, situation modification, cognitive reappraisal, and attention deployment. One response-focused strategy was identified, response modulation. Situation selection refers to choosing to engage in or avoid situations based on their anticipated emotional consequences. Situation modification strategies are used to alter the situation to promote the desired emotions. Cognitive reappraisal strategies are used to modify how one understands a situation in order to promote desired emotions. Attention deployment strategies are those used to redirect one’s attention to influence their emotions. Response modulation strategies are efforts focused on influencing the experiential, behavioural, or physiological components of an emotional response (Gross, 1998).

Williams (2007) used Gross’s (1998) process model of emotion regulation as a basis upon which to categorise interpersonal emotion regulation strategies. Williams (2007) proposed four categories of interpersonal emotion regulation strategies; altering the situation, altering attention, altering the cognitive meaning of a situation and modulating the emotional response. Altering the situation involves modifying or changing the situation to influence the emotional impact on the target. Altering attention are strategies used to divert the targets attention to influence their emotions. Modulating the emotional response involves actions used to alter the targets current experience or expression of emotion. Altering the cognitive meaning of a situation are strategies used to help the target think about an issue differently to alter the emotional impact.
There are many theories that explain how people can influence other people’s emotions including the communicative theory of emotions (Oatley & Johnson-Laird 1996), EASI (emotions as social information) model (Van Kleef, 2008), emotion script theory (Gibson, 2008), and emotions cycles (Hareli & Rafaeli, 2008). Taken together, these theories explain that people communicate their thoughts, feelings, and intentions through their emotional displays and behaviours. Since the effect of these displays/behaviours can be predictable, people can use their emotional displays strategically for goal directed purpose.

This research draws on literature from emotion regulation in the context of everyday life, emotional labour, and occupation-based emotion regulation. Research on intrapersonal emotion regulation at work has mostly focused on which intrapersonal emotion regulation strategies, from Gross’s (1998) process model of emotion regulation or Hochschild’s (1983) emotional labour strategies, do people use and what are the differential effects of these strategies on various associated outcomes, including employee health and wellbeing (e.g., Holman, Martinez-Inigo & Totterdell, 2008), customer satisfaction (e.g., Hulsheger & Schewe, 2011), and sales performance (e.g., Christoforou & Ashforth, 2015). The association between the use of intrapersonal emotion regulation strategies and associated outcomes is moderated by a number of factors, including emotional climate (Grandey, Foo, Groth & Goodwin, 2012), emotional intelligence (Prentice, 2013), and customer response (Zhan, Wang & Shi, 2016). Research has also identified affective events and display rules as important antecedents to emotion regulation used at work (Diefendorff, Richard & Yang, 2008).

While research on interpersonal emotion regulation is in its infancy compared to research on intrapersonal emotion regulation, the general focus of research has been similar. Researchers have sought to understand what interpersonal emotion regulation strategies people use and why they use these strategies. People use a wide range of interpersonal emotion regulation strategies to make the target feel worst or better depending on the expected outcome of such actions (Netzer, VanKleef & Tamir, 2015). Regarding outcomes, researchers have found that use of interpersonal emotion regulation strategies to improve or worsen a target’s affect has a similar effect on the agent (Niven, Totterdell, Holman & Headley, 2012). In organisational settings, researchers have concluded that a leader’s ability to make others feel positive emotions has a positive impact on innovation and the communication of creative ideas in teams (Madrid, Totterdell & Niven, 2016; Madrid, Totterdell, Niven & Barros, 2016).
While research on intrapersonal and interpersonal emotion regulation has been growing exponentially in recent years, there are some important gaps in the literature that need to be addressed. Many of these studies are limited in terms of the type of emotion regulation strategies being investigated, mostly considering the regulation of negative emotions to the exclusion of positive emotions and mainly only considering interpersonal or intrapersonal emotion regulation strategies, rather than the range of naturally occurring strategies used in response to affective events. In addition, there are few studies that consider the emotion regulation contribution of both dyadic partners or how emotion regulation strategies develop over time. Key research questions raised by these gaps in the literature include; What emotion regulation strategies are used in response to specific affective events at work and how are these strategies implemented in a context specific way? How does the use of emotion regulation strategies evolve over time in interpersonal relationships at work?

Addressing these knowledge gaps will lead to a more nuanced understanding of how and why people use emotion regulation at work. Improving our understanding is important because emotions play an important role in determining and helping people understand relationship dynamics (Reis, Collins & Berscheild, 2000). Relationships at work, particularly in the healthcare context, have an important impact on employee, customer/patient, and organisational outcomes (e.g., Hall et al, 2010; Hochschild, 1983; Hulsheger, Lang, Schewe & Zijlstra, 2015). For this reason, understanding how people utilise emotion regulation at work can lead to a better understanding of how they can use these strategies to the benefit of themselves, the organisation, and stakeholders.

1.3 Research Design, Questions, and Rationale

To address the above-mentioned knowledge gaps, this study aims to answer the following research questions:

- How do therapists and patients use emotion regulation strategies during the therapeutic relationship?
- What turning points characterise high and low-quality therapeutic relationships?
- How do emotion regulation strategies develop during the therapeutic relationship?

Answering these research questions is important to help develop a more nuanced understanding of how therapists use emotion regulation at work and how dyadic emotion
regulation contributes to developing therapeutic relationships. These research questions are also important because there is a lack of studies on emotion regulation in occupational therapy and physiotherapy.

These research questions are answered using qualitative methods in two studies. In the first study, semi-structured interviews with occupational therapists, physiotherapists, and patients receiving occupational therapy or physiotherapy services were used to understand their experience and perception of emotion regulation during their therapeutic relationships. In the second study, patient/therapist dyads were observed during their interactions throughout the therapeutic relationship and then a participant verification interview was conducted to further my understanding of their use of emotion regulation during therapeutic relationships. Several methods were used to ensure the trustworthiness of the study as recommended by Guba and Lincoln (1994), including participant verification strategies, member checking, and methodological triangulation.

This research contributes to the current knowledge base in the broad areas of emotion regulation, emotional labour, interpersonal relationships, service relationships, and therapeutic relationships. This study is unique because of its longitudinal design, access to patient/therapist interactions over the duration of their relationship and ability to capture both dyadic partners’ perceptions of emotion regulation in context. It is also unique because it considers interpersonal and intrapersonal emotion regulation strategies used in response to positive and negative emotions stemming from relationship turning points. In addition, a conceptual model that illustrates factors that influence the dynamic nature of interpersonal emotion regulation use in therapeutic relationships is presented. This represents an important theoretical contribution to the knowledge base on emotion regulation and can be used as a basis for further studies. Since emotion regulation is an important part of service employees’ work, particularly in the healthcare sector, developing a better understanding of what healthcare workers do and how they develop relationships is a step in the direction of understanding how they can improve their services. For example, the conclusions regarding patients’ and therapists’ perceptions of common turning points can be used in universities’ and employers’ training programs to help students and therapists learn how to successfully deal with these situations. If healthcare professionals are able utilise emotion regulation at work more effectively, this can have a positive impact on their own and their patients’ health and wellbeing. This will in turn have a positive impact on the organisation.
1.4 Micro and Macro Environment

Micro and macro environmental factors have an important impact on how people in an organisation function and the quality of their services (Bate, 2014). The micro environment includes intra-organisational factors such as organisational and divisional culture, group norms, interaction norms, and political processes (Bate, 2014). The micro environment differs for each organisation. Features of the micro environment that are particularly relevant to this research include the emotional climate and the emotional capability of the organisation. The emotional climate of an organization refers to how members of the organization perceive the emotions of the majority of its members (Yurtsever & de Rivera, 2010). The emotional capability of an organisation is its ability to recognise, acknowledge, monitor, discriminate, and attend to its members emotions through organisational norms and routines (Schein, cited in Huy, 1999).

The macro environment includes extra-organisational factors such as the broader economic and social context, demographics, changes in patients’ expectations, and political trends (Bate, 2014). Features of the macro environment that are particularly relevant to this research are the professionals’ roles and current healthcare policy. The role of occupational therapists and physiotherapists is to work with patients to help rehabilitate them after illness or injury. Occupational therapists help patients learn or relearn activities of daily living, such as bathing one’s self, driving, and home maintenance. Physiotherapists help patients mobilise, regain functional movement, and build physical strength. There is considerable overlap in the functional role of occupational therapists and physiotherapists. In fact, in the specialty of hand therapy occupational therapists and physiotherapists do the exact same job.

Occupational therapists and physiotherapists may work with clients for time durations that span one treatment session or many treatment sessions over several months. Treatment may take place in the client’s home or in the clinic. They work with patients with a wide range of diagnoses, including stroke, multiple sclerosis, carpel tunnel syndrome, and hip fractures.

The type of treatment used is dependent on the patient’s diagnosis, but the rehabilitation process is similar across cases. Treatment begins with an assessment of functional strengths and weaknesses. Client centred goals are developed to address functional deficits and optimise functional strengths. These goals steer treatment planning and implementation. The
patient is discharged from therapy services when the patient reaches his or her maximum level of functional potential. At the end of treatment, the patient's progress is evaluated.

In hand therapy, therapists work in the clinic. The patients are typically able-bodied except for their hand injury. Common diagnosis seen in hand therapy clinics are finger fractures, Dupuytren’s contracture, carpal tunnel syndrome, and arthritis in the hand. Treatments include scar reduction strategies, like using vibration or ultrasound, custom splint design, and home exercise programs. In this speciality, more than others, patients are expected to take responsibility for their rehabilitation. They learn exercises and positioning strategies in therapy and are expected to regularly practice or utilise these strategies at home.

Occupational therapists’ and physiotherapists’ role differs from other healthcare professions. Doctors, paramedics and nurses are focused on ensuring patients’ medical stability. Care assistants are focused on assisting clients with daily tasks. In contrast, the main emphasis for occupational therapists and physiotherapists is facilitating independence and an optimal level of functional abilities.

The nature of interaction between patients and therapists is focused around the reason for therapy and the role of the patient and therapist. The therapist’s role is to help rehabilitate the patient, and the patient’s role is to participate in the rehabilitation process. Ideally, interaction is like a partnership in that the expertise of both parties is utilised and respected. The therapist’s expertise is in the treatment of the illness or injury, and the patient’s expertise is in the experience of the illness or injury. A recent meta-analysis on the factors that influence therapist/patient interactions concluded that the main influential factors are the therapist’s communication and interpersonal skills, the therapist’s practical skills, patient-centred care, and organisational/environmental factors (O’Keeffe et al, 2016).

The context of occupational therapy and physiotherapy is ideal for the study of emotion regulation because it is a high-contact professional service, where emotions play an important role (Jayanti, 1996). Therapists often must negotiate emotionally intense situations when working with patients, such as helping a patient adjust to the loss of the ability to walk or see. In these situations, therapists must regulate their own and their patients’ emotions to do their jobs effectively. Despite the importance of emotion regulation in this context, there is a lack of research on emotion regulation that is specific to these professional groups. Research is needed to understand how occupational therapists and physiotherapists use and experience emotion regulation in their interactions with patients at work.
Research in this area is also needed given the challenges presented by the current health policy context in the United Kingdom. A prominent feature of the current health policy context is its simultaneous focus on cost containment and quality improvement. The National Health Service (NHS), one of the largest employers of therapists in the United Kingdom, is struggling to deal with the increasing needs of the population due to limited resources (NHS, 2014). Within the NHS there is a gap between funding and anticipated costs, which is estimated at around £22 billion by 2020. At the same time the NHS has set the target of delivering 2 to 3 percent productivity improvements, which is more than double the long-run average (Williams, Brown & Healy, 2016). To meet these targets, the NHS proposes a value-based health agenda that pushes for maximising health outcomes while minimising expenditure (Bromley & McIntosh, 2016). This plan sets out new priorities and models of care including strategies to get patients out of hospital beds and back to their homes quicker (Kings Fund, 2015), focusing on prevention rather than cure, and streamlining the service which in some cases leads to professionals’ roles expanding (NHS, 2014).

These cost containment strategies combined with pressures to improve the quality of services present a challenge for therapists regarding the amount of time they have to building a relationship with their patients. Getting to know their patients and providing client centred treatment is needed to provide high-quality services but can be time consuming. The pressure to work in more time efficient ways may compel therapists to minimise the time that they spend building rapport with patients. Research that leads to an increased understanding of how therapists can regulate emotions during interactions with patients can lead to a better understanding of how therapists can best utilise the limited time that they have for building positive therapeutic relationships with patients.

1.5 Overview of Thesis Content and Structure

Chapter 1 is the introduction to the thesis. It provides an overview of the main concepts, research objectives, and methods used in this research. Chapter 2 provides a literature review on therapeutic relationships. This chapter begins with a review of the most general type of relationship research, interpersonal relationships. Next research on service relationships, a type of interpersonal relationship that occurs in organisational settings, is reviewed. Lastly, research on the specific type of service relationship that is the focus of this study, therapeutic relationships, is discussed. This chapter is presented in this hierarchical fashion to fully integrate and draw links between the three research areas. For each type of relationship,
research is reviewed on how these different types of relationships are conceptualised, how quality is understood, and how these relationships develop.

In Chapter 3, the literature review integrates research from emotional labour, emotion regulation in the everyday context, and emotion regulation within the healthcare context. This section starts by describing the emotion regulation process. Next prominent frameworks used to categorise intrapersonal and interpersonal emotion regulation strategies and the relationship between these two types of strategies are discussed. The effectiveness of emotion regulation strategies and factors that influence the effectiveness of these strategies is also discussed. This leads to a discussion on why people use emotion regulation strategies in the everyday context and in the organisational context. To conclude, gaps in the literature are identified and the research questions that will be addressed in this study are listed.

Chapter 4 describes the methods used to answer the research questions. The research consists of two studies. The methods used in the first study are discussed in its entirety before discussing the second study. For each study, the research methods and rationales are described. Details on the data collection tools used, the research process, and the emergent design of the study are described. Specifics regarding the participants, recruitment strategies, and challenges associated with the research are highlighted. After that, the data analysis strategies are described and justified. This leads to a discussion on the limitations of each study. This chapter ends with a discussion on my reflexivity, the context in which the research is conducted, and ethical considerations.

Chapter 5 and 6 outline the findings of the research questions and discuss these findings within the context of the wider knowledge base. Chapter 5 focuses on what emotion regulation strategies therapists and patients use and how they use them. Chapter 6 focuses on the turning points within therapeutic relationships and how the use of emotion regulation develops over time in therapeutic relationships. Chapter 7 concludes the thesis by summarising the key themes that emerged throughout the study, including presenting a model of factors that influence the dynamic nature of interpersonal emotion regulation use in therapeutic relationships. Theoretical and methodological contributions are highlighted as well as practical implications, the trustworthiness and limitations of the study.
Chapter 2 Therapeutic Relationships

The therapeutic relationship refers to the interpersonal relationship between the healthcare professional and patient (Peplau, 1997). The importance of the therapeutic relationship is widely recognised across healthcare professions (e.g., nurses - Peplau, 1997; physicians - Weeger & Farin, 2017; psychotherapists - Martin et al, 2000). Specifically, in the context of occupational therapy, researchers associate therapeutic success with the quality of the therapeutic relationship (Taylor, Lee, Kielhofner & Ketkar, 2009; Weiste, 2018). In physiotherapy, therapeutic relationships have been found to have a significant impact on measures of healthcare quality including clinical outcomes (Ferreira et al, 2013; Hall et al, 2010; Fuentes et al, 2014) and patient satisfaction (Beattie et al, 2002). Despite the importance of therapeutic relationships, there are a few significant gaps in the knowledge base on this topic. The purpose of this chapter is to review the relevant literature on this topic and identify these gaps.

A starting point to understanding therapeutic relationships is exploring the broader categories of relationships that encompass therapeutic relationships. Interpersonal relationships are the most rudimentary type of relationship between two people. Service relationships are a type of interpersonal relationship between an employee and a customer. Therapeutic relationships are a type of service relationship between a particular type of employee, healthcare professionals, and a particular type of customer, patients. Integrating research on both these types of relationships provides a full understanding of the current knowledge base on therapeutic relationships.

For this reason, this chapter will begin with a review of the literature on interpersonal relationships and service relationships prior to reviewing the literature on therapeutic relationships. The topics that will be explored regarding each type of relationship includes how each type of relationship is conceptualised and what are the important component parts or characteristics. In addition, how people understand the quality of these relationships and what is known about how they develop will also be explored. Since emotions are an important part of social interaction (Zajonc, 1998), a particular focus is given to the role of emotion in each type of relationship.

This chapter concludes with a discussion on how the literature on interpersonal and service relationships can inform how we can understand therapeutic relationships. This leads to the identification of two important gaps in the literature. Firstly, we do not have a complete
understanding of how therapeutic relationships develop (de Roten et al, 2004). Secondly, even though emotions are an important component in relationships that influence the trajectory of relationships and how we understand them (Planalp, 1999; Lawler & Thye, 1999), researchers have not explored therapeutic relationship development using emotion-based mechanisms.

2.1 Interpersonal Relationship

The conceptualisation of the relationship construct, like many social phenomenon, is problematic because it is subjectively as opposed to objectively experienced and understood. This problem is compounded by inconsistencies in relationship science researchers’ use of terminology, theoretical orientations, and levels of analysis (Kelley, 2000). Despite these problems, many researchers agree that the core and defining feature of relationships is interaction (Kelley, 2000).

Hinde (1979) defined relationships as a sequence of interactions between two people that involves some degree of mutuality and continuity. Mutuality means that the behaviour of one member takes some account of the behaviour of the other. Continuity means that previous interactions affect future interactions. These interactions involve both partners behavioural contribution and this behaviour is typically meaningful to the other dyadic partner. The duration of the interaction and the number of interactions required to constitute a relationship vary depending on the context (Hinde, 1979). Interpersonal relationships take place in a social context and cannot be understood without reference to that context. They are essentially dynamic in that the status of the relationship changes with each interaction. The trajectory of interpersonal relationships is influenced by factors inside and outside of the relationship (Hinde, 1979).

There are two superordinate categories of relationship types; personal relationships, such as relationships between friends or family members, and formal relationships, such as the relationships between co-workers or cashiers and customers. These two broad categories of relationships differ regarding the constraints on the content of the relationship. In formal relationships much of the behaviour during interactions is constrained by the norms and expectations of the dyadic partner’s position or roles in society (Hinde, 1979). For example, the behaviour of a cashier when interacting with a customer may be limited by organisational norms and there may be repercussions for behaviours that fall outside of those norms. Similarly, even the customer’s behaviours may be limited by societal norms. In contrast, in
personal relationships the interaction is not usually constrained as much by dyadic partner’s societal roles but more by their knowledge of each other (Hinde, 1979).

A recent study by Finkel and colleagues (2017) identified four principles that characterise the nature of relationships based on common themes from relationship science theories. Firstly, the partners are dependent on one another to facilitate the pursuit of their goals and needs. Secondly, the relationship outcomes depend on the specific qualities of each partner and the unique patterns that emerge when the partners’ qualities intersect. Thirdly, opportunities and motivations for interdependence tend to facilitate cognitive, affective, motivational, and behavioural merging between partners. Lastly, the trajectory of relationship dynamics is determined by each partner’s updated perceptions of their relationship-relevant interactions (Finkel, Simpson & Eastwick, 2017).

2.1.1 Quality in Interpersonal Relationships

Interpersonal relationship quality can be understood by the extent to which relationships have certain attributes. Attributes such as trust, satisfaction, commitment, intimacy, and love are commonly used to measure relationship quality in empirical and theoretical research (Fletcher, Simpson & Thomas, 2000). Relationships that rate high on these attributes can be considered high-quality relationships. Conversely, relationships that rate low on these attributes can be considered low-quality relationships.

There are many theories that explain how quality can be understood in interpersonal relationships. An example of one such theory is social exchange theory. According to social exchange theory, people base their assessment of the quality of their relationship on subjective cost/benefit analysis of being in the relationship compared to alternative relationships (Hinde, 1979). The benefits associated with being in a relationship are the positive aspects of relational association. Examples of benefits in close relationships can be anything from love and intimacy to financial security. The costs refer to the negative aspects associated with being in relationships. Examples of costs can be stress, increased responsibility, and lack of freedom (Hinde, 1979). Relationships where the benefits outweigh the cost may be considered high-quality relationships, whereas relationships where the costs outweigh the benefits may be considered low-quality relationships.

Finkel and colleagues (2017) summarised the common themes from theories in relationship science on the characteristics of high and low relationship quality. Responsiveness is one such characteristic. It refers to the extent to which dyadic partners are sensitive to and
supportive of each other’s needs. When people think their partner is responsive to their needs, this is an indication of a higher quality relationship. Conversely, when people think their partner has apathetic or destructive responses to their needs, this is an indication of lower quality relationships. The way dyadic partners deal with conflict is also an indication of relationship quality. For example, if transgressors make strong amends and victims forgive wholeheartedly, this is an indication of a higher quality relationship. Conversely, if transgressors deny their wrong doing and victims ruminate on the problem, this is an indication of lower quality relationships. Lastly, higher quality relationships are those where partners behaviours are orientated to maintain the relationship even at the expense of their immediate self-interests. However, in relationships where one or both partners put their own needs before their partner’s needs, it is more likely to be perceived as a lower quality relationship (Finkel, Simpson & Eastwick, 2017).

Emotions and emotion regulation plays an important role in how people evaluate the quality of their relationships. For example, love is an emotion that is measured as an indication of quality in relationships (Fehr, Harasymchuk & Sprecher, 2014). Making one’s dyadic partner feel good and know that they are cared for, which may require interpersonal and intrapersonal emotion regulation, are characteristics of high-quality relationships.

2.1.2 Interpersonal Relationship Development

Three of the most prominent theories or families of theories on relationship development are social exchange theory, stage theories and dialectical theory (Planalp, 2003). Social exchange theory, which postulates that relationship quality can be understood in terms of the costs and benefits associated with being in the relationship, was previously discussed. These perceived costs and benefits over time can also be used to explain how relationships develop. Relationship development occurs in situations where the actions of one person provides benefits for the other person and vice versa. Recurrent interactions bring new types of exchange that produce further benefits for both parties. In contrast, relationship break down occurs when recurrent interactions produce punishments or costs rather than benefits (Homans, 1979).

Stage theories of relationship development focuses on the stages, the rules concerning movement through the stages, and how interpersonal interaction differs at each stage
Social penetration theory (Altman & Taylor, 1973) is one prevalent stage theory that explains relationship development. According to social penetration theory, relationship development is characterised by changes in interpersonal communication moving from shallow and superficial communication to deep and intimate communication (Altman & Taylor, 1973). This means that initially, when a relationship is young, the communication may focus on superficial topics like the weather or activities that one participated in over the weekend. However, when a relationship matures communication may focus on more personal topics like political and religious convictions. This communication may include verbal, nonverbal and environmentally oriented behaviours (e.g., access to special possessions or places) (Altman & Taylor, 1973).

The level of intimacy in self-disclosure is a key concept in this theory because self-disclosure leads to getting to know a dyadic partner and results in relationship closeness in the same way that peeling back the layers of an onion reveals the core. As the information is disclosed, the layers of the onion are peeled back to reveal the core, and this signifies relationship development (Altman & Taylor, 1973). In contrast, relationship dissolution occurs in the opposite fashion where self-disclosure becomes progressively less intimate (Mongeau & Henningsen, 2008).

Social penetration theory describes four increasingly intimate levels of self-disclosure. The surface layer is the most superficial where self-disclosure contains information that can be learned by just looking at a person. The next layer, the peripheral layer, includes information that one would share in just about any social circumstances, like hometown or university major. This layer is followed by the intermediate layer which includes information one would share infrequently but does not feel the need to hide. The most intimate layer is the central layer where information is extremely private and is disclosed only when the relationship is very close (Altman & Taylor, 1973).

Using these layers of self-disclosure, Altman and Taylor (1973) define four relationship development stages. The orientation stage takes place during the initial interaction between strangers when only surface and peripheral information is exchanged. In the next stage, the exploratory stage, the level of intimacy in self-disclosure mainly includes peripheral level and some elements of intermediate level information. The affective stage is where self-disclosure includes information at the intermediate level and some guarded information at the central
level. It is only at the most intimate stage called the stable stage, where most central level information is given freely (Altman & Taylor, 1973).

Finally, dialectical theory seeks to explain relationship development by conceptualising change within relationships (Montgomery & Baxter, 1998). This theory defines change as stability or instability within the relationship. Change is constant and is created by the interplay between conflict and resolution within relationships. In contrast to stage theories, dialectical theory proposes that relationship change is not linear, but rather multi-directional in a sense that it is characterised by back-and-forth motions embedded within the broader directional development (Montgomery & Baxter, 1998). These changes have multiple meanings and cannot be understood in isolation from other changes within the relationship. For example, a change in a therapeutic relationship may be triggered by a disagreement between the therapist and patient. The meaning of this change is dependent on whether the conflict was resolved and the wider context of the ongoing relationship.

The importance of emotion in relationships is a common thread in theories on relationship development and dynamics. For example, social exchange theory explains that relationship development is dependent on the outcome of individual’s analysis of the costs and benefits of the relationship. Social exchange theorists recognise some of these costs and benefits are related to emotions (Lawler & Thye, 1999). For example, a benefit of being in a relationship may be that the dyadic partners make each other happy. In addition, stage theories posit that relationships develop through a series of stages and emotional dynamics are one of the driving forces that move relationships from one stage to another (Mongeau & Henningsen, 2008). For example, in social penetration theory, a prominent stage theory, the increasing intimacy of emotional disclosure may be a driving force behind relationship development.

These theories, however, have been criticised for not appreciating the full extent of the role of emotions in relationship development and maintenance (Lawler & Thye, 1999; Planalp, 2003). Emotions play a central role in relationships as they affect the context, process, and outcomes of social exchange (Lawler & Thye, 1999). Moreover, emotions give meaning to social interaction and help one understand information arising from that social interaction (Planalp, 1999). Since emotions affect people’s behaviour in relationships (Van Kleef, 2008), emotions play an important role in explaining relationship dynamics (Reis, Collins & Berscheid, 2000).
A theory that emphasises the role of emotions in interpersonal relationship development is the emotions-in-relationships model (Berscheid, 1983). The basic premise behind this theoretical model is people construct plans, called action sequences, for how to accomplish their goals. People feel negative emotions when others interfere with their ability to achieve their goals and positive emotions when others facilitate their ability to achieve their goals. Relationships form as individuals integrate their action sequences over time. The quality of the relationship is determined by the perceived amount of interference and facilitation each person experiences.

An established research method used, particularly in relationship science studies, to understand how interpersonal relationships develop and change is called turning point analysis (e.g., Kellas et al, 2008; Dailey, Brody, LeFebvre & Crook, 2013; Baxter, Braithwaite & Nicholson, 1999). Turning points are the most significant events that influence the trajectory of a relationship from the dyadic partners’ point of view (Baxter & Bullis, 1986). Turning points cause actions, reactions, emotions, and thoughts that affect each dyadic partner’s ongoing perception of the relationship. In this way, these events constitute the dynamics of interaction within relationships (Kelley, 2002).

Research on interpersonal relationships can inform the way therapeutic relationships are understood and investigated. Given the important role that emotions play in interpersonal relationship development and maintenance, it would logically follow that emotions also play an important role in therapeutic relationship development and maintenance. Also, turning point analysis may be a useful method to use to understand therapeutic relationship dynamics. The next section will explore conceptualisations of service relationships to provide a broader context for understanding therapeutic relationships, a specific type of service relationship.

2.2 Service Relationships

Relationships at work are a sub-phenomenon of interpersonal relationships (Becker, 1960). Work relationships refer to patterns of exchanges between interacting dyadic partners at the individual, group, or organisational level (Ferris et al, 2009). There are many types of relationships at work, some within the organisation, such as leader-member or mentor-mentee, and some include people outside the organisation, such as patient-therapist or customer-cashier. This research focuses on relationships that employees have with
individuals outside of the organisation. These relationships are typically called service relationships. Gutek and colleagues (1999) defined service relationships as one where the customer has repeated interactions with the same employee.

Service relationships share many of the same qualities as interpersonal relationships. Both can be highly complex, multidimensional, context dependent, dynamic, and emotionally charged. They can also have similar trajectories since service relationships can merge into interpersonal relationships (Price & Arnould, 1999). The main difference between service relationships and interpersonal relationships is the organisational context (Ferris et al, 2009) and the fact that service interactions, unlike interpersonal relationships, are, at least initially, specifically structured around the service (Coulter & Ligas, 2004). Similar to interpersonal relationships, in service relationships each dyadic partner has a specific role and associated expectations and obligations. However, unlike interpersonal relationships, that role is defined by the nature of the job for the employee and by the purpose of the exchange for the customer (Coulter & Ligas, 2004).

Gutek and colleagues (1999) distinguished service relationships from service encounters and pseudorelationships. A service encounter is when the customer interacts with a different employee each time. A pseudorelationship is when a customer interacts with a different employee each time but within a single company. In this case the customer becomes familiar with the service of the provider, rather than the individual, and in this way gets some of the familiarity of a service relationship (Gutek, Bhappu, Liao-Troth & Cherry, 1999)

Service relationships differ from encounters and pseudorelationships in a few ways (Gutek et al, 2000). In service relationships, unlike encounters or pseudorelationships, through repeated transactional interactions, customers and employees can get to know each other, first as role occupants and potentially over time as acquaintances or friends (Gutek, Bhappu, Liao-Troth & Cherry, 1999). As a result, unlike encounters and pseudorelationships, service relationships are characterised by high levels of trust, emotional attachment and friendship (Coulter & Ligas, 2004; Gutek, Bhappu, Liao-Troth & Cherry, 1999; Gutek et al, 2000). In addition, service relationships are associated with high levels of customer loyalty, word of mouth referrals (Bendapudi & Berry, 1997), customer satisfaction, and higher usage rates (Gutek, Bhappu, Liao-Troth & Cherry, 1999; Gutek et al, 2000).

Another important difference between service relationships and encounters / pseudorelationships is service relationships are typically more personalised (Gutek, Bhappu,
Liao-Troth & Cherry, 1999). Personalised services are customised to each individual client and involve a high degree of employee discretion and personal contact (Wang & Groth, 2014). The services that patients receive from therapists are an example of a highly personalised service model. In contrast, service encounters and pseudorelationships are more standardised, meaning that they emphasize speed, cost, efficiency, and reliability of services over customisation and employee discretion (Bowen, 1990). An example of this service model is McDonald’s restaurants since they provide a standard, quick service, with no expectation of personalised relationships between customers and workers (Leidner, 2003).

While Gutek and colleagues (1999) description of service relationships is helpful in understanding it as a model of service, it stops short of describing the social aspects of the relationship between customers and employees. In fact, the only component of their conceptualisation of service relationships that corresponds with conceptualisations of interpersonal relationships is the emphasis on repeated or prolonged interaction as a prerequisite to relationship formation. This is problematic because service relationships take place in a social context, so the social aspects of the relationship should not be ignored (Herington, Johnson & Scott, 2009). In response to this gap in the literature, researchers have attempted to understand the social aspects of the interpersonal relationship between employees and customers using concepts borrowed from interpersonal relationship literature.

For example, Coulter and Ligas (2000) identified and described four types of service relationships: professional relationships, casual acquaintances, personal acquaintances, and friendships. These relationship types differ based on the customer’s emotional attachment to the employee, their tendency to seeking personal advice from the employee, and their tendency to socialise with the employee (Coulter & Ligas, 2004). According to Coulter and Ligas (2000), professional relationships are instrumental in nature and there is no personal attachment. A casual acquaintance relationship is mostly instrumental, but the parties are beginning to divulge personal information and form an emotional attachment. In a personal acquaintance relationship, the dyadic partners begin to learn more about each other and their emotional attachment and the intimacy of their socialisation deepens. The last type of service relationship is friendship, which is characterised by strong emotional and social bonds and a strong tendency to socialise outside of the service encounter.

Researchers have also sought to understand service relationships by identifying key interpersonal relationship components. Dalziel, Harris, and Laing (2011) conducted a
literature review of the key characteristics of service relationships and then proposed a relationship typology based on these key characteristics. They identified four key characteristics that are prevalent in relationship marketing literature: trust, relationship commitment, relationship benefits, and buyer-seller bonds. Trust is a multidimensional construct that includes elements, such as competence, integrity, benevolence, and predictability. Relationship commitment is the conscious intention of parties to maintain a relationship. Relationship benefits are the perceived incentives that customers have to maintain the relationship (Dalziel, Harris, & Laing, 2011). Buyer-seller bonds are defined as exit barriers that maintain the relationship (Storbacka, Strandvik & Gronroos, 1994).

Interestingly, although emotion was an underlying element, it was not considered a key component in service relationships according to the study by Dalziel, Harris, and Laing, (2011). This is surprising because the importance of emotion in interpersonal relationships is uncontested, albeit at times under-emphasised (Planalp, 2003), and researchers consider emotion to be a central element in service relationships (Oliver, 1997; Ashforth, Tomiuk & Kulik, 2008). Also, the emotion that arises during customer encounters influences customer perceptions of the service and overall satisfaction (Mattila & Enz, 2002).

This diminished level of importance that researchers ascribe to the role of emotions in service relationships may be due to the fact that service relationships can have differing levels of the key relationship components (Dalziel, Harris, & Laing, 2011). For example, a customer’s relationship with a hair dresser may require more trust than the same customer’s relationship with a dry cleaner. Also, studies on this topic take place in contexts with different service models, and different service models facilitate differing levels of emotional attachment within service relationships (Gutek et al, 2000). In high-contact professional services, such as medical services, emotions play an important role in service relationships (Jayanti, 1996; Johnson & Zinkhan, 1991).

2.2.1 Quality in Service Relationships

Similar to interpersonal relationships, not all researchers have the same view of what signifies quality in service relationships (Dalziel, Harris & Laing, 2011). Nevertheless, researchers have attempted to understand quality in service relationships by conceptualising what constitutes the strength of relationships. The strength of a service relationship is the intensity and depth of the relationship which is reflected in the frequency of contact and personal
rapport between both partners (DeCanniere, De Pelsmacker & Geuens, 2009; Gremler & Gwinner, 2000). Unfortunately, this conceptualisation is rather vague. For example, frequent contact does not mean that those interactions are perceived as positive by either party. Also, people can have highly intense negative or positive feelings about a relationship, so intensity alone does not indicate quality.

A more precise understanding of service relationship quality was proposed by Berghall (2003). According to Berghall (2003), the quality of a service relationship can only be understood through the ongoing perceptions of the employees and customers involved (Berghall, 2003). They base their perceptions of what is a high or low-quality relationship on emotional and economic perceptions of the costs and benefits of interacting compared to alternatives (Berghall, 2003). Initially relationships are purely transactional encounters, which only reach relationship status when emotions begin to register (Berghall, 2003). The quality of interactions at the beginning of a relationship may be mostly based on people’s perception of economic transactional costs and benefits. As the relationship develops, the emotional costs and benefits of being in the relationship become salient. These perceptions influence both parties’ actions and behaviours (Berghall, 2003).

Another approach that researchers have used to understand the quality of service relationships is exploring the characteristics of high-quality service relationships. These relationships are characterised by trust, satisfaction, commitment (Fullerton, 2011; De Wulf, Odekerken-Schroder & Iacobucci, 2001), emotional attachment, and sometimes even friendship (Coulter & Ligas, 2004; Gutek et al, 1999). It is important to note that high-quality core services are also an important characteristic in high-quality service relationships (Coulter & Ligas, 2004). There is also research that shines light on low-quality service relationships by exploring negative customer encounters. These negative encounters are characterised by the presence of incivility (Sliter, Jex, Wolford & McInnerney, 2010; Walker, van Jaarsveld & Skarlicki, 2014), aggression, the expression of negative emotions (Grandey, Dickter & Hock-Peng Sin, 2004), mistreatment (Rupp & Spenser, 2006; Skarlicki, van Jaarsveld & Walker, 2008), and other negative events, such as unrealistic expectations, interpersonal conflict, or hostility (Chi, Tsai & Tseng, 2013).

Service relationships can have varying levels of positive and negative characteristics (Dalziel, Harris & Laing, 2011). Dalziel and colleagues (2011) proposed a service relationship typology that ranged from relationships having mostly positive characteristics to relationships
having mostly negative characteristics. Using qualitative interviews with retail banking customers, they identified key service relationship components: trust, commitment, buyer-seller bond or relationship exit barriers, and relationship benefits. Service relationships that are high in these components can be considered high-quality relationships and those that are low in these components can be considered low-quality relationships. They described four levels of relationships with respect to quality: faltering, functional, perceptual and affective. The level with the least positive characteristics is faltering relationships and therefore, the lowest in terms of quality. These relationships lack trust and commitment and may continue due to reasons other than satisfaction with services. The next level with slightly more positive characteristics is called functional relationships. These relationships may have some basic elements of trust, but commitment is based on ‘if it aint broke don’t fix it’ sentiments, rather than satisfaction with the service. Both faltering and functional relationships do not have any benefits associated with the relationship. Perceptual relationships are the next level and have more positive characteristics than Functional relationships. These relationships contain some trust, emotional attachment, and relationship benefits. The last level is called affective relationships. This level has the most positive characteristics and therefore, represents the highest quality relationships. In these relationships, there is a healthy amount of trust and commitment. The commitment is based on the belief that the service is better than alternatives, and there is more personalisation of services at this level. There is also more emotional attachment at this level, compared to the other levels. Dalziel and colleagues (2011) understood these service relationships to be multidimensional, dynamic, and contextual. Therefore, a service relationship may at one point in time be categorised at one level and at a different point in time be categorised at a different level.

A recent study by Methot and colleagues (2017) used the valence and intensity of emotions to understand workplace relationship quality. They concluded that emotions generated and accrued over repeated interactions determine if the relationship is positive, negative, ambivalent, or indifferent. They conceptualised positive relationships, or high-quality relationships, as being marked by pleasant interpersonal interactions and relatively intense positive emotions. In negative or low-quality relationships, interactions are characterised by conflict, negative intentions, and relatively intense negative emotions. Ambivalent relationships involve concurrent negative and positive emotions and feelings about their partner and their interactions. Lastly, indifferent relationships are those that lack emotion, either negative or positive, and emotional intensity (Methot, Melwani & Rothman, 2017).
It is typically assumed that a low-quality relationship would be discontinued by customers (Oliver, 1997). However, there are several reasons why customers may continue a service relationship even though they consider it a low-quality relationship, such as lack of alternatives, the presence of exit barriers, and indolence (Dalziel, Harris & Laing, 2011). This is consistent with interpersonal relationship literature on domestic abuse that shows that some interpersonal relationships may be continued even though they may be considered low-quality relationships. It is also assumed that employees remain docile even when interacting with aggressive customers (Bolton & Houlihan, 2005). However, recent research on employee service sabotage (e.g., Chi, Tsai & Tseng, 2013; Skarlicki, van Jaarsveld & Walker, 2008) underlines the complexity of the actions and behaviours of dyadic partners that contribute to the quality of the service relationship.

2.2.2 Service Relationship Development

Service relationships develop through repeated service encounters (Lovelock, 1983; Bitner, Booms & Tetreault, 1990). The more customers and employees interact, the more opportunity they have to develop an increasingly personal relationship (Liljander & Strandvik, 1995) through friendly exchanges (Kurth, 1970). In this way, service relationships develop in a similar fashion to the way interpersonal relationships develop (Deighton & Grayson, 1995).

There is not much research on how service relationships develop. One of the few research teams that addressed this topic, Dwyer, Schurr and Oh (1987), developed a model of relationship formation between business buyers and sellers based on social exchange theory. This model includes five phases: awareness, exploration, expansion, commitment, and dissolution. In the first phase each dyadic partner becomes aware that the other is a potential exchange partner. In the next phase, exploration, potential exchange partners consider the pros and cons of engaging in a transaction, and if they deem interaction to be beneficial they will engage in transactions. The expansion phase is where the exchange partners increase their interdependence and the commitment phase is where the partners implicitly or explicitly pledge their allegiance to the relationship. The last stage, dissolution, is where the dyadic parties discontinue their affiliation. Of course, all business relationships do not go through each of these stages. For example, some may go from exploration straight to dissolution if they do not believe that interacting with the seller/buyer is beneficial. Although this model is
based on business to business relationships, it is applicable to relationships between two individuals.

How service relationships develop can also be understood by looking at Coulter and Ligas’s, (2004) research on the various types of service relationships. As noted above they proposed a typology of service relationships that sit on a continuum from a purely professional relationship to a friendship or informal relationship. The difference between the four types of relationships on the continuum is based on three factors; the level of the customer’s emotional attachment, the tendency to seek personal advice from each other, and the tendency to socialise with each other even outside of the service context. Each of these three factors increase as the relationship moves from professional to informal (Coulter & Ligas, 2004). The researchers were clear that research is needed to establish whether service relationships develop from professional to increasingly informal, since their purpose was just to develop a typology. However, this development pattern is logical since it is consistent with the way interpersonal relationships develop according to social penetration theory.

Research on service relationships can inform how we understand therapeutic relationships. In particular, the categorisation of different types of service relationships, ranging on a spectrum from professional to friendship, may be applicable to therapeutic relationships. Also, service relationship research highlights the complexity of relationships at work where even though employees and customers have specific roles and expectations, their behaviour is not always predictable. Lastly, service relationship research provides an example of the benefits of integrating research on interpersonal relationships. This integration has led to the acknowledgement of the role of emotion in the way service relationships develop and are maintained. Importantly, emotions help employees and customers evaluate the quality of the service relationship. This is important because the quality of employee-customer interactions is a key determinate of important customer outcomes (Heskett, Sasser & Schlesinger, 1997).
2.3 Therapeutic Relationships

Therapeutic relationships are a type of service relationship, typically in healthcare services. The therapeutic relationship refers to the interpersonal relationship between the therapist or healthcare professional and patient. In these relationships therapists typically work with patients on a 1:1 basis over a number of treatment sessions. The recurrent nature of therapeutic service encounters leads to opportunities for friendly exchange that can lead to the development of more intense relationships (Kurth, 1970). The healthcare professionals’ role in these relationships is to use their expertise to help patients get better. They have a high degree of autonomy in decision making, a specialised skill set, and their services are tailored to each individual patient. In these ways, therapeutic relationships are more like service relationships in professional services (e.g., relationships between lawyers and accountants and their customers) than relationships in non-professional services (e.g., relationships between cashiers or waitresses and their customers). Also, in therapeutic relationships, particularly in the context of rehabilitation, patients may be required to assume a more active role, than in other types of service relationships. For example, patients may be required to do exercises or learn a new skill. The end of the therapeutic relationship is marked by the patient being discharged from therapy or other healthcare services.

The professional bodies in occupational therapy and physiotherapy, the College of Occupational Therapy and the Chartered Society of Physiotherapists, compel therapists to maintain appropriate relationships with patients and provide documented guidance on what can be considered an appropriate or inappropriate therapeutic relationship. In particular, the relationship should be focused on the needs of the patient and their family/carer and must not exploit them in any way. Therapists should avoid entering a close personal relationship with patients that may impair the therapists’ judgement, objectivity and/or give rise to advantageous or disadvantageous treatment of the patient (College of Occupational Therapists, 2015).

In research literature, therapeutic relationships may be referred to using a number of terms, including therapeutic alliance, helping alliance, and working alliance. Although there is significant divergence in the theoretical conceptualisations of the components that make up the therapeutic relationship, most theoretical definitions include three components: collaborative working (e.g., Frieswyk, Colson & Allen, 1984), an affective bond (e.g., Luborsky, 1984), and agreement on goals and tasks (e.g., Bordin, 1979; Martin, Garske &
Davis, 2000). Other conceptualisations of the therapeutic relationship emphasise the importance of additional constructs including trust (Morse, 1991), communication (Taylor, Lee, Kiellhofner & Ketkar, 2009; Tickle-Degnen & Gavett, 2003), and patient empowerment (Kim, Boren, & Solem, 2001). However, these conceptualisations have been criticised for conflating necessary conditions for a relationship with the conceptualisation of the therapeutic relationship and under-emphasising the interpersonal aspect of the therapeutic relationship (Gelso, 2014).

A conceptualisation of the therapeutic relationship in psychotherapy that attempts to highlight the interpersonal aspects of the relationship was proposed by Gelso and Carter (1985). They understand the therapeutic relationship to consist of three components; a working alliance, a transference-countertransference configuration, and a real relationship. The working alliance is the alignment of the therapist and client for the purpose of work (Gelso & Carter, 1994). The transference-countertransference configuration is the client’s and the therapist’s perceptual distortions of the relationship (Gelso & Carter, 1994). The real relationship is the interpersonal relationship between the therapist and client. It is reflected in how genuine the therapist and patient are with each other and the extent to which each perceives the other in ways that benefits the other (Gelso, 2011).

It is important to note that most conceptualisations of therapeutic relationships in occupational therapy and physiotherapy are based on psychotherapy and medical conceptualisations of this phenomenon (Babatunde, MacDermid & MacIntyre, 2017). The intentional relationship model is a rare example of an occupational therapy specific conceptualisation of therapeutic relationships proposed by Taylor (2008). The model identifies four variables that have an important influence on the therapeutic relationship; client interpersonal characteristics, interpersonal events, therapist’s responses to interpersonal events, and the client’s occupations. The client’s interpersonal characteristics are the client’s behaviours, actions, and emotions. These characteristics are influenced by enduring and situational attributes. Enduring attributes are factors, such as the client’s personality, communication style, and capacity for trust. Situational attributes are factors, such as the client’s pain, diagnosis, and injury. Interpersonal events are the naturally occurring happenings that occur during dyadic interactions that may influence the quality of the therapeutic relationship, such as agreement or disagreement on therapeutic goals. The therapist’s response to interpersonal events refers to how therapists use interpersonal skills to
intentionally develop and maintain the relationship. Lastly, the client’s occupations refer to
his or her engagement in the therapeutic process (Taylor, 2008).

2.3.1 Quality in Therapeutic Relationships
Some studies in psychotherapy have used theoretical conceptualisations of therapeutic
relationships to understand the characteristics of high and low-quality therapeutic
relationships, where the quality of relationships can be understood in terms of the extent to
which dyadic partners perceive the relationship as having particular attributes (Elvins &
Green, 2008). Common attributes include agreement on task, goals, trust, liking,
interpersonal skills, responsiveness, and shared decision making. Relationships that rate high
on these constructs are considered high-quality therapeutic relationships and those that rate
low on these items are considered progressively lower quality relationships (Elvins & Green,
2008). The quality of the therapeutic relationship in psychotherapy has also been
conceptualised as the level of authenticity and positive regard that dyadic partners display
towards each other (Gelso, 2014). These conceptualisations have been criticised for
overlooking emotional constructs that indicate relationship quality (Greenhalgh & Heath,
2010), since these are important factors that help dyadic partners understand their
relationships.

Other studies have sought to understand the characteristics of high and low-quality
therapeutic relationships by accessing patients’ and healthcare professionals’ perceptions.
O’Keeffe and colleagues (2016) conducted a qualitative systematic review of studies
examining physiotherapists’ and patients’ perceptions of factors that influence the quality of
therapeutic relationships. They identified four themes that were perceived to influence the
quality of therapeutic relationships; the therapist’s interpersonal and communication skills,
the therapist’s practical skills, patient-centred care, and organisational/environmental factors.

According to O’Keeffe and colleagues (2016), interpersonal and communication skills that
patients and therapists perceived as important to developing positive therapeutic relationships
included the therapist’s ability to be an active listener, show empathy, interact with the
patient in a friendly manner, and exude confidence. Patients and therapists view the
therapist’s practical skills as an important influence on therapeutic relationship quality
because when therapists appear competent, patients are more likely to trust them. Patient-
centred care was also an important characteristic of high-quality therapeutic relationships.
This means that the therapist considered the patients point of view and encouraged and empowered them to take an active role in their rehabilitation. Lastly, aspects of the organisation/environment, such as the therapists having enough time to interact with their patients without being rushed and flexibility in scheduled appointments, were also perceived as characteristics of high-quality therapeutic relationships. Similar studies in different professional disciplines had similar conclusions (e.g., occupational therapy- Morrison & Smith, 2013; doctors - Ridd, Shaw, Lewis & Salisbury, 2009). Although emotions and emotion regulation were not specifically mentioned in O’Keeffe and colleagues’ (2016) study, it was clear that patients and therapists viewed the therapist’s ability to make their patients feel positive emotions, which requires therapist’s ability to use intrapersonal and interpersonal emotion regulation, as an important pre-requisite in building high-quality therapeutic relationships.

2.3.2 Therapeutic Relationship Development

Given the importance of the therapeutic relationship, it is important to understand how it develops. A prevalent theory on therapeutic relationship development in nursing literature was proposed by Peplau (1997). This theory postulates that therapeutic relationships develop through three stages; orientation, working, and termination. In the orientation phase, contact is mostly one way as the healthcare professional attempts to gather pertinent information from the patient. In the context of occupational therapy and physiotherapy, the therapist assesses the patient’s strengths and weaknesses, finds out about the patient’s rehabilitation goals, and informs the patient about the therapeutic process. The working phase is the time when the therapeutic treatment takes place. During this phase, the therapist and patient work together to achieve the patient’s goals. The termination phase is the end of the therapeutic relationship (Peplau, 1997). In the context of occupational therapy and physiotherapy, this may include discharge planning, home assessment, training regarding home exercise programs, and prescription of adaptive equipment. The problem with this theory is it is focused on the development of the therapeutic process, rather than the development of the patient-nurse or patient-therapist relationship. In other words, it is focused on the technical work that healthcare professions do involving their practical skills, rather than the interpersonal ‘work’ that is done to build the therapeutic relationship.
To understand therapeutic relationship development, researchers have looked at the development of various component parts within the therapeutic relationship. For example, Wilson, Morse, and Penrod (1998) conducted a study in caregiving relationships on how trust develops in therapeutic relationships and Tickle-Degnen and Gavett (2003) conducted a study in speech and language therapy on how nonverbal behaviour develops in therapeutic relationships. In both studies the beginning stages of the therapeutic relationship were characterised as both parties learning the rules of engagement, including emotional interactions. As the relationship progressed, given these rules of engagement were followed, this led to emotional closeness and decreased interpersonal boundaries. Despite the importance of emotion in interpersonal and service relationships, researchers have not considered emotional processes as a primary underlying mechanism that steers the trajectory of therapeutic relationship development.

Mainly in the professional context of psychotherapy, researchers have sought to explain relationship development in terms of how the strength of the therapeutic relationship changes during the course of the relationship. Strength typically refers to how well the dyadic partners work together, how much they agree on goals, and how much they like each other (Elvins & Green, 2008). The more they do these things, the stronger the therapeutic relationship. Researchers measure the strength of the therapeutic relationship using quantitative measures based on their theoretical conceptualisation of the therapeutic relationships and their clinical experience (Bedi, 2006). These measures are taken at different times during the therapeutic relationship to chart the trajectory of the relationship.

Using this approach, researchers have found that the therapeutic relationship in psychotherapy can have a stable, linear, or quadratic development pattern. A stable development pattern has little change across sessions. In a linear growth pattern, the strength of the relationship increases with each session. A U-shaped pattern is characterised with high affective bond in the first and last sessions and lower affective bond in the middle (Kivlighan & Shaughness, 2000). Lastly, a more up and down pattern is characterised by incidences that happen in which negative feelings occur and are then resolved (Safran & Muran, 1996). Most studies on this topic concluded that a U-shaped alliance pattern was associated with better outcomes than the other patterns (Safran, Muran, Samstag & Stevens, 2001). This is because as therapy progresses challenges arise that creates tension. Once the tension has been resolved the relationship is restored or enhanced (McLaughlin et al, 2014).
Another related way that researchers explain relationship development in psychotherapy is to investigate change processes within developing therapeutic relationships, called ruptures and repairs (Safran, Muran, Eubanks-Carter, 2011). Ruptures and repairs are defined as tensions, conflicts, or misunderstandings and the eventual resolutions in relationships between patients and therapists, through which the relationship develops (Safran & Muran, 2006). Ruptures are inevitable interpersonal events (Safran, Muran, & Eubanks-Carter, 2011) and are common in high and low-quality therapeutic relationships (Eubanks-Carter, Muran, Safran, & Hayes, 2011). According to Safran & Muran (2006) there are two types of relationship ruptures; withdrawal ruptures, where the patient avoids the therapist and confrontation ruptures, where the patient expresses his anger in a direct manner.

There are three main problems with these studies on ruptures and repairs. Firstly, the events that affect relationships may be positive or negative, but ruptures only focus on the negative events. Secondly, except for a recent study by Coutinho and colleagues (2014), this research tends to focus on only one rupture and repair incident, thereby ignoring the multiple rupture and repair incidents that may occur throughout the relationship and influence the trajectory of the relationship. Thirdly, these studies do not consider the role of emotions in ruptures and repairs in any significant way, with one notable exception being a study by Kramer and colleagues (2014).

Research on critical incidents in therapeutic relationships is similar to rupture and repair research in that it attempts to understand change processes within therapeutic relationship development. Unlike research on ruptures and repairs, research on critical incidents recognises both negative and positive events. Examples of critical incidents that have a positive effect on therapeutic relationship quality is a therapist using humour with a patient and the treatment yielding positive results. Examples of critical incidents that have a negative effect on therapeutic relationship quality include a therapist disregarding the patient’s desires or a misunderstanding between the patient and therapist. However, similar to research on ruptures and repairs, research on critical incidents in therapeutic relationships mostly only focuses on one event within a relationship, rather than each event that influences relationship development throughout the course of the relationship. Research on critical incidents in therapeutic relationship development has been conducted mostly in nursing (Tejero, 2016) and psychotherapy (Bedi, Davis & Williams, 2005).
Research on therapeutic relationships does not refer to research on interpersonal or service relationships in any significant way. As such our understanding of and the methods we use to investigate therapeutic relationships does not benefit from research on these hierarchically related types of relationships. This explains why the role of emotions and emotion regulation has been deemphasised or overlooked in research on how people understand therapeutic relationship quality and development. Given the important role that emotions and emotion regulation play in research on interpersonal and service relationships, it is likely that exploring the role of these constructs in therapeutic relationships will lead to a better understanding of the interpersonal aspects of therapeutic relationships.

2.4 Conclusions

There are a number of important gaps in the knowledge base on therapeutic relationships. Research on this topic seems to have attempted to “reinvent the wheel” as little or no reference to predating research on interpersonal or service relationships is used to understand therapeutic relationships. An obvious by-product of this is research on therapeutic relationships has either overlooked or underemphasized the interpersonal relationship within the therapeutic relationship until Gelso and Carter’s (1994) research on the ‘real relationship’ in therapeutic relationships, and to date little has been done systematically to conceptualise and study the real relationship within therapeutic relationships (Gelso & Silberber, 2016).

The conceptualisation of therapeutic relationships also suffers from a lack of research that explores the concept from different angles. For example, research on therapeutic relationships has not explored the possibility that there may be different types of therapeutic relationships. Research on service relationships has demonstrated that service relationships can range from being purely professional to being as informal as a friendship. Transferring this knowledge on service relationships to the therapeutic relationship context introduces new ways of understanding how therapists and patients interact.

Another problem with our understanding of therapeutic relationships is the majority of research on this topic is based in the psychotherapy context. While there are many similarities between therapeutic relationships in psychotherapy and therapeutic relationships in healthcare professions, like occupational therapy and physiotherapy, there are a few important differences; two notable differences are the environment where the therapy takes
place and the therapeutic focus and process. For this reason, the applicability of psychotherapy-based research on therapeutic relationships to the occupational therapy and physiotherapy context is questionable (Babatunde, MacDermid & MacIntyre, 2017).

More research is needed to advance our understanding of how therapeutic relationships develop (de Roten et al, 2004). Specifically, researchers have not sufficiently focused on change mechanisms that move therapeutic relationships from one stage to another. More research is needed to clarify the underlying processes through which therapeutic relationships develop and change (Elvins and Green, 2008; Li, 2004). Research on ruptures and repairs and critical incidents take an important step in that direction but have deficits that can be improved upon. Utilising turning point analysis, a method typically used in research on interpersonal relationship development, presents a novel way to access change processes within therapeutic relationships. Research that identifies the turning points encountered and how therapist and patients negotiate these events can add to the knowledge base on how and why therapeutic relationships develop and change.

A potentially important change mechanism within therapeutic relationships is emotional processes. Emotions play a significant role in deciding the trajectory of relationships (Berscheild, 1983). Also, emotions are one of the drivers that move relationships from one stage to another (Planalp, 2003). Considering the importance of therapeutic relationships in therapeutic outcomes and the potentially important function that emotions play in developing and maintaining such relationships, it is surprising that researchers have not explored the role of emotion regulation in therapeutic relationships. The next chapter will focus on the current knowledge base on how and why people use emotion regulation at work.

Chapter 3 Emotion Regulation

3.1 Introduction

Emotions are omnipresent in organisational settings and have an important impact on employees, customers/patients, and organisations. Emotions at work have an impact on employees’ overall wellbeing (Fredrickson & Joiner, 2002; Vacharkulksemsuk &
Fredrickson, 2013) and their ability to build relationships at work (Gross, 2002), an essential part of working lives. Emotions influence customers’ evaluation of services (Pugh 2001; Cote, 2005) and customer willingness to recommend services to a friend and return to the organisation (Tsai 2001). This can influence the organisation’s bottom-line.

An employee’s experience or expression of emotions may be helpful or unhelpful to their own and/or organisational goals depending on the context. For example, in some contexts employees experience of positive emotions are associated with increasing factors that facilitate job performance, such as information integration (Estrada, Isen & Young, 1997), creativity (Isen, Daubman & Nowicki, 1987; Isen, 1999), decision making (Isen, 1993), innovation (Rank and Frese, 2008), initiative (George & Brief, 1992), motivation (Isen & Baron, 1991; Isen, 1993), organisational commitment (Meyer, Allen & Smith, 1993) and building relationships (George, 1991). Similarly, studies found that negative moods lead to less-effective performance (Erez & Isen, 2002), is negatively correlated to goal setting, motivation and task self-efficacy (Judge & Ilies, 2002) and is positively correlated to employee absence (Hardy, Woods & Wall, 2003). In contrast, in some contexts the experience and display of negative emotions has been found to have a positive effect on factors that impact upon job performance, such as creative problem solving (Kaufmann and Vosburg, 1997) and innovation (Howell & Shea, 2001; Ashkanasy and Tse, 2000). The intensity level of the experience or display of emotion can also be helpful or unhelpful to their own or organisational goals. For example, studies have found that when positive emotion is particularly intense, it may decrease decision making quality (Schwarz & Bless, 1991; Mackie & Worth, 1991, 1989). Also, low levels of negative affect can encourage innovation amongst leaders and followers (Howell & Shea, 2001). These studies highlight the importance of employees’ ability to experience and display the right emotions, in the right way, at the right time.

Through emotion regulation individuals can exert control over their own and other’s emotions and therefore emotion regulation can play an important role in achieving individual and organisational goals at work. Employees can use emotion regulation to influence their own and other’s emotions for the purpose of building and maintaining relationships. They can also use emotion regulation to avoid unhelpful emotions, promote helpful emotions, and modulate their emotional experience and expression to facilitate goal achievement.
Emotion regulation is particularly important in work environments where employees must interact with the public, such as in healthcare. In healthcare-oriented jobs, like occupational and physiotherapy, the regulation of one’s own emotions and the emotions of patients and colleagues is an integral part of one’s work role (Miller et al, 2008). In fact, in these organisational settings it is increasingly acknowledged that job performance depends on the accomplishment of both technical and emotional work (Bolton, 2000).

The purpose of this chapter is to review literature on emotion regulation in the workplace with a view to understanding the current knowledge base on how people use emotion regulation at work. Pertinent information on this topic is found in a few different research streams. The most general stream of literature investigates emotion regulation in everyday life. The next stream of literature investigates emotion regulation within the context of the workplace. A prominent area of research within this stream investigates intrapersonal emotion regulation at work, which is typically called emotional labour. Emotional labour is the process by which workers are expected to manage their feelings in accordance with organisationally defined rules (Hochschild, 1983). Research on emotional labour can further be categorised into research that is focused on emotion and emotion regulation and research that is focused on emotion regulation but proceeds from the vantage point of a specific occupation (Wharton, 2009). In this chapter, particular attention is paid to occupation specific research from the vantage point of healthcare professionals, including doctors, nurses, and therapists.

Each section in this chapter will start by reviewing research on emotion regulation in everyday life and then progress to research on emotion regulation in more occupation-specific work contexts. This chapter begins by describing the emotion regulation process and defining intrapersonal and interpersonal emotion regulation. Prominent categorisations of emotion regulation strategies are presented and what is known about the effectiveness of common emotion regulation strategies is discussed. This leads to a discussion on some of the important factors that influence the use and effectiveness of emotion regulation strategies, with a focus on social interactional and temporal influences. This is followed by a review of why people use emotion regulation strategies with attention given to emotion regulation goals, motivations, and affective events. Finally, this section concludes with a summary of the main gaps in the literature and why these gaps need to be addressed.
3.2 Emotion Regulation Process

Gross (2015) described the intrapersonal emotion regulation process has having three stages: identification, selection and implementation. The identification stage is when a person notices or anticipates an emotion that in their view needs to be regulated based on their judgement of the congruency between the anticipated effect of the emotion on the current situation and their ideal current situation. The selection stage is when the person selects an emotion regulation strategy or a number of emotion regulation strategies to regulate the targeted emotion based on its perceived potential to regulate in light of contextual factors. The implementation stage is when the person translates the general emotion regulation strategy or strategies into tactics that are situation specific. Although Gross was referring to intrapersonal emotion regulation, this process is relevant to interpersonal emotion regulation.

Throughout the emotion regulation process, these stages continue to cycle over time in a way that enables a person to adapt to the changes in the targeted emotion (Gross, 2015). As the perception of the congruency between the effect of the emotion regulation strategy on the current situation and their ideal current situation evolves, the selection and implementation of emotion regulation strategies changes accordingly to facilitate the ideal situation (Gross, 2015). For example, if it appears that the emotion regulation strategy is not affecting the target emotion in a desired way, a person may select a different emotion regulation strategy or attempt to use the same strategy differently.

Throughout each stage in the emotion regulation process, people consciously and unconsciously make a number of decisions regarding if they should regulate emotions and if so, how they should do it. Research on emotion regulation choice shines light on factors that influence people’s emotion regulation choices. In general, people choose emotion regulation strategies based on their perception of which strategy is likely to help them achieve their goals (Gross, 2015). They select the strategies that they are best equipped to use (Urry & Gross, 2010) based on emotional (e.g., level of emotion intensity), cognitive (e.g., level of cognitive effort required), and motivational factors (e.g., goal of emotion regulation), (Sheppes et al, 2014). In addition, certain relationship factors, such as level of closeness, can also influence emotion regulation choice (Winterheld, 2016). There are many emotion regulation strategies that people can chose from. The next section presents some of the prominent taxonomies that attempt to capture the multitude of strategies that people use.
3.3 Emotion Regulation Strategies

Emotion regulation is the goal-directed process of regulating the occurrence, magnitude, or duration of emotional responses (Gross, Sheppes & Urry, 2011). The regulation of one’s own emotional responses is called intrinsic or intrapersonal emotion regulation. The regulation of other’s emotions is called extrinsic or interpersonal emotion regulation (Gross, 2015).

While intrapersonal and interpersonal emotion regulation strategies are distinct categories, they are interrelated and difficult to separate for a number of reasons (Kappas, 2013). Firstly, both intrapersonal and interpersonal emotion regulation are influenced by intrapersonal processes (e.g., psychological changes and changes in action readiness) and interpersonal processes (e.g., social cues) (Kappas, 2013). This is true even in cases where a person is using emotion regulation in social isolation (Kappas, 2013). Therefore, intrapersonal emotion regulation is not purely an intrapersonal process, and interpersonal emotion regulation is not purely an interpersonal process.

Secondly, interpersonal emotion regulation strategies are often used simultaneously (Kappas, 2013) because after any one emotion-causing event people experience their own emotions, perceive others’ emotions and attempt to influence their own and other’s emotions. For example, if a patient has an angry outburst directed at a therapist, the therapist is likely to simultaneously attempt to regulate her own frustration stemming from being yelled at and the patients anger that caused him to yell in the first place.

Lastly, emotion regulation strategies can be used for interpersonal and intrapersonal purposes at the same time (Little, Kluemper, Nelson, & Gooty, 2012). Since emotional displays provide an important source of information and communication (English & John, 2013), intrapersonal emotion regulation can influence other people’s emotions (Gross, 2002). For example, a person who displays sadness by crying may do so as a genuine display of emotion (intrapersonal emotion regulation) or to encourage others to feel pity for them (interpersonal emotion regulation) or for both reasons. Similarly, interpersonal emotion regulation strategies can have an effect on the target and the agent (Niven, Totterdell, Holman & Headley, 2012). For example, a therapist who goes out of her way to make a patient feel good may at the same time make themselves feel good. Even though these two processes are functionally intertwined they are typically studied separately.
There are a wide range of emotion regulation strategies. For this reason, researchers have sought to categorise them. The next two sections look at the most prevalent classification systems for intrapersonal and interpersonal emotion regulation.

3.3.1 Intrapersonal emotion regulation strategies

There are a number of intrapersonal emotion regulation taxonomies (e.g., Koole, 2009; Parkinson & Totterdell, 1999). However, the most widely used classification of intrapersonal emotion regulation strategies is the process model of emotion regulation proposed by Gross (1998). It proposes five families of strategies distinguished by the point in the emotion-generative process at which they have their primary impact. Emotion regulation strategies that manipulate emotion before it is generated are called antecedent-focused emotion regulation. Situation selection, situation modification, attentional deployment, and cognitive change or reappraisal are all antecedent-focused emotion regulation strategy families. Emotion regulation strategies that manipulate the emotion after it is generated are called response-focused emotion regulation. Response modulation is the only family of intrapersonal emotion regulation strategies that falls into the response-focused category (Gross, 1998).

According to the process model of emotion regulation (Gross, 1998), situation selection is taking actions to ensure that one will be in a situation that promotes the desired emotions. An example is a therapist who avoids seeing a difficult client to avoid the negative emotions she experiences when she works with the client. Situation modification is taking actions to change a situation in order to promote desired emotions. A therapist that starts her treatment session by clarifying to the patient what behaviour is and is not appropriate, as a strategy to prevent herself from experiencing the negative emotions typically caused by this patient’s rude behaviour, is using situation modification. Attentional deployment refers to directing one’s attention to influence one’s emotional response. This strategy is illustrated by a therapist who ignores a patient’s rude remark by continuing with the treatment session, to avoid experiencing the anger that she would experience if she focused on it. Cognitive change refers to modifying how one appraises a situation in order to promote the desired emotional response. An example of this strategy is a therapist who, after a patient makes a rude remark, avoids getting angry by convincing herself that the patient did not really mean to say what he said. Finally, response modulation refers to strategies that directly influence the experiential, behavioural, or physiological components of the emotional response. A
therapist who is angry and frustrated while interacting with a difficult patient but hides these emotions by faking a smile is using this strategy.

This model is typically used to categorise emotion regulation strategies used to regulate negative emotion. However, a recent review of a broad range of literature by Quoidbach, Mikolajczak & Gross (2015) identified a number of strategies that are used to upregulate positive emotions and organised these strategies into the process model of emotion regulation. Examples of such strategies are savouring, which can be categorised as an attentional deployment strategy and social sharing, which can be categorised as a response-focused strategy. Savouring is perseverating on a thought or happening that is enjoyable to prolong the enjoyment (Bryant, Chadwick & Kluwe, 2011). Social sharing is communicating an emotional experience with others (Curci & Rime, 2012). Interestingly, they acknowledged that these strategies could be used at any point in the emotion generation cycle. They did not include strategies used to down regulate positive emotion.

The intrapersonal emotion regulation strategies identified by Gross (1998) typically occur within the individual and therefore, are not easily detected by an observer. For this reason, they can be considered covert emotion regulation strategies (Aldao & Dixon-Gordon, 2014). However, there are some intrapersonal emotion regulation strategies that are used to regulate emotion only in certain circumstances. Exercise, watching television, and eating are examples of behaviours that are sometime used as intrapersonal emotion regulation strategies but at other times used for other purposes. Since these strategies are easily observed they can be considered overt strategies (Aldao & Dixon-Gordon, 2014). Recently, researchers have begun to investigate how people utilise other people to regulate their own emotions (e.g., Hofmann, Carpenter & Curtiss, 2016), this is sometimes considered intrinsic interpersonal emotion regulation (Zaki & Williams, 2013) and is another overt emotion regulation strategy. For example, a person may use social sharing of an incident that made them feel sad to help them think through it, so they can feel better about it. Overt emotion regulation strategies may be categorised in any of the five emotion regulation strategy families identified by Gross’s (1998) process model of emotion regulation depending on the function of the strategy and when the strategy is used during the emotion generation cycle. One of the shortcomings of research on emotion regulation in everyday life is researchers have focused on a limited number of strategies that fall into each of the five families of emotion regulation strategies identified by Gross’s (1998) process model of emotion regulation (Webb, Miles & Sheeran, 2012).
Literature on intrapersonal emotion regulation at work, or emotional labour, mainly focus on two strategies, deep acting and surface acting. These strategies were first introduced by Hochschild (1983) and then reconceptualised to link with the broader emotion regulation literature by Grandey (2000). Deep acting is an antecedent-focused emotion regulation strategy used in order to appear to authentically experience organisationally required emotions, such as cheerfulness. Surface acting is a response-focused intrapersonal emotion regulation strategy focused on hiding or faking emotions to keep emotional displays in line with organisational requirements (Grandey, 2000). Similar to research on emotion regulation in everyday life, a shortcoming of emotional labour research is researchers’ tendency to focus on a limited number of strategies, in this case deep and surface acting.

In healthcare-based literature on emotion regulation, researchers mainly consider strategies that fit into the broad categories of intrapersonal emotion regulation described by Hochschild (1983) and Gross’s (1998). For example, a number studies found that healthcare professionals use deep acting and surface acting (e.g., Mann & Cowburn, 2005; Zammuner & Galli, 2005) including one study in the professional context of physiotherapy (Foster & Sayers, 2012). Other studies have found that healthcare professionals use some of the intrapersonal emotion regulation strategies described by Gross’s (1998) process model of emotion regulation or considered how the use of these strategies affected a particular outcome (e.g., Hayward & Tuckey, 2011; Martinez-Inigo & Totterdell, 2016).

In healthcare-based research, there are a few studies that identify specific intrapersonal emotion regulation strategies, beyond the emotion regulation strategy category. For example, healthcare professionals may use identifying communication barriers, digging deep within oneself, seeking support (Foster & Sayers, 2012), humour (Bolton, 2000), and experiencing and expressing one’s true emotions (Zammuner & Galli, 2005) to regulate their own emotions. Hammonds and Cadge (2014) identified intrapersonal emotion regulation strategies used by healthcare professionals to address residual emotions stemming from affective events at work. These include venting to colleagues, getting social support from family, participating in distracting activities, and calling in to work to check on patients. Smith and Kleinman (1989) identified strategies that healthcare workers use to emotionally distance themselves as a way to deal with undesired emotions, including using derogatory humour to de-humanise their patients and focusing on medical aspects to avoiding dealing with the psychosocial aspects of the patient.
Maintaining emotional/professional boundaries is sometimes considered an emotion regulation strategy (e.g., Hayward & Tuckey, 2011) but other times is considered more of a gauge used to monitor emotional closeness (e.g., Pergert, Ekblad, Enskar & Bjork, 2008; Hammonds & Cadge, 2014). Emotion regulation strategies used to manipulate emotional/professional boundaries include rationalisation, controlled expression, avoidance, distancing, self-disclosure, power display, and positioning one’s self to manage these emotions (Pergert, Ekblad, Enskar & Bjork, 2008).

All these strategies can be mapped onto Gross’s process model of emotion regulation (1998). For example, avoidance is an example of situation selection. Identifying communication barriers could be considered a situation modification strategy. Humour and rationalisation are examples of an attentional deployment strategy and a cognitive change strategy, respectively. Working to maintain a controlled expression is an example of a response modification strategy.

Research on emotion regulation used in everyday life mostly investigates the broad families of intrapersonal emotion regulation strategies from Gross’s process model of emotion regulation (1989). Emotional labour research is mostly concerned with the two intrapersonal emotion regulation strategies proposed by Hochschild (1983), deep and surface acting. Occupational-based research on emotion regulation that is specific to healthcare has focused on the intrapersonal emotion regulation strategies proposed by Gross (1989) and Hochschild (1983) and also some strategies that are less prevalent in the literature. It is important to note that studies on how occupational therapists and physiotherapists use emotion regulation strategies are scarce. The main problem with literature on this topic is it is only concerned with a limited range of emotion regulation strategies. This bias in strategy popularity may reflect theoretical priorities, rather than priorities base on what strategies people actually use (Webb, Miles & Sheeran, 2012). Research is needed to identify the strategies people actually use in particular contexts.

3.3.2 Interpersonal Emotion Regulation
Most of the research on emotion regulation is focused on intrapersonal emotion regulation, and only recently have researchers began to turn their attention to interpersonal emotion regulation (Dixon-Gordon, Bernecker & Christensen, 2015). There are two prevailing definitions for interpersonal emotion regulation. The first conceptualisation, and the one used
throughout this thesis, is defined by the target of the regulation. Interpersonal emotion regulation “refers to the deliberate regulation of someone else’s affect” (Niven, Totterdell, Holman, 2009, pg. 498). The second definition was proposed by Zaki and Williams (2013) and defines interpersonal emotion regulation as strategies using interpersonal interaction to regulate one’s own or other’s emotions. The former definition is preferred to the later because unlike the latter, the former definition provides a clear distinction from intrapersonal emotion regulation. For example, Zaki and Williams’s (2013) conceptualisation of intrinsic interpersonal emotion regulation, regulating one’s own emotions using interpersonal interaction, overlaps with the widely accepted conceptualisation of intrapersonal emotion regulation involving the regulation of one’s own emotions, regardless of using interpersonal or intrapersonal means (e.g., Gross, 1998).

Niven, Totterdell and Holman (2009) have proposed a framework that classifies interpersonal affect (a construct that includes emotion and mood) regulation strategies according to their motive (affect worsening or affect improving) and their means (cognitive or behavioural). This framework results in four categories of interpersonal affect regulation; cognitive affect worsening, cognitive affect improving, behavioural affect worsening, and behavioural affect improving. Cognitive affect improving strategies are those used to improve the targets affect by changing the target’s thoughts about his or her situation or affect. Cognitive affect worsening strategies are those used to worsen the targets affect by changing the target’s thoughts about his or her situation or affect. Using one’s own behaviour to improve the targets affect or situation are behavioural affect improving strategies. Using one’s own behaviour to worsen the targets affect or situation are behavioural affect worsening strategies (Niven, Totterdell & Holman, 2009). An example of cognitive affect worsening is a therapist telling a patient that he or she is not working up to his or her potential. An example of behavioural affect worsening is a therapist ostentatiously avoiding making eye contact with a co-worker to avoid saying hello. Cognitive and behavioural affect improving examples are a therapist who greets her patients cheerfully (behavioural) and expresses concern about their wellbeing (cognitive). While, this framework has been criticised for a lack of empirical evidence for the affect-worsening dimensions (Hofmann, Carpenter & Curtiss, 2016) there is a growing amount of research that supports the notion that people use emotion regulation strategies to worsen others’ emotional states (Netzer, Van Kleef & Tamir, 2015).

Another framework used to categorise interpersonal emotion regulation strategies was proposed by Williams (2007). This framework is based upon Gross’s (1998) families of
intrapersonal emotion regulation strategies and includes four categories; altering the situation, altering attention, altering the cognitive meaning of a situation and modulating the emotional response. Altering the situation involves modifying or changing the situation to influence the emotional impact on the target. Altering attention are strategies used to divert the targets attention to influence their emotions. Modulating the emotional response involves actions used to alter the targets current experience or expression of emotion. Altering the cognitive meaning of a situation are strategies used to help the target think about an issue differently to alter the emotional impact (Williams, 2007).

Studies on how employees use interpersonal emotion regulation at work are sparse compared to studies on how employees use intrapersonal emotion regulation at work. Niven and colleagues (2010) investigated the extent to which prison guards and inmates used common emotion improving and emotion worsening emotion regulation strategies using the strategies derived from their previous study on how people deliberately seek to influence other’s emotions. The emotion improving strategies included in the study were complementing, listening, joking, using soothing tones or words, and pointing out the upsides. The emotion worsening strategies included in the study were criticising, ignoring, mocking, using aggressive tones or words, and pointing out the downsides.

Emotional gift giving is a type of interpersonal emotion regulation strategy that is featured in literature on emotion regulation at work in healthcare contexts. Emotional gift giving is providing extra emotion work which goes beyond organisational expectations of emotional display (Bolton, 2000) for altruistic reasons. Examples of emotion regulation strategies used in this way include using humour to ease a patient’s embarrassment or therapists masking their emotions to protect their patient’s emotions (Bolton, 2000). Although Bolton wrote about emotional gift giving in her discussion of nurses’ emotional labour, the rationale that the nurses gave for using the strategies were to influence their patient’s emotions, which makes it more of an interpersonal emotion regulation strategy.

Overall, research on interpersonal emotion regulation strategies used in healthcare settings is particularly scarce. However, studies on emotional communication in healthcare work environments can indirectly shine light on this topic. These studies focus on how healthcare professionals respond to patients’ expression of negative emotions but do not specify if the motivation for these responses are for emotion regulatory purposes. One such study by Adams and colleagues (2012) qualitatively analysed videotaped patient-doctor admission
encounters. They found that in encounters where patients verbally expressed negative emotions, the physicians responded with statements that either focused on the emotion, focused away from the emotion, or were neutral, in that they neither focused on or away from the emotions. They found that neutral and towards focusing statements compared to away focusing statements were associated with potentially beneficial patterns of further communication. Emotion focused, or neutral responses resulted in patient disclosures that physicians used to guide further communications with the patient, tailor their treatment plan, and build the therapeutic relationship. Whereas, responses that focused away resulted in distance and discord between the patients and physicians (Adams, Cimino, Arnold & Anderson, 2012). Similarly, other studies have found that healthcare professionals may address patients’ emotions by acknowledging their emotions, providing information, and using empathetic responses (Finset, 2012; Mjaaland, Finset, Jensen & Gulbrandsen, 2011). However, at times healthcare professionals avoid addressing the emotional cue (Uitterhoeve et al, 2008; Eide, Quera, Graugaard & Finset, 2004).

There are no studies on interpersonal emotion regulation in occupational therapy or physiotherapy contexts. However, research in occupational therapy and physiotherapy literature has focused on various strategies that therapists use to influence patients’ emotions or actions to develop the therapeutic relationship, although these strategies are not specifically labelled as interpersonal emotion regulation. Therapeutic use of self, empathy, and niceness are examples of such concepts. Therapeutic use of self refers to the purposeful use of the therapist’s personality, insights, perceptions, and judgments as part of the therapeutic process (Punwar & Peloquin 2000) and for the purpose of managing client’s emotions and behaviour (Azima & Azima 1959; Conte 1960). Empathy is an emotion related concept that is prominent in occupational therapy literature. It is the ability to understand a patient’s situation and communicate that understanding and one’s intention to help the patient (Fields et al, 2011). A related concept from the nursing profession is “niceness”, which is presenting oneself in such a way as to be perceived as friendly, charismatic, and understanding. According to Li (2004), maintaining a nice professional front is central to building therapeutic relationships. These concepts represent black boxes in the literature because how one displays niceness and empathy and uses one’s self therapeutically is unclear (Taylor, Lee, Kielhofner & Ketkar, 2009; Li, 2004). Some of the healthcare literature that begins to peer inside of these black boxes look at specific interpersonal emotion regulation strategies, such as humour (e.g., Leber & Vanoli, 2001;
Vergeer & MacRae, 1993) and touch (e.g., Chang, 2001; Fredriksson, 1999; Gleeson & Timmins, 2005). More research is needed to identify how occupational therapist and physiotherapists work to regulate their patient’s emotions.

A few studies have explored strategies that patients use to influence how their therapists feel about them, but again, the studies were not specifically referring to interpersonal emotion regulation. For example, Hockey (cited in Li, 2004) conducted an observational study and found that patients used strategies, such as making efforts to appear good-natured and caring, to make themselves more acceptable to the care staff. Also, when they required assistance they would approach the nurses cautiously and politely. In addition, patients would praise nurses for their efforts to present themselves as nice people and put on a brave face to mask their own suffering (Copp, cited in Li, 2004).

Research on interpersonal emotion regulation is less developed compared to research on intrapersonal emotion regulation (Troth, Lawrence, Jordan & Ashkanasy, 2017). While research in this area is growing in general, it is virtually non-existent in healthcare-based research on emotion regulation. Given the importance of healthcare professionals’ ability to influence their patients’ emotions, more research is need in this area.

3.3.3 Effectiveness of Intrapersonal Emotion Regulation Strategies
People base their perception of the effectiveness of their emotion regulation strategies on to what degree the emotion changed as intended and to what degree the change in emotion triggered a change in behaviour that is desirable (Aldao & Christensen, 2015). One of the major focuses of emotion regulation research is on assessing the effectiveness of different strategies (Gross, 2015). Webb and colleagues (2012) conducted a meta-analysis on the effectiveness of the emotion regulation strategies from Gross’s (1998) process model of emotion regulation on intrapersonal outcomes, such as physiological (e.g., cardiovascular or skin conductance measures), experiential (e.g., emotional state), and behavioural (e.g., expression of anger) responses. They reviewed 306 experimental comparisons of different emotion regulation strategies. Overall, they found that cognitive change was the most effective, response modulation was minimally effective, and attentional deployment had no effect. Situation selection and situation modification were not included in the meta-analysis because most studies did not address the effectiveness of these strategies.

Webb and colleagues concluded that a number of factors moderated the effectiveness of emotion regulation strategies on experiential, physiological, and behavioural outcomes. Many
of the moderating factors were concerned with the design and characteristics of the study. Factors, such as instructions given for emotion regulation, the frequency of use and intended purpose of the emotion regulation strategy, and the way the emotion was induced all influence the effectiveness of strategies. They also found that whether the emotion to be regulated was a positive emotion or negative emotion affected the outcome of the emotion regulation strategy, with positive emotions being more successfully regulated than negative emotions.

Research on the effectiveness of intrapersonal emotion regulation strategies in the context of everyday life can be criticised for several reasons. Firstly, most of the studies on emotion regulation in everyday life used experimental and correlational methods (Gross, 2015) and were conducted in laboratories where participants were exposed to an emotion causing stimulus and received instructions on which emotion regulation strategy to use. For this reason, the ecological validity of these studies is problematic and the transferability of the conclusions of these studies to real life is questionable. The fact that one of the moderating factors that had an impact on the effectiveness of emotion regulation strategies in Webb and colleagues’ (2012) study was the research design and characteristics, highlights the fact that the artificial nature of a study’s design has an impact on the study’s conclusion. More naturalistic studies on this topic would make a useful contribution to our knowledge base on emotion regulation processes in the real world (Heiy & Cheavens, 2014).

Secondly, this research tends to favour those strategies that are by definition used to regulate emotions and overlooks behaviours that can serve as intrapersonal emotion regulation strategies under certain circumstances (Aldao & Dixon-Gordon, 2014). Of those strategies that are by definition used to regulate emotions, only a few (e.g., attentional deployment, cognitive change, and response modification), are typically the focus of empirical investigations (Webb, Miles & Sheeran, 2012). Given that emotion regulation strategies that are less popular in the literature, such as situation modification and situation selection, are used in real life, they are worthy of scientific investigation.

Thirdly, this area of research is mostly concerned with the regulation of negative emotions and therefore, overlooks intrapersonal emotion regulation strategies that are commonly used to regulate positive emotions (Heiy & Cheavens, 2014). This is problematic because people must regulate both negative and positive emotions in their everyday lives, but little is known about how they regulate positive emotions. In response to this gap in the literature
Quoidbach, Mikolajczak and Gross (2015) conducted a literature review to determine the level of research support for the effectiveness of strategies used to up-regulate positive emotions based on the quality of research methods. They found that there is more empirical support for cognitive change, attentional deployment, and response modulation for short term increases in positive emotion than situation selection and modification. For longer term increases of positive emotion, there is more evidence for the effectiveness of situation selection and attentional deployment than cognitive reappraisal, response modulation, and situation modification. They concluded that more research is needed to improve our understanding of how people regulate their positive emotions.

Studies on the effectiveness of intrapersonal emotion regulation strategies have mainly focused on intrapersonal outcomes, such as one’s own emotional state. However, since intrapersonal emotion regulation is often utilised during social interaction (Kappas, 2013), research on the interpersonal outcomes associated with intrapersonal emotion regulation is growing. Most of these studies only go as far as demonstrating that emotion regulation strategies have an impact how the actor is perceived but stops short of identifying specific strategies that are more or less effective. For example, researchers have found that inexpressive winners are liked more than expressive winners (Kalokerinos, Greenaway, Pedder & Margetts, 2014; Schall, Martiny, Goetz & Hall, 2016). Other studies have pointed out that dysregulation of emotions is associated with low-quality relationships (e.g., Abbott, 2005; English, John & Gross, 2013; Tani, Pascuzzi & Raffagnino, 2015) and emotion regulation ability is positively related to high-quality relationships (Lopes et al, 2005, Lopes et al, 2011). There is a lack of studies that have gone further to identify the differential effects on interpersonal outcomes depending on the specific emotion regulation strategy used. A notable exception is a study by Richards, Butler and Gross (2003) which found that during tense social interactions, reappraisal increases memory of what is said, while suppression decreases memory of what is said. Since research has shown that couples who are better able to remember their conversations about relationships have a better understanding of their partner’s perspective (Sillars, Weisberg, Burggrat & Zietlow, 1990), conversation memory may be associated with better relationship functioning (Richards, Butler & Gross, 2003).

While research on the effectiveness of intrapersonal emotion regulation strategies used at work suffers from many of the same deficits as research on emotion regulation in everyday life, such as a focus on few emotion regulation strategies and the regulation of negative emotion as opposed to positive emotion, this area of research makes an important
contribution to the knowledge base on the associated outcomes of emotion regulation strategies (Grandy, 2015). This area of research focuses on intrapersonal, interpersonal and job performance outcomes. Hulsheger & Schewe (2011) conducted a meta-analysis on the costs and benefits of emotional labour, the process by which workers are expected to manage their feelings in accordance with organisationally defined rules (Hochschild, 1983), in several different work context, including healthcare. On an intrapersonal level, they found that surface acting is generally associated with the regulator experiencing negative emotions and has a strong positive relationship with burnout facets of emotional exhaustion. Deep acting, on the other hand, is generally associated with the regulator experiencing positive emotions. On an interpersonal level they found deep acting is associated with building positive relationships with customers, while surface acting is associated with building negative relationships with customers. Also, authentic displays of emotions, which are associated with deep acting, are more likely to evoke positive responses from customers than inauthentic displays of emotion, which are associated with surface acting (e.g., Henning-Thurau, Groth, Paul & Gremler, 2006; Grandey, Fisk, Mattila, Jansen & Sideman, 2005).

Regarding job performance outcomes, Hulsheger & Schewe (2011) found that surface acting had a strong association with impaired wellbeing and was negatively related to emotional performance (i.e., the degree to which employees fulfil organisational display rules), task performance, and customer satisfaction. Deep acting, on the other hand, had a weak relationship with indicators of impaired wellbeing. While no positive relationship was found between deep acting and task performance, deep acting had a positive relationship with emotional performance and customer satisfaction. It is important to note that none of the studies in this review were in the context of occupational therapy or physiotherapy.

Since Hulsheger and Schewe’s meta-analysis in 2011, researchers have worked towards gaining a deeper and more nuanced understanding of emotion regulation strategies and associated outcomes. Researchers are beginning to investigate a wider range of emotion regulation strategies used at work. For example, Hadley (2014) investigated the effects of social sharing of negative and positive emotions with colleagues at work on the regulator’s emotions from the regulator’s perspective. She found that the effectiveness of social sharing is dependent on the context. In particular, she identified three contextual conditions that support successful emotion regulation outcomes; group norms, supervisor’s behaviours and co-worker responsiveness. These results are consistent with previous research that has shown...
that positive/negative expression of emotion can have both positive and negative outcomes (e.g., Brown, Westbrook & Challagalla, 2005; Fredrickson, 2001; Dasborough, 2006).

Other researchers have sought to understand why some studies have contradictory findings regarding the effectiveness of certain emotion regulation strategies by differentiating the effects of specific strategies that fall into the same family of emotion regulation strategies. For example, Wang & Groth (2014) examined the moderating effects of the employee/customer relationship and the type of service, on the effects of surface acting on customer outcomes. As part of this, they also sought to find out if two different strategies used to surface act, faking and suppressing, had differing effects on customer satisfaction. They found that faking positive emotion has no effect on customer satisfaction, but suppressing negative emotion has a negative effect on customer satisfaction, particularly in encounters when no relationship exists or in highly personalised service encounters. Customers that know the employee well are less sensitive to the negative effects of suppressed emotions and customers in highly personalised service encounters are more sensitive to the negative effects of suppressed emotions (Wang & Groth, 2014).

In general research has shown that some strategies (e.g., cognitive reappraisal and deep acting) tend to be more adaptive than other strategies (e.g., response modulation and surface acting). However, developing a comprehensive understanding of the effectiveness of intrapersonal emotion regulation strategies is complicated because the effect of strategies is context dependent and moderated by several factors. Our understanding of the effectiveness of intrapersonal emotion regulation strategies is limited by researchers’ tendency to investigate a small number of strategies and focus on emotion regulation in response to negative emotion as opposed to positive emotion. To fully understand the effectiveness of emotion regulation strategies, research is needed that fully describes the context in which strategies are effective and avoids unnecessary limitations in scope.

3.3.4 Effectiveness of Interpersonal Emotion Regulation Strategies

Similar to literature on intrapersonal emotion regulation, research on interpersonal emotion regulation has focused on identifying adaptive and maladaptive strategies given a particular context (Dixon-Gordon, Bernecker & Christensen, 2015). This area of research is in its infancy but there are a few studies that have investigated the intrapersonal and interpersonal outcomes associated with interpersonal emotion regulation. While some of these studies were
conducted in a workplace environment, none were conducted in the context of occupational therapy or physiotherapy.

Regarding intrapersonal outcomes, a recent study conducted partially in a healthcare work environment found interpersonal emotion regulation strategies aimed at worsening the targets emotions had a depleting effect on the actor’s personal resources, as indicated by level of emotional exhaustion. In contrast, interpersonal emotion regulation strategies aimed at improving the targets emotions initiated positive feedback from the target. This positive feedback decreased the association between interpersonal emotion regulation aimed at improving the targets emotion and personal resources depletion (Martinez-Inigo, Poerio & Totterdell, 2013). Another study by Niven and colleagues (2012) concluded that the use of interpersonal emotion regulation strategies focused on improving other’s emotions had a positive effect on the agent’s emotions. Similarly, interpersonal emotion regulation strategies focused on worsening other’s emotions had a negative effect on the agent’s emotions. These findings were consistent with an earlier study by the same authors (Niven, Totterdell & Holman, 2007) in an organisational setting that found that positive interpersonal emotion regulation strategies were associated with positive moods and high-quality relationships. Negative emotion regulation strategies were associated with negative mood and low-quality relationships, except for one negative emotion regulation strategy, criticism.

In general, research on the interpersonal outcomes of interpersonal emotion regulation has concluded that using strategies to improve others emotion is more adaptive than using strategies to worsen other emotions. For example, research has shown that people who attempt to use interpersonal emotion regulation strategies to improve other’s emotions are able to build and maintain better dyadic relationships than those who attempt to worsen other’s emotions (Niven, Holman & Totterdell, 2012; Niven et al, 2015). Developmental research on this topic has found similar results (e.g., Crowell et al, 2013; Morelen & Suveg, 2012). This is also true in a group setting since the emotions of observers are influenced by other’s interpersonal emotion regulation efforts (Totterdell et al, 2012). The rationale for this is supported by theories, like the emotions in relationships model and social exchange theories, that purport that people like people who make them feel good.

There is a lack of studies that address outcomes of interpersonal emotion regulation in healthcare settings. However, in related research on emotional communication, researchers have found that healthcare professionals’ empathic responses to patients’ expression of
emotion are associated with positive patient outcomes in terms of reduced distress (Zachariae et al, 2003), patient adherence to recommendations (Kim, Kaplowitz & Johnston, 2004), and symptom resolution (Hojat et al, 2011).

In general, studies have found that strategies focused on improving other people’s emotions are more adaptive than strategies focused on worsening other people’s emotions. These strategies have an effect on the target and the agent. However, this area of research is in its infancy and more research is needed to understand the adaptiveness of emotion regulation strategies in various contexts. In particular, researchers have called for more research to examine interpersonal emotion regulation processes over the course of interactions (Dixon-Gordon, Bernecker & Christensen, 2015). Researchers have also called for more studies that focus on both dyadic partners use and experience of interpersonal emotion regulation strategies (Zaki & Williams, 2013). This means there is a significant gap in our understanding of how people influence other people emotions and the effectiveness of these strategies. Given the importance of healthcare professionals ability to influence their patient’s emotions, research is needed in this area.

3.4 Factors that Influence the Use and Effectiveness of Emotion Regulation Strategies

Many factors influence the use and effectiveness of emotion regulation strategies. In research on this topic in the workplace context, researchers have identified several factors that moderate the impact of emotion regulation strategies on outcomes. For example, a study by Grandey and colleagues (2012) found that the emotional climate within a workplace has an impact on whether emotional labour leads to burnout. In another study by Wang & Groth (2014), employee-customer relationship strength was found to mediate the relationship between the employee suppressing negative emotions and patient satisfaction. Other moderating factors found to influence the outcomes of emotion regulation include emotional intelligence (Prentice, 2013), perceived organisational support (Hur, Han, Yoo, Moon, 2015), the customer’s response to emotion regulation strategies (Zhan, Wang & Shi, 2016), and customer orientation (Allen, Pugh, Grandey & Groth, 2010). Two influential factors that are particularly relevant to this study are social interactional and temporal influences. These factors will be discussed in the next two sections.
3.4.1 Social Interactional Influences

A driving feature behind the outcome of emotion regulation strategies is the response of others. This is true in intrapersonal emotion regulation (e.g., social sharing of emotion) and interpersonal emotion regulation (Hadley, 2014). Emotion regulation is a bi-directional process in which each dyadic partner’s ongoing use of emotion regulation is influenced by their partner’s response (Diefendorff & Gosserand, 2003). The target’s response influences the agent’s perception of the effectiveness of their emotion regulation efforts. Based on this perception, the agent may decide to continue, discontinue, or alter their use of emotion regulation in order to achieve their goals. For example, a therapist who used humour to make a patient feel better will stop if the patient responds with anger. For this reason, it is difficult to fully understand the effectiveness of emotion regulation strategies during dyadic interactions without considering the behaviour and perception of both dyadic partners.

There are several studies on emotion regulation in romantic couples and familial dyads (e.g., mother and child or siblings) that include the behaviour and/or perception of both dyadic partners. These studies typically examine how the use of common intrapersonal emotion regulation strategies, specifically expressive suppression and reappraisal, are associated with outcomes, such as wellbeing, relationship quality, and factors that influence relationship quality, for example a partner’s perception of constructive or hostile criticism or a partner’s recollection of their discussion (e.g., Klein, Renshaw & Curby, 2016; Richards, Butler & Gross, 2003). In general, the conclusions of these studies are in line with non-dyadic studies on the effectiveness of these emotion regulation strategies, in that they found that expressive suppression is typically less adaptive than reappraisal. There are also dyadic studies that investigate the outcomes associated with strategies that are only at times used for emotion regulation purposes, such as touch (e.g., Debro, Schoebi, Perrez & Horn, 2013; Hertenstein & Campos, 2001).

In organisational research, dyadic studies on emotion regulation mostly involve leader-member (employee) dyads. These studies typically examine how emotion regulation is associated with leader-member exchange (LMX) quality or how emotion regulation moderates the relationship between LMX and other organisationally relevant factors, such as organisational citizenship behaviours and job satisfaction (e.g., Fisk & Friesen, 2012; Glaso & Einarsen, 2008; Richards & Hackett, 2012). LMX represents the relationship between leaders and members. A high-quality exchange relationship is characterised by both the leader and the follower working in partnership to achieve mutual goals, where individuals
may step beyond formal organisational role requirements to achieve desired goals. In contrast, low-quality exchange relationships are characterised by a lack of trust, respect and sense of devotion, where individuals perform as they are required by the contract of their employment but do not offer any further assets (Graen & Uhl-Bein, 1995). These studies typically utilise quantitative questionnaires. While this data collection method enables them to have larger sample sizes, the quantitative nature of the questionnaires may preclude them from gaining a more detailed and nuanced understanding of how each strategy is being used in context.

However, in occupation-based research on emotion regulation, studies that access the behaviour and perceptions of both dyadic partners are rare. One such study by Lu and Liou (2015) examined the influences of personnel officials’ emotional labour on teachers’ perceptions of the personnel officials’ emotional displays. They also assessed the effects of these perceptions on teacher-personnel official relationship quality. They found that personnel officials’ use of deep and surface acting was significantly related to the teachers’ perception of each respective emotion regulation strategy. They also concluded that the teachers’ perception of personnel officials’ authenticity was related to better relationship quality.

Another study that explored dyadic use of emotion regulation in an organisational setting was conducted by Tumbat (2011). Using observation and unstructured interviews she sought to understand the lived experience and evolution of interactions among service providers and clients during a prolonged service interaction. This was done in the context of commercial high-altitude mountaineering expeditions where the customers were mountain climbers and the service providers were mountain climbing guides. Service interactions in this organisational context may last from three to nine weeks or more, however, the author did not specify how long she observed the clients. The sample size consisted of 19 clients and guides.

The major contribution of this study is that the researcher found that customers, like service providers, felt the need to regulate their own emotions and to influence the guide’s and other customer’s impression of them. For example, customers may engage in emotion regulation to convince a guide that they are physically able to climb. They may also engage in emotion regulation to convince other climbers that they are comparatively better climbers or can be depended on in an emergency. The study did not identify specific interpersonal emotion
regulation strategies used. The author also found that customers, like service providers, utilised “back-stages” for opportunities to prepare for ongoing “front stage” emotion regulation. For example, climbers retreated to their tents and used intrapersonal emotion regulation strategies, such as listening to music, writing emails, and reading books, to recover both physically and emotionally. The study did not comment on how emotion regulation strategies developed within the service relationship.

In occupation-based emotion regulation research that is specific to healthcare, there are few studies that access both dyadic partners’ point of view. One such study, by Lovatt and colleagues (2015), explored the experience of emotional labour from the healthcare assistant and family members’ (of the patient) point of view using semi-structured interviews. They found that healthcare assistants view providing emotional support to patients and their families as a key component in their job and family members value this emotional support. No studies based in occupational therapy or physiotherapy were identified on this topic.

Social interaction has an important influence on the use and effectiveness of emotion regulation strategies. This highlights the importance of studies on emotion regulation including the perspectives of both dyadic partners. While there are some dyadic studies in research on work relationships (e.g., research on LMX), there are fewer such studies in healthcare and none in occupational therapy or physiotherapy. Given the importance of emotion regulation in these professions, research in this area would improve our understanding of how patients and therapists use and experience emotion regulation.

**3.4.2 Temporal Influences**

Contextual factors underlying interactions and relationships are constantly changing over time. For example, contextual display rules change over time (Diefendorff & Richard, 2008) and the motivations for or need for using emotion regulation is constantly changing within social interaction. For this reason, effective emotion regulation strategies used at one point in time may be ineffective if used at another point in time.

This is also the case when considering dyadic relationships at work (Ferris et al, 2009). How people use emotion regulation may change as the relationship develops (Bolton, 2005). For example, a patient who does not know his therapist well may try to hide his tears or sorrow. However, when the patient and therapists have built up a certain level of rapport, the patient may feel more comfortable crying in front of his therapist. Also, each interaction is influenced by previous interactions and expectations of future interactions (Boiger &
Mesquita, 2012). For this reason, interaction styles may change over time (Ferris et al, 2009). In addition, emotion intensity levels change as relationships develop and since the effectiveness of emotion regulation strategies varies depending in part on the intensity of the emotion (Sheppes and Gross, 2011), this is further reason to expect changes in the way emotion regulation strategies are used over time in dyadic interaction.

Despite calls for more research on temporal factors associated with emotion regulation (Sheppes & Gross, 2011) and appeals for more organisational research that considers temporal aspects of behaviour in organisations (Ancona, O'huysen, & Perlow, 2001; George & Jones, 2000), research in this area has been criticised for considering emotion regulation as a discrete event rather than a dynamic process (Cote, Moon, Miners, 2008). This is because most of the research on emotion regulation is concerned with the duration of the emotion generation cycle, which may last for a fraction of a second, a relatively short time span. These studies do not appear to consider that emotions stemming from affective events are dynamic and may linger long after the event (Hammonds & Cadge, 2014). At the other end of the extreme, there is a substantial body of research on how emotion regulation develops over the lifespan, a relatively long time period.

There is a need for research on how emotion regulation is used over different time frames (Grimm, Ram, & Hamagami, 2011). There are a few studies that have focused on how emotion regulation is used during the course of a day (e.g., Brans et al, 2013; Nezlek & Kuppens, 2008; Verduyn, Van Mechelen & Tuerlinckx, 2011). One study explored how the use of emotion regulation strategies change over time during and after emotion regulation training (e.g., Goldin et al, 2014). Another study conducted by Hammonds & Cadge (2014) examined how nurses managed residual emotions leftover at the end of the work day from emotional experiences that occurred during the workday. They found that nurses utilised social support systems, called into work to check on patients, and engaged in activities to distract themselves, such as watching television and exercising.

Gabriel and Diefendorff (2015) examined employees use of deep and surface acting, felt emotion, and vocal tone over time during one transaction. They took measurements every 200 milliseconds during a single interaction between employee-customer dyads. Their two main findings were that deep and surface acting are used simultaneously to manage emotional labour demands, and customer behaviour influences within-episode changes in emotion, emotion regulation, and vocal tone.
A study by Curci and Rime (2012) took a rare approach to studying emotion regulation over time, in that they specifically examined how the use of a particular emotion regulation strategy evolves over time. They investigated the evolution of social sharing of emotions over a nine-month period after an emotional event. They concluded that social sharing tends to diminish over time leading to an increased sense of emotional recovery. However, if social sharing is prolonged, it is associated with poor emotional recovery.

To develop our understanding of emotion regulation, more research needs to consider how it operates over time (Gross, 2015). There are few studies that focus on emotion regulation use over time. Those that do generally investigate what strategies are used at different points in time. They also typically do not include both dyadic partners’ perspectives. Even more rare are studies investigating how the implementation of particular strategies change over time. Research that focuses on how different strategies are used over time in specific contexts can fine-tune our understanding of how emotion regulation strategies are used.

3.5 Why Do People Use Emotion Regulation Strategies?

Emotion regulation is typically used for goal directed purposes (Gibson, 2008) in response to an emotion causing stimulus (Gross, 2015). Sometimes the change in the emotion is the goal. For example, a therapist may make a joke to make themselves or their patient better. Other times the change in emotion is required for a broader goal. For example, a patient may make a joke to facilitate their therapist to have positive emotions, so the therapist will think positively of their interactions and subsequently, their relationship. The goal may also be to change the intensity of the emotion, rather than the type of emotion. For example, a therapist who is excited because she just got a promotion, may want to decrease her level of excitement when interacting with the next patient. A person’s emotion regulation behaviour may be simultaneously motivated by competing or synergistic motivations, and a person’s emotion regulation behaviour depends on the integration and prioritisation of their goals (von Gilsa & Zapf, 2013).

A person’s emotion regulation behaviour may also be motivated by affective events. Emotional events or affective events are happenings to which people respond emotionally (Wiess & Cropanzano, 1996). Affective events are omnipresent in our daily lives, including our working lives. This section begins with a review of research on goals and motivations.
that compel people to use emotion regulation, first in an everyday context and then in a work context. This is followed by a review of research on affective events at work.

3.5.1 Goals and Motivations for Emotion Regulation

People are motivated to use intrapersonal and interpersonal emotion regulation to serve their best interests (Gross, 2015). On an intrapersonal level people are motivated to feel good, and thus attempt to use emotion regulation to experience positive emotions and avoid negative emotions (Fischer et al., 2004). However, people are willing to experience negative emotions for instrumental purposes (Tamir, 2007) if it is in their best interest. On an interpersonal level, people are motivated to make others feel better or worse if they deem it to be beneficial to themselves (Netzer, Van Kleef & Tamir, 2015).

In general, emotion regulation use may be motivated by norms and rules governing how people should feel, appear to feel, or interact with others and the expectation that it is in one’s best interests to comply (Fischer et al., 2004). People may use emotional regulation to be in line with socially defined emotional display rules (Goffman, 1959). These display rules define appropriate and inappropriate displays of emotion. Social display rules may be attached to norms with cultures, gender, or social groups (Goffman, 1959).

Fischer and colleagues (2004) identified three categories of motives for using intrapersonal emotion regulation; impression management, influence, and prosocial. Impression management is when people are motivated to regulate their emotions in order to be perceived favourably. Influence implies that people are motivated to use emotion regulation to influence others behaviour. Lastly, prosocial motives mean people are motivated to regulate their emotions in ways that are beneficial rather than harmful to others. Although they were referring to intrapersonal emotion regulation, the categories are relevant to interpersonal emotion regulation.

In a workplace context, there are many factors that may motivate employees to use emotion regulation strategies. Bolton (2005) proposed four categories of emotion management based on motivations for use of strategies: prescriptive, pecuniary, presentational, and philanthropic. Prescriptive emotion management is motivated by prescribed rules of conduct, such as organisational display rules. For example, a therapist may smile when first meeting her patient because organisational display rules require her to appear pleasant. Pecuniary emotion management is typically motivated by commercial gain and is similar to prescriptive emotion management. The main difference is pecuniary display rules are externally imposed.
by the customer rather than internally imposed by the organisation. An example of pecuniary emotion management is a therapist in private practice who manages her emotions so that she can present herself as cheerful to encourage patient satisfaction and retain the patient’s business. Presentational emotion management is motivated by self-presentation goals. For example, a therapist may hide her anxiety when working with a patient with a highly contagious disease to present herself in a professional way. Lastly, philanthropic emotion management is motivated by altruism. For example, the therapist may remove her glove to shake the hand of a patient with a highly contagious disease to prevent the patient from feeling like a pariah.

A more recent classification of service workers’ motivations for using emotion regulation, proposed by von Gilsa & Zapf (2013), included three categories; instrumental, pleasure, and prevention. Instrumental motives are focused on achieving a prioritised goal. The use of emotion regulation for the purpose of adhering to organisationally dictated display rules falls into this category. Other examples of instrumental motives are the use of emotion regulation strategies to achieve goals, such as building relationships, appearing confident, getting the job done quickly, or to show respect. The second category, pleasure motives, is focused on facilitating the experience of pleasurable emotions, such as happiness and pride. The third category is prevention motives, which are emotion regulation strategies used for the purpose of preventing conflict. For example, a therapist may ignore (attentional deployment) a patient’s angry outburst to avoid responding in an angry fashion which could antagonise the patient.

There is a general assumption in research on emotion regulation at work that employees regulate their emotions in customer interactions mainly to be in line with display rules (von Gilsa & Zapf, 2013). Display rules at work refer to the expressions of emotion that are (or are not) appropriate for employees as defined by the organisation (Diefendorff, Richard & Croyle, 2006). These rules specify the range, intensity, duration, and object of emotions that are expected to be displayed (Mann, 2007). Display rules represent shared perceptions of norms and may be shared amongst various groups of individuals, including teams and organisational or professional groups (Martinez-Inigo, Totterdell, Alcover & Holman, 2009). They are generally a function of societal norms, occupational norms and organisational norms (Ashforth & Humphrey, 1993).
Display rules may be explicit or implicit job requirements (Grandey, 2000). The organisation and professional bodies may explicitly communicate display rules through signage and training. The organisation and professional bodies may implicitly communicate display rules through their code of ethics and conceptualisation of professionalism.

Healthcare professionals display rules towards patients prescribe the expression of positive emotions and empathy and the suppression of negative emotions (Diefendorff, Richard & Croyle, 2006). For example, therapists may have to use intrapersonal emotion regulation to disguise their own painful and upsetting emotions at work, such as frustration, sadness, and worry (Taylor, Lee, Kielhofner & Ketkar, 2009). Similarly, therapists may have to use interpersonal emotion regulation to manage difficult behaviours that patients display, such as emotional dependence, manipulative behaviour, attention seeking, and attention demanding behaviour (Taylor et al, 2009).

Employees are motivated to adhere to emotional display rules to varying degrees depending on several factors. For example, a study by Diefendorff and colleagues (2010) concluded that employees use more control in adhering to display rules if their interaction partner had higher relative power than if the interaction partner had lower or equal relative power. Similarly, they found that employees use more control when interacting with a partner with whom they did not have a close interpersonal relationship than when interacting with a partner with whom they did have a close interpersonal relationship (Diefendorff, Morehart & Gabriel, 2010).

Another factor that may motivate employees to adhere to emotional display rules is to avoid the reprisals that they may experience as a consequence of contravening display rules. At the organisational level, the employee who does not adhere to emotional display rules may be reprimanded by her employer, required to get training, or even fired. At the professional level, professional bodies may impose sanctions on therapists who contravene display rules such as restricting a therapist’s scope of practice or striking them off the register completely, thereby forbidding them to practice in the profession.

It is important to note that there are times when employees are motivated to disregard display rules. Deviance from display rules occurs when employees consciously display emotions to customers or patients that are unsanctioned by the organisation (Dahling, 2017). Such deviance can have a detrimental effect on customer satisfaction and the organisation’s bottom line. Employees are sometimes motivated to deviate from display rules in this way.
particularly if they experience mental exhaustion or unfair treatment from a customer (Dahling, 2017).

Research on motivations for emotion regulation at work is mostly concerned with the emotion regulation motivations of the worker and overlooks customer motivations for emotion regulation during interactions. Although patients do not have display rules that are prescribed and enforced by an employer, they would more or less subscribe to rules of proper conduct that are defined by the wider society (Goffman, 1967). Such display rules may be publicised and enforced by the organisation which the customer is patronising. For example, it is increasingly common to see signs posted in tube stations, post offices, and banks reminding customers that rude behaviour will not be tolerated.

There may be some service situations that place more demands and expectations on customers to engage in emotion regulation beyond adhering to the societal emotion display rules. In other words, customers may be more motivated to engage in emotion regulation in some service situations than others. This may be the case in service situations that require the customer to perform, rather than just passively receiving the service. For example, in a study on customer emotion regulation in stressful, extended service encounters, customers were expected to perform a physical task (mountain climbing) while receiving support from a mountain climbing guide (Tumbat, 2011). This ethnographic study found that customers perceived an obligation to perform emotion work for self-presentational and utilitarian purposes (Tumbat, 2011). For instance, the customers felt that they needed to appear like they were willing and able to climb the mountain and therefore were motivated to hide any anxiety they may have experienced concerning the task. This is a contextual factor that has not been thoroughly explored in the limited amount of research on customer’s use of emotion regulation.

Service encounters in therapeutic services are similar to service encounters in a mountain climbing context in that they may happen over an extended period of time and both the therapist and the patient are required to perform. For this reason, occupational therapy and physiotherapy patients may be motivated to use more emotion regulation than customers in other types of service models. Patients’ performance may include trying their best during therapy sessions and learning/implementing therapists’ recommendations. These performances may require the use emotion regulation strategies. For example, they may feel
the need to hide their anxiety when their therapists ask them to attempt to stand after being wheelchair bound for a period of time.

There are many factors that motivate people to use emotion regulation. In a workplace context, researchers have focused on employees’ motivations to the exclusion of customers’ motivations. Research is needed to address this gap in the literature. Since occupational therapy and physiotherapy services are environments where professionals and patients work together over relatively longer periods of time and the patients are more than passive recipients of services, this environment is ideal for studying the patient’s role in dyadic emotion regulation.

3.5.2 Affective events at work

People use emotion regulation strategies to address emotions stemming from affective events. The importance of affective events at work is highlighted by affective events theory which postulates that affective events impact upon employees’ emotions and mood and this, in turn, influences employees’ attitudes and behaviour (Weiss & Cropanzano, 1996). Ohly and Schmitt (2015) have identified eleven negative and positive categories of emotional events at work. Goal attainment, positive feedback, and externally determined positive experiences are examples of positive affective events. Interpersonal conflict, hindrances to goal attainment, and technical difficulties are examples of negative affective events.

Since not all emotions or affective events require emotion regulation and negative affective events tend to require more emotion regulation than positive affective events (Taylor, 1991), Diefendorff and colleagues (2008) investigated which negative affective events and associated negative emotions are most often identified as antecedents of emotion regulation at work. To address this question, they used surveys with a sample of students working in several different occupations, including sales/service, clerical, healthcare, education, professional/technical, and skilled labour. They found that interpersonal conflict with customers and personal/physical problems were the most common antecedents of emotion regulation at work. Other affective events that are common antecedents to emotion regulation at work include interpersonal conflict between co-workers, management or others, goal failure, technical problems, high/low workload, and aversive work. The negative emotions that were commonly associated with these events were frustration, annoyance, anger, boredom, discouraged, and fatigue. More intense emotions, such as frightened,
intimidated, misery, and fury were less commonly associated with these effective events (Diefendorff, Richard & Yang, 2008).

In healthcare-based research, some insight into affective events can be gained through studies focused on adverse medical events and occupational stressors in healthcare working environments, such as patient falls, interpersonal conflicts, and medical error (e.g., Andersson et al., 2015; Santos, Barros & Carolino, 2010). However, this research is not purely focused on emotion causing events. A study exploring emotional labour in healthcare settings found that managing distress, suffering, trauma, death, bereavement, anxiety, and anger are common sources of emotional labour (Riley & Weiss, 2016). Also, there is a small segment of nursing-based research that focuses specifically on negative and positive affective events, called hassles and uplifts. Examples of hassles from nurses’ point of view include dealing with patients who are demanding, violent, rude, or ungrateful. Examples of uplifts include instances when the patient is cooperative, the nurses can be honest with their patients, the patient’s family is helpful, and when the nurses have plenty of time to care for their patients (Elder et al., 2003). From patients’ point of view, hassles include worries about physical illness, being lonely or bored, and difficulties with seeing and hearing. Uplifts include praying, visits from loved ones, socialising, and gossiping (Miller, Wilcox & Soper, 1985).

Although interpersonal events are considered an important element in therapeutic relationships (Taylor, 2008), there are no studies in the occupational therapy or physiotherapy context that identify affective events.

To fully understand emotion regulation at work we must understand the source of emotion (Ohly & Schmitt, 2015). Healthcare based research has not studied affective events directly but has instead focused on related topics, such as hassles and uplifts. This topic has mostly been overlooked in occupational therapy and physiotherapy professional services. This represents an important gap in the literature that impedes our understanding of emotion regulation in these professional contexts. In addition, since hassles and uplifts have been found to have an important influence on interpersonal relationship quality due to its impact on personal resources (Totenhagen, Serido, Curran & Butler, 2012), affective events may also impact upon therapeutic relationship quality. Given the importance of therapeutic relationships in healthcare settings (Peplau, 1997), more research is needed to understand the affective events that occur within the context of therapeutic relationships.
3.6 Summary

Despite the exponential growth of emotion regulation research, there are many gaps in the literature that impede our understanding of how people use emotion regulation. The most general subsection of emotion regulation literature that focuses on emotion regulation in everyday life, provides a strong theoretical foundation upon which other subsections of literature are built. This area of literature is also a main contributor to our understanding of causal relationships regarding emotion regulation since most of these studies involve laboratory-based experimental manipulations utilising an emotion-eliciting stimulus, such as a sad movie and instructions on how to regulate the resulting emotion (Heiy & Cheavens, 2014; Grandey, 2015). However, the trade off with using this mode of methodological inquiry and the main problem with this area of research, is the lack of ecologically valid methods. This is problematic because the conclusions found under laboratory conditions may not be the same as conclusions found under natural conditions.

In addition, these studies in many ways tend to oversimplify the complex nature of the emotion regulation process. They tend to focus on a limited number of emotion regulation strategies even though people may use a wide range of emotion regulation strategies (Webb, Miles & Sheeran, 2012). Also, despite emerging evidence that people use multiple emotion regulation strategies at once in response to emotion eliciting stimulus, most studies assume that individuals use only one regulation strategy in response to an emotion-eliciting stimulus or situation (Aldao & Nolen-Hoeksema, 2013). These studies also tend to study only intrapersonal or interpersonal emotion regulation despite the fact that people use these concurrently in real life (Kappas, 2013). Lastly, research on emotion regulation favours the regulation of negative emotions over the regulation of positive emotions even though people regulate both positive and negative emotions in their daily lives (Heiy & Cheavens, 2014).

Research on the use of emotion regulation at work contributes to our understanding of the practical real-world relevance of emotion regulation in terms of health, job performance and organisational implications (Grandey, 2015) and provides a more defined contextual theme than research on emotion regulation in everyday life. In this area of research literature, a common mode of inquiry is self-reported surveys, and in this way this research tends to be more ecologically valid than research on emotion regulation in everyday life. Unfortunately, this research suffers from some of the same problems as research on emotion regulation in everyday life, including focusing on the regulation of negative as opposed to positive...
emotion, a limited number of emotion regulation strategies and the use of one strategy at a time.

The most naturalistic subset of emotion regulation research is the occupation-based emotional labour studies. While many of these studies are in healthcare work environments, there is a lack of such studies specifically in occupational therapy and physiotherapy work environments. These studies tend to use ethnographic methods, including interview and observation (Wharton, 2009), to identify the emotion regulation strategies that employees use but typically stop short of identifying the outcomes or effectiveness of these strategies. While, the qualitative nature of these studies complements the quantitative methods used in emotion regulation research in everyday contexts, it also limits their generalisability. Another problem with occupation-based emotional labour research is it is largely disjointed and therefore, does not benefit from the gains made in each respective research stream. For example, research on occupation-based emotional labour has not utilised research on affective events or uplifts/hassles to try to understand the events that cause healthcare workers to use emotion regulation. In addition, these studies have mostly overlooked healthcare professionals use of interpersonal emotion regulation strategies.

These knowledge gaps impede researchers understanding of emotion and emotion regulation in service interactions. Research addressing these gaps can help researchers understand how employees can best use emotion regulation at work and the role that patients/customers play in emotion regulation during dyadic services interactions. The knowledge gained from research in this area can have important implications for employee, patient/customer, and organisational outcomes.

This chapter and the previous chapter have identified a number of knowledge gaps regarding the role of emotion regulation in therapeutic relationships. In response to these gaps in the literature, the following research questions will be addressed: What emotion regulation strategies do patients and therapists use? How does the use of these strategies change as the relationship develops? What turning points characterise high and low-quality therapeutic relationships? Qualitative methods are used to answer these questions. The next chapter will describe the methods used to address these research questions.
Chapter 4 Methodology

4.1 Introduction

The overall purpose of this research was to understand how patients and therapists use emotion regulation and how their use of emotion regulation unfolds as the relationship develops. To this end two qualitative studies were conducted. In the first study, semi-structured interviews were used to access patients’ and therapists’ perceptions of their use of emotion regulation strategies. The second study built upon the first by collecting data using unstructured observation and participant verification interviews. A pilot study was conducted prior to both studies for the purpose of fine-tuning the data collection process.

Data collection and data analysis are discussed separately but were conducted iteratively throughout this study. Conducting the research this way lead to an emergent design in that each successive data collection cycle benefited from the knowledge gained from the previous data analysis cycle. This is a recommended strategy since an emergent design enables researchers to base their interviews on the perceptions of those being studied, and these perceptions may not be apparent at the outset of the study (Lincoln & Guba, 1985).

Throughout the research process I documented the rationale for the decisions made regarding the emergent design in a reflexive journal as recommended by Miles and colleagues (2013).

This chapter begins by clarifying my epistemological stance and this leads to my rationale for using qualitative methods. Each of the two studies are then discussed separately. First the development of the data collection tools and the data collection process are described. I then explain the process by which I recruited participants for the study, including the sampling strategy, inclusion/exclusion strategy, and participant demographics. Next the data analysis rationale and process are described. The studies limitations are then discussed. This is followed by a description of my reflexivity, the context of the study, and the ethical issues raised and addressed. The last section summarises the chapter.

4.2 Methodological Approach and Rationale

Ontology is concerned with the nature of reality (Guba & Lincoln, 1994). A researcher’s ontological perspective determines whether the researcher thinks reality exists entirely separate from human practices and perceptions or whether the researcher thinks reality cannot be separated from human practices and perceptions. A realist ontological perspective takes
the former view and a relativist ontological perspective takes the latter (King & Brooks, 2017). However, there are many variations of ontological perspectives that range along the continuum between realism and relativism. My ontological perspective leans towards the realist end of the spectrum in that some aspects of emotions and emotion regulation exist outside of human practices and perceptions. For example, a patient who is crying, which may be an emotion regulation strategy, is a reality that occurs regardless of human practices and perceptions; in other words, it is an objective reality. However, my ontological stance is not purely realist in that I understand the reality of emotion regulation in therapeutic relationships to be a social phenomenon with multiple, context dependent truths; a viewpoint that is indicative of a relativist ontological perspective.

Epistemology is concerned with the way in which knowledge is best acquired (Ormston, Spencer, Barnard & Snape, 2013). Qualitative research is typically viewed as a ‘bottom-up’ or inductive process of knowledge acquisition where we come to understand in patterns derived through observations. In contrast quantitative research knowledge acquisition is typically viewed as a ‘top-down’ or deductive process where hypotheses are tested against observations (Ormston, Spencer, Barnard & Snape, 2013). However, there is no such thing as purely inductive or deductive knowledge acquisition. For example, when inductive researchers interpret their data, they cannot approach this with a blank mind (Blaikie, 2007).

Another epistemological issue is what it means to accept particular claims as true. In the natural sciences the correspondence theory of truth is dominant. This theory of truth stipulates that a statement is true if it matches independent reality. In social science the coherence theory of truth is more appropriate. It stipulates that an account is true if it is supported by several other accounts (Ormston, Spencer, Barnard & Snape, 2013).

Epistemology is also concerned with the nature of the relationship between the researcher and reality (Guba & Lincoln, 1994). The objective reality that I seek to understand is obscured by my own perceptions, as the researcher, and the participants’ perceptions. In order to understand the reality of how therapists and patients experience emotion regulation during therapeutic relationships, I must access and understand their perceptions of this phenomenon. In this way, my research takes a constructivist epistemological stance. Given the subjective nature of perception, it is clear that one’s understanding of objective reality will inevitably be skewed. Therefore, it is important to use strategies to ensure that the participants and my own perceptions are as close as possible to an accurate reflection of the objective reality.
However, despite diligent efforts to access the objective reality, since the knowledge that I seek is perspectival, it is impossible to reach an absolute truth (King & Brooks, 2017).

Given a realist leaning ontology combined with a constructivist epistemology, my research takes a limited realist approach (King & Brooks, 2017). Limited realists believe the world has a reality outside of human constructions of it but our understanding of it is always limited by our position within it. Limited realists research is often concerned with producing causal explanations of social phenomena, seeks some degree of generalizability (King & Brooks, 2017) and often draws on and seeks to develop theory (Maxwell, 2012 cited in King & Brooks, 2017). While limited realist qualitative research does not claim objectivity, it rejects the position of more relativist and constructionist researchers that no interpretation of data is “better” than any other. Therefore, when analysing data, the researcher needs to question her assumptions and seek to develop an interpretation that is as credible as possible. Reflexivity is therefore an important part of the research process (King & Brooks, 2017). This approach logically leads to a qualitative methodology.

Methodological considerations are principles and ideas that guide how knowledge should be obtained (Holloway & Wheeler, 2010). There are several principles and ideas that guide qualitative methodological inquiry. The most basic idea associated with a qualitative methodology is the best way to understand people’s experiences and perceptions is to observe and listen to them. Another important qualitative methodological principle stipulates that understanding the context is a prerequisite to understanding the phenomenon. Also, qualitative methodology is not completely precise because human beings do not always act logically or predictably (Holloway & Wheeler, 2010). Reflexivity is an important consideration because the researcher cannot divorce herself from the phenomenon under study. In addition, the research design cannot be fully predesigned before the start of the research because the data has primacy in that it guides the research process. Therefore, qualitative inquiry must be dynamic and developmental by nature (Holloway & Wheeler, 2010).

Qualitative methods enable researchers to understand, describe, and explain social phenomena by accessing and analysing the experience of individuals in their natural context (Lincoln & Guba, 1985). Qualitative research methods enable the researcher to gain insight on how people make sense of their experiences and their world (Holloway & Wheeler, 2010). In this research, I need to understand therapists and patients experience of emotion regulation.
during the therapeutic relationship from their point of view, and therefore, qualitative methods are ideal for this purpose.

Although a quantitative methodological approach could be used to gain knowledge on social phenomenon, this approach was not compatible with my research objectives. The research question on how emotion regulation strategies develop within therapeutic relationships is one that has not previously be studied. Qualitative approaches are more appropriate than quantitative when little research has been done on the topic (Cresswell, 2003). Also, this research seeks to build a theoretical model rather than test a theory. Due to the exploratory nature of qualitative approaches, they are appropriate for building or adding to a theory. In contrast, the reductionist nature of quantitative approaches makes them more appropriate when testing a theory (Cresswell, 2003). In addition, this research aims to understand people’s experiences using their words rather than numbers. This is more indicative of a qualitative approach rather than a quantitative approach.

A qualitative approach was also chosen to address gaps in the relevant literature. Qualitative approaches are particularly useful in healthcare research focused on caring, communication, and interaction (Holloway & Wheeler, 2010) because these phenomena often need to be understood through people’s perceptions of their experiences. Most of the research on emotion regulation in everyday life and emotional labour use quantitative methods of inquiry. While these methods have many advantages, such as ability to establish cause and effect and potential for generalisation, they also have a number of disadvantages that can be addressed by qualitative research. In particular, quantitative research, unlike qualitative research, usually does not enable the researcher to probe answers from participants. Probing answers enables qualitative researchers to obtain more detailed and rich data. Also, in quantitative research data the context is minimised, whereas in qualitative research, the researcher strives to understand and describe the context (Cresswell, 2003). This is particularly important in the study of emotion regulation since the adaptiveness of emotion regulation strategies are context-dependent. Therefore, qualitative studies can illuminate the context in which emotion regulation strategies are used and can provide a more nuanced understanding of the phenomenon.
4.3 Study 1 Research Design

4.3.1 Introduction
As a first step in addressing the research questions, I used semi-structured interviews with occupational therapists, physiotherapists, and patients receiving occupational therapy or physiotherapy services. I chose to use this data collection method before using observation in the second study for three main reasons. First, using semi-structured interviews to understand a person’s perception of their use of emotion regulation strategies is quicker than observing each relationship. Secondly, since semi-structured interviews are less intrusive than observation, using semi-structured interviews provided an opportunity to find out about therapeutic relationships in more invasive therapeutic specialties where I may not be able to observe for ethical reasons. Thirdly, interviews are more accessible since it takes less of the interviewer’s time. Being able to quickly get the perspectives of patients and therapists from a wide breadth of therapeutic specialities enabled me to get an overview of emotion regulation in therapeutic relationships. A pilot study was conducted to fine-tune the interview schedule and process.

4.3.2 Data Collection
Data were collected using in-depth, semi-structured interviews. This data collection strategy was chosen because it is ideal for accessing people’s perceptions and is commonly used in research aimed at understanding patients’ and healthcare professionals’ perceptions of their therapeutic relationships (e.g., Mottram, 2009; Pazargadi et al, 2015). Other strategies, such as focus groups and questionnaires, were considered but were deemed inappropriate for the purposes of this research. Focus groups were not used because they are typically used to get a consensus rather than to appreciate each individual’s subjective understanding. Questionnaires were not used because they would not generate the rich level of data that is desired for this research.
Similarly, semi-structured interviews were chosen instead of unstructured or structured interviews because while a semi-structured interview provides a topical focus, it also enables the interviewee to steer the discussion and gives the interviewer the flexibility to probe deeper into topics that come up. It is through this discussion that the researcher can gain an understanding of the interviewees’ view on emotion regulation within their therapeutic relationship. Unstructured interviews were not used because this data collection method lacks the sufficient level of focus needed to address the research questions. In contrast,
structured interviews would have been too rigid for the purposes of this research (Kvale & Flick, 2007)

4.3.3 Interview Schedule and Visual Aids

The questions on the interview schedule were developed to address the research questions. Therefore, they were drafted with the research questions in mind. The initial questions on the schedule were informed by an on-going review of literature on the topic and research methods, my experience of therapeutic relationships as an occupational therapist, and the pilot study. Once I formulated the questions, I translated the professional and academic jargon into layperson’s terms that could be more readily understood by interviewees. As suggested by Kvale and Flick (2007), open ended questions were used to encourage interviewees to explain their ideas. Cognitive interviewing techniques were incorporated in the interview schedule and process for the purpose of enhancing interviewees’ ability to recall details. Such strategies included asking the interviewee to recall what they did during each treatment session as a way to help them remember details, minimizing disruptions, and allowing pauses between the interviewees’ responses and my next question (Willis, 2005). Once the interview schedule was completed, ongoing adjustments were made to planned prompts to pick up on themes emerging from the data. The prompts were worded carefully to avoid leading questions as suggested by King and Horrocks (2010). Changes made to the interview schedule and the rationale for them were recorded in a reflexive journal as they occurred to enhance the transparency of the study (Lincoln & Guba, 1985).

The interview began with broad questions that orientated the interviewees to the topic and got them thinking about it. The purpose of the first couple of questions was to gain an understanding of the interviewees’ self-focused and other-focused emotion regulation goals. An example of a question in this section is: “How do you want your patients/therapists to feel when working with you?” The next couple of questions asked about the negative and positive emotions that the interviewees typically experienced at work and if they typically showed those emotions or not. They were invited to use the visual aid that listed positive and negative emotions as needed to help them translate emotion-related terms into distinct emotions (see appendix 11 for list of 135 positive and negative emotions used as a visual aid). The last two questions in this section asked interviewees to describe a high and a low-
quality therapeutic relationship (see appendix 1 for full interview schedules). These beginning questions provided background information for the three research questions.

In the remainder of the interview, the interviewees were asked to describe a current or recent therapeutic relationship they had from beginning to end in a storyline fashion and in doing so identify the major turning points within the relationship. All three research questions are addressed through the narratives that the interviewees described. The interviewees were asked to tell the story of a specific therapeutic relationship because using comprehensive accounts of specific situations enables the researcher to obtain concrete meanings of an individual’s understanding rather than generalisations. Also, talking about specific relationships brings the interviewee back into the moment in question, and makes the interviewee more likely to re-experience or remember the emotions they felt at the time and the nuances of the relationship (Kvale & Flick, 2007). In addition, using a storyline approach allows the interviewee to freely discuss any issue that they saw as relevant, whether these issues derived from within their interaction or outside their interaction. This was important because events that happen outside of relationships can affect dyadic interactions within relationships and consequently, the quality of relationships (Grzywacz, Almeida, & McDonald, 2002).

Therapists were asked to talk about a high-quality and a low-quality therapeutic relationship. Since it was not assumed that patients would have had multiple therapeutic relationships with therapists, patients were asked to talk about their current therapeutic relationship. To begin this section, interviewees were asked to describe their dyadic partner and the things that they worked on together. This is a cognitive interviewing technique designed to spark the interviewees’ memory (Willis, 2005). To ensure that interviewees understood what was meant by turning points, the interviewer defined turning points using the same explanation as they used in a study by Pitts and Miller-Day (2007), and then showed them a graph of the turning points within a romantic relationship borrowed from a study by Huston and colleagues (1981) (see appendix 12 for graph of turning points in a romantic relationship used as a visual aid). Examples of the turning points listed in the romantic relationship example were the first big fight, the first sexual encounter, and the marriage proposal. Even though romantic relationships are different from therapeutic relationships, the interviewees could identify with the turning point examples and were able transfer this understanding to the context of the therapeutic relationship. This part of the interview schedule addressed the
research question on the turning points that characterise high-quality and low-quality therapeutic relationships.

Once each interviewee finished telling the story of their therapeutic relationships, they were asked to identify the emotions that were caused by the turning point and the intrapersonal/interpersonal emotion regulation strategies used to address the emotion. They were also asked to explain their motivation for using the emotion regulation strategies and to describe the quality of the relationship at each turning point in the relationship. Linking the emotion regulation strategies used to the turning points in the relationship was based on methods used in similar studies (e.g., Hadley, 2014; Brown, Westbrook & Challagalla, 2005). Since there are some emotion regulation strategies that are at times used for purposes other than regulating emotion, such as eating and exercising, linking the emotion regulation strategies to the turning point and resulting emotion was a good way to ensure that the emotion regulation strategies identified were indeed being used for emotion regulation purposes. This part of the interview schedule addressed how patients and therapist use emotion regulation strategies and how the use of emotion regulation strategies unfolds as the relationship develops.

I used a visual aid, called a theme-map, to record the turning points, emotions and emotion regulation strategies in chronological order (see appendix 9 for example of theme-map). The purpose of the theme-map was to help me collaboratively record important themes with the interviewee. The theme-map is a graph, similar to the graph of the turning points in a romantic relationship given to the interviewees as an example. On the X axis, the turning points within the relationship were plotted along a timeline. On the Y axis, the quality of the therapeutic relationship was plotted on a scale of 0 to 10. Despite the quantitative nature of the scale, it was used to aid the discussion on qualitative changes in the relationship and the factors that influenced those changes. Under each turning point on the timeline was a place to write in the resulting emotion, the interpersonal and intrapersonal emotion regulation strategies used, and the motivation for using the strategies. The theme-map helped the interviewees think in terms of the sequence of events and helped to ensure the precision and accuracy of meaning interpretation. In essence, it served as an immediate form of member checking. Similar visual aids have been used by other qualitative researchers to increase the trustworthiness of their interpretations (e.g., Whiting & Sine, 2012).
Pre-planned and spontaneous prompts were used throughout the schedule to ensure that thematic omissions were intentional and not due to the interviewee neglecting to mention the theme. The prompts used varied to some degree throughout the data collection process as the importance of specific themes became clearer through the reiterative cycles of data collection and data analysis. For example, as it became clear that patients and therapists utilise emotion regulation strategies not only reactively, but also proactively, more prompts were used to ask about their proactive use of emotion regulation. Also, information from the first part of the interview was used to inform my questions during the remainder of the interview. For example, if an interviewee had previously told me that they want their patients to feel happy, I could then ask them how they attempted to achieve that interpersonal emotion regulation goal considering the situational context that they described.

The last part of the interview included questions regarding demographic information. Demographic data, such as age, nationality, and gender, were collected. These demographic factors were collected because research on individual differences in emotion regulation has shown that people in certain demographic groups, specifically age, nationality and gender, have similar tendencies in their emotion regulation choices (e.g., Schirda, Valentine, Aldao, & Prakash, 2016; Parkinson & Totterdell, 1999; Anderson et al., 2016). In addition, therapists were asked about their years of experience and area of practice. Patients were asked about their employment status. These factors may also influence a person’s emotion regulation tendencies.

The interview schedule for patients and therapist were virtually the same. This was appropriate because I expected both therapists and patients to have a layperson’s understanding of emotions and emotion regulation. There were two main difference between these two interview schedules. Firstly, the word “therapist” was substituted for “patient” or vice versa as appropriate. Secondly, therapists were asked to describe two therapeutic relationships, one that they consider high-quality and one that they consider low-quality, whereas the patients were only asked to describe their current therapeutic relationship.

4.3.4 Interview Process
The local collaborator was the person at each facility who volunteered to be my liaison with the research facility and assist me as needed. One of the main functions of the local collaborator was to recruit participants and schedule interviews during business hours. All the interviews were conducted on a one-to-one basis on a single occasion. The interviews
lasted for about an hour and were audio taped. The interviews typically took place in private rooms on the hospital premises. These rooms were quiet, contained a table and chairs, and had adequate lighting. On a couple of occasions interviews with therapists were done in public spaces (e.g., coffee shops and libraries) for the convenience of the interviewees. Although this environment was not as quiet as the private rooms, it was adequate.

On the day of the interview, the local collaborator introduced me as the researcher. I then reviewed the participant information form (see appendix 7 for participant information form for study 1) with the potential participant, who had previously been introduced to it by the local collaborator. Once all questions were addressed, the potential participant signed the consent form (see appendix 6 for consent form) and the interview commenced. The materials used during the interview were the interview schedule, a pen and paper to take notes, and a small audio recorder. I also used three visual aids during the interview to facilitate my own and the interviewee’s understanding; a list of positive and negative emotions, a graph of the turning points in a romantic relationship and a theme-map.

The interview questions were read directly from the schedule. To ensure that the interviewees understood the questions and could respond appropriately, unfamiliar concepts, such as ‘turning points’ and ‘emotion regulation’ were explained. I would rephrase questions if the interviewee needed clarification. I used pre-planned prompts to explore important emerging themes if they were not mentioned to ensure that thematic omissions were on purpose rather than by accident. I used impromptu prompts to delve deeper into the meaning of what the interviewee said. As suggested by Kvale and Flick (2007), impromptu prompts were triggered not only by what the interviewee said but also by the interviewee’s vocal tone, body language, and facial expressions. I checked my understanding of the interviewee’s perceptions as needed by immediately paraphrasing what the interviewee said to get their confirmation or disconfirmation. Throughout the interview I took notes on key responses that I needed to revisit, but this was kept at a minimum so that I could pay attention to the interviewee’s verbal and nonverbal communication.

While the interviewees were telling me the story of their therapeutic relationship, I recorded the turning points on the theme-map in chronological order. Then after they completed the story, I checked the turning points that I recorded with them to ensure they were accurate. Next, at each turning point the interviewee was asked to identify the emotions that stemmed from the turning point, the intrapersonal and interpersonal emotion regulation strategies used
in response to the emotion, their motivation for using the emotion regulation strategies, and their rating of the quality of the relationship. Information from the first part of the interview, where interviewees identified their emotion regulation goals and their understanding of therapeutic relationship quality, was used to inform this part of the interview. For example, if a therapist said in the first part of the interview that they want to feel calm when they work with their patients and they told me about a turning point that made them feel anxious, I would ask them how they made themselves feel calm in that situation. Lastly, the interviewees were asked to rate the quality of their relationship on a 0 to 10 scale, considering their own perception of the relationship and their impression of their dyadic partners perception. They were told that a rating of 10 represents a high-quality therapeutic relationship and a rating of 0 represents a low-quality therapeutic relationship.

The theme-map was completed in collaboration with the interviewees. I would turn the theme-map on the table, so we could both look at it, and I invited the interviewee to help me fill it out. As the interviewee told me the story of the therapeutic relationship, I jotted down incidents that seemed to cause emotion and may be considered turning points by the interviewee. After they finished telling me the story, we turned our attention to filling out the theme-map together based on the narrative the interviewee described. I would check the incidents that I jotted down and the order in which I located them on the theme-map with the interviewee’s perception. This enabled them to agree, disagree, and clarify the themes emanating from their story. After we identified each turning point and the chronological order, we went back through the turning points to discuss the emotions stemming from the turning points, the emotion regulation strategies used in response to the turning points, and the motivation for using the emotion regulation strategies. Using the theme-map helped me to align my understanding of the interviewees’ perceptions with their understanding of their experience.

The interaction between the interviewer and the interviewee is an important part of the data collection process (Kvale & Flick, 2007). Therefore, throughout the interview I tried to be friendly and develop a good rapport to encourage open responses from interviewees. To manage the power asymmetry that is typically in favour of the interviewer (Kvale & Flick, 2007), I told the interviewees that I value their opinions and they were helping me tremendously. I was also dressed in a casual manner and used layperson’s terms instead of professional or academic terminology. Managing the power asymmetry is important because if the interviewee is intimidated by the interviewer’s questions, the interviewee may give
answers that they think the interviewer will agree with, rather than their true thoughts (Kvale & Flick, 2007). I tried to encourage interviewees to be reflexive in answering the questions by asking them follow up questions and assuring them that their ideas were valuable to me. This is a good way to gain access to interviewee’s thoughts and feelings (Holloway & Wheeler, 2010).

At the end of the interviews, interviewees were given an opportunity to add any information or feedback and ask any questions that they may have. Finally, interviewees were thanked for their participation. After each interview I reflected on what I learned and wrote down my initial impressions.

One of the main problems that I had was completing the interview in the allocated time. This was typically one hour for the therapists who were being interviewed during their workday. Part of the reason this was particularly problematic was the therapists were asked to discuss two different therapeutic relationships, whereas the patients were only asked to discuss one therapeutic relationship. However, as I did more interviews, I got more time efficient. I knew which questions should be answered quickly so I could allow more time for other questions. I tended to spend more time on the part of the interview where the interviewees told me the story of their relationship and less time on the beginning of the interview, regarding emotion regulation goals, emotions experienced and understanding of high/low-quality therapeutic relationships. I also spent less time on small talk in the beginning of the interview, but this had to be balanced because this was one of the main ways that I used to build rapport.

In preparation for data analysis, the audio taped interviews were transcribed using a professional transcription service that is on Manchester Business School’s preferred provider list. I vetted the transcripts for accuracy by listening to the audio file while reading the transcript.

4.3.5 Pilot Study for Study 1
Since this was my first time collecting data using semi-structured interviews, before I did the pilot study, I practiced interviewing 4 people and analysing the data. I interviewed a financial councillor, a surgeon, and two people who previously had physiotherapy. Although these people did not fit the inclusion criteria for the study, three of them had experience with emotion regulation in therapeutic relationships and the forth one had experience with emotion
regulation in service relationships. The main pilot study consisted of 8 occupational therapists.

Based on what I learned from the pilot study, I made a number of changes to the interview schedule and the way I conducted the interview. I began to develop a comfortable sequence in which I asked the questions. I cut out some questions that were redundant or not likely to yield useful data. I changed some of the wording of questions to make it clearer. I also added questions and prompts as needed. For example, it was at this stage that I decided that I should ask therapists to describe both a high-quality and low-quality relationship.

During the pilot study, I noticed that when asked about emotions the interviewees would discuss emotion-related terms like trust and feelings instead of distinct emotions. In response to this problem, I began to give interviewees a list of 135 positive and negative emotions published by Shaver and colleagues (1987). This visual aid was used in an exploratory way to help the interviewees identify the exact emotion that explained or underscored their feelings. The list of emotions was easy to use because the positive and negative emotions were listed separately in order from low to high intensity emotions.

I also made some important changes to the theme-map as a result of the pilot study. Initially I was trying to understand which emotion regulation strategies people used during each stage in the therapeutic relationship using Peplau’s (1997) stages of therapeutic relationship development; orientation, working, and termination. Through analysing the data, I began to understand that people did not change their use of emotion regulation strategies according to the stage of the relationship. Instead they seemed to change their use of emotion regulation according to events that occurred during their interactions. This is what prompted me to use turning points on the theme-map rather than the stages of the relationship. As I read more about turning points, I found a graph of the turning points within a romantic relationship in a study by Huston and colleagues (1981) and decided to use it as a visual aid to help interviewees understand turning points within relationships.

4.3.6 Gaining Access and Recruitment
The main way that access to potential interviewees was obtained was by contacting the therapy manager or research lead at different hospitals and clinics via email and telephone. I sampled hospitals and clinics mainly based on their location considering my ability to travel to the site. I verbally informed them about my research and emailed them a participant information form and a written summary of my research. I answered any questions they had.
and explained the role of a local collaborator. Next, I asked if there was a person who would be willing to be the local collaborator for this study. If they responded favourably, I then contacted their Research and Development Department and provided the required documents to get access to the facility. The people who agreed to be local collaborators were either the occupational therapy/physiotherapy team leaders or research leaders. I also recruited a few therapists through personal contacts.

The local collaborator’s main role was to recruit therapists and patients to participate in the study. They used the same recruitment process for both. First, they identified therapists and patients who met the inclusion criteria. With therapists this was no problem because every physiotherapist and occupational therapist working at the facility in direct patient care met the inclusion criteria. For patients, this was a bit more difficult because the local collaborator had to make a judgement on patients’ mental ability to give informed consent. However, since the local collaborators were therapists, they were skilled in making this type of judgment.

The local collaborator approached those who met the inclusion criteria to ask if they would like to participate. I was not present during this first contact with potential participants for ethical purposes. The local collaborator would give the potential participants verbal information about the study. This included the aims and purpose of the study, why they are being asked to participate, the participation requirements, and their right to decide not to participate. They answered any questions the potential participants may have had and gave them a participant information form covering the information they had already discussed. After that, the local collaborator would ask them if they would like to participate in the study. Potential participants were informed that they did not have to decide immediately. To motivate the therapists to participate they were offered a certificate of participation that they could use as proof of their participation in continuing professional development activities, which is mandated by professional ethics and professional regulatory bodies. The patients were not offered anything in exchange for their participation.

If the potential participant refused to participate, they were not asked about it again. If they said they wanted to think about it, they were instructed to use the researcher’s contact details on the provided participant information form if they later decided to participate or if they had more questions. If the potential interviewee responded favourably, the local collaborator would set a time for that person to meet with me. During this meeting I would recap the
information initially provided by the local collaborator and answer any further questions. I emphasised that willingness or refusal to participate will in no way affect their job (in the case of a therapist) or treatment (in the case of a patient). If the potential interviewee agreed to participate at this point, they would be given a consent form to sign and the interview would commence.

4.3.7 Sampling Strategy
A purposive sampling strategy was used because I needed to select the target population (occupational therapists, physiotherapists, and patients of occupational therapists and physiotherapists) based on their knowledge and experience regarding emotions within the therapeutic relationship and their ability to answer the interview questions (Holloway & Wheeler, 2010). It was assumed that if they worked as a therapist or were receiving therapeutic services that they would have relevant knowledge and experience.

The sample size is a question of how many interviewees are needed to find out what one needs to know (Kvale & Flick, 2007). While the sample size in qualitative research can range from as many as 200 interviewees to as few as two, in general qualitative research sample sizes tend to range from between 4 to 40 interviewees (Holloway & Wheeler, 2010). Prior to beginning the study, I aimed to recruit a purposive sample of 15 occupational therapists and 15 patients to participate in this study.

This sample size was deemed appropriate because it would enable sufficient data to be collected whilst also being manageable considering constraints on time and resources. In addition, other qualitative studies investigating emotion regulation in healthcare work environments have used similar sample sizes (e.g., Williams, 2013 (a and b); Gray & Smith, 2009; Weir & Waddington, 2008; Hayward & Tuckey, 2011). However, I understood that if during data analysis I found that this sample size did not reach the point of thematic redundancy then data collection would continue until that point was reached. Morse (1995) specified that frequency, quantity, and repetition of ideas do not signify thematic redundancy. Instead she proposed that thematic redundancy is the point when no new data are gained from additional data collection and rich descriptions representing the full variation of data has been collected.
This sample size was expected to be sufficient to build a comprehensive and convincing theoretical model. Ultimately, the sample size was eight therapists for the pilot study and 11 patients and 14 therapists for the main study. Recruitment of interviewees ended at this point because the data reached a point of thematic redundancy (see table 1 for demographics of participants in study 1).

Table 1: Demographics of Participants in Study 1

<table>
<thead>
<tr>
<th>Pilot study pseudonyms for therapists</th>
<th>occupation</th>
<th>Years of experience</th>
<th>age</th>
<th>gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1P-1-T</td>
<td>Occupational therapist</td>
<td>6</td>
<td>20</td>
<td>F</td>
</tr>
<tr>
<td>S1P-2-T</td>
<td>Occupational therapist</td>
<td>5</td>
<td>30</td>
<td>F</td>
</tr>
<tr>
<td>S1P-3-T</td>
<td>Occupational therapist</td>
<td>6</td>
<td>20</td>
<td>F</td>
</tr>
<tr>
<td>S1P-4-T</td>
<td>Occupational therapist</td>
<td>5</td>
<td>unknown</td>
<td>F</td>
</tr>
<tr>
<td>S1P-5-T</td>
<td>Occupational therapist</td>
<td>6</td>
<td>20</td>
<td>F</td>
</tr>
<tr>
<td>S1P-6-T</td>
<td>Occupational therapist</td>
<td>3</td>
<td>30</td>
<td>F</td>
</tr>
<tr>
<td>S1P-7-T</td>
<td>Occupational therapist</td>
<td>2</td>
<td>30</td>
<td>F</td>
</tr>
<tr>
<td>S1P-8-T</td>
<td>Occupational therapist</td>
<td>6</td>
<td>40</td>
<td>F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main study pseudonyms for patients</th>
<th>occupation</th>
<th>service</th>
<th>age</th>
<th>gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1-P</td>
<td>retired</td>
<td>Physiotherapy</td>
<td>60</td>
<td>M</td>
</tr>
<tr>
<td>1-2-P</td>
<td>Sales manager</td>
<td>Physiotherapy</td>
<td>40</td>
<td>F</td>
</tr>
<tr>
<td>1-3-P</td>
<td>psychotherapist</td>
<td>Occupational therapy</td>
<td>60</td>
<td>F</td>
</tr>
<tr>
<td>1-4-P</td>
<td>retired</td>
<td>Physiotherapy</td>
<td>60</td>
<td>M</td>
</tr>
<tr>
<td>1-5-P</td>
<td>Pension analyst</td>
<td>Physiotherapy</td>
<td>40</td>
<td>M</td>
</tr>
<tr>
<td>1-6-P</td>
<td>receptionist</td>
<td>Physiotherapy</td>
<td>40</td>
<td>F</td>
</tr>
<tr>
<td>1-7-P</td>
<td>lecturer</td>
<td>Occupational therapy</td>
<td>50</td>
<td>F</td>
</tr>
<tr>
<td>1-8-P</td>
<td>retail</td>
<td>Physiotherapy</td>
<td>20</td>
<td>F</td>
</tr>
<tr>
<td>1-9-P</td>
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<td>40</td>
<td>M</td>
</tr>
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<td>1-10-P</td>
<td>professor</td>
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<td>M</td>
</tr>
<tr>
<td>1-11-P</td>
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<td>50</td>
<td>M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main study pseudonyms for therapists</th>
<th>occupation</th>
<th>Years of experience</th>
<th>age</th>
<th>gender</th>
</tr>
</thead>
</table>

4.3.8 Inclusion Criteria
Both occupational therapists and physiotherapists were eligible to participate in this study because their jobs are similar enough, in terms of the focus of their interactions with patients, that their experiences of emotion regulation and therapeutic relationships should be similar. In fact, in the specialty of hand therapy, occupational therapists and physiotherapists do the same job. Patients and therapists were eligible to participate if they could communicate in English, give informed consent, and were between the ages of 19 and 75. The upper and lower age limits were imposed during the ethical approval process to avoid populations that are considered vulnerable. It was important to have interviewees who could speak about current or recent therapeutic relationships to increase the likelihood that they would be able to remember the important details of the relationship. For this reason, therapists were eligible to participate if they were currently employed in a role that involves patient contact. Patients were eligible to participate if they were currently receiving therapy services.

4.3.9 Participants
Most therapists and patients were recruited from two hospitals and one clinic in the United Kingdom using purposive sampling. However, six therapists were recruited through personal acquaintances and they all worked at various hospitals/clinics.
In the pilot study eight occupational therapists participated. They were all females and all their ages were in the 20’s and 30’s. Their years of experience working as occupational therapists ranged from one year to six years. They were all white British except one who was black British. They practised in several areas including orthopaedics, neurology, and accident and emergency.

In the main study, nine physiotherapists, five occupational therapists and 11 patients participated in the research. There were 11 female therapists and three male therapists. The therapists ranged in age from their 20’s to their 60’s. Most of the therapists were white British except one Spanish, three black British of Caribbean decent and two black British of African descent. They worked in various specialty areas, such as musculoskeletal, accident and emergency, and neurology. They ranged in years of experience from two years to 35 years.

Regarding the 11 patients who participated, six of whom were female and five were male. They ranged in age from their 20’s to their 60’s. They were all white English except one Asian, one Italian and three black British people of Caribbean descent. They were all seeing therapists for physical problems that hindered but did not prevent their ability to function in life, including conditions, such as back pain, carpal tunnel syndrome, and rotator cuff injuries.

4.3.10 Data Analysis

The data were analysed using template analysis. Template analysis is a type of thematic analysis where the researcher starts with a template of hierarchical thematic codes that he or she expects to see in the data. As themes emerge from the data, the researcher incorporates these themes into the template. In this way, the researcher adds, deletes, and fine-tunes the thematic codes on the template until it is an accurate representation of the themes emanating from the data (King, 2004). This method was chosen because it is a relatively flexible technique that can be tailored to specific research needs and compared to similar techniques, such as interpretive phenomenological analysis (IPA), it is better for use with relatively large data sets (King, 2004).

Grounded theory is another similar data analysis approach that was considered. The main reason I did not choose grounded theory is when using grounded theory, the researcher attempts not to utilise pre-existing conceptualisations (Charmaz, 1995). Whereas in this
I wanted to utilise pre-existing conceptualisations in the initial template and then use the data to develop, transform, and fine-tune it. While some aspects of grounded theory data analysis are relevant to this study, such as simultaneous collection and analysis of data and the use of memos to make research decisions and theory development more transparent, overall this method of data analysis is less compatible with my research aims and epistemological stance than a template analysis. Modernist grounded theory subscribes to a more positivist ontology (Charmaz, 2000) which contrasts with my ontological perspective. Constructivist grounded theory focuses on social processes rather than individual experiences, thoughts, feelings and beliefs (Charmaz, 1995). In this study the individual’s thoughts and feelings are needed to understand the phenomenon. Lastly, grounded theory is less flexible and more prescribed so less pliable to the needs of the research.

All data analysis was done using NVivo 10 software package. Using this type of data analysis software is valuable because it makes the analysis process more formal and transparent (Sinkovic & Alfoldi, 2012).

### 4.3.9.1 Template Development

The data analysis began with the formulation of an initial provisional template, which consisted of codes based on expected themes from relevant literature, the pilot study, and my experience of therapeutic relationships from when I worked as an occupational therapist. In particular, for intrapersonal emotion regulation strategies I incorporated the categories from Gross’ process model of emotion regulation (1998). For the interpersonal emotion regulation strategies, I utilised Williams’ (2007) categorisation of interpersonal emotion regulation strategies which are based on the process model of emotion regulation. Lastly, for the turning point themes, I used Ohly and Schmitt’s (2015) categories of emotional events at work (see appendix 3 for the beginning template).

As suggested by Crabtree and Miller (1999), in making the initial template I tried to get a balance between having too few and narrow codes and creating codes so encompassing that every line of text requires coding (Crabtree & Miller, 1999). Generally, researchers could either use a structured template developed prior to data analysis or could develop the template only after an initial exploration of the data (Crabtree & Miller, 1999). I chose to take an intermediate approach where I started with some codes and then augmented these with the first few interview transcripts.
I used this initial template to code relevant sections of each transcript using King’s (2004 a & b) description of the process as a guide. The template was revised by adding, deleting, and changing the scope and/or hierarchy of codes in response to relevant themes emanating from each successive transcript not already reflected in the template. The purpose of revising the template was to ensure that the final template accurately reflects the important themes from all the transcripts. Once the final template was complete, the data were interpreted in terms of what the themes communicated about the research questions (see appendix 4 and 5 for the final template for therapists and patients, respectively).

4.3.9.2 Data Coding and Interrogation
The data analysis process consisted of two concurrently ongoing processes, coding and interrogation of the data. My approach to these processes was informed by Miles, Huberman and Saldana (2013) and King (2004 a & b). The first cycle of coding began with reading the transcripts and the corresponding theme-maps and notes and listening to the corresponding audio recordings with a view to familiarise myself with the data. I then read and coded relevant themes in all the transcripts. These codes were used to revise the initial template. The theme-map was useful during this process because it enabled me to see the turning points and emotion regulation strategies in chronological order. My notes were also useful because they helped me to remember my initial impressions and things that I thought were important. Initially the coding focused on categorising and identifying themes and patterns in the data. As the data analysis progressed the coding focused on refining the codes to make them more accurately reflect the themes emanating from the data as described in Miles, Huberman and Saldana (2013). I used a method similar to that described by Graham (1997) to code the trajectories according to visual similarity. As a starting point, I used patterns previously found in other studies (e.g., Kellas, Bean, Cunningham & Cheng, 2008; Kivlighan & Shaughness, 2000) on relationship trajectories as a template.

After the initial coding of the data, I interrogated the data in several ways using the approaches outlined by Miles, Huberman and Saldana (2013). I looked for logical relationships between the themes. I reflected on how the data addressed the research questions. To find patterns in the data, I attempted to compare, contrast, and categorise themes while looking for disconfirming data. In addition, I also used the NVivo tools to explore the data. For example, I used NVivo to search for words used most often by interviewees. This enabled me to see key words that I could use to get further acquainted with the data.
This initial interrogation of the data made it necessary to re-read and re-code the transcripts looking for answers to questions that came up during this process and themes that were overlooked. This cycle benefited from the more finely tuned template and my more intimate level of familiarity with the data, which I developed through the previous data analysis cycle.

During this entire process, I augmented and adjusted the template. This entailed a reiterative process of revising the template by adding, deleting, and changing the scope and/or hierarchy of the codes to make the template more accurately reflect the themes emanating from the data (King, 2004 a & b). More general codes were higher in the hierarchy and more specific codes were lower in the hierarchy. The interview schedule was also continuously improved using the information gained from the analysis.

4.3.11 Limitations

While semi-structured interviews provide valuable insight into subjective perceptions of relationships, this method was limited by a few factors. The information that interviewees provide may be limited by their understanding of what is being asked of them. However, I tried to explain the concepts in layperson’s terms and use visual aids to help them understand. Overall, they did not seem to have difficulty understanding key concepts, such as emotion regulation and turning points. The information that interviewees provide may also be limited by deficiencies in their memory. For this reason, I asked therapist to tell me about recent relationships and I used cognitive interviewing strategies to help spark their memory. The patients were recruited from the healthcare facility where they were currently receiving therapy, so their interviews were based on their current therapeutic relationships.

The information that interviewees provide may also be limited by what interviewees are willing or able to disclose (Florsheim & Moore, 2008). There is a risk that patients and therapists may have censored their responses to be in line with what they think they are supposed to say or what they think the researcher expects. Patients may have chosen to provide information that does not truly reflect their thoughts on their therapeutic relationship to avoid getting their therapist in trouble. Therapists may not have been completely honest when discussing, for example, how they dealt with their anger towards a patient to avoid the potential consequences of such disclosure. To address this, I informed the participants that their interviews were confidential. However, I clarified to them that for ethical reasons, if
they disclosed anything to me that was evidence of serious misconduct, which endangered others, I would have to disclose that information.

Another limitation of the study concerns who was recruited and who was not recruited. For ethical reasons, I was not present when the local collaborator was recruiting patients and therapists. For this reason, I am unaware of how many potential interviewees declined to participate. This is a limitation because the people that declined may be characteristically different from the people who agreed to participate.

4.4 Study 2 – Research Design

4.4.1 Introduction

The purpose of the second study was to further develop my understanding of how emotion regulation develops within therapeutic relationships. This study involved unstructured observation of patients and therapists interacting during the course of their therapy and a participant verification interview with both dyadic partners separately at the end of the therapeutic relationship. A pilot study was conducted to fine-tune the data collection process.

The second study was informed by the first study in several ways. In the first study, I got background information on what patients and therapists considered characteristics of high-quality and low-quality therapeutic relationships, emotion regulation goals, and their thoughts on the ideal emotional appearance of patients and therapists. This gave me an idea of patients’ and therapists’ typical orientation and priorities and informed how I understood my observations in the second study. I began to understand that emotion regulation strategies may develop from using strategies in a risk-adverse and purely professional manner, to using them in a more risky and intimate manner. Therefore, in the second study I was looking for changes in the way emotion regulation strategies were being used. Since in the first study intrapersonal emotion regulation strategies did not appear to develop in any significant way during the therapeutic relationship, in the second study I looked for disconfirming information to this developing theme. In the first study, I became aware of particular emotion regulation strategies and turning points that were common within therapeutic relationships. This enabled me to be sure that I looked for these strategies and turning points when observing patient-therapist interactions, and I asked about these strategies and turning points during the interview at the end of the relationship. In addition, the interview schedule, theme-
map, and template developed in the first study was ideal to use in the second study, with ongoing adjustments and augmentations as the data analysis informed the data collection. The second study also benefited from my increased proficiency with conducting semi-structured interviews that I developed through conducting the first study.

In addition to being informed by the first study, the second study builds upon the first study in several ways. In this second study, I interviewed and observed patients and therapists who were working together. Whereas, in the first study the patients and therapists were not working together, and I did not observe the relationships. Also, in this study I observed most, if not all, of the interactions between patient/therapist dyads throughout the duration of their therapeutic relationships. This enabled me to gain intimate first-hand knowledge of the relationship, which I used to ask more informed questions during the interview at the end of the relationship. Using observation to understand how interpersonal interaction develops over time is rarely used in research on therapeutic relationships and it provides a unique opportunity to understand interactional dynamics within these relationships as they unfold.

4.4.2 Data Collection

Data were collected using unstructured non-participant observation combined with a participant verification interview at the end of the relationship. I decided to use observation because I wanted to gain intimate knowledge of the relationship between the patient and therapist which I could use to ask informed questions during the participant verification interviews. Observation provides the most direct access to the social phenomenon that is being studied and enables the researchers to get an insider’s perspective (Salmon, 2015). It is an ideal way to collect rich data on behaviour and interpersonal interaction under the most natural circumstances (Mulhall, 2003; Kelley, 2002).

I decided to use nonparticipant observation rather than participant observation because I wanted to focus on observing patient-therapist interactions and using participant observation was not practical because I did not work at the facilities where I was collecting data. However, I appreciate that it is difficult to completely refrain from participating when collecting data through observation as indicated by Atkinson and Hammersley (1994). This is particularly true in rehabilitation settings where the nature of the situations being observed may mean that the researcher is included in social conversations (Clarke, 2009).

I used unstructured observations; this type of observation is not unstructured in a sense that it is unsystematic, rather it is unstructured in a sense that it does not follow an approach of
strictly checking a list of predetermined behaviours, as is the case with structured observation (Mulhall, 2003). I initially attempted to use a more structured observation technique in the pilot, but this was problematic because there were an exhaustive number of emotion regulation strategies that could be used, and I was more concerned with how the strategies were used rather than how often they were used. A more structured approach would have been too reductionistic for the aims of this study and structured observation is more often associated with a positivist paradigm (Mulhall, 2003), which is contrary to my epistemological and ontological viewpoint. Unstructured observation provides good insight into human interaction in healthcare settings and for this reason should be used more (Mulhall, 2003).

Initially, I planned to use interviews after each treatment session rather than observing each treatment session. I decided to use observation instead because it would require less of the participant’s time, and I would benefit from seeing the interactional dynamics develop. I also considered using a diary study but decided against it because it would not have yielded the richness of data that could be obtained through observation.

Observing emotion regulation is difficult for several reasons. Some strategies that are used to regulate emotions are also at times used for other purposes. Therefore, just because I observed a therapist touching a patient, which was a prominent emotion regulation strategy theme from the first study, does not mean that in this particular situation touch is being used for emotion regulation purposes. Also, many intrapersonal emotion regulation strategies are not visible because they happen within a person’s mind. For example, cognitive reappraisal is an intrapersonal emotion regulation strategy that is not detectable by an observer. Since the purpose of using emotion regulation is to regulate emotions and emotional responses, it serves to complicate a researcher’s ability to observe affective events and emotional consequences. For example, a patient may say something that makes a therapist angry, but if the therapist uses emotion regulation to hide that anger, it makes it more difficult for the observer to pick up on it. Finally, some intrapersonal emotion regulation strategies are used before or after therapy and for that reason could not be observed during the treatment session. For example, the therapist who got angry due to her patient’s comment may leave the therapy session and go have an indulgent lunch to decrease her anger.

Despite these problems, observation is a useful data collection method to understand how emotion regulation strategies are used and how the use of emotion regulation strategies
develops over the course of the therapeutic relationship. Although some emotion regulation strategies cannot be observed, I can observe emotion, even though it may be skewed by the participant’s use of emotion regulation. An observer can identify other’s emotions using indications, such as speech-embedded vocal prosody, contextual cues, facial expressions, affect vocalizations (e.g., laughter or screams), body language, and physiological cues (Planalp, DeFranciso, Rutherford, 1996; Hawk, Van Kleef, Fischer & Van Der Schalk, 2009). I can also observe affective events that occur during interactions. Observation is a useful way to understand the events that happen during social interactions and unfolding behavioural sequences (Zhao & Ji, 2014). The understanding that I gained from the first study about patients’ and therapists’ use of emotion regulation strategies in response to affective events, gave me an idea of what I should look for in the second study.

I used the participant verification interview schedule and the theme-map to verify that my observations were congruent with the participants’ perceptions. For each dyad, I augmented the interview schedule with prompts and questions informed by my observations. For example, if it appeared that a particular incident was a turning point in the relationship, I would ask both dyadic partners about it during the interview at the end of the relationship. I used the theme-map in the same way during the participant verification interviews as I did in the first study.

Semi-structured interviews are an ideal complement to observation data collection methods. Observational methods enable understanding of the phenomenon to a deeper extent than just using information from interviews (Salmon, 2015). Using observation can address inconsistencies between what people say they do and what they actually do (Coker, Ploeg, Kaasalainen & Fisher, 2013). Since observation is an ongoing dynamic activity, it is more likely than interview data to provide evidence for how a social phenomenon evolves over time (Mulhall, 2003), and this is essential to understand the process of emotion regulation development. However, observation data, more than interview data, is subject to interpretation by the researcher (Mulhall, 2003). For this reason, it is important for qualitative researchers to clarify and demonstrate how verification strategies are used to ensure trustworthiness (Morse et al, 2002).

4.4.2.1 Observation and Participant Verification Interview Process

My observations took place in the clinic, the natural setting of therapeutic relationships in hand therapy. I attended the therapy sessions of the dyads being observed, from the first
session, when the patient and therapist first met, to the last, when the patient was discharged from therapy services. I attempted to attend all the therapy sessions, but at times this was not possible due to scheduling conflicts. For this reason, for some dyads, I may have one or two sessions. However, for many of the dyads I attended all their therapy sessions.

The therapy sessions usually lasted about 30 to 45 minutes. An audio recorder was placed near the patient and therapist to record their dialog. I either sat in a corner or at a table where I could view and hear the session, but out of the way of the therapist and patient. I kept my interactions with the therapist and patient to a minimum during the treatment session in an effort to blend into the surroundings. However, there were times when the patient and/or therapist would talk to me. There was typically more than one dyad working in the clinic at any given time. However, I only observed one dyad at a time, and I only observed the dyads who gave consent.

My observations focused on displayed emotion, affective events/turning points, and understanding the interaction and relationship dynamics. Since touch and facial expressions are potential interpersonal emotion regulation strategies that cannot be captured in an audio recording, I paid particular attention to these during my observation. I used a data collection form that I developed with this focus in mind. Since observers who spend too much time writing notes miss the details of the interaction (Mulhall, 2003), I was careful to prioritise observing over writing.

Initially, during the pilot study, the observation data collection form was more structured. I learned from conducting the pilot study that a less structured form would better suit the needs of the study, so I changed it accordingly. On the form, (see appendix 2 for the observation data collection and participant verification interview form)I recorded treatment session information including the time, date, dyad, and audio file at the top of the page. In the next section, I recorded emotions, potential turning points and emotion regulation strategies that I observed. There was also a section to record questions stemming from my observations that would be used in the participant verification interviews. For example, if I noticed a patient made a few jokes during the therapy session that may have been used for emotion regulation purposes, I would record a question to ask them why they did that and pose the question during the participant verification interview. These sections of the data collection form were typically completed during the therapy session. I completed the last two sections of the form immediately after the therapy session. In these sections, I recorded my impressions of
relationship quality, my thoughts on any changes in the way emotion regulation strategies were used since the last session, and my summary of the relationship narrative. I was careful to augment my field notes with my reflexions as soon as possible after the treatment session to avoid details being forgotten, as is recommended by Mulhall (2003).

I also found it useful to collect data after the therapy session when therapists were in the office. I would use that time to write notes on the therapy session I had just observed. I found that while I was sitting in the office, sometimes therapists would spontaneously make comments about their perception of their interaction with their patients. I made note of these comments on the data collection form.

At end of the therapeutic relationship, upon the discharge of the patient, I interviewed both dyadic partners separately. I learned from the pilot study that if I did not interview the patients directly after their last treatment session, it could be difficult to organise another time to meet them for the interview. For this reason, the patient interviews took place directly after the last therapy session. The therapists typically had to go on to their next patient, so I would set an appointment to meet with the therapist at another time for the interview. The interviews took place in a private room on the premises. This was sometimes the staff office or private treatment rooms. The purpose of the interview was to verify my impressions from my observations with the participant’s point of view and jointly complete the theme-map.

Prior to the interview, I would review my notes to reorientate myself to the details of the relationship. I used the same interview schedule and theme-map from the first study. However, I augmented the interview schedule with the questions that I wrote on the observation data collection form. Also, instead of the participants telling me the story of their relationships as they did in the first study, we reviewed it together. The turning points identified through observation were reconciled with each dyadic partner’s perception. The emotion that I observed was compared to the participants actual emotion, and the associated intrapersonal emotion regulation strategies used were identified. Also, each interviewee’s perception of their dyadic partner’s emotion, and the interviewee’s use of interpersonal emotion regulation strategies to address their partner’s emotions was compared to my observations. Particular attention was given to the way that the emotion regulation strategies were used as the relationship developed. The participant verification interviews were audiotaped.
I encountered a number of problems in the data collection process. Observing the therapy sessions was sometimes difficult because at times patients would not come to their treatment sessions or they would reschedule without informing me. A few patients came for one therapy session and then either discontinued treatment or were switched to another therapist. In these cases, I could not use the data collected because I needed to observe at least two different therapy sessions since I was looking for change in emotion regulation use.

Another problem that I had was being sure when the patients were going to be discharged. There were a few occasions when patients were discharged unexpectedly. In these cases, I was able to contact them via telephone for the interview. To address this problem, I started to check with the therapists more frequently regarding their forecasted discharge date. Also, when it started getting close to the time when the patient would likely be discharged, I would go to the therapy sessions early so that I could catch the patients in the waiting area. I used that time to ask them a few questions to start the interview.

The therapists’ interviews were also at times problematic because the therapists could only allocate a limited amount of time for the interview. They would schedule 30 minutes to an hour for the interview during their workday. For this reason, I had to conduct the interview as quickly as possible. There were a few occasions where I could only do part of the interview during the scheduled time, so we would have to reschedule the remainder of the interview for a different time.

4.4.3 Pilot Study for Study 2
Prior to the main study, I conducted a pilot study to fine tune my data collection process. Six patient-therapist dyads participated in the pilot study. As a result of the pilot study I made three major changes to the way data was collected. Firstly, I realised that one cannot observe emotion regulation accurately because some emotion regulation strategies happen in the brain, so they are not observable, and some emotion regulation strategies are used for purposes other than emotion regulation. I also realised that participants use of emotion regulation to some degree obscured the emotion that I needed to observe to understand the interaction. These realisations helped me understand that the main benefit of using observation to collect data was to gain insight on micro-level interactions to use as a basis to ask informed questions during the participant verification interviews. For this reason, I added a section on the observation schedule to write questions based on my observations which I would pose during the participant verification interviews.
Secondly, I changed the data collection form from being more structured and requiring more note taking during the observation session, to being less structured and requiring more note taking after the observation session. Initially the data collection form had many prompts to record various bits of information every ten minutes and more of a focus on observable emotion regulation strategies. From doing the pilot study I learned that I needed a less structured data collection form that allowed me to take notes more freely but focus most of my attention on observing during the therapy session.

The third change that I made had to do with when I conducted the participant verification interviews. I noticed that too often patients were discharged without me getting prior notice and therefore without me getting a chance to do the participant verification interview. This meant that at times I had to do the verification interviews over the telephone during the pilot. To remedy this problem, I began to check more often on the forecasted discharge date for the patients. I also began to come early to the scheduled treatment sessions so I could catch patients in the waiting room where I could begin to ask them some questions from the verification interview.

4.4.4 Gaining Access and Recruitment
I chose to recruit in hand therapy clinics for three main reasons. Firstly, some areas of occupational therapy and physiotherapy practice are relatively invasive, requiring patients to disrobe or discuss sensitive topics. I assumed it would be easier to get ethical approval and to get patients to participate if I chose an area of practice that is minimally invasive, like hand therapy. Secondly, hand therapy patients typically do not have associated cognitive deficits, so it would be easier to get informed consent in a hand therapy setting than in other areas of practice. Thirdly, both occupational therapists and physiotherapist work as hand therapists.

Access to the facility was obtained in the same way described in the first study and the clinics were sampled based on their location, in consideration of my ability to travel to the site. Once access was granted, the local collaborator would identify therapists who were willing to participate. I met with all the therapists who agreed to participate, gave them information about the study, and answered any questions they may have had. I was purposely vague regarding the specific emotion regulation strategies that I was looking for because I did not want them to be conscious of these behaviours and therefore, act unnaturally. I then gave them the participant information form (see appendix 8 for participant information form for study 2) and consent form to sign (see appendix 6 for consent form).
To recruit patients, each therapist told me when they had appointments scheduled with new patients. I would come to the clinic at that time. Upon the patient’s arrival, the therapist would retrieve the patient from the reception, without me being present. The therapist would give the patient information about the study including the purpose, what would be required of them, and their right to decline or except without penalty. They would then ask if the patient wanted to participate, making it clear that they did not have to decide at that moment. If the patient gave verbal consent, I was then introduced to the patient and would begin to observe the treatment session.

Immediately after the treatment session, I would follow the patient to the reception to give them more information about the study and answer any additional questions they may have. Again, I was vague about the specific emotion regulation strategies. I told them I was looking at how they were interacting with their therapist. I gave them a participant information form and consent form. I told them they could take it home, read it, and bring the signed consent form with them to the next treatment session. Since patients often forgot to bring the consent form back with them, I always had extra copies for them to sign upon their return.

It would have been more ideal to get the patients to sign the consent form prior to the first therapy session. Unfortunately, this was not possible because the therapist only had a few minutes to give the patient enough information to get verbal consent before the treatment sessions started. For ethical purposes, it was better for the participants to be able to take more time to think about whether they want to continue to participate after the first session. While all the patients who were asked to participant agreed, I had two patients who decided to discontinue their participation after the first observation for undisclosed reasons.

4.4.5 Sample Size and Strategy

Purposive sampling was used to recruit therapist-patient dyads. I initially aimed to recruit eight dyads. Ultimately, I recruited six dyads (six patients and two therapists) for the pilot study and eight dyads (eight patients and eight therapists) for the main study. The rationale for the sampling strategy and sample size is the same as in the first study. Also, similar observational studies have utilised similar sample sizes (e.g., Zhao & Ji, 2014; Bolster & Manias, 2010; Dihle, Bjolseth & Helseth, 2006).
4.4.6 Inclusion Criteria
The inclusion criteria for participants were the same as in the first study with a few additions. Firstly, participants must be recruited prior to their first treatment session. Secondly, the expected length of the therapeutic relationship must be less than six months. Lastly, both dyadic partners must agree to participate in the research.

4.4.7 Participants
The patient-therapist dyads were recruited from three hospitals in London. In the pilot study, I observed two therapists working with three of their patients each. In the main study, I observed eight dyads, consisting of eight patients and eight therapists. Overall, the therapists who participated ranged in ages from their 20’s to their 40’s, had between two and 20 years of experience, and were all white British except two, who were Asian British. Three of the therapists were physiotherapists, and the remaining five were occupational therapists. The patients ranged in age from their 20’s to their 60’s. They were an ethnically mixed group, with half of them being white British and the other half being of various ethnic and national backgrounds. Table 2 features the participant demographics for the second study.

Table 2: Demographics of Participants in Study 2

<table>
<thead>
<tr>
<th>Study 2 Pilot</th>
<th>occupation</th>
<th>Years of experience</th>
<th>age</th>
<th>gender</th>
<th>pseudonym</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyad 1A - Therapist</td>
<td>Occupational therapist</td>
<td>2</td>
<td>30</td>
<td>M</td>
<td>S2P-1-T</td>
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<tr>
<td>Dyad 1A - Patient</td>
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<td>F</td>
<td>S2P-1A-P</td>
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<td>S2P-1-B</td>
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<tr>
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<td>F</td>
<td>S2P-1B-P</td>
</tr>
<tr>
<td>Dyad 1C - Therapist</td>
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<td>30</td>
<td>M</td>
<td>S2P-1-T</td>
</tr>
<tr>
<td>Dyad 1C - Patient</td>
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<td>M</td>
<td>S2P-1C-P</td>
</tr>
<tr>
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<td>20</td>
<td>40</td>
<td>F</td>
<td>S2P-2-T</td>
</tr>
<tr>
<td>Dyad 2A - Patient</td>
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<td>50</td>
<td>F</td>
<td>S2P-2A-P</td>
</tr>
<tr>
<td>Dyad 2B - Therapist</td>
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<tr>
<td>Dyad 2B - Patient</td>
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<td>Dyad 2C - Patient</td>
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</table>

**Study 2**

<table>
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<th>occupation</th>
<th>Years of experience</th>
<th>age</th>
<th>gender</th>
<th>pseudonym</th>
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</thead>
<tbody>
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<tr>
<td>Dyad 1 – Patient</td>
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<td>M</td>
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<td>Dyad 2 – Patient</td>
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<td>F</td>
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<td>Dyad 3 – Patient</td>
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<td>F</td>
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<tr>
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<td>F</td>
</tr>
<tr>
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<td>M</td>
</tr>
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<td>F</td>
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</tbody>
</table>
4.4.8 Data Analysis
Template analysis was used to analyse the data using the same rationale described in the first study. This method was ideal for this study because it enabled themes from the first study to be further refined in this second study. All data analysis was done using NVivo 10 software package.

4.4.7.1 Template Development
The final template from the first study was used as the initial template in the second study. The template was developed in the same way described in the first study (see appendix 4 and 5 for the final template for therapists and patients, respectively).

4.4.7.2 Data Coding and Interrogation
I began analysing the data by transcribing the audio files. Since I did the transcribing myself, it gave me an opportunity to become familiar with the data. Once I finished transcribing the data, I began to analyse each dyadic case separately. The first step was to review my observation notes to reorientate myself to the case. I would then look at the theme-maps and the participant verification interviews transcripts for each dyad to see what emotion regulation strategies were used and which emotion regulation strategies were used more than once by either dyadic partner. I also found it necessary to take note of the affective events that occurred in the relationships in addition to the turning points because the participants used emotion regulation in response to both. I coded these themes in the same way described in the first study.

Once I found out which emotion regulation strategies were used more than once by either dyadic partner, I needed to understand how the use of the strategy changed as the relationship progressed. I quickly realised that it was not possible to appreciate changes in how interpersonal emotion regulation strategies are used from reading the transcripts of their interactions. Transcribed information hinders one’s ability to understand interaction because it leaves out vocal inflections, sarcasm, pregnant pauses, and awkwardness. Humour was particularly difficult to pick up on by just reading the transcripts. I needed to hear the laughter or light-heartedness in a person’s voice to appreciate that humour was being used. Reading the transcripts lets you know what was said but does not capture how it was said. It was particularly important for me to understand how things were said because I was trying to
understand how the emotion regulation strategies were being used. For this reason, I reviewed the audio recordings of the therapy sessions to hear how the strategies were being used. For example, if the theme-map and participant verification interview indicated that humour was an emotion regulation strategy that was used by the therapist in the beginning of a relationship and then again towards the end of the relationship, I listened to understand if there was any difference in the way the therapist used humour in the first instance compared to the second instance.

I was particularly looking to understand and compare the level of risk in the way they used interpersonal emotion regulation strategies as their relationships progressed. My rationale is based on my findings from the first study. As the relationships developed, I did not see any patterns in terms of which strategies were used. However, I did see patterns in how the strategies were used regarding the level of risk the agent was willing to take. For example, a patient who wants to show gratitude to a therapist early in the relationship may do that by shaking hands, a form of touch. Later in the relationship, that patient may show gratitude by giving the therapist a hug, a relatively riskier form of touch. I defined risk in terms of the likelihood that the emotion regulation strategy could be misconstrued. I did not predefine what constitutes more or less risky use of interpersonal emotion regulation strategies. Instead, I coded all instances of the strategy being used, and then I went back through the coded data listening for evidence of the strategy being implemented in a more or less risky way. Generally, understanding broad differences in the level of risk within the use of an emotion regulation strategy is logical. For example, it is clear that a hug is riskier than a touch on the hand because a hug could more easily be misconstrued. Similarly, it is clear that self-disclosure about one’s personal life is more risky than self-disclosure about one’s ride to work.

I did not expect to see any development in the use of intrapersonal emotion regulation strategies because I did not see that in the first study. The way I rationalise this is that people typically use the emotion regulation strategies that they think will be the most effective. They may change the strategies that they use and/or how they use these strategies when they think the strategy is not producing the desired effect. Over the course of a relationship each dyadic partner is getting to know the other and how to regulate each other’s emotions. Therefore, there may be some trial and error when using interpersonal emotion regulation strategies. However, people already know how to best regulate their own emotions, so one would not expect to see the same amount of trial and error. People learn how to regulate their
own emotions over the course of a lifetime, so a much longer time period would be needed than the duration of a therapeutic relationship to see the trial and error development of how people use intrapersonal emotion regulation.

4.4.9 Limitations
While there were many benefits to using the observation method to collect data, there were also a few limitations. In general, there is always a possibility that participants behaviour may change if they know they are being observed. Also, observation is informed by the researcher’s understanding, rather than the interviewee’s understanding. For that reason, it was important that my understanding was verified by the participants’ understanding using interviews. Videotaping instead of audio taping the patient and therapist working together would have improved the trustworthiness of this study but the intrusive nature of videotaping in a public clinic would have posed ethical problems.

Using observation to observe emotion is problematic because the very function of emotion regulation strategies may obscure one’s ability to observe another person’s true emotions. Also, it is difficult to observe emotion regulation strategies. Some emotion regulation strategies, like cognitive reappraisal (intrapersonal emotion regulation strategy) and hiding/faking emotions (interpersonal emotion regulation strategy), are difficult or impossible to observe because they involve mental processes rather than social processes. Also, some behaviours that can be used as interpersonal emotion regulation strategies are sometimes used for other purposes, so it is difficult for the observer to be clear about such emotion regulation strategies without asking the interviewee. However, one of the main benefits of using observation in conjunction with participant verification interviews is the observation helps the researcher understand the context, which can enable the researcher to ask informed questions about the strategies that cannot be observed.

4.5 Reflexivity
Since I have taken a limited realist approach in this study, I appreciate that my understanding of the social world is limited by my position in it and I can never completely remove my subjectivity from the research process (King & Brooks, 2017). However, I strive for as much ‘empathic neutrality’ as possible, meaning I strive to avoid obvious, conscious, or systematic
bias and to be as neutral as possible in the knowledge generation process (Ormston, Spencer, Barnard & Snape, 2013). Reflexivity can help researchers identify threats to the quality of interpretation and consider the overall strategy for addressing these (King & Brooks, 2017). For this reason, using reflexivity throughout the research process is a valuable tool to use to proceed towards empathic neutrality. Holloway and Wheeler (2010) defined reflexivity as critical reflexion on the process of knowledge generation and the factors that influenced it. They contended that being reflexive means taking in consideration the interaction between the researcher and interviewees and the research process, findings, and outcomes (Holloway & Wheeler, 2010).

My culture, profession, and research skills are factors that would have an influence on the process of knowledge generation. My culture is American, but I understand the British culture where the research was conducted, as I have lived in London for many years. These cultures influence my understanding of relationship dynamics and interaction norms.

My experience working as an occupational therapist has shaped each stage of the research process. Prior to collecting data, I already had an understanding of the therapeutic process and the professional code of ethics and conduct for therapists. I have experienced many therapeutic relationships with patients. For this reason, I have experience using emotion regulation during therapeutic relationships and I have my own impressions of patients’ tendencies regarding emotion regulation use. I also have my own understanding of the characteristics of high-quality and low-quality therapeutic relationships.

This previous experience and knowledge has given me an insider’s perspective and has inevitably influenced each stage of the research process to some degree. It influenced the questions I asked and how I understood the answers participants provided. It influenced what occurrences stood out in my mind when observing therapist-patient interactions and the subsequent questions I asked in the participant verification interviews. For example, when in the second treatment session I observed a patient tell the therapists he is using a store-bought splint, after the therapist made him a custom splint in the first session, I knew that was a happening that I should ask the therapist about during the participant verification interviews. Although the therapist did not behave as if she was angry or irritated, I understood from my experience being a therapist that is a type of situation that would annoy a therapist. My insider’s perspective also influenced how I analysed the data and my resulting conclusions.
since my perception of the data and the reality I seek to understand is influenced by my position and experiences in the social world.

In some ways this insider’s perspective may be helpful. Being an insider may enhance the depth and breadth of the researchers understanding since the researcher shares a similar identity, language, and experiences. This similarity may give the researcher more legitimacy and acceptance which may help the researcher gain access to the target population and can encourage participants to share more (Dwyer & Buckle, 2009). However, in some ways this insider’s perspective can introduce challenges in that the researcher may struggle with a conflict between loyalty and findings, role confusion, or may lead the participants to share less because of assumed familiarity (Dwyer & Buckle, 2009). The researcher may also be susceptible to their assumptions resulting in leading questions or seeing what he or she wants to see in the data.

I used a number of strategies to address the challenges associated with being a researcher with an insider’s perspective. A researcher’s values and thoughts play a role in shaping the research process, and therefore, needs to be explicit (Holloway & Wheeler, 2010). I have endeavoured to make my thoughts explicit by using a reflexive journal throughout the research process. In the journal, I recorded and critically analysed my research activities, opinions, assumptions, and conclusions. I documented questions that I had and the answers that I eventually found. I also took notes on the rationale for the decisions I made throughout the research process. Anytime I learned something that impacted upon the research process, I recorded it along with the date. In this way, the reflexive journal provides a clear picture of the emergent design of the research and the development of my skills as a researcher.

I tried to minimise the influence of my interactions with participants on the research. I dressed casually and spoke using layperson’s terms to avoid perceptions of power asymmetry. I assured the participants that the information they provided was confidential within ethical limits. In the second study, I tried to stay as quiet as possible while I observed. Despite my efforts, I appreciate that my asking questions and my presence influenced the information that the participants disclosed and their behaviour. For example, during one of my observations in the second study, a therapist said to me in a joking way, “Please don’t judge the quality of my splint making skills”. I assured her that I would not be able to judge the splint because hand therapy was not my specialty. Also, at times patients would engage in casual conversations with me.
There are a number of features of the design that I used to reduce bias and help achieve the most accurate interpretation of the data. There is a risk that interviewees may just agree with the interviewer or answer questions in a way that shows themselves in a positive light. There is also a risk that interviewees may not understand or remember relevant information. To reduce these risks, I used a number of strategies including, asking questions based on my observations of interactions (in the second study), encouraging interviewees to ask questions, and asking interviewees to discuss current or recent therapeutic relationships. Additional strategies that I used were providing visual and verbal examples for clarity, avoiding using leading questions, telling interviewees that I value their perspective, and conducting interviews in private rooms. Despite these efforts, it is impossible to fully eliminate the effects of bias in this study. For example, some emotion regulation use is subconscious so it would be difficult for interviewees to fully appreciate when they used these strategies. For this reason, their description of the use of such strategies will likely be limited.

4.6 Context

Context refers to situational characteristics and variables that affect the occurrence and meaning of organisational behaviour and the relationships between variables (Johns, 2006). Context can have subtle and powerful effects on organisational behaviour. Contextual factors may discourage or abet certain organisational behaviours. These contextual variables may affect organisational behaviour independently or act as part of a bundle of factors (Johns, 2006).

Context is an important methodological consideration because it affects the range and perceived importance of organisational variables. It can also influence the outcomes and trustworthiness of a study (Johns, 2006). Contextualised research helps to convey the applications of research findings and can explain study-to-study variations in conclusions (Johns, 2006). In essence, if we do not understand the context, we cannot understand the organisational interactions that happen within that context (Johns, 2006). For this reason, researchers should ensure their research is contextualised. Contextualised research entails linking observations to a set of relevant facts, events, or points of view (Rousseau & Fried, 2001).
It is particularly important for emotion regulation research to be contextualised because the use and effectiveness of emotion regulation strategies is dependent on context (Gross, 2015; Dixon-Gordon, Bernecker & Christensen, 2015). While theoretical and conceptual studies place emphasis on the importance of the context, empirical studies have not emphasised this importance to the same degree (Aldo, 2013). A closer delineation of contextual factors influencing emotion regulation can enable a more nuanced understanding (Aldao, 2013).

In contextualising research, it is difficult to consider every aspect of the context, so researchers should consider those aspects of the context that are most salient and have the strongest impact on organisational behaviour. Contextual factors that have a strong influence on organisational behaviour constrain individual differences in behaviour and may be obvious norms and rigid roles. In contrast, contextual factors that are weak allow more variation in individual differences in behaviour (Johns, 2006). Researchers can identify important contextual factors in organisational behaviour by telling the story of what is researched. This can be done by describing who, what, when, where, and why (Johns, 2006). I will now describe these contextual factors in relation to this research.

“What” contextual information constitutes what the research is about and “why” contextual information constitutes the rationale for the study (Johns, 2006). Both of which were described in preceding chapters in this thesis. “Who” contextual information, in terms of participant demographics, was also previously described. In particular, the professional role as an occupational therapist or physiotherapist is a strong “who” contextual factor that is likely to influence how therapists behave. While emotion regulation ability is a contextual factor that would influence dyadic partners’ behaviour, it was not considered necessary to collect data on it for the purposes of this study. One “who” contextual factor that may have had an important influence on what emotion regulation strategies were used concerned the patient’s reason for referral to therapy and their resulting functional capabilities. I did not appreciate this in the first study, so I did not collect data on patient diagnosis. It was not until the second study that I noticed that the severity of the patient’s diagnosis may affect the emotions experienced and displayed within therapeutic relationships and therefore, the emotion regulation strategies used. In the second study, all the patients were being seen for problems concerning their hands. These types of diagnoses have relatively little effect on the patients’ ability to function in everyday life compared to other diagnoses. For this reason, hand therapy clinical settings may not require as much use of emotion regulation for
therapists or patients as clinical settings where the patient’s functional capabilities are more seriously impaired.

“Where” contextual information refers to the location of the research site (Johns, 2006). All the research was done within the cultural context of the United Kingdom, although some of the participants were from other cultural backgrounds. Most of the data were collected in the natural environment for the therapeutic relationship, the hospital or clinic, except for a few interviews that were done in public places. A “where” contextual factor that may have influenced organisational behaviour was the presents of others or lack thereof. Some therapists interact with patients in private settings, for example a patient’s room or home, while other therapists work with patients in busy clinics. In the second study, due to the nature of the specialty area, all the therapists worked in the clinic where they could be seen by others. However, in the first study some of the therapists worked in secluded environments. This is an important contextual factor because the way patients and therapists use emotion regulation strategies may have been influenced by the presences of witnesses.

“When” contextual factors refer to temporal aspects relating to when the research was conducted or when events occurred (Johns, 2006). In the first study, data were collected from the therapists after their therapeutic relationships ended. For the patients, data were collected prior to the therapeutic relationship ending but after the occurrence of the affective events and turning points that were discussed in the interview. In the second study, data were collected from the beginning to the end of therapeutic relationships and therefore, before and after the occurrence of affective events and turning points. The longitudinal design of this study helped to capture contextual changes that influenced the dynamic nature of therapeutic relationships.

Since emotion regulation use and effectiveness is dependent on the context, the more stable the context between cases, the easier it is to focus on the issue of interest. The factors that remain constant between dyads is the patient’s and therapist’s role, the purpose of their interactions and the cultural context. There are an infinite number of contextual factors that vary between the cases, including the events within and outside the relationship, individual emotion regulation skills and preferences, patient diagnoses, and the duration of the relationships. The context in the first study varied more than the context in the second study because in the second study, all the therapists worked in hand therapy; in the first study the therapists worked in different practice areas.
4.7 Ethical Considerations

Ethical clearance was obtained from the National Health Service and the University of Manchester’s ethics committee. This research was guided by the four principles of ethical scientific inquiry described by Beauchamp and Childress (2001); justice, non-maleficence, beneficence, and autonomy. Justice refers to treating people equitably. All people, who met the inclusion criteria at the healthcare facilities where I collected data, were eligible to participate. The inclusion criterion was designed to avoid unfair exclusion from the study while ensuring those who were invited to participate were able to make an informed decision. I was prepared to make appropriate arrangements for people who had disabilities (e.g., hearing impaired) that hindered their ability to participate. However, no situations arose where eligible participants needed any special arrangements to participate. All participants were treated equally.

The principles of non-maleficence and beneficence mean to do no harm and to promote well-being respectively. Therapists were offered certificates of participation that they could use in their continuing professional development portfolios. Patients were not offered anything in return for their participation. I was conscious of the fact that the participants were giving me their time, and I tried to be as time efficient as possible. During the research, the respect and comfort of interviewees and potential interviewees was a priority. The interviewee’s thoughts and ideas were respectfully accepted. Every effort was made to ensure that potential interviewees did not feel coerced in any way to participate in the study.

There were minimal risks associated with this research. To minimise risks, I avoided recruiting from more vulnerable patient populations, such as children, older people, and people with mental illnesses. For the second study, I chose to observe in hand therapy clinics partially because that speciality is less invasive than other speciality areas. Since we were discussing emotions, there was a risk that participants may get upset or feel overexposed. To address this risk, I told the participants they could discontinue their participation at any time. I had a plan in place to address such situations and the local collaborator was always available to assist. Lastly, there was a risk that potential participants could feel coerced during recruitment. To minimise that risk, I utilised a local collaborator, a person who did not have a vested interest in the research, to recruit participants.
Autonomy recognises each individual’s right to make their own decisions and act in their own best interests. Informed consent and confidentiality are central to this ethical principle (Carpenter & Suto, 2008). I employed several strategies to ensure data confidentiality. A minimal amount of person-identifiable information was recorded. This included the interviewees’ first name, phone number, and demographic information, such as age, years of work experience (in the case of a therapist), and ethnic background. The data were only used for the purpose for which it was provided. Access to this data were limited to myself, my research supervisors, and individuals with regulatory responsibilities within the University of Manchester, the NHS Trust, or other regulatory bodies.

While at the research site I maintained confidentiality by conducting interviews in private rooms on a one-on-one basis. While on the hospital premises, I avoided discussing details of data collected and I stored all data and data collection tools in a suitcase that I kept with me at all times. I have experience handling confidential documents (e.g., patient’s medical records) while on hospital premises through my work as an occupational therapist.

I stored the data and data collection tools in a locked cabinet in my office. My office has the extra level of security offered by swipe-card entry. Electronic data were encrypted. When storing the data, I referred to participants with just their first names. No patient-identifiable information will be included in publications arising from this research; participants are referred to using pseudonyms.

I also used a number of strategies to obtain informed consent. In the first study, a potential interviewee’s ability to give informed consent was assessed first by the local collaborator and then by me. The local collaborator was in a good position to identify potential interviewees who were able to give informed consent because the local collaborator had knowledge of the study, the inclusion/exclusion criteria, and was familiar with the potential interviewees at their facility. The local collaborator verbally explained relevant information about the study and gave potential interviewees a participant information form, so they could review it at their leisure. The participant information form outlined the purpose, design, procedure, benefits, and risks of the study. If they agreed to participate, the local collaborator scheduled a time for them to meet with me.

During this meeting, I reviewed the purpose and nature of the research in detail, including the benefits, risks, and burdens associated with participating in the research. Layperson’s terms were used to ensure the potential interviewees understood, and I asked if the potential
interviewees had any further questions to clarify their understanding prior to commencing the interview. I emphasised the potential interviewees’ rights to accept or decline the invitation to participate without penalty. I also emphasised that if they choose to participate, they have the right to discontinue their participation at any time.

In the second study, informed consent was gained in a different way. The therapists were recruited by the local collaborator in the same way as described in the first study. However, the therapists, not the local collaborator, recruited the patients. Since I needed to observe the first treatment session, the therapists would go and introduce themselves to their new patients and give them some verbal and written information about the study. If they agreed to participate, I would immediately come and observe the first treatment. After that session, I would give the participant some more information and give them the consent form for them to take home, sign, and then return to me upon their next treatment session. I had to do it this way because there was only a small space of time between when the therapist and the patient first met and the first treatment session. I could have asked the therapists to call their new patients prior to them coming to their first treatment session, but I wanted to be careful not to unduly inconvenience the therapists.

In both studies, I used my professional judgement to assess if the potential interviewees were competent to give informed consent. I have experience obtaining informed consent to engage in therapeutic procedures from people with disabilities and people who are considered vulnerable. For this reason, I could be sensitive to signs that may indicate that a potential interviewee was unable to give informed consent, such as the potential interviewee having difficulty remembering my name or mistaking me for someone else even after I have introduced myself. People who agreed to participate in the study and were able to understand and retain information about the study were given two informed consent forms to sign; one form for the participant to keep and one form for me to keep. I recognised that informed consent is an ongoing agreement; for this reason, I endeavoured to address questions regarding the research as needed. In the second study, I had two participants agree to the first observation but decline subsequent observations for undisclosed reasons.

In addition to considering how the research may directly affect participants, researchers must also consider the macro-ethical implications, which are ethical considerations regarding the broader social impact of the research (Kvale, 2007). An important macro-ethical consideration is that the purpose of this research is to improve our understanding of a
psychological phenomenon and add to the knowledge base. This research can have a positive
effect on the human condition in the sense that it can help therapists understand how to build
better therapeutic relationships. This understanding will be beneficial for the therapist and
the patients.

4.8 Chapter Summary
Qualitative methods in two studies were used to answer the research questions. The overall
aim was to understand how emotion regulation develops within therapeutic relationships. In
the first study, semi-structured interviews were conducted with patients and therapists. In the
second study, patient/therapist dyads were observed throughout their therapeutic relationship
and then interviewed at the end of their relationship. This research addresses a number of
gaps in literature on emotion regulation in the workplace and therapeutic relationships.

Several strategies were used to increase the trustworthiness of this research. The emergent
design in both studies began with a pilot study. Cognitive interviewing techniques were used
to help participants remember the details of their relationship. Visual aids were used to help
participants speak in terms of emotions and understand what was being asked of them. The
theme-map represented a unique approach to member checking where the participants and
myself worked together to make a visual representation of their experience of emotion
regulation in therapeutic relationships. In the second study, participant verification interviews
were used to more closely align my observations with the participants’ perceptions. I used a
reflective journal throughout the two studies to aid my critical reflexion on the research
process and to make it more transparent. Lastly, methodological triangulation was used to
explore the phenomenon from different vantage points.

I benefited from prolonged engagement as I have been an occupational therapist for more
than 20 years; therefore, I have experienced therapeutic relationships with patients.
However, while being familiar with the setting and profession helps in understanding the
data, it could make the researcher more susceptible to miss important issues and
considerations due to preconceived notions (Holloway & Wheeler, 2010). One strategy that
I used to maintain awareness of my subjectivity was to write down my preconceived thoughts
about the themes in the beginning stage of the research so that if I began to see those themes
in my analysis, I could scrutinise them more closely.
Chapter 5 Findings: Therapists’ and Patients’ Use of Emotion Regulation

5.1 Introduction

This chapter provides an overview of the combined findings from the first and second study that address the first research question: How do therapists and patients use emotion regulation strategies during the therapeutic relationship? The findings are presented, first from the therapists’ perspective and then from the patients’ perspective. This discussion begins with a description of therapist’s and patient’s goals and motivations. I then turn my attention to their use of intrapersonal emotion regulation in response to positive and then negative emotion. Next, I discuss how they use interpersonal emotion regulation strategies. Following on from there, I discuss my findings on the reciprocal nature of dyadic emotion regulation. An important outcome of my analysis is emotion regulation behaviour is influenced by therapists’ familiarity with affective events and resulting emotions that occur during their encounters. Interactions that feature commonly encountered, familiar affective events and emotions are defined as routine encounters. Interactions that feature uncommonly encountered, unfamiliar affective events and emotions are defined as non-routine encounters. This leads to a distinction between the characteristics of routine and non-routine encounters in the occupational therapy/physiotherapy context.

In the first study, I explored encounters where non-routine emotions and affective events were prevalent by asking therapists to tell me about two recent therapeutic relationships; one that they consider as high-quality and one that they consider as low-quality. These relationships featured significant affective events that resulted in intense emotions that were relatively uncommon and therefore, required a trial and error approach to emotion regulation. In the second study, I explored routine encounters by observing the everyday interactions of therapist/patient dyads. These everyday encounters featured common affective events with less intensive emotional experiences and the use of an emotion regulation approach that draws on previous experiences of similar situations.

This chapter concludes by placing these findings in the context of the wider debates within the literature. In particular, I identify the main contributions of this study in relation to the above stated research question. Firstly, intrapersonal and interpersonal emotion regulation strategies are used proactively, in response to expected emotion, and reactively, in response
to experienced emotion. Secondly, a key factor in shaping therapists’ emotion regulation behaviour within therapeutic relationships is whether the antecedent affective event and resulting emotion are routinely encountered.

5.2 Therapists’ and Patients’ Emotion-Focused Goals and Motivations

Understanding therapists’ and patients’ intrapersonal and interpersonal emotion-focused goals and motivations is a prerequisite to understanding how they use emotion regulation strategies. Regarding therapists’ intrapersonal emotion-focused goals, therapists stated they wanted to experience and display positive emotions, such as satisfaction, cheerfulness, optimism, caring, and enthusiasm; and they often felt these emotions. However, they did not expect to experience extreme positive emotions, such as euphoria and feeling triumphant. Therapists wanted to avoid experiencing and displaying negative emotions, but often experienced frustration, disappointment, and sadness. Therapists’ intrapersonal emotion regulation goals were in line with common display rules within healthcare organisations which in general, stipulate the display of positive emotion and avoiding the display of negative emotions (e.g., Diefendorff, Richard & Croyle, 2006). Therapists often experienced many emotions at once and tended to use multiple intrapersonal emotion regulation strategies to address their emotions in an effort to achieve their intrapersonal emotion-focused goals.

Regarding interpersonal emotion-focused goals, therapists wanted their patients to feel positive emotions, such as satisfaction, hopefulness, relief, and happiness. For the most part, therapists did not want their patients to feel negative emotions. Therapist reported using interpersonal emotion regulation strategies in pursuit of these goals.

Therapists’ motivations for using intrapersonal and interpersonal emotion regulation strategies fall into all three of the categories proposed by von Gilsa & Zapf (2013); pleasure, prevention, and instrumental. Pleasure motivated therapist to use emotion regulation strategies because therapists wanted to avoid unpleasant emotions and facilitate pleasant emotions. For example, therapists at times used humour to help their patient experience positive emotions. Preventative motivations also guided therapists’ use of emotion regulation. For example, a therapist may hide and ignore their own experience of anger to avoid conflict with a patient. Therapists also reported instrumental motivations for using emotion regulation strategies. For example, therapists used emotion regulation strategies to encourage their patients to experience positive emotions and avoid negative emotions.
because they understood negative emotions to be a hindrance to their ability to get their work done.

In addition, altruism, meaning acting in the interest of others, was a prominent motivation described by therapists. Examples of strategies used altruistically include providing a card to offer condolences, visiting patients who have been moved to different wards, and giving a hug to a patient. Therapists reported using these strategies to show that they cared, as opposed to just to get the work done. In this way, these strategies can be considered emotional gift giving, which is providing extra emotion regulation work that goes beyond organisational expectations of emotional display for altruistic reasons (Bolton, 2000).

Patients reported experiencing a wide range of negative emotions during their interactions with their therapist. At times they felt anger when their therapists caused them pain or when service errors were made. They felt anxiety and fear when they did not know what to expect. They felt disappointment when they did not make progress. Patients use intrapersonal emotion regulation strategies to avoid or decrease their experience and expression of these negative emotions. Patients also experienced a wide range of positive emotions when working with their therapists. They felt happiness and relief when the treatment was effective, and they made progress. They felt hopeful and optimistic when they got positive feedback from their therapists. They felt fondness and liking towards their therapist as the relationship developed. Like therapists, patients’ intrapersonal emotion-focused goals were to avoid negative emotions and experience positive emotions during their encounters with therapists.

Patients interpersonal emotion-focused goals were similar to therapists in that they wanted their therapists to appear to have positive emotions including cheerfulness, optimism, and enthusiasm. They did not want their therapist to appear to have negative emotions, particularly anxiety. While patients did use some interpersonal emotion regulation strategies to achieve these interpersonal emotion-focused goals, they did not believe it was their responsibility to manage their therapist’s emotions. Overall, patients shared the same motivations for using intrapersonal and interpersonal emotion regulation strategies in their encounters with therapists; to experience pleasure, avoid problems, and utilise the therapeutic process to get better.
5.3 Therapists’ Use of Intrapersonal Emotion Regulation in Response to Negative Emotion

Therapists reported using all the intrapersonal emotion regulation strategies described in Gross’s (1998) process model of emotion regulation to regulate their own negative emotions. Table 3 lists examples of therapists’ use of emotion regulation strategies used in response to negative emotions that fall into each category specified by Gross’s (1998) process model of emotion regulation. Situation selection is choosing to engage or not engage in situations to avoid undesired emotions and promote desired emotions (Gross, 1998). The main way that situation selection is used by therapists within therapeutic relationships is by avoiding interacting with patients that cause them to have negative emotions. Therapists may do this by swapping patients with another therapist or therapy student.

“Me and the physios split them up, and she’ll go one day, and I’ll go another. And we’ve got a student, so we send the student the other day. So, it spreads the load a little bit.”

(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s

Situation modification strategies are used to alter a situation to promote desired emotions (Gross, 1998). Therapists use situation modification strategies to steer their encounter in a way to avoid negative emotions. Often this entailed efforts to prepare oneself emotionally and practically. For example, one therapists explained how she prepared herself prior to working with a patient to avoid feeling the anxiety and embarrassment associated with appearing nervous or incompetent.

“… prepared myself before going in…. You know how you kind of psych yourself up. You really think through what your treatment plan’s going to be, think through what you’re going to say just in case the family comes and it’s the whole deep breath, in you go.”

(1-8-T) Physiotherapist, 13 years’ experience, age range – 30s

I interpreted this as situation selection because if the therapist did not prepare herself, she may appear incompetent, which may result in her feeling anxious or embarrassed. In preparing for the session, she modified the situation from one where she could have been ill-prepared, to one where she is prepared. In the quote the therapist mentions that she “psyches”
herself up. This can be interpreted as providing evidence that she is simultaneously using cognitive reappraisal to prepare for the treatment session.

Therapists also reported using cognitive reappraisal, strategies used to modify how one appraises a situation in order to promote the desired emotions (Gross, 1998). My analysis revealed that therapists used these strategies to protect themselves, to feel better, to maintain their professionalism, and to be able to get their job done. They tended to use cognitive reappraisal to reframe the cause of patients or their family’s negative behaviours or to remind themselves of the limits of their remit. One therapist described how she used cognitive reappraisal to deal with the sadness she felt when one of her patients died one week after he was discharged home by thinking about the positive aspects of the situation.

“I felt it’s, it was, he’s gone to rest, the suffering has gone because there was so much pain and it’s a loss but he’s now, he’s had good care… the best that we could offer… and so that gives me that satisfaction that, you know. And him having that one week at home which was vital.”

(1-14-T) Occupational Therapist, 35 years’ experience, age range – 60s

Therapists also used cognitive reappraisal to give themselves permission to feel negative emotions but in a controlled way.

“…actually, sometimes unfortunately, like, you can only do what you can do. And so, you have to sometimes, it sounds bad, but be at peace with that. And know that actually, you know yes, there’s things that you can do and as long as you know you’ve done everything to the best of your ability, or within your remit, your scope of practice, then you need to, it’s fine to feel that helplessness and fine to feel that frustration but you just be at peace with that at times.”

(1-7-T) Physiotherapist, 3 years’ experience, age range – 20s

Attentional deployment strategies are those focused on directing one’s attention to influence one’s own emotional experience (Gross, 1998). One of the main ways that therapists used attentional deployment is by ignoring negative affective events, such as patient’s display of irritation or anger directed towards them.

“I guess I just blocked it out after I knew that I couldn’t change the outcome…”

(1-13-T) Physiotherapist, 4 years’ experience, age range – 20s
Over time they can become accustomed to the common affective events that cause them negative emotion and these affective events may decrease in their affective significance.

“I think having been in the NHS now for… 6 years. Certain frustrations now bounce off my back because I can’t influence them… What’s the point in worrying about things I can’t influence? … It’s nice to get a feeling from the doctors that you’re helping or you’re not slowing up things for them. But then you have to get a thick skin and just sort of deal with it, if it doesn’t.”

(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s

This quote can be interpreted as an example of a therapists using attentional deployment and cognitive reappraisal concurrently. The therapist talks about the need to have thick skin and letting frustrations bounce off her back. These are indications of the therapist using attentional deployment. When the therapist questions the point of worrying about things she cannot influence, this is an indication of her using cognitive reappraisal.

Response-focused strategies are efforts focused on influencing the experiential, behavioural, or physiological components of an emotional response (Gross, 1998). Examples of therapists use of such strategies include, holding back tears, hiding their frustration, and taking a deep breath to try to control anxiety. They used these strategies to maintain a professional veneer and to deescalate tense situations. Therapists also reported moderating their expression of negative emotion to communicate with the patient the seriousness of the situation or to display it in a professional way. One therapist described how she muted the sadness she felt to show it in an appropriate way when visiting a patient, who had recently been readmitted to the hospital, and his wife.

“I kept it (the sadness) within me because I felt I was going to see the wife. So, I mean obviously I went in, we hugged each other, we embraced … and I think that is a lot… and that way I didn’t have to say much, but she knew that I was deeply concerned with what was going on.”

(1-14-T) Occupational Therapist, 35 years’ experience, age range – 60s

The strategies that therapists use that fit within Gross’s (1998) process model of emotion regulation can be considered covert strategies because they constitute an intrapsychic phenomenon that can easily go unnoticed by others (Aldao & Dixon-Gordon, 2014). The data showed that therapists also used what Aldao and Dixon-Gordon (2014) consider overt
intrapersonal emotion regulation strategies. Overt emotion regulation strategies are those strategies that are at times used for emotion regulation purposes but can also be used for purposes other than emotion regulation. These strategies may be more easily observed by others. Examples of overt strategies used by therapists include eating, crying, venting, seeking support, and exercising. Overt emotion regulation strategies may be categorised in any of the five emotion regulation strategy families identified by Gross’s (1998) process model of emotion regulation depending on the function of the strategy and when the strategy is used during the emotion generation cycle.

Therapists also reported using intrinsic interpersonal emotion regulation, regulating their own emotions using interpersonal interaction, as described by Zaki and Williams (2013). This can also be considered an overt intrapersonal emotion regulation strategy. Therapists at times felt sad when their patients were sad. In these situations, therapists attempted to make themselves feel better by making their patients feel better. One therapist described using intrinsic interpersonal emotion regulation after a situation occurred that made her and her patient feel sad.

“I think the way I dealt with it inside (referring to her own negative emotions) was by going to her (the patient) and talking to her… and by being able to pass that on to her and make her feel a bit better, made me feel better about it.”

(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s

Therapists choose which intrapersonal emotion regulation strategies to use based on what they understand from previous experience works for them. For example, a therapist discussing how she regulates the negative emotions she experiences at work said the following:

“I am an eater, I know that I am. If I’m feeling a bit rotten then I’ll have a big bag of crisps. And that works. And that does work at work as well. It’s been a bad day; shall we go out for lunch? It’s quite a common thing in our office.”

(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s

In addition to using intrapersonal emotion regulation strategies during the encounter, therapists also use these strategies prior to and after the encounter. For example, prior to the
encounter a therapist may study the patient’s diagnostic condition to prevent themselves from having anxiety during the encounter. After the encounter, therapists may use strategies like venting, “switching off”, and exercising to address residual emotions.

Therapists use intrapersonal emotion regulation strategies proactively and reactively. Antecedent-focused intrapersonal emotion regulation strategies by definition are used proactively, that is, prior to the experience of emotion. Likewise, response-focused intrapersonal emotion regulation strategies, by definition are used reactively, meaning in response to the experience of emotion. Overt intrapersonal emotion regulation strategies, however, may be used proactively or reactively.

From my analysis, it is clear that therapists at times use more than one intrapersonal emotion regulation strategy to address emotions stemming from an affective event. They may use multiple emotion regulation strategies to address one emotion or to address more than one emotion experienced simultaneously. This was particularly true in situations where therapists experienced strong negative emotions. For example, many therapists described hiding negative emotions while at the same time trying to solve the problem that caused the negative emotions. Then after the treatment session, therapists may vent to their colleagues to address the residual emotions stemming from the affective event. Often therapists described hiding emotions at the same time as faking emotions. Hiding/faking emotions and cognitive reappraisal were also often used concurrently. My interpretation is that therapists needed to hide/fake emotions until the cognitive reappraisal helped them to change their emotions. In some cases, it appears that multiple strategies were used because the first strategy did not work.
Table 3: Intrapersonal Emotion Regulation Strategies Used by Therapists in Response to Negative Emotion

|---|---|
| Situation selection - Strategies used to ensure that one will be in a situation that promotes the desired emotions (Gross, 1998). | “… I didn’t feel I could work with her and so it’s (meaning treatment of the patient) gone to one of my colleagues.”  
(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s |
| Situation modification – Strategies focused on taking actions to change a situation in order to promote emotions that are desired (Gross, 1998). | “That’s the prep before the visit. So, for me, I don’t like to go into a situation cold. I need to have looked at the background, I need to know what kind of illness I’m dealing with, what kind of family dynamics, so I’ve got some semblance of what I’m about to expect.”  
(S1P-8-T) Occupational Therapist, 6 years’ experience, age range – 40s |
| Attentional deployment – Strategies focused on directing one’s attention to influence one’s own emotional response (Gross, 1998). | “So, I just distracted myself I suppose and went from there.”  
(1-12-T) Physical Therapist, 3 years’ experience, age range – 30s |
| Cognitive change – Strategies used to modify how one appraises a situation in order to promote the desired emotional response | “I think a lot of the way that I dealt with the situation as it went through was more just not taking it personally. Just recognising that it wasn’t a personal attack on me.”  
(1-9-T) Physical Therapist, 8 years’ experience, age range – 30s |
(Gross, 1998).

| Response-focused - Strategies that directly influence the experiential, behavioural or physiological components of the emotional response (Gross, 1998). | “… because you don’t want to come across too sad in front of your patients. So yes, probably hide it I’d say, hide it.”
(1-11-T) Physical Therapist, 11 years’ experience, age range – 30s |
|---|---|
| Intrinsic interpersonal emotion regulation – regulating one’s own emotions using other people (Zaki and Williams, 2013). | “I think the way I dealt with it inside (referring to her own negative emotions) was by going to her (the patient) and talking to her… and by being able to pass that on to her and make her feel a bit better, made me feel better about it.”
(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s |
| Overt emotion regulation strategies - strategies that can be used for other purposes but are at times used for emotion regulation purposes (Aldao & Dixon-Gordon, 2014). | “… I exercise because of work, I think, more than anything else and probably at times have a glass of wine.
(S1P-6-T) Occupational Therapist, 3 years’ experience, age range – 30s |
5.4 Therapists’ Use of Intrapersonal Emotion Regulation Strategies in Response to Positive Emotion

Therapists did not regulate positive emotion to the same extent as negative emotion. For this reason, it is not surprising that therapists reported using a limited number of emotion regulation strategies to regulate positive emotion. In particular, they only described using response-focused emotion regulation strategies in response to positive emotions to the exclusion of situation selection, situation modification, attentional deployment, and cognitive change. Table 4 lists an example of a therapist’s use of a response-focused emotion regulation strategy used in response to positive emotions. However, it is possible that they may use these strategies automatically and subconsciously, whereas they may not realise that they are using them. Therapists mostly reported that they often just experienced and expressed positive emotion naturally, in the moment, because these emotions were deemed desirable and useful to building and maintaining the therapeutic relationship. At the same time, during the workday therapists did not have time to indulge in these positive emotions because they needed to move on to the next patient.

“…sometimes it is difficult within the job to hold on to it (happiness) for too long because you tend to end the session and be happy and then go on to the next session or next thing. So, you kind of compartmentalise a little bit.”

(1-9-T) Physiotherapist, 8 years’ experience, age range – 30s

However, some therapists reported that they capitalise on and share positive emotions. Capitalising refers to beneficially interpreting positive emotions and events (Langston, 1994). Social sharing of emotions is a process that takes place after an emotional episode where the person who experienced it describes the episode to others (Rime, Mesquita, Philippot & Boca, 1991). Capitalising and sharing positive emotions can be categorised in Gross’s (1998) process model of emotion regulation as response modulation after the event (Quoidbach, Mikolajczak & Gross, 2015). Therapists reported capitalising on positive emotions by using them as a source of strength throughout the day and throughout their career.

“…I see horrendous things all day long… with these patients…But you get one patient where you’ve made a big difference… and that makes you feel really glad that you’ve been able to help someone in that way. It drives you on to then see the next patients and to get you through those times when you’re seeing patients and you’re like this is a really rough situation here. And they may not be improving at all. So, I
think it’s a drive for me, I think that happiness is a drive, a driving thing as to why I do the job.”

(1-7-T) Physiotherapist, 3 years’ experience, age range – 20s

“I experienced it for what it was, but it’s always one of those things that, you can have in the back of your mind (when working) with someone that you’ve had a difficult time getting to know and you can then utilise again, those reflexions, and throw it back into your practice.”

(2-7-T) Physiotherapist, 6 years’ experience, age range – 30s

“I definitely kept hold of it (referring to positive emotion) because… she was the first polytrauma that I had …I think actually she drove me on to get where I am now, to know that I could do that with someone, and I really enjoyed it and I want to continue doing that.”

(1-7-T) Physiotherapist, 3 years’ experience, age range – 20s

One therapist described how she used social sharing with her colleagues to regulate the positive emotion (satisfaction) she felt after she had a good treatment session with a patient who was normally rather grumpy.

“…I said, oh, I had a really good session with him today and you can kind of instil that into someone that may have had a bit of a rubbish day, and you try to ‘gee’ (meaning cheer) them up a bit as well.”

(1-12-T) Physiotherapist, 3 years’ experience, age range – 30s

While therapists mainly either just experienced and expressed their positive emotion naturally or attempted to utilise it for their own benefit, there were times that therapists needed to dampen down their positive emotions. This could be considered response modulation (Quoidbach, Mikolajczak & Gross, 2015). They did this in situations where the display of positive emotion was not appropriate either due to the situation or the intensity of the positive emotion.

“…if the next patient I saw was very unwell, those (positive) emotions then would have been held in, dampened down… it’s having appropriate emotions for the situation”
Another therapist described how she dampened down her level of excitement by ‘getting it out of her system’ prior to interacting with her patient.

“…I think it’s just not being quite as enthusiastic, which at times is hard because that is me. I am quite an enthusiastic, quite passionate person about what I do. And I think that to try and rein that in is hard at times but yet necessary. So, I just think it’s a bit, being a bit quieter. The physio that I have on my ward is very friendly and we’re both quite similar and we both get quite excited… And I think if we’re together and we both are excited I think that comes across. Sometimes we do have to think, I don’t think this lady quite wants to be quite that excited. And then we have to… go away and have a little laugh for a bit to try and like come back down to a more, I suppose more appropriate level.”

(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s

Table 4: Intrapersonal Emotion Regulation Strategies Used by Therapists in Response to Positive Emotion

<table>
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<tr>
<td>Response-focused - Strategies that directly influence the experiential, behavioural or physiological components of the emotional response (Gross, 1998).</td>
<td>“if the next patient I saw was very unwell, those (positive) emotions then would have been held in, dampened down… it’s having appropriate emotions for the situation”</td>
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(1-8-T) Physiotherapist, 13 years’ experience, age range – 30s

5.5 Therapists’ Use of Interpersonal Emotion Regulation Strategies

Therapists considered regulating their patients’ emotions as an essential part of their job. In fact, they reported that at times regulating their patients’ emotions took priority over participating in therapeutic interventions because the patients’ emotions influenced their ability to participate in therapy.
“I think rather than necessarily focusing on therapy and things, I just spoke to her on her level with her family there, with them not there, about how she was feeling and about how she wanted to go forwards. So, it was one of those situations where even though I was going to see her as a physio, we didn’t necessarily do any physio sessions. It was more talk and let her deal with her emotions. And then next time we come and do the physio session.”

(1-8-T) Physical Therapist, 13 years’ experience, age range – 30s

Therapists reported using a wide range of strategies to achieve their patient-focused emotion goals. These strategies can be categorised according to Williams’ (2007) interpersonal emotion management framework, which is based upon Gross’s (1998) families of intrapersonal emotion regulation strategies. Williams’ (2007) interpersonal emotion management framework includes four categories; altering the situation, altering attention, altering the cognitive meaning of a situation, and modulating the emotional response.

Altering the situation involves modifying or changing the situation to influence the emotional impact on the target (Williams, 2007). Therapists used this type of strategy proactively, that is in anticipation of emotion rather than in response to emotion, to avoid negative emotions. For example, therapists graded the level of difficulty in therapeutic tasks to ensure the patient’s successful completion of the task. Their rationale for doing this was to prevent their patients from experiencing the disappointment that would typically result from lack of success with such a task. A few therapists stated that at times they tell their patients they may not achieve full recovery as a tactic to manage the patient’s expectations and avoid patient disappointment if the patient does not fully recover. One therapist mentioned that she tells her patients up front that the decision regarding whether they get the equipment they want is not up to her, even though it was, in order to avoid patient anger directed at her if the desired equipment is not received.

Altering attention is attempting to divert the targets attention to influence their emotions (Williams, 2007). Therapists used small talk as a diversion from painful or taxing therapy. They redirected their patient’s attention away from negative emotion causing stimuli, such as a decline in patient status or their uncertain future functional status. One therapist explained that while she allows her patients to express their worries, she attempts to dissuade them from ruminating on them by refocusing them on the task at hand.
“If they’re (the patient) tearful, I listen. I’ll be respectful and understanding but then I’ll move on. ‘That’s okay, that’s that, so how can I move on?’”

(S1P-8-T) Occupational Therapist, 6 years’ experience, age range – 40s

Similarly, another therapist described how she used the therapy as an attention altering strategy.

“I just reassured him and said these things happen. And try not to focus on it and be too hard on yourself because lots of people have been in the same situation. And those sorts of things. So, and then just focusing on the getting him up and doing more active things to take his mind off it and feel like he is achieving.”

(1-9-T) Physical Therapist, 8 years’ experience, age range – 30s

This is an example of therapists using more than one type of interpersonal emotion regulation strategy concurrently. In telling the patient that many people have been in the same situation, this therapist was also trying to help the patient to appreciate that he is not alone. This strategy can be categorised as altering the cognitive meaning of a situation, which is helping the target think about an issue differently to alter the emotional impact.

Altering the cognitive meaning of a situation strategies are often used when patients are feeling sad about their lack of functional independence as a way to help the patients to see “the bright side of things”. For example, therapists encouraged their patients to focus on incremental improvements rather than the long rehabilitation journey ahead. Therapists use this strategy to help patients appreciate that although they are not where they want to be functionally, they are making significant progress.

“… they’re frustrated because they’re used to walking miles and all of a sudden they get up on their feet and they can take two steps. So, you have to reassure them that’s normal and that’s where they should be really, where they’re at, that they’re actually doing really well.”

(I-11-T) Physical Therapist, 11 years’ experience, age range – 30s

Therapists explaining their rationale for treatment decisions to help patients understand and buy into the process is another example of a strategy that fits into the altering the cognitive meaning of a situation category. Therapists use this strategy when patients appear to experience negative emotions stemming from disagreeing with the therapist’s
recommendations or treatment regime. One therapist described using this strategy with a patient who was reluctant to engage with therapy because he thought his ability to walk was fine. The therapist videotaped the patient ambulating and allowed the patient to view it. The patient was embarrassed by what he saw; he did not appreciate that his ability to walk was so encumbered. The therapist attempted to alter the meaning of the situation to decrease the patient’s embarrassment by explaining the purpose of using the video.

“…And we spoke to him and we said, ‘look we don’t do these things, and we don’t do them for no reason, and it’s not to embarrass you, it’s to help you realise as to where you are and to help you improve’. So, we tried, we explained to him that it’s not about being embarrassed, it’s about just realising what you need to do to improve and where you’re at now and this is merely just a tool to help you improve. So that he didn’t feel humiliated.”

(1-7-T) Physical Therapist, 3 years’ experience, age range – 20s

Modulating the emotional response involves actions used to alter the targets current experience or expression of emotion (Williams, 2007). Therapists in general believed that patients had the right to feel negative emotions. As such, they did not try to encourage them to suppress negative emotions unless the emotions were particularly intense and directed at the therapist. One therapist discussed how she attempted to regulate her patient’s emotional expressions by setting and enforcing boundaries on what emotional expressions are and are not appropriate. Emotional expressions that falls outside of those boundaries drew undesirable consequences.

“… I think a large part of it was building boundaries and then letting him (the patient) know where the boundaries lie in terms of what he could and couldn’t do (talking about the patient’s emotional expression) … So, you’re saying, I’m not going to accept it. If you’re going to shout, then I’ll come back when you’ve calmed down.”

(1-9-T) Physical Therapist, 8 years’ experience, age range – 30s

Although, generally therapists want their patients to feel positive emotions as opposed to negative emotions, sometimes therapists feel the need to dampen down their patient’s positive emotions slightly to ensure that the patients have a realistic understanding of their situation and to maintain patients’ motivation to continue to work towards rehabilitation.
goals. For example, one therapist discussed how she attempted to reduce her patient’s optimism about how soon he will achieve his goal of walking.

“…So, he’s (the patient) got the boot (a type of rehabilitation equipment) and now thinks that he will walk the next day and I was like, ‘oh it’s going to be a bit longer’. So, I kind of maybe reduced it slightly (referring to the patient’s positive emotion) because I was just being more realistic.”

(1-13-T) Physical Therapist, 4 years’ experience, age range – 20s

Since affective events often have emotional consequences for both dyadic partners within the therapeutic relationship, therapists often simultaneously use both intrapersonal and interpersonal emotion regulation strategies in response to affective events. In fact, at times the boundary between interpersonal and intrapersonal emotion regulation strategies is blurred because one strategy can be used for both intrapersonal and interpersonal reasons. For example, therapists appear to hide their emotions, an intrapersonal response-focused emotion regulation strategy, for interpersonal reasons, such as to avoid upsetting the patient. Another example can be provided using the previously discussed therapist who tells her patient that the final decision as to what equipment is provided is not up to her (altering the situation), although it was. She said this falsehood in order to avoid patient anger if the desired equipment is not received (interpersonal emotion regulation). It is clear, however, that if the patient had become angry at the therapist, it would have likely caused the therapist to experience negative emotions. Therefore, telling the patient the decision was not up to her was also a proactive intrapersonal emotion regulation strategy. Table 5 lists interpersonal emotion regulation strategies that therapists used when interacting with patients.
**Table 5: Interpersonal Emotion Regulation Strategies Used by Therapists**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Example</th>
<th>Participant Details</th>
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<tr>
<td>Altering the situation - Modifying or changing the situation to influence the emotional impact on the target (Williams, 2007).</td>
<td>“Because she (the patient) obviously said this previous comment about us being a physio-terrorist or something. And I said, well it’s the terrorists, here we are! And then it becomes a bit, it doesn’t become an elephant in the room. It becomes more of a fun thing you can use and she kind of went with that and it was, it created a bit more positivity I think.”</td>
<td>(1-11-T) Physical Therapist, 11 years’ experience, age range – 30s</td>
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<tr>
<td>Altering attention- Attempting to divert the targets attention to influence their emotions (Williams, 2007).</td>
<td>“So, for example, if I feel that they’re quite, if they’re in like an angry mind-set, I try to joke with them, interact, be playful, talk about their family, talk about pictures. I won’t go straight to the assessment. I try to defuse the situation if I sense that.”</td>
<td>(S1P-8-T) Occupational Therapist, 6 years’ experience, age range – 40s</td>
</tr>
<tr>
<td>Altering the cognitive meaning of a situation- Helping the target think about an issue differently to alter the emotional impact (Williams, 2007).</td>
<td>“…we spoke to him and we said, look we don’t do these things… to embarrass you, it’s to help you realise as to where you are and to help you improve. So, we tried, we explained to him that it’s not about being embarrassed, it’s about just realising what you need to do to improve and where you’re at now and this is merely just a tool to help you improve. So that he didn’t feel humiliated.”</td>
<td>(1-7-T) Physical Therapist, 3 years’ experience, age range – 20s</td>
</tr>
<tr>
<td>Modulating the emotional response - Involves actions used to alter the targets current experience or expression of emotion (Williams, 2007).</td>
<td>“I apologised for having that conversation in front of him if he didn’t feel happy with that conversation…”</td>
<td>(1-8-T) Physical Therapist, 13 years’ experience, age range – 30s</td>
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5.6 Patients’ Use of Intrapersonal Emotion Regulation Strategies in Response to Negative Emotions

Understanding dyadic emotion regulation requires consideration of how both partners use and experience emotion regulation during their interactions. The previous sections discussed the therapist’s role in dyadic emotion regulation. I will now focus on the patient’s role in dyadic emotion regulation.

Patients use a wide range of intrapersonal emotion regulation strategies in response to negative emotions that represent all the categories in Gross’s process model of emotion regulation (1998) (see table 6). Patients discussed hypothetical or contemplated use of situation selection strategies that would result in the discontinuation of the therapeutic relationship. For example, when discussing an emotional event where a patient was expressing her anger to a therapist, the patient remarked:

“…clearly when I was being angry with her, if she turned around and was angry with me, I would have walked out and put in a complaint.”

(1-7-P) Occupational therapy patient, profession – lecturer, age range – 50s

Another patient who was angry about the amount of physical pain that he experienced during his treatment contemplated using situation selection by discontinuing therapy but talked himself into continuing his treatment.

“I used to come out of there feeling hurt… I felt angry and I thought to myself many times, I’m not going to go back. Especially after the first visit I thought, I’m not going to go back. But I knew I had to. If my arm was ever going to get, start moving again, I had to go back.”

(1-2-P) Physiotherapy patient, profession – sales manager, age range – 40s

The main situation modification strategies that patients used were asking questions and trying to solve the problem. When patients first started treatment, they often asked questions to avoid or alleviate anxiety stemming from not knowing what to expect. Asking questions enabled them to change the situation into one where they have a more comfortable grasp on the treatment regimen. I have interpreted these strategies as situation modification because they are doing this right in the beginning of the treatment session and the patients are trying
to modify the situation from one where they do not understand the regime, to one where they do understand the regime. I did not interpret it as a cognitive reappraisal strategy because the patients are not trying to change their interpretation of something.

“I just talked to him (the therapist) and asked questions and the nervousness went away.”

(1-5-P) Physiotherapy patient, profession – pensions analyst, age range – 40s

“…Focused on any questions that maybe I would need to ask. Trying to remember everything that I needed to tell him in order to obviously be diagnosed properly.”

(1-8-P) Physiotherapy patient, profession – retail, age range – 20s

Patients also attempted to solve problems as a way of modifying the situation to facilitate the experience of positive emotions and avoid the experience of negative emotions. For example, one patient, who was anxious about her therapist deciding to use a new treatment approach that may be painful, asked her therapist to consider an alternative treatment approach that could potentially be used instead.

“Maybe the reason I said that (referring to asking for the alternative treatment approach) was to indicate, oh, if you keep up the ultrasound then you won’t necessarily have to manipulate my arm and give me pain.”

(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s

Attention deployment strategies were used to avoid or ignore unwanted negative emotions. Some patients focused on something particular like their breathing, and other patients just avoided focusing on the problem.

“I just tried to ride the anxiety out… distract myself”

(1-8-P) Physiotherapy patient, profession – retail, age range – 20s

“Breathe. I use breathing exercises. So, and trying to relax. Intentionally relaxing because I know for a fact that if you relax it helps the person treating you and it also helps you. It would help me.”

(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s

Patients used cognitive reappraisal to address unwanted negative emotions that arise when working with their therapist. They used these strategies to talk themselves down so that they
resist acting on maladaptive response tendencies, such as angry outbursts that would have a negative effect on their relationship with their therapist. They also used cognitive reappraisal to perceive their therapist as competent as a way to alleviate their anxiety regarding participating in therapy.

“I thought to myself, give him a chance, he’s is doing his job, he is a professional.”

(1-1-P) Physiotherapy patient, profession – retired, age range – 60s

“I thought that he knows what he is doing, so I had faith”

(1-5-P) Physiotherapy patient, profession – pensions analyst, age range – 40s

In addition, they also used cognitive reappraisal to manage their emotions in situations where they did not make as much progress as they would have liked.

“…I know that he (the therapist) can’t work miracles so I supposed in my mind… I wouldn’t have expected masses of differences in the early stages. So, I suppose within my mind I was quite realistic about, or I wasn’t unrealistic in what I expected.”

(1-8-P) Physiotherapy patient, profession – retail, age range – 20s

Patients reported using response modulation, a response-focused intrapersonal emotion regulation strategy. For example, a patient who was angry because of the pain he experienced during therapy, described thinking about expressing his anger violently towards the therapist but instead modified his expression of anger in a more acceptable fashion.

“I wanted to punch him… when he was hurting me… and I used to go out when I’d finished and go outside into the road and kick a tree or something. You know what I mean? Something to take away the frustration out on something. And if I got a, I remember once I drove up there by mistake and I got a parking ticket because I had overstayed and if I’d seen the traffic warden, I probably would have punched him.”

(1-1-P) Physiotherapy patient, profession – retired, age range – 60s

Patients did not use hiding/faking emotion, a response-focused intrapersonal emotion regulation strategy, to the same extent as therapists. Instead, patients believed they had the right to feel the way they truly felt. For this reason, they often showed their true emotion even if it was negative. One patient discussed how she expressed her anger towards her therapist after she was invited to attend the therapy session at the wrong time.
“I just said, this is wasting my whole day from work, you know. Why can’t you get it right!”

(1-7-P) Occupational therapy patient, profession – lecturer, age range – 50s

Another patient discussed how she regulated her sadness, stemming from the recent death of a close family member, when she came to treatment.

“So, I think I actually just went in there and blurted it all out. I didn’t cry but I was feeling very emotional.”

(1-2-P) Physiotherapy patient, profession – sales manager, age range – 40s

However, this entitlement was not without boundaries as many patients thought that if they expressed extreme negative emotions, such as rage, it would have a negative impact on their therapeutic relationship and their rehabilitation.

“Yes extreme (emotions), only used for sort of very, very specific situations and I don’t believe sort of when you’re receiving treatment from someone that you should display those emotions, yes. That’s what counselling and stuff is for! Um, so yes I’d say that those (extreme emotions) are bad and that can have an impact on how that person perceives you and how you’re treated as well.”

(1-8-P) Physiotherapy patient, profession – retail, age range – 20s

Like therapists, patients at times used more than one intrapersonal emotion regulation strategy at a time. One patient talked about ignoring negative emotion by ‘taking it day by day’ (attentional deployment) and at the same time thinking about what she would do if the problem returned (situational modification).

“I guess it was just a question of taking it day by day, how I was feeling. Because really the trepidation was, it, is that pain going to come back? And what will I do then if it does? Do I go back to my GP? And so, I suppose it’s thinking through on a cognitive level.”

(1-10-P) Occupational therapy patient, profession – retired, age range – 60s
|---|---|
| Situation selection - Strategies used to ensure that one will be in a situation that promotes the desired emotions (Gross, 1998). | “…clearly when I was being angry with her if she turned around and was angry with me I would have walked out and put in a complaint.”  
(1-7-P) Occupational therapy patient, profession – lecturer, age range – 50s |
| Situation modification – Strategies focused on taking actions to change a situation in order to promote emotions that are desired (Gross, 1998). | “Maybe the reason I said that (referring to asking for the alternative treatment approach) was to indicate, oh, if you keep up the ultrasound then you won’t necessarily have to manipulate my arm and give me pain.”  
(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s |
| Attentional deployment – Strategies focused on directing one’s attention to influence one’s own emotional response (Gross, 1998). | “Breathe. I use breathing exercises. So, and trying to relax. Intentionally relaxing because I know for a fact that if you relax it helps the person treating you and it also helps you. It would help me.”  
(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s |
| Cognitive change – Strategies used to modify how one appraises a situation in order to promote the desired emotional response (Gross, 1998). | “…I know that he (the therapist) can’t work miracles so I supposed in my mind…I wouldn’t have expected masses of differences in the early stages. So, I suppose within my mind I was quite realistic about, or I wasn’t unrealistic in what I expected.”  
(1-8-P) Physiotherapy patient, profession – retail, age range – 20s |
| Response-focused - Strategies that directly influence the experiential, behavioural, or physiological components of the emotional response (Gross, 1998). | “So, I think I actually just went in there and blurted it all out. I didn’t cry but I was feeling very emotional.”  
(1-2-P) Physiotherapy patient, profession – sales manager, age range – 40s |
|---|---|
| Intrinsic interpersonal emotion regulation – regulating one’s own emotions using other people (Zaki and Williams, 2013). | “I remember saying to him, is it more mobile than what you realised? So, he said, yes, it is more mobile than what, because I can do that, you see. And I think he thought that I couldn’t move my shoulder as much as what I could. And because I wanted him to see the progress as well because that would make me feel better...If he’s pleased and optimistic about my progress then to me that indicates that it is curable, and I am making progress. So, I think, I remember verbalising to him and saying, ‘Good, I’m pleased that you’re pleased that it’s more mobile than what you thought’.”  
(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s |
| Overt emotion regulation strategies - strategies that can be used for other purposes but are at times used for emotion regulation purposes (Aldao & Dixon-Gordon, 2014). | “I go to yoga because I find that helps me relax completely and I think a lot of my problem is I’m all, I’m very tense. So yes, I was going to yoga outside of the treatments”  
(1-2-P) Physiotherapy patient, profession – sales manager, age range – 40s |
5.7 Patients’ Use of Intrapersonal Emotion Regulation Strategies in Response to Positive Emotions

Since patients deemed positive emotions as desirable, they often did not feel the need to regulate the expression of these emotions in any way. Instead they expressed them naturally. However, at times they did use intrapersonal emotion regulation strategies to amplify the positive emotion that they felt since these emotions were desirable and enjoyable. For example, a patient described how she facilitated her experience of positive emotions using attentional deployment after the event as described by Quoidbach and colleagues (2015).

“I don’t think I did anything (to regulate my emotions) other than just thinking about my progress and the pain changing. The pain improving. Although it’s still pain but it is changing and there is progress.”

(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s

This patient also discussed how she used interpersonal interaction with her therapist as a means to increase her experience of positive emotions, an example of intrinsic interpersonal emotion regulation strategies described by Zaki and Williams (2013).

“I remember saying to him, is it more mobile than what you realised? So, he said, yes, it is more mobile than what, because I can do that, you see. And I think he thought that I couldn’t move my shoulder as much as what I could. And because I wanted him to see the progress as well because that would make me feel better...If he’s pleased and optimistic about my progress then to me that indicates that it is curable, and I am making progress. So, I think, I remember verbalising to him and saying, ‘Good, I’m pleased that you’re pleased that it’s more mobile than what you thought’.”

(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s

Patients did not report using many strategies to decrease the experience of positive emotion. This may be because the strength of the positive emotion and/or the situation did not warrant such actions. Since patients in both studies described their current therapeutic relationship, as opposed to a high or low-quality therapeutic relationship, it may be that in encounters where there is more extreme positive emotion, a wider variety of emotion regulation strategies may be used to regulate positive emotion.
5.8 Patients’ Use of Interpersonal Emotion Regulation Strategies

In general, patients did not think it was their responsibility to play a role in regulating their therapist’s emotions.

“…it’s just a very one-way (relationship), when you go to your doctor, you don’t think, I’m going to go there to manage your doctor’s emotion. And therapists fall into the same, they’re there to manage you, you know... I don’t think, ‘well I’m going to have to manage her emotion’. That’s not what I’m there for. I’m there for, you’re giving me some relief from this pain and allowing me to get on with my job.”

(1-7-P) Occupational therapy patient, profession – lecturer, age range – 50s

They also may not use many interpersonal emotion regulation strategies in their interactions with their therapists because therapists try to display only those emotions that fit into the confines of organisational display rules. For these two reasons, patient reported using fewer interpersonal emotion regulation strategies than therapists. However, patients mentioned they would give positive feedback and say, ‘thank you’ to their therapists as a way of sharing their positive emotions. Patients also said that they try to put their therapists at ease by chatting (self-disclosure) and joking.

Like therapists, patients also used interpersonal emotion regulation proactively. For example, a few patients said they would be sure to be compliant with the therapist’s home exercise recommendations to avoid the therapist being frustrated with them during the next treatment session. One patient described how she had to be strict with herself to ensure she did her exercises regularly to avoid her therapist being disappointed.

“I had to do a lot of, sort of like, thinking about the actual, how I was going to fit the exercises around my daily routine… it required me to do that at work as well. I kind of had to kick any anxiety that I had that work wouldn’t let me do them and just be sort of like, no I am doing them. And to kind of kick my butt to make sure that I did them. So that I wouldn’t feel like I’d let him down by not keeping up with them and doing them as he’d told me to do them.”

(1-8-P) Physiotherapy patient, profession – retail, age range – 20s
5.9 Reciprocal Emotion Regulation

To illustrate the reciprocal nature of emotion regulation during therapeutic relationships, below I have summarised my findings from analysing two patient/therapist dyads:

First Dyad: B (2-6-T) & S (1-6-P)

The therapeutic relationship between B, the therapist and S, the patient, extended over three treatment sessions. I observed each session. In the first session, the therapist assessed the patient’s level of hand function and interviewed the patient regarding his previous level of function and rehabilitation goals. The therapist explained what the patient can expect from treatment and the patient asked questions. She then made the patient a splint, instructed him on how to use it, and instructed him on a home exercise program.

During this session, S said he was frustrated with his current level of hand function and wants his hand to return to its previous functional status. B told him that may not happen, but they would work towards that goal. The patient and the therapist engaged in small talk in between the therapist’s assessment questions. They talked a little about their family and used a little humour in their discourse. For example, when the therapist was asking about the patient’s previous functional status of his hand, he mentioned that he plays the piano. The patient joked that no one in his home wants to hear his music, nevertheless, he loves to share it. The therapist then talked about how her father likes to play his music loudly and while it annoys her, she cannot complain because he is her father.

My interpretation of their interaction during this first treatment session is both S and B followed rules of normal social conduct and behaved in predictable ways. Neither B or S displayed any emotions that the other would sense required regulation. Although S, mentioned he was frustrated, he did not use any body language cues to signal that frustration. As a result, B only responded to the functional content of his statement and appeared to overlook the emotional content of this statement. The humour in their discourse seemed to be welcomed by both as indicated by them both taking part in it. I sensed that the humour and chatting was an indication of the relationship starting on a positive note.
In the second session, the therapist reassessed the patient’s hand function and asked the patient how he was getting on with his home exercise program. The patient’s hand function improved, and the therapist praised him for doing a good job. The patient also asked questions about his rehabilitation, and the therapists provided answers. In between their discussion focused on the patient’s rehabilitation, they made small talk. In particular, they talked about the patient changing his job and adjusting from having a military job to having a civilian job.

In the third and final session, the therapist reassessed the patient’s hand function and noted the progress. The patient also noted that his hand had made improvements. He stated he was happy he could do push ups, as that was one of his main goals. As in previous sessions, in between discussions about the patient’s rehabilitation, they again made small talk. On this day, the therapist started the small talk by asking the patient why he was dressed up.

From my observation, I did not observe any emotional displays or affective events that would indicate a need for either dyadic partner to use emotion regulation. Their joking and small talk seemed to be an indication of a growing fondness for each other that was appropriate for the contextual environment. After their last treatment session, I interviewed each of them to ask them about their perception of affective events, resulting emotions, and emotion regulation strategies used to address those emotions during their relationship.

The therapist identified the initial treatment session, when they were learning about each other through small talk, as an affective event, whereas, the patient did not. The therapist said that in response to this affective event she felt cheerful and believed the patient felt happy. Therefore, no intrapersonal or interpersonal emotion regulation strategies were needed to address these emotions.

Both the patient and therapist identified the time during the second treatment session, when it was clear that the patient made progress, as an affective event. At that time the patient felt particularly happy and satisfied with his progress because he was initially sceptical about the probability of the therapy yielding favourable results. He stated he did not use any intrapersonal emotion regulation strategies to address his happiness and satisfaction because there was no need to do so. The patient also stated that he did not feel the need to use any interpersonal emotion regulation strategies to
address the therapist’s emotions. However, he did report using small talk throughout the relationship to build rapport. The therapist noted that the patient seemed satisfied and happy and she did not attempt to do anything to change those positive emotions. She did admit, however, that she used small talk as a way to maintain her patient’s positive emotions. In this way, it appeared that small talk was used as a proactive emotion regulation strategy by the patient and the therapist. As a result of this affective event, the therapist reported feeling happy and satisfied. She did not report using any intrapersonal emotion regulation strategies to address her positive emotions.

An affective event that I identified, as an observer, was when the therapist told the patient that his hand may not fully recover. During the interview the therapist explained that her rationale for saying that was to avoid the patient’s disappointment if his hand did not fully recover. In this way, she was using this statement as a proactive interpersonal emotion regulation strategy. Although neither dyadic partner mentioned that was an affective event, I considered it an affective event because the patient said it made him feel disappointed and frustrated. He stated that the intrapersonal emotion regulation strategy that he used in response to these negative emotions was that he decided to try harder to rehabilitate his hand. Interestingly, the therapist did not mention that she used any interpersonal emotion regulation strategies to address the patients declared frustration in the first session. This may be because although the patient said he was frustrated and disappointed, visually he did not appear to feel that way.

Second Dyad: A (2-7-T) & K (2-7-P)

I observed five of the six therapy sessions between therapist, A and patient, K. In each session they appeared to interact in a friendly but professional manner. I noticed that there was a large amount of chatting and joking between the patient, therapist and the patient’s father, who regularly attended therapy sessions. The patient disclosed information about herself and her family life, but the therapist did not disclose nearly as much personal information. Since only positive emotions were being displayed, I did not notice any emotions from either the patient or the therapist that appeared to require regulation. I did, however, notice a couple of instances that may have been affective events. In the first treatment session, the therapist told the patient she cannot
go back to work yet. I thought that may be an affective event because it may be perceived as either good or bad news by the patient. In the fifth treatment session, I notice that the patient told the therapist that her hand is getting better due to her treatment. In every session, the therapist noted the patient’s progress and I wondered if this was an interpersonal emotion regulation strategy. To further my understanding, I used the participant verification interviews, to check my impressions against the patient’s and therapist’s perspectives.

During the participant verification interview with the therapist, she stated that she did not experience any negative emotions and she did not sense a need to regulate any of her patient’s emotions in this case. Therefore, her use of intrapersonal and interpersonal emotion regulation in this case was limited from her perspective. Despite that, the therapists used chatting and humour during every treatment session. When asked why she used these strategies, she said she regularly uses them to build rapport and put patients at ease. Therefore, chatting and humour seemed to be routinely used as proactive interpersonal emotion regulation strategies. I also asked the therapist about how it made her feel when the patient thanked her for making her hand better. The therapist stated it made her feel pleased, an emotion that she did not feel the need to regulate. The patient, however, did not report using the positive feedback as an interpersonal emotion regulation strategy.

Consistent with the therapist’s perceptions, the patient reported experiencing positive emotions during her interactions with the therapist, including cheerfulness and hopefulness. She did not feel the need to regulate these emotions. However, she also reported experiencing some negative emotions. During the first treatment session, the patient stated that she felt anxiety because she did not want the therapist to hurt her hand. The therapist did not mention that she perceived the patient to be anxious, and from an observer’s standpoint it was not obvious. However, the therapist’s routine uses of proactive interpersonal emotion regulation strategies, humour and chatting, may indicate that the therapist is aware that patients may often feel anxious and uneasy. While the patient joked and chatted back with the therapist and noted that she thought the therapist was friendly, the patient indicated during the participant verification interview that she thought the joking was a bit too much. She stated she would have preferred less joking and more focus on her hand. In this way, the therapist’s implementation of these proactive interpersonal emotion regulation...
strategies could be considered as slightly misaligned with the patient’s needs and preferences.

The patient also experienced a number of emotions, of which the therapist was either unaware of or did not perceive them as significant enough to regulate. I asked the patient about how she felt when the therapist told her, in the first treatment session, that she could not go back to work. The patient described her emotions as being worried about the effect this would have on her employment and also relieved that a professional supported what she had already been thinking. The patient described using attentional deployment and cognitive reappraisal to address her negative emotions. The therapist did not report any awareness of the patient’s emotions attached to this affective event.

Also, during the interview the patient stated she was disappointed with the amount of progress in her hand function. Although the therapist told her that she was making progress, she did not agree. She thought the therapist said that to make her feel good. However, the therapist did not report using positive feedback as an interpersonal emotion regulation strategy in this case. The patient was also disappointed with some aspects of the service. In particular, she thought the treatment sessions were too infrequent and it was too difficult to get treatments scheduled because it was a busy clinic. She said she regulated this disappointment by just doing what she could do, mostly doing the exercises prescribed by the therapist. She did not express her disappointment to her therapist, and again, it was not obvious from an observer’s standpoint. Despite the patient’s disappointment, she still understood her relationship with her therapist to be of high-quality. Similarly, the therapist also believed it was a high-quality relationship.

Overall, therapists and patients appeared to be accurate forecasters of the emotional consequences of affective events during their relationship. For example, therapists knew that if they responded to patients anger with their own anger, it would make the patients angrier. Similarly, patients knew that if they did not do their recommended home exercises, their therapists would be annoyed upon their next encounter. Also, the strategies that patients and therapists used in response to affective events typically had the desired effect or close to the
desired effect. For example, if a therapist or patient gave positive feedback to improve their dyadic partner’s emotions, the partners typically said it made them feel good.

However, interpersonal emotion regulation is often not an exact endeavour. Dyadic partners may not notice their partner’s emotions and therefore, may miss cues of when interpersonal emotion regulation is needed. The fact that each partner uses intrapersonal emotion regulation can make it difficult to identify these cues. Also, the use of emotion regulation strategies may be effective or ineffective, but it may also be partially effective. In addition, many actions and behaviours that effect emotion are not necessarily used for interpersonal emotion regulation purposes.

Another finding regarding the reciprocal nature of emotion regulation is that both therapists and patients responded similarly in terms of emotions to affective events. When patients made progress both the therapist and the patient were happy. When patients did not make progress both experienced negative emotions, such as disappointment and sadness. One possible explanation for this is therapists and patients have the same goals. They wanted the patient to get better. They also wanted to have a high-quality therapeutic relationship and they had a similar understanding of the characteristics of a high-quality therapeutic relationship. Therefore, they responded similarly to affective events that facilitated or hindered their progression towards these goals. Recent research on emotion convergence of customers and employees service relationships theorised that customers’ and employees’ emotions convergence due to a phenomenon they call shared frontline experience (Zablah et al, 2017). They define shared frontline experience as the tendency for service dyads in relationships to not only experience the same affective events but develop a tendency to respond to those affective events similarly.

5.10 Emotion Regulation Work in Routine and Non-Routine Encounters

Through my analysis, I began to distinguish between routine and non-routine encounters and understand them to be key factors in shaping therapists’ emotion regulation behaviour within therapeutic relationships. Routine encounters featured commonly encountered affective events and emotions. Commonly encountered affective events may be a patient making incremental progress, a patient experiencing a minor setback in functional status, or a patient and therapist sharing a laugh. These affective events engender emotions that are commonly experienced and displayed in a clinical environment, such as satisfaction, happiness, and
disappointment. The commonality of emotion refers to the intensity of the emotion rather
than the discrete type of emotion, with low intensity emotions being more common than high
intensity emotions in therapist-patient encounters.

The routine nature of affective events and resulting emotions mean that the therapist gains
experience navigating these affective events and regulating the resulting emotions. As
therapists gain experience, they may become increasingly adept at dealing with these
situations. For example, therapists may often need to use emotion regulation strategies to
address a patient’s disappointment after a minor functional status setback. Over time, the
therapists’ method of regulating these emotions may become increasingly proficient.

Therapists did not report needing to use much emotion regulation in response to routine
affective events and emotions. This may be because the emotions that surfaced in routine
encounters were either desired or not significant enough to require regulatory efforts. When
they did need to regulate emotions in these situations, the therapists appeared to do this in an
effortless and efficient manner. Also, the common nature of the emotions and affective
events in these routine encounters led the therapists to expect them and as a result, at times
attempt to regulate them proactively.

Non-routine encounters are uncommonly experienced or unexpected affective events and
emotions that occur during patient/therapist interactions. Uncommonly encountered affective
events may be a patient falling while working with a therapist or a patient expressing his
infatuation with his therapist. Such non-routine affective events are likely to stimulate intense
emotional reactions in both the patient and the therapist that are uncommon in the particular
clinical setting. As a result, the therapist is tasked with regulating intense emotions that they
do not often encounter in their clinical context. Regulating intense emotions in unfamiliar
situations may require the use of emotion regulation strategies or approaches that they do not
use often. For example, a therapist whose patient has expressed his infatuation towards her
may need to use an unfamiliar cocktail of emotion regulation strategies to regulate her own
and her patient’s emotions.

In non-routine emotion regulation encounters, therapists needed to regulate more extreme
emotions and navigate more significant affective events. This may be why therapists in non-
routine encounters reported using more emotion regulation strategies than in routine
encounters. The lack of commonality in affective events and resulting emotion made it
necessary for therapists to improvise to navigate these situations. This improvisation led to
more trial and error use of emotion regulation strategies. This was evident because in non-
routine encounters, therapists’ use of emotion regulation strategies varied more throughout
their encounter, demonstrating they needed to try more than one strategy to address the
emotion. In addition, in these types of encounters, compared to routine encounters, it was
more commonly necessary for the therapist to use emotion regulation strategies after the
encounter to address their own residual emotions. See table 7 for differences in the way
emotion regulation is used in routine and non-routine encounters.
Table 7: Differences in Emotion Regulation Use in Routine and Non-Routine Encounters

<table>
<thead>
<tr>
<th></th>
<th>Frequency of use</th>
<th>Emotion Regulation Strategy</th>
<th>Emotion intensity level</th>
<th>Emotional event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Encounters</td>
<td>Requires relatively less use of emotion regulation</td>
<td>Emotion regulation strategies are familiar because used often, and over time become more automatic and therefore, may be less effortful. May also be used more proactively</td>
<td>Emotion intensity is relatively minimal (e.g., satisfaction)</td>
<td>Emotional event is common</td>
</tr>
<tr>
<td>Non-routine Encounters</td>
<td>Requires relatively more use of emotion regulation</td>
<td>Emotion regulation strategies are unfamiliar because not used often and may be used by trial and error and therefore, may be more effortful</td>
<td>Emotion intensity is relatively extreme (e.g., euphoria)</td>
<td>Emotional event is uncommon</td>
</tr>
</tbody>
</table>
5.11 Discussion
This chapter focused on what emotion regulation strategies patients and therapists use during therapeutic relationships and how they used these strategies to achieve their emotion-focused goals. This chapter has two main findings. Firstly, patients and therapists use intrapersonal and interpersonal emotion regulation strategies proactively and reactively. I defined proactive use as emotion regulation used in response to expected emotions, rather than experienced emotions. I defined reactive use as emotion regulation used in response to experienced emotion. This is similar to Gross’s (1998) conceptualisation of antecedent-focused and response-focused emotion regulation. Proactive and reactive emotion regulation differs from Gross’s (1998) conceptualisation in that it is referring to the use of intrapersonal and interpersonal emotion regulation, whereas Gross’s conceptualisation is only referring to intrapersonal emotion regulation. Secondly, a key factor in shaping therapists’ emotion regulation behaviour within therapeutic relationships is whether the encounter is routine or non-routine. I defined routine encounters as those that feature commonly experienced emotions and affective events. I define non-routine encounters as those that feature unexpected and uncommonly experienced affective events and emotions. My conceptualisation of routine and non-routine encounters is related to what Morris and Feldman (1996) referred to task routineness. They considered routine tasks as being quick, scripted encounters; whereas, non-routine tasks were longer, more likely to be personalised, and thus lack uniformity.

While some aspects of these findings are consistent with recent studies, other aspects of these findings address important gaps in the literature on emotion regulation in the workplace and emotional labour. Previous research on this topic has been criticised for taking an overly simplified view of how intrapersonal emotion regulation strategies are used, in particular, assuming that emotion regulation is a discrete event rather than a dynamic process (Cote, Moon, Miners, 2008). In response to this critique, researchers have attempted to gain a more realistic understanding of how people use emotion regulation strategies. My findings are consistent with many of these studies. Similar to previous studies, I found that therapists use a wider range of intrapersonal emotion regulation strategies than those that are prevalent in the literature (e.g., Aldao & Dixon-Gordon 2014) and may use more than one intrapersonal emotion regulation strategy at once (e.g., Aldao & Nolen-Hoeksema, 2013). Also, like other studies, I found that the use of intrapersonal emotion regulation may continue long after the precipitating emotional event (e.g., Wiese, Heidemeier, Burk & Freund, 2017). While other
studies have asserted that people use intrapersonal emotion regulation strategies proactively and reactively (e.g., Gross, 1998; Hayward & Tuckey, 2011), this is one of the first studies to consider the proactive use of interpersonal emotion regulation.

This research makes a unique contribution to the knowledge base on emotion regulation at work in many ways. Firstly, most studies on emotion regulation and emotional labour has focused on either intrapersonal emotion regulation or interpersonal emotion regulation. This study is unique in that it is one of the few studies that looks at intrapersonal and interpersonal use of emotion regulation concurrently. My findings show that therapists, and patients to a lesser degree, often simultaneously use both intrapersonal and interpersonal emotion regulation strategies in response to affective events within the therapeutic relationship. In fact, I found that the boundary between intrapersonal and interpersonal emotion regulation strategies is porous because both types of strategies can be used for both intrapersonal and interpersonal emotion regulation purposes. Also, intrapersonal and interpersonal emotion regulation strategies have both intrapersonal and interpersonal consequences. For these reasons, studies that focus on either intrapersonal or interpersonal emotion regulation provide only a partial picture of emotion regulation processes at play during social interaction.

This study is also significant in that it considers antecedent negative and positive emotions. Even though healthcare professionals need to regulate both positive and negative emotions as part of their work role, many studies on this topic have only considered the regulation of negative emotions. This study addresses this gap in the literature by exploring how healthcare professionals regulate the positive emotions that they experience. In general, therapists do not feel the need to regulate the expression or experience of many of the positive emotions that they experience because these emotions are pleasurable to experience and desirable to display in patient-therapist interactions. However, therapists may regulate the expression of positive emotions, particularly extreme positive emotions like excitement, if they are deemed inappropriate or counterproductive to their goals.

While there are some dyadic studies on emotion regulation in personal relationships, there are far fewer in service relationships. In particular, research on customer use of emotion regulation during interactions with employees is rare (Medler-Liraz & Yagil, 2013). The studies on service relationships that do consider the dyad tend to focus on the emotion regulation strategies of one dyadic partner and the effect of those strategies on the other dyadic partner, rather than the reciprocal dyadic behaviour (e.g., Zhan, Wang & Shi, 2016;
Chi, Grandey, Diamond & Krimmel, 2011). These studies also tend to focus on transactional rather than relational context (Zablah et al, 2017).

Similarly, there is a lack of studies that focus on dyadic use of emotion regulation in the healthcare context. There are no studies specifically in the context of occupational therapy and only one study in the context of physiotherapy that focuses on the use of emotion regulation strategies, and this study did not access both dyadic partners perspectives. Most emotion regulation studies in the healthcare context focus on healthcare professionals use of strategies. While there is research on how patients, mostly with mental health diagnosis, use adaptive and maladaptive intrapersonal emotion regulation strategies (e.g., Aldao, Jazaieri, Goldin & Gross, 2014; Atherton, Nevels & Moore, 2015), these studies do not focus on the use of these strategies within the context of the therapeutic relationship. There are studies that focus on patients’ verbal expression of negative emotions during encounters with healthcare professionals, but these studies do not consider the emotion regulation that occurs during these encounters (e.g., Anderson et al, 2008). This study is the first to explore patients’ use of emotion regulation strategies within the context of the therapeutic relationship. My findings show that patients and therapists have compatible emotion regulation goals and motivations, and therefore, tend to react similarly to the same affective events. Patients and therapists also tend to accurately interpret their partner’s emotional responses to affective events and their interpersonal emotion regulatory efforts.

While there are organisational studies that look at the interpersonal consequences of intrapersonal emotion regulation strategies and interpersonal emotion regulation research has been growing in recent years (e.g., Cote, Van Kleef & Sy, 2013; Cote, 2005), I have been unable to locate any such studies in a healthcare context. My findings address this gap in the literature. The findings indicated that therapists use a wide range of interpersonal emotion regulation strategies, both proactively and reactively. They decide how they use interpersonal emotion regulation strategies with their patients using social cues. The main way that patients reported using interpersonal emotion regulation strategies was proactively. Patients, however, did not use interpersonal emotion regulation strategies as much as therapists. This finding is consistent with studies that have found that patients/clients viewed their therapists as primarily responsible for building positive therapeutic relationships (Bedi, Davis & Williams, 2005; Bachelor, 1995).
In addressing these gaps in the literature, these findings make an important contribution to the current knowledge base on emotion regulation in the workplace and provides insight on areas of research that require further investigation, particularly related to proactive use of emotion regulation strategies and routine/non-routine encounters at work. Antecedent intrapersonal emotion regulation strategies, situation selection and modification, can be considered proactive strategies since they are used prior to the experience of emotions. This is one of the first studies to consider proactive use of interpersonal emotion regulation strategies. These findings are related to research on empathic and affective forecasting. Affective forecasts are people’s predictions of how they expect they will feel in particular situations (Wilson & Gilbert, 2003). Empathic forecasts are people’s predictions of how others would feel in particular social situations (Moons, Chen & Mackie, 2017).

My findings regarding the proactive use of intrapersonal and interpersonal emotion regulation strategies are important because affective and empathetic forecasting plays a key role in shaping choices and decisions used to achieve self and other-focused emotion goals (Dane & George, 2014; Moons, Chen & Mackie, 2017). Also, expected emotions have been found to have a direct impact on self-regulatory behaviour, whereas experienced emotions have been found to have an indirect impact on self-regulatory behaviour through guiding expectations (Brown & McConnell, 2011; Baumeister; Vohs; DeWall & Zhang, 2007). In other words, expected emotions may explain and guide emotion regulation behaviour more than experienced emotion. Given this fact and the fact that most emotion regulation research focuses on the use of emotion regulation strategies in response to experienced emotion, which I define as reactive use of emotion regulation, more research is needed on proactive intrapersonal and interpersonal emotion regulation to understand emotion regulation behaviour.

My findings also demonstrate that routine and non-routine encounters have an important impact on emotion regulation behaviour. Since non-routine encounters are characterised by extreme emotions and unfamiliar affective events, the emotion regulatory load may be increased, and therapist may need to improvise to navigate these situations. Routine encounters may require less emotion regulation use, and due to the familiar nature of these encounters, therapists may use emotion regulation strategies effortlessly and efficiently. The familiar nature of routine encounters may also lead therapists to develop routines in how they navigate these situations using emotion regulation. Routines form the basis of organisational learning and provide insight into how organisations and individuals provide their product or
service and how these processes change over time (Parmigiani & Howard-Grenville, 2011). For this reason, developing an understanding of therapists’ or other types of employee’s emotion regulation routines would improve our understanding of emotional labour. Current research on emotion regulation and emotional labour has only gone as far as to investigate people’s emotion regulation style or tendency in response to any affective event (e.g., Cossette & Hess, 2015), usually using diary studies or questionnaires. These studies have not considered how employees respond habitually to specific types of affective events at work. This represents a significant gap in the literature and may be a rewarding new area of inquiry for future research on emotion regulation in the workplace.

In particular, research on routine encounters can make an important contribution to our understanding of how employees develop their ability to use emotion regulation strategies effectively and efficiently. Frequently encountered emotions are easier to regulate than less frequently encountered emotions (Wood & Neal, 2007). Frequently encountered affective events and emotions enable therapists to develop established ways of addressing them, or routines. Routine emotion regulation enables people to learn ways of responding that over time becomes increasingly more automated (Eder, Rothermund & Proctor, 2010; Bargh & Williams, 2007) and more efficient (Christou-Champi, Farrow & Webb, 2015). Automated or habitual use of emotion regulation strategies require less effort because it utilises less cognitive and physiological resources (Christou-Champi, Farrow & Webb, 2015). It is more efficient because people learn from previous emotion regulation experiences and use this learning to guide future behaviour (Baumeister, Vohs, DeWall & Zhang, 2007). In contrast, non-routine emotion regulation may require more effort to perform because the greater the task novelty, the more effort is required to complete the task (Zaccaro & Lowe, 1985).

One of the principal areas of inquiry in emotional labour research is focused on the impact of emotion regulation on employee health and wellbeing. Despite studies that demonstrate that effort and efficiency are moderating factors that influence the relationship between emotional labour and employee wellbeing (e.g., Kentworthy, Fay, Frame & Petree, 2014; Gross, 2002; Hulsheger & Schewe, 2011, Wong, Tschan & Semmer, 2017), researchers have not considered contextual factors, such as routine and non-routine encounters, that may impact upon employees’ level of effort and efficiency. Considering such contextual factors has the potential to deepen our understanding of the costs of emotional labour.
Research is also needed to focus on non-routine encounters. The trial and error approach utilised in non-routine encounters underscore the importance of emotion regulation flexibility and improvisation. Emotion regulation flexibility is the ability to implement emotion regulation strategies that are synchronised with changing contextual demands. It can be adaptive or maladaptive dependent on whether it facilitates or interferes with goal pursuits (Aldao, Sheppes & Gross, 2015). This is a growing area of emotion regulation research that can inform our understanding of how employees adapt in non-routine encounters.

Improvising is dealing with the on the spot needs of customer encounters. Employee improvisation is associated with innovation (Lai, Lui & Hon, 2014) and is needed to provide excellent customer service (Wilder, Collier & Barnes, 2014). This is especially true in services like healthcare, that are highly personalised and require the customer to be directly involved in the service delivery process (John, Grove & Fisk, 2006). In service exchanges, the main ways an employee can improvise is by adapting the actual service offering or their interpersonal behaviour (Gwinner, Bitner, Brown & Kumar, 2005). Therefore, emotion regulation improvisation may be an important way that employees adjust to unexpected situations that threaten emotion goal attainment. Emotional labour research has focused on the effects of perceived autonomy, which is the ability to self-determine how and when to engage in emotional labour, on intrapersonal outcomes (e.g., Gopalan, Culbertson & Leiva, 2013; Johnson & Spector, 2007). However, it has virtually overlooked how employees utilise that autonomy to adapt their emotion regulation behaviour as needed to provide service excellence.
Chapter 6 Findings: Emotion Regulation Development in Therapeutic Relationships

6.1 Introduction

The last chapter described how therapists and patients use emotion regulation strategies during the therapeutic relationship. One of the main findings was that therapists use emotion regulation strategies differently in routine versus non-routine encounters. In this chapter, I now look more closely at the encounters that play a critical role in relationship development, the role of emotion regulation in steering the trajectory of the relationship during these encounters, and how emotion regulation strategies develop during the course of the therapeutic relationship.

Encounters are the building blocks upon which therapeutic relationships are built. People, to a large extent, base their understanding of the quality of their relationships, including therapeutic relationships, on how their encounters make them feel (Berscheid, 1983). Affective events at work are happenings during encounters that cause emotions and influence behaviour (Weiss & Cropanzano, 1996). Turning points are a similar concept to affective events. They can be defined as significant events that influence each dyadic partner’s ongoing perception of the relationship and therefore the trajectory of relationships (Baxter & Bullis, 1986). Since turning points are significant events that occur within relationships from the dyadic partners’ perspectives, they often have emotional consequences. In this way, they can be considered particularly significant affective events. Turning points are useful in understanding relationship dynamics and have yet to be used in the context of therapeutic relationships.

This chapter addresses two research questions: What turning points characterise high and low-quality therapeutic relationships? How do emotion regulation strategies develop during the therapeutic relationship? To answer these questions, in the first study, therapists were asked to describe two recent experiences of therapeutic relationships, one that they perceived as high-quality and one they perceived as low-quality. As part of their descriptions, they were asked to highlight the turning points that influenced their understanding of relationship quality. In the second study, patient/therapist encounters were observed during the course of the therapeutic relationship. At the end of the relationship both dyadic partners were interviewed regarding their perceptions of the turning points within the relationship, the
emotion regulation strategies used in response to the turning points, and the resulting quality of the relationship.

This chapter begins by describing the characteristics of a high and low-quality therapeutic relationship from therapists’ and patients’ point of view. It then moves on to discuss the turning points and trajectories within high and low-quality therapeutic relationships. From there I discuss how emotion regulation strategies develop within therapeutic relationships using the turning points as signposts in their development.

Finally, I discuss my two main findings and place them in the wider context of relevant extant literature. Firstly, I found that turning points can be categorised as constructive and nonconstructive and are often antecedents to emotion regulation processes. Constructive turning points are those that help dyadic partners develop high-quality therapeutic relationships. Non-constructive turning points are those that hinder dyadic partners from achieving high-quality therapeutic relationships. I discuss the role of emotion regulation in addressing the emotional consequences of turning points and how this influences the trajectory of the relationship. Secondly, I found that as the relationship develops, therapists use their increasing knowledge of their client’s emotional preferences, tendencies, and needs to tailor their interpersonal emotion regulation strategy use to achieve their goals. One important way that therapists tailor their use of interpersonal emotion regulation strategies is by adjusting their approach on a spectrum ranging from professional to personal. Initially, their interpersonal emotion regulation approach may be more professional, meaning more formal and guided by organisationally prescribed display rules. As the relationship progresses, their interpersonal emotion regulation approach may become progressively more informal and guided by display rules emerging from the social context.

6.2 Therapists’ Perspectives on Characteristics of Therapeutic Relationship Quality

Therapists strived for high-quality therapeutic relationships because they considered it necessary to facilitate the rehabilitation process. They shared similar understandings of the characteristics of high and low-quality therapeutic relationships. In general, they considered high-quality therapeutic relationships as those where they ideally like each other and are able to work together harmoniously. They also considered agreement on goals as an important characteristic in high-quality therapeutic relationships. These sentiments are illustrated in the following quotes from therapists describing high-quality therapeutic relationships.
“That you get along, that you’ve all got the same objectives, the same goals. You’re both realistic and both, yes working towards the same things, both motivated that you’re trying to achieve the best.”

(1-13-T) Physical Therapist, 4 years’ experience, age range – 20s

“a two-way system in terms of a give and take. In terms of while you've got your agenda of what you want for the client, you also have to know what the client’s agenda is and making sure the two mirror each other to move forward.”

(1-1-T) Occupational Therapist, 7 years’ experience, age range – 30s

Getting to know the patient on a more personal level, where both dyadic partners authentically can be themselves to some degree, was also considered a characteristic of high-quality therapeutic relationships. For example, they may make small talk about their weekend or hobbies to find common ground. Therapists sought an ideal balance of interacting with patients on a professional and personal level.

“… I think the best therapists and the best therapeutic relationships are those ones that are like a combination of professional and personal.”

(1-7-T) Physical Therapist, 3 years’ experience, age range – 20s

While having some interactions on a personal level was considered desirable, therapists prioritised the professional nature of the relationship. For example, one therapist reflected on how developing an affective bond or mutual liking with the patient is ideal but not necessary or realistic.

“One side of it, yes I think it’s human nature if you like the person. But the other side of it, we are professionals and you are supposed to take that (whether or not you like the person) out of it. And no matter who you are, you can’t completely take that out of it…Because we’re human. So, I’d be lying if I said I thought that (liking the patient) wasn’t a slight element of it. But I thought here’s a young guy (discussing her patient) with a similar sort of age to me, he’s the sort of guy that I’d see, I’d meet on a night out sort of thing and would grind on me (meaning irritate) a bit sort of thing. I wouldn’t think he was a particularly like, someone that I wanted to be mates with. But that aside, you’ve got to put those emotions aside because we meet all sorts of
different people who might even be difficult for reasons that are not due to their own fault and reasons.”

(1-7-T) Physical Therapist, 3 years’ experience, age range – 20s

Therapists described low-quality therapeutic relationships as having the opposite characteristics of high-quality therapeutic relationships. These relationships suffer from lack of trust, poor communication, and divergent goals. Patients may be non-compliant, display challenging behaviours, or lack motivation to utilise the rehabilitation process. For example, patients who refused to participate in therapy, neglected to follow their therapist’s recommendations, or were aggressive or manipulative were common in therapists’ descriptions of low-quality therapeutic relationships. Therapists also considered the display of negative emotions during interactions as an indication of a low-quality therapeutic relationship.

“…any anger or anything like that would cause a poor relationship between the therapist and patient.”

(1-10-T) Physical Therapist, 8 years’ experience, age range – 30s

Therapists considered patients’ lack of progress, even if it had nothing to do with the service provided by the therapist or the interactions with the therapist, as a characteristic of low-quality therapeutic relationships.

“…the relationship… between therapy and him (discussing a patient) faltered on many occasions and so the bond that we have with him, because we want him to do well, is stronger than the bond that he has with us...It’s a poor therapeutic relationship I think because they didn’t get out of it what they could have done because of the external factors.”

(1-12-T) Physical Therapist, 8 years’ experience, age range – 30s

6.3 Patients Perspectives on Characteristics of Therapeutic Relationship Quality

Overall, patients’ understandings of the characteristics of high and low-quality therapeutic relationships were similar to therapists understanding. Like therapists, patients want to have high-quality therapeutic relationships with their therapists. Their motivation for wanting
high-quality therapeutic relationships was not so much to facilitate the rehabilitation process, but more to adhere to codes of normal behaviour and to avoid awkwardness. According to patients, in high-quality relationships therapists are empathetic and caring. Patients consider communication as an important part of high-quality therapeutic relationships. In particular, patients want to be able to talk to their therapist openly.

“… an open relationship where…I can be open about what I want to achieve from the treatment and perhaps we can be realistic in what I can expect from the treatment, but that we’re both open about that. We can talk openly, feel comfortable, all of those things. Relaxed.”

(1-2-P) Physiotherapy patient, profession – retired, age range – 60s

“Well you should be able to talk to them, comfortably, without feeling awkward. And get a good response back.”

(1-6-P) Physiotherapy patient, profession – receptionist, age range – 40s

Ultimately, they put the responsibility on the therapist regarding ensuring open communication and getting to know them and their needs.

“I would want my therapist to feel, I would also want him to feel attuned to me. Attuned, you know like when a mother is attuned to her baby… I think the meaning of attunement is getting into their (a patient’s) world… (to) engage in their narrative… Yes, being able to be attuned, understanding, a good listener. If you’re able to talk through and understand each other I think that’s a (good)quality. Understanding the person’s narrative.”

(1-3-P) Occupational therapy patient, profession – psychotherapist, age range – 60s

Patients thought that general chatting or small talk is an important part of communicating with therapists that helps build high-quality relationships. General chat may be about any superficial topic, such as the weather, what they are going to do on the weekend, or how their day has been.

“…if they (the therapist) were taciturn, you know, they didn’t talk to you or kept it down to the minimum, I think I’d feel uncomfortable.”

(1-4-P) Physiotherapy patient, profession – retired, age range – 60s
In high-quality therapeutic relationships, patients reported that the therapist would ideally display positive emotions, such as cheerfulness, optimism, and compassion. In general, they did not think therapists should show negative emotions, such as anger and frustration. In particular, they did not think that therapists should show anxiety for any reason because patients understood this as a lack of competence. One patient stated that if his therapist appeared anxious he would immediately discontinue treatment with that therapist.

“Oh no, I’d be gone!”

(1-1-P) Physiotherapy patient, profession – retired, age range – 60s

Like therapists, patients described low-quality therapeutic relationships as having the opposite characteristics of high-quality therapeutic relationships. They indicated that when therapists do not have the time or inclination to build rapport this can lead to poor therapeutic relationships. They also reported that situations where the therapist is complacent, disinterested, or nonresponsive to patient’s needs are indicative of poor therapeutic relationships. Patients also considered therapists who give them physical pain as contributing to poor therapeutic relationships.

“I didn’t like him much when I first went to him… he actually really hurt me.”

(1-1-P) Physiotherapy patient, profession – retired, age range – 60s

Overall, patients and therapists echoed many of the themes from theoretical conceptualisations of the important characteristics of therapeutic relationships (see Table 8), such as trust (e.g., Morse, 1991), affective bond (e.g., Luborsky, 1984), genuineness (e.g., Gelso et al, 2005; Gelso, 2014) and agreement on goals (e.g., Bordin, 1979; Martin, Garske & Davis 2000). However, patients’ conceptualisations were more focused on how they communicate with their therapist, than whether they agreed on goals. Also, unlike these theoretical conceptualisations, both patients and therapists described the display of positive emotions during patient/therapist interactions as a characteristic of high-quality therapeutic relationships and the display of negative emotions during such interactions as a characteristic of low-quality therapeutic relationships.
### Table 8: Patient and Therapists Perspectives on Characteristics of High Quality Therapeutic Relationships

<table>
<thead>
<tr>
<th>Characteristics of High Quality Therapeutic Relationships</th>
<th>Therapists Perspectives</th>
<th>Patients Perspectives</th>
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<tbody>
<tr>
<td>Collaborative working</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Frieswyk et al, 1984</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affective bond</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(e.g., Luborsky, 1984)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreement on goals and tasks</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(e.g., Bordin, 1979; Martin, Garske &amp; Davis 2000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Morse, 1991),</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Taylor et al, 2009, Tickle-Degnen &amp; Gavett, 2003)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genuineness refers how authentic a person can be</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>with their dyadic partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Gelso et al, 2005; Gelso, 2014)</td>
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Given the importance of the therapeutic relationship, why some relationships come to be perceived as high-quality and others as low-quality is a worthy topic of inquiry. As seen in chapter two, turning point analysis has long been used in research on personal relationships to understand relationships dynamics over time (Baxter & Bullis, 1986). Turning points that result in positive emotions tend to encourage people to feel more positively about the relationship and compel each individual to act accordingly. Similarly, turning points that stimulate negative emotions tends to encourage people to appraise their relationship more negatively and compel them to act accordingly (Parkinson, Fischer & Manstead, 2005). In this way, using a turning point analysis may be a useful way to understand how therapeutic
relationships develop over time. The next two sections discuss therapists’ and patients’ perceptions of turning points and resulting emotions within therapeutic relationships.

6.4 Therapists Perspectives on Turning Points

In telling their stories of high and low-quality therapeutic relationships, therapists identified a number of turning points that they believed influenced their own and their patient’s perception of relationship quality and provoked emotional responses. Using Ohly and Schmitt’s (2015) taxonomy of affective events at work to inform my initial template, I found six categories in the data: progress towards goals, set-backs in progress towards goals, interpersonal problems with patients, positive feedback, interpersonal affective bonding with patients, and negative feedback (see Table 9). Next these turning points are described including the emotional consequences, typical emotion regulation responses, and their impact on and prevalence in high and low-quality relationships.

6.4.1 Progress Towards Goals

Progress towards goals was the most prevalent turning point in therapeutic relationships that therapists perceived as high-quality but was also present in therapeutic relationships that therapists described as low-quality. Turning points falling into this category concern the achievement of or progress towards rehabilitation goals in relation to the patient’s status or the provision of treatment. Progress towards goals regarding the patient’s status included the patient feeling better, decreased pain or improved functional status. It also included the patient becoming more empowered, compliant, being able to walk or go back to work, and finding ways to overcome difficulties. Progress towards goals regarding the provision of treatment included getting equipment in good time, smooth referrals to continuing care agencies, or finding funds for patient carers.

Therapists considered these turning points as conducive to their goals because they facilitated positive emotions in patients and therapists and had a positive effect on the quality of the relationship. For example, one therapist identified a turning point where her patient made some functional improvements. In response to these improvements, the therapist felt satisfaction which she then shared with her co-workers. She also felt increased fondness towards the patient and noted that this turning point led to increased rapport and trust.
between her and her patient. The therapist perceived that the patient felt relief and cheerfulness, and therefore the therapist did not need to do anything to address these emotions.

In general, therapists did not report performing emotion regulation in response to these turning points since positive emotions are desirable. At times, however, therapists needed to dampen down the patient’s positive emotions stemming from some of these turning points. Therapists’ rationale for doing this was to keep their patients motivated to continue with therapy and to have realistic expectations.

“… it was also about trying to manage those (positive) emotions and manage her expectations. So, you kind of have a bit of a mental wrestling match in your head. Between going, I don’t want to take this (referring to her happiness) away from her because it’s great. But she’s got so far to go still, and I need her to realise that.”

(1-7-T) Physical Therapist, 3 years’ experience, age range – 20s

“… so, he’s got the boot (a type of rehabilitation equipment) and now thinks that he will walk the next day and I was like, ‘oh it’s going to be a bit longer’. So, I kind of maybe reduced it (referring to the patient’s happiness) slightly because I was just being more realistic … ‘you haven’t moved for a month like, we need to get you moving now’. So, just like bringing him back down just to a realistic.”

(1-13-T) Physical Therapist, 4 years’ experience, age range – 20s

6.4.2 Set-backs in Progress Towards Goals

Turning points in this category were mostly setbacks in patients’ progress or difficulties with the provision of services. The therapists described setbacks in the patient’s progress, such as the patient being unwell, experiencing increased pain, and the patient not being able to do as much as he or she expected. They also described setbacks, such as the patient experiencing a fall, embarrassing situations like a patient accidentally moving their bowels on the floor, and the patient’s family realising they cannot cope with the patient at home. Difficulties with the provision of services included ordered equipment arrived and was inappropriate, difficulties in getting required services funded, and difficulty in getting the patient a placement in a continuing care facility.
Turning points in this category are non-constructive to therapists’ emotional goals because they typically provoked negative emotions, such as anger, frustration, and embarrassment and had a negative effect on the quality of the relationship. In response to these turning points, therapists reported using intrapersonal and interpersonal emotion regulation strategies to help themselves and their patients feel better and to continue progressing towards their rehabilitation goals. These turning points were described in therapists’ description of high and low-quality therapeutic relationships.

For example, a therapist identified a turning point where the patient experienced increased pain because she was doing her exercises incorrectly. The therapist reported that in response to this event he was frustrated, irritated, and on the verge of losing his temper. He confirmed that while he tried to hide his negative emotions, he probably showed them a little because he wanted the patient to understand the gravity of the situation. He perceived that the patient was experiencing a host of negative emotions including frustration, annoyance, grumpiness, and dread. The therapist attempted to bring down the patient’s negative emotions by telling her that therapy can work, but it will only work if she is compliant. He noted that this turning point had a negative effect on his perception of the relationship quality.

6.4.3 Interpersonal Problems with Patients
This was the most prevalent type of turning point in therapists’ descriptions of low-quality relationships. However, one therapist described such a turning point in her description of a high-quality relationship. Turning points in this category includes disagreements and misunderstandings caused by the patient or the patient’s family not listening, being distrustful or lacking insight. This turning point category also includes situations where the patient is being noncompliant, manipulative, hostile, or just not participating in the rehabilitation process.

These turning points were non-constructive to the therapist’s goals of building positive therapeutic relationships. They typically had a negative impact on the therapists’ emotions, the relationship quality, and future interactions. From the data, it appeared that the main way therapists responded to these turning points was to use emotion regulation strategies to deescalate the situation. In particular, they reported hiding their negative emotions. They believed that using emotion regulation strategies in this way was necessary because if they showed their true emotion, it would exacerbate the problem. Therapists also used various
strategies to try to fix the problem and therefore decrease the experience of negative emotions.

To illustrate, a therapist described a turning point with a difficult patient where she had just lifted him up, into his chair and he asked her to fetch his dressing gown. When the therapist retrieved it from the bag it was in, she noticed it was filthy and crawling with bugs. She was hesitant to give it to him, but he insisted. She took it outside to try and shake off the bugs, brought it back, and gave it to him. She then informed the Head Sister on the ward, who directed her to take the dressing gown off the ward to prevent an infestation. She had to take the dressing gown off him, despite his protests, and he was extremely cross. To regulate the patients’ emotions (interpersonal emotion regulation) the therapist said she tried several things. First, she tried to get rid of the bugs and give the dressing gown to him. Then she tried to explain to him why they needed to get the dressing gown off the ward. She offered him drinks and lunch but that did not seem to calm him down. She even considered purchasing him an inexpensive dressing gown using her own money. Meanwhile, she hid her disgust, an intrapersonal emotion regulation strategy, in an effort to maintain a professional appearance. She reflected on the state of their therapeutic relationship after that incident and their ongoing interactions.

“…then today he’s almost going over the top and thinking that I’m killing him, and I’m giving him lots of problems because I won’t give him the dressing gown back… so, something really simple like that, now our therapeutic relationship is rock bottom.”

(1-13-T) Physical Therapist, 4 years’ experience, age range – 20s

6.4.4 Positive Feedback

Turning points in this category were conducive to therapists’ emotion-focused goals and were mostly identified in therapists’ descriptions of high-quality relationships. Therapists received positive feedback from patients verbally, or in the form of a letter or a gift. Sometimes patients showed their appreciation in their behaviour, such as hugs or smiles. Other times patients showed appreciation by apologising for previous incidents. These turning points facilitated therapists to experience positive emotions, such as happiness, pride, and satisfaction and had a positive effect on their understanding of the relationship quality.
Therapists did not report needing to use emotion regulation strategies to change the positive emotions that they experienced in response to these turning points, instead they enjoyed the emotion and at times savoured and/or shared the positive emotion. This was the case even in more intense situations. For example, a therapist described a situation where she visited one of her patients who had a terminal illness. The doctors did not expect him to live through the day because his oxygen levels were so low. His family were present and very emotional. During the therapist’s visit with the patient, she noticed that his oxygen mask was not fitted properly and corrected it. As a result, the patient recovered and lived another month and a half. When the patient could, he showed his appreciation for her help. The therapist appreciated his gratitude so much that she cried. She stated that she cried because it was natural, and he was crying too. She further explained that she cried because she understood what he had gone through and wanted to express that she cared. She perceived that the patient felt loved. The therapist believed this turning point had a positive effect on the quality of their therapeutic relationship.

6.4.5 Interpersonal Affective Bonding with Patients

Turning points that fall in this category were identified in therapists’ descriptions of high-quality therapeutic relationships. This type of turning point was not identified in therapists’ descriptions of low-quality therapeutic relationships. Therapist described turning points as simple as instances when patients and therapists are just talking, getting to know each other, and finding common ground. Therapist also described more pronounced turning points, such as instances where therapists provide emotional gifts to patients. Examples of which are a therapist making Christmas on the ward more festive to help a patient and his family enjoy their time on the ward, or a therapist going to visit a patient when they have been moved to a different ward. Events that fall into this turning point category help to build the patient’s and the therapist’s favourable impression of each other and their relationships. For example, one therapist described a turning point in a therapeutic relationship where her patient over heard the therapist advocating on the patient’s behalf, which in turn made the patient think more positively about the therapist. These turning points are conducive to therapists’ emotion-focused goals as they engender positive emotions and positive perceptions of relationship quality. Therapists did not describe using emotion regulation strategies to address the positive emotion produced from these turning points. They were careful, however, not to over step professional boundaries.
One therapist described a situation where her patient, who had been discharged home, returned to the hospital. He was admitted to the intensive care unit after his health declined. The therapist went to visit him and his wife there. The therapist said she was sad and worried about the client and described how she regulated these emotions within herself.

“I kept it within me because I felt I was going to see the wife. So, I mean obviously I went in, we hugged each other, we embraced each other and hugged each other, and I think that is a lot…. and that way I didn’t have to say much but she knew that I was deeply concerned with what was going on.”

(1-14-T) Occupational Therapist, 35 years’ experience, age range – 60s

The therapist perceived the patient’s wife’s emotions to be happy to see her but sad because of the situation. She described how she attempted to address the wife’s sadness.

“It’s by talking to her and giving her time. Because that was what was needed at that time. Give her time. I wasn’t in any rush. I made her talk, I made her express and she let me know what was going on, what went on and what she was worried about and concerned.”

(1-14-T) Occupational Therapist, 35 years’ experience, age range – 60s

6.4.6 Negative feedback

Turning points involving patients or their family giving negative feedback were described in high and low-quality relationships. These are non-constructive turning points because they provoke negative emotions and have a negative impact on the quality of the relationship. Patients gave negative feedback mainly regarding pain that they experienced due to their therapy. Patients also gave formal and informal complaints to management and other healthcare professionals regarding their dissatisfaction or disagreement with their therapist. For example, one patient’s family complained to a doctor to try to get the doctor to encourage the therapist to reconsider a decision she made with which the patient and the patient’s family disagreed. This made the therapist very angry and had a negative effect on the quality of the relationship.

Therapists reported using a number of intrapersonal and interpersonal emotion regulation strategies to address their own and their patient’s negative emotions stemming from these turning points. For example, one therapist recalled a turning point where she ordered a bed
for her patient who was being discharged home. When he got home and received the bed, he found that the bed did not meet his expectations. Although the therapist worked hard to find a solution to the problem, the family ultimately issued a formal complaint. The therapist reported that she was ‘livid’. She said that she regulated this emotion by seeking support from her manager.

“…I said to my manager, ‘I bent over backwards to help this family, and this is what I get, you know’.”

(1-14-T) Occupational Therapist, 35 years’ experience, age range – 60s

The complaint was issued after the patient was discharged, so the therapist did not need to attempt to regulate the patient’s or the patient’s family’s emotions.

Table 9: Therapists’ Perceptions of Constructive and Non-Constructive Turning Points

<table>
<thead>
<tr>
<th>Constructive Turning Points</th>
<th>Non-constructive Turning Points</th>
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<tbody>
<tr>
<td>Progress Towards Goals</td>
<td>Set-backs in Progress Towards Goals</td>
</tr>
<tr>
<td>Interpersonal Affective Bonding with Patients</td>
<td>Interpersonal Problems with Patients</td>
</tr>
<tr>
<td>Positive Feedback</td>
<td>Negative Feedback</td>
</tr>
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</table>

While the majority of relationships had constructive and non-constructive turning points, high-quality relationships had more constructive turning points and low-quality relationships had more non-constructive turning points. In high-quality relationships, the most prevalent turning points were progress towards goals. The two second most prevalent types of turning points were set-backs in progress towards goals and affective bond building. The most prevalent turning points in low-quality relationships was interpersonal problems with patients. In contrast, this turning point was described only once in a high-quality relationship. The second most prevalent type of turning points in low-quality relationships was set-backs in progress towards goals. Interpersonal affective bond building was prevalent in high-quality relationships but was not described in relationships perceived as low-quality.
6.5 Patients’ Perspectives on Turning Points

Patients in the first and second study described their current therapeutic relationships with their therapists. They were not asked to describe a high-quality and low-quality relationship because I did not suspect that they would have experienced many therapeutic relationships from which to choose. While some did not identify any events that they thought were significant enough to be considered turning points, other patients identified turning points that they believed influenced their own and their therapist’s emotions and perceptions of relationship quality. Using the turning points found in the therapists’ descriptions and the patient nominated therapeutic relationship building critical incidents taxonomy developed by Bedi and colleagues (2005) to inform my initial template, I identified 5 categories of turning points from the patients’ point of view. The categories include: progress towards goals, setbacks in progress towards goals, interpersonal affective bonding with therapists, agreement with therapists and changes in treatment (see Table 10).

6.5.1 Progress Towards Goals

The most prevalent turning point category among patients was the treatment/provision process worked. The turning points in this category included the therapist quickly found and fixed the patient’s problem, pain decreased, functional abilities improved, and the patient received needed equipment quickly. This turning point category is similar to the therapist turning point category, Progress Towards Goals.

These turning points were conducive to patients’ goals of developing and maintaining positive therapeutic relationships because they understood them to have a positive effect on their own and their therapist’s emotions. They also understood these turning points to have a positive impact on the quality of the relationship. In fact, they were the most impactful in terms of patient’s perception of how much they changed the quality of the relationship. Patients did not describe the need to use intrapersonal emotion regulation strategies to address the positive emotions they experienced stemming from these turning points. Generally, patients did not report using interpersonal emotion regulation strategies in response to these turning points except for sharing the positive emotion with their therapist. For example, one patient described a turning point where the therapist used a treatment that was unexpectedly effective.
“He (referring to the therapist) pulled my leg. Literally. And I didn’t even know it was going to happen… that was a bit of a shock. It took the words away from me…it didn’t hurt but it was, I wasn’t expecting it, so… But then it turned to even more surprise when I could see the results of what that had done. So, one pull on my leg and it kind of rectified the problem a little bit. So, I was very surprised that that would even have an effect.”

(1-8-P) Occupational therapy patient, profession – retail, age range – 20s

The patient reported that she just experienced and expressed the surprise that she felt naturally. She did not perceive the therapists had any emotions at the time that required her to use interpersonal emotion regulation.

**6.5.2 Set-backs in Progress Towards Goals**

Patients described a number of turning points that can be categorised as Set-backs in Progress Towards Goals. Turning points in this category include experiencing treatments that caused pain, lack of progress, experiencing a decline in function associated with the treatment, and being provided with the wrong information. This turning point category is similar to the therapists’ turning point category of the same name. Unsurprisingly, turning points in this category tended to have a negative effect on the patient’s emotions and perception of relationship quality and therefore, were non-constructive to their therapeutic relationship goals. Patient reported using a number of intrapersonal emotion regulation strategies, such as talking themselves down and deep breathing. They used these strategies to change or lessen the negative emotions they experienced in response to these turning points and to convince themselves to continue attending therapy sessions. Other patients, in response to these turning points, allowed themselves to express their emotion naturally. For example, one patient talked about the emotions she experienced and how she displayed those emotions when she received the wrong information which led her to go to her therapy session on the wrong day.

“I was annoyed. Because we both clearly had taken time out for this and nothing was going to happen. I had got myself all worked up and, so I was annoyed… I just said, ‘this is wasting my whole day from work, you know. Why can’t you get it right?’ You know, so I think, you know my whole dialogue with her was of a negative nature.”
While this patient initially said she did not do anything to address her annoyance, upon reflexion she admitted that she thinks that venting her emotions in the way she did was, in a sense, a way that she was attempting to get rid of her negative emotions. However, she admits that it did not make her feel better.

“It didn’t make me feel better because I think I might have been over the top a bit. So, and I did feel very upset that I’d actually given her (referring to her therapist) a hard time and it really had nothing to do with her.”

Most patients did not report using interpersonal emotion regulation strategies to address their therapist’s emotions in response to these turning points. The patient from the example above reported that her therapist appeared calm and caring despite her angry exclamation, and therefore, there was no need for her to attempt to address the therapist’s emotions.

6.5.3 Interpersonal Affective Bonding with Therapists

This was another prevalent turning point category that is constructive to patients’ therapeutic relationship goals. This turning point category involves instances that build the affective bond between patients and their therapists. Patients described turning points in this category as superficial as just talking to and laughing with to their therapist, to more intimate events, such as a therapist helping a patient with his research project in her personal time. Through getting to know and finding common ground with their therapists, patients experienced positive emotions and developed a positive view of their therapist and the relationship as a whole. One patient described how she felt when, through conversation she and her therapist discovered they previously worked for the same organisation.

“I think there’s a sense of identification because we’ve talked about the negative points as well as the positive points (of working for the organisation). So, understanding what the other one is saying. Because it’s a sense of, well, yes, I know exactly how that feels because I’ve worked with them, and I know what that feels like because I have experienced that. So, there’s a bit of identification I suppose… and understanding. As I’ve got to know him I’ve got to like him more.”
Another patient spoke about an important turning point in her therapeutic relationship where she disclosed personal information to her therapist and the therapist responded compassionately. She explained this was a turning point because her therapist’s response made her think that the therapist was “lovely”. This patient, like many other patients, did not report using intrapersonal or interpersonal emotion regulation strategies to address the positive emotions stemming from this type of turning point.

6.5.4 Agreement with Therapist

Patients described agreements with their therapists as important turning points in their therapeutic relationships. In this category, patients described instances where their therapist helped them make important decisions or confirmed their thoughts or feelings. For example, one patient described a turning point in his relationship with his therapist where his therapist helped him make a decision with which he was struggling.

“…she told me I think you have made the right decision, but I didn’t make the decision. She helped me make the decision. I was able to make the decision through her and this is important communication... I felt that I could express myself freely (with the therapist).”

These instances may be noteworthy in patients’ perceptions of their relationships because the therapist’s agreement can serve to allay the patients fears and anxieties. For example, a patient described an interaction with her therapist where the therapist confirmed the patient was not ready to return to work.

“I was nervous about not getting back to work because I was worried about my job and how they would feel with me being off work for so long...I didn’t know if I was imagining, you know, putting off going back to work, so it made me feel better that someone who knows what they were talking about was saying that I wasn’t ready for work.”
These turning points had a positive effect on the patients’ emotions and the quality of the relationship. Patients did not describe using emotion regulation strategies to change the positive emotions stemming from these events.

6.5.5 Changes in Treatment
Finally, patients described turning points that can be categorised as changes in treatment. Patients described feeling anxiety and fear prior to the first treatment session due to not knowing what to expect. They also described feeling anxiety and hopeful when changes were made to the treatment regime and when they were preparing for discharge. For example, a patient described how he felt when his therapy changed to focus on scar massage, a type of therapy that required his therapist to touch him more than was the case up to that point.

“Having her work on my hand was incredibly positive. I felt that was just going to sort everything out because I felt very positively about her. It’s like how could the bad stuff resist being driven away by her (the therapist) care.”

(1-9-P) Occupational therapy patient, profession – unknown, age range – 40s

Since turning points in this category lead to both positive and negative emotions, the effect on the quality of the relationship was also mixed. While patients did not report using intrapersonal emotion regulation strategies to address the resulting positive emotions, they did report using intrapersonal emotion regulation strategies to alter their experience of negative emotions and motivate themselves to continue with rehabilitation. For example, to decrease the anxiety that patients feel at the beginning of a treatment session, patients reported using relaxation techniques, such as breathing exercises, asking questions to understand what to expect from the rehabilitation process, and attempting to disregard the emotion. One patient described a turning point when his therapist told him that she would no longer be working with him on a 1 to 1 basis due to an administrative change. He said he was “heartbroken” by the news and described how he addressed his emotions after the therapy session.

“That was just before Easter, I think, so I had an Easter that, in a tiny and pitiful way, mimicked the Christian Easter because I had a day of despair on the Friday; then on Saturday I stopped and thought about stuff; Sunday I thought about stuff and then on
Monday I rose again. I think I kind of had the opportunity to digest what she had told me and think about how things should work. And decide what I was going to, you know, recognise that I had to do more. If she wasn’t going to be there every week, I needed to make sure I was on the ball.”

(1-9-P) Occupational therapy patient, profession – unknown, age range – 40s

Table 10: Patients’ Perceptions of Constructive and Non-Constructive Turning Points

<table>
<thead>
<tr>
<th>Constructive Turning Points</th>
<th>Non-constructive Turning Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress Towards Goals</td>
<td>Set-backs in Progress Towards Goals</td>
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<tr>
<td>Interpersonal Affective Bonding with Therapists</td>
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<tr>
<td>Agreement with Therapist</td>
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<tr>
<td>Change in Treatment*</td>
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</tbody>
</table>

*indicates that turning point may be either a constructive or non-constructive turning point.

6.6 Congruency of Patients’ and Therapists’ Perceptions of Turning Points

In the second study, patient and therapist dyads were observed during their interactions and then interviewed about the relationship. This provided a unique opportunity to gain insight on how dyadic partners perceived the same relationship events and turning points. When describing turning points, patients and therapists tended to identify corresponding turning points rather than the exact same turning points. I will illustrate using the case of C (2-5-T), the therapist, and A (2-5-P), the patient.

C’s and A’s therapeutic relationship spanned three treatment sessions. A said that a turning point in their relationship happened when he found out that his therapist’s name is C. He said that the name brought back fond memories; it was the name of an old girlfriend of his, from many years ago, when he was a young man. C identified the first turning point as when she perceived that A turned up to the first session prepared to listen to her. On the surface these turning points may seem to be unrelated. However, they may represent two sides of the same coin in that they represent both C and A perception of a positive first meeting in their own words.
In the second treatment session, C identified a turning point where A brought in a store-bought splint that he was using instead of the splint that she made for him during the first treatment session. C explained to him why the store-bought splint was not appropriate for his needs. She explained that if he was having problems with the splint she made for him, he should have come to her, so she could fix it. C said she felt annoyed with herself because she worried that she did not make it clear to A that he could bring the splint back to her to fix. She also felt a bit irritated and demotivated because she felt that he just discarded the work she had done. She perceived that the patient may have been upset by her response to his store-bought splint. She attempted to regulate her own emotions and A’s emotions using humour. She joked with him, saying ‘you’re going to put me out of business’. A accepted her feedback and agreed to use the custom-made splint. Significantly, he did not identify this incident as a turning point.

In the third and final treatment session, C helped A come to a decision regarding a surgical procedure that A was worried about. A considered this an important turning point in their relationship and stated that he felt relieved by the decision that C helped him to make. He gloated about her skills as a therapist and proclaimed that she deserved a promotion. C, however, did not identify helping A come to a decision as a turning point, instead her perception of the turning point was that A seemed to be satisfied with the service he received. While A did not consider his bringing in a store-bought splint a turning point, it is clear that he had some awareness of the significance of the incident because during the ending interview he said that part of the reason that he said she deserved a promotion is because she previously joked that he was trying to put her out of business.

6.7 Turning Points and Therapeutic Relationship Trajectories
The turning points identified in this study highlight the type of incidences that contribute to therapist’s perceptions of high and low-quality therapeutic relationships. To understand how turning points influenced how therapeutic relationships come to be perceived as high or low-quality relationships, I asked therapists to rate their perceptions of their relationship quality on a 0-10 scale at each turning point throughout their relationship. The 0-10 scale rating was on the y axis. The turning points were on the x axis. Figure 1 is a graph of therapists’ quality ratings at turning points in relationships perceived to be of high-quality. Figure 2 is a graph of therapists’ quality ratings at turning points in relationships perceived to be of low-quality.
The data in the graphs are from the first study where therapists were asked to describe a high and low-quality therapeutic relationship.

Figure 1: Graph of Therapists’ Perception of Therapeutic Relationship Quality at Each Turning Point in High-Quality Therapeutic Relationships

Figure 2: Graph of Therapists’ Perception of Therapeutic Relationship Quality at Each Turning Point in Low-Quality Therapeutic Relationships
It is important to note that typically increases in therapists’ perception of relationship quality corresponded to constructive turning points and decreases in perceived relationship quality corresponded with non-constructive turning points. Relationships that were perceived as high-quality typically had an upward trend and relationships that were perceived as low-quality tend to have a downward trend. This is not surprising since, as stated above, high-quality relationships had more constructive turning points and low-quality relationships had more non-constructive turning points. Interestingly, relationships that were perceived as high-quality typically had a final turning point that had a positive effect on perceived relationship quality. Similarly, relationships that were perceived as low-quality tended to have a final turning point that had a negative effect on perceived relationship quality.

Most therapeutic relationship trajectories had an up and down pattern with few trajectories displaying a straight upward, downward, or horizontal pattern. Since constructive turning points typically had a positive effect on therapist’s perception of relation quality and non-constructive turning points typically had a negative effect on therapist’s perception of relation quality, the up and down pattern is illustrative of the fact that most high and low-quality therapeutic relationships feature both constructive and non-constructive turning points. Therefore, the presence of non-constructive turning points does not guarantee low-quality therapeutic relationships. Likewise, the presence of constructive turning points does not guarantee high-quality therapeutic relationships. It is clear that turning points are not the only factors that influence the therapeutic relationship trajectory.

Since turning points tend to have emotional consequences and emotions play an important role in how people understand the quality of their relationships (Berscheild, 1983), emotion regulation may play an important role in influencing people’s perceptions of their relationship quality and in this way, help steer therapeutic relationship trajectories. Using the example from above to illustrate, when the patient, A, brought in the store-bought splint, the therapist, C, perceived the incident as a non-constructive turning point in their relationship and, as a result of this turning point she felt irritated, annoyed, and demotivated. C sensed the patient may be upset by her telling him that the splint was not appropriate and that he should have brought the original splint back to her, so that she could fix it. C used humour as an interpersonal emotion regulation strategy in order to facilitate positive emotions and deescalate the situation. By doing this, she was able to remain on track with her interpersonal emotion-focused goal of ensuring the patient experienced positive emotions. This is evident in that the patient did not note this incident as a turning point in the relationship and there was
no corresponding decline in his perception of relationship quality at that point. If she had responded in a way that increased negative emotions and escalated the situation, he may have also understood this incident to be a non-constructive turning point, possibly resulting in a decline in his rating of relationship quality. In this way, C used humour as an interpersonal emotion regulation strategy to steer A’s emotions and therefore, influence his perception of relationship quality and the resulting relationship trajectory.

In the next section, I have used turning points as signposts to understand how emotion regulation strategy use develops over the course of the therapeutic relationship. I am using the turning points in this way because turning points are often used as markers of relationship development, and they often have emotional consequences that require the use of emotion regulation. Therefore, tying emotion regulation strategy use to markers of therapeutic relationship development enabled me to sample and compare how the strategies were used at important points in the development of the relationship.

6.8 Emotion Regulation Strategy Development within Therapeutic Relationships
I did not find evidence that patients’ and therapists’ use of intrapersonal emotion regulation strategies developed significantly over the course of the therapeutic relationship. However, my data shows that therapists’ use of interpersonal emotion regulation strategies developed during the therapeutic relationship. Through a learning process, interpersonal emotion regulation strategies develop within therapeutic relationships to be increasingly tailored to suit patient’s emotional needs and preferences. At the beginning of a relationship, a therapist may be unfamiliar with how to best regulate a patient’s emotions because the therapist does not know the patient or how the patient will respond to interpersonal emotion regulation strategies. However, the therapist may utilise her knowledge of interpersonal emotion regulation gained from previous experiences working with patients and interacting with people in general to inform her interpersonal emotion regulation behaviour in new therapeutic relationships. With each interaction during the course of the relationship, the therapist learns more about the patient’s emotional response tendencies and can use this knowledge to tailor her use of interpersonal emotion regulation strategies specifically to the patient. In this way, the use of interpersonal emotion regulation strategies during therapeutic relationships is informed by previous and ongoing interactions. In other words, people learn emotion
regulation consequences from previous encounters and use that knowledge to shape their behaviour in future encounters (Baumeister, Vohs, De Wall & Zhang, 2007). For example, two therapists described how they learned to regulate their patient’s negative emotions better as their relationship progressed.

“I think as you get to know a patient more maybe you might feel more, if someone’s upset you might feel more confident in knowing how, how you’re going to comfort that patient, or what you might need to do to make them feel better. Or if they’re angry, what sort of things dampen the situation.”

(S1P-6-T) Occupational Therapist, 3 years’ experience, age range – 30s

“You had to be very careful to try and contain it (referring to the patient’s level of frustration). Because if it got to the point where it was a nine out of ten, then that would be the end of the session… I think once I had a lot more of an understanding for it, then it didn’t necessarily worry me too much because I felt like I had the tools to be able to bring her back down (meaning her level of frustration) to a two or three out of ten… Before, I found it quite overwhelming because she could be very aggressive with it as well. And maybe felt that I done completely the wrong thing or didn’t fully understand why she’d got so frustrated. But as I got to know her better I felt like I had a bit more control over being able to bring her back to a more positive situation.”

(1-9-T) Physical Therapist, 8 years’ experience, age range – 30s

One way that therapists tailor their use of interpersonal emotion regulation strategies as they get to know a patient is by adjusting their approach on a spectrum ranging from professional to personal. A more professional approach to interpersonal emotion regulation may appear more formal and is mainly guided by organisational emotional display rules. Organisational emotional display rules in healthcare dictate that care providers must display compassion, caring, and empathy (Hinds, Quargnenti, Hickey & Mangnm, 1994) and must avoid negative emotional displays, such as anger, or fear (Diefendorff, Erickson, Grandey & Dahling, 2011). This approach is similar to Bolton’s conceptualisation of prescriptive emotion management (Bolton, 2005) as if performed sincerely it can assist the actor in getting the job done. However, if performed cynically the actor may come across as cold and detached.
A more personal approach to interpersonal emotion regulation is typically more informal and is mainly guided by contextual display rules regarding emotion. Diefendorff and Richard (2008) define contextual display rules as those that fluctuate based on the features of the situation. This is a more flexible approach than strictly adhering to organisational display rules where actors calibrate their use of interpersonal emotion regulation strategies to correspond with the dynamic nature of interpersonal interaction (Diefendorff & Richard, 2008). For example, if a therapist has built up a strong rapport with a patient, she may be able to show negative emotions more honestly during their interactions. It is similar to Bolton’s conceptualisation of presentational and philanthropic emotion management (Bolton, 2005) in that if done properly this flexibility can leave spaces for the actor to display their humanity through humour and compassion, but if done improperly the emotion regulation behaviour may be offensive and counterproductive.

In general, early in the therapeutic relationship therapists describe their use of interpersonal emotion regulation strategies as mainly professional. Initially, they approached patient’s emotions cautiously because they do not know the patient or how the patient will react to emotion regulation strategies. In following organisationally defined display rules, the therapists are utilising a relatively safe approach to interacting emotionally with patients. As the relationship progresses and they get to know the patient better, the therapists may change their emotion regulation approach according to relational contextual cues. To illustrate, two therapists described how their use of humour and teasing with their patients changes as the relationship develops.

“It’s difficult with things like humour and the informal stuff. Some people you can tell straight away exactly what that relationship is going to be like, and you know that you can be informal from the beginning. But I’d say mainly it probably comes (referring to her use of humour) in the treatment bit. As you’ve established your relationship, then you both kind of know where you’re at and you know how to judge that person’s personality… you can judge how informal you can be and whether there is going to be humour involved or whether it needs to be actually quite serious and professional.”

(S1P-7-T) Occupational Therapist, 2 years’ experience, age range – 30s

“So, it’s knowing how hard you can push someone and how emotional they are. You know with some people that you can say, ‘go on, stop being lazy, do another one’.
And you know that, that’s not an insult at all. It’s the relationship you have with them. But if you say that at the start, if I said, went up to someone the first time I met them, ‘come on lazybones, get out of bed’. Well you’d never get anything out of that patient at all. But if you’ve been treating them, and you have that relationship with them, you can be a bit more cheeky and a bit more relaxed and I think people respond, some people respond really well to that. Other people prefer a more formal approach.”

(1-8-T) Physical Therapist, 13 years’ experience, age range – 30s

Throughout the relationship, therapist strive to strike the right balance between utilising a personalised approach to interpersonal emotion regulation while maintaining their professionalism. In this way, therapists manage the level of emotional closeness between themselves and their clients. Purely professional displays of emotion that appear inauthentic lead to interpersonal distance (Kernis & Goldman, 2006; Swann & Pelham, 2002). Authenticity, openness, and investment of emotional resources are characteristics that are associated with a more personal approach to interpersonal emotion regulation and are crucial in establishing an emotional connection in relationships (Hayward & Tuckey, 2011; Reis & Patrick, 1996). Hayward & Tuckey (2011) referred to this balancing point as an emotional boundary. The emotional boundary can be defined as the boundary between emotional connection and distance in healthcare professionals’ and their patients’ relationships (Hayward & Tuckey, 2011). A therapist described how she uses interpersonal emotion regulation strategies to manipulate the emotional boundary and achieve the ideal level of emotional closeness when working with a patient who was having a tough time.

“So rather than saying, ‘oh I’m so sad for you’ and start crying to show empathy. You’d say, ‘that must be really hard for you, you must feel really sad about that’. Although you can show your emotions with your expressions, I think there’s a line that you shouldn’t cross, generally. There are always exceptions… I think it depends on the relationship, but I wouldn’t see myself routinely bursting into tears to show empathy to somebody.”

(S1P-2-T) Occupational Therapist, 5 years’ experience, age range – 30s

Over time what is considered to be the ideal level of emotional closeness may change in response to changing contextual factors. For example, one therapist described how as her relationship grew, the acceptable level of authenticity in her emotional display also changed.
“I suppose with patients, say towards the end of their life, if you’ve known them a long time, it feels more natural for the family to see that you’re upset as well because you’re regarding them as a human being and you’re showing that you’ve got sorrow for their mother who is a human being, not just a patient… I think when you know them more you can have a little bit more familiarity with the patient and the relatives… probably show more humanity and show more and I guess bottle things up less, so you don’t have to feel like, no I’ve got to keep a professional front on all the time.”

(1-8-T) Physical Therapists, 13 years’ experience, age range – 30s

How therapists manage their emotional boundaries and perceive the appropriate balance between professional and personal use of emotion regulation is influenced by a number of factors. The most important of which are cues from patients regarding how they want to interact. One therapist explained how she takes cues from the patient regarding the ideal balance between a professional and personal approach to interpersonal emotion regulation. Normally, only after the relationship has developed, will she cautiously use a more personal approach.

“It depends on the person and how quickly they open up to you. I mean if they share some humour with you, you’d respond and perhaps share something, a story off your own back. But it depends very much on the patient. Sometimes if they don’t have much humour themselves but you’ve built a relationship with them you might say something like, oh - if they’re ranting and raving about something but you know that the trust is there and they’re comfortable with you, you might say something like – ‘oh you are grumpy, aren’t you?’ But only if you know that they can take that and they’re not going to be sensitive about it, and you’d stay and see that through to make sure that actually they hadn’t taken it in the wrong way.”

(S1P-2-T) Occupational Therapist, 5 years’ experience, age range – 30s

Another therapist echoed the same sentiments but pointed out that there are times when a personal approach is appropriate prior to the relationship becoming fully developed.

“I maintain that professional exterior and I wouldn’t really kind of (change towards being more personal), unless they indicated they need it… you really do have to take your cues from other people. Because right at the beginning some people have been
extremely anxious, maybe have grabbed on to you and hold your hand because
they’re scared of actually getting up, and that’s a cue in itself. …then you can tell
what sort of person you’re dealing with, if that makes sense. So, you know that then
they’re probably a bit more acceptable to contact than other people. Because some
people really just do not like it. They like their own personal space and you’ve got to
be aware of that. So, I watch what the other people, what the patients do, what they
seem to be indicating that they want.”

(S1P-4-T) Occupational Therapist, 5 years’ experience, age range – unknown

Interestingly, therapists noted that the clinical setting in which they work has an influence on
how they manage the emotional boundary between themselves and their patients. One
therapist reflected on how working in more inherently informal settings, like the patient’s
home, can have an impact on how therapists understand the ideal level of emotional closeness
and therefore, the appropriate balance between a professional and personal approach to
interpersonal emotion regulation.

“…because I used to work in the community before I came here, and I think your
relationship you have with somebody in the community is different to that of working in an
acute hospital. Because you’re in their home. I think you become, I think your professional
boundaries probably loosen a lot earlier than they do here. …I still had a uniform on and I
was still very much behind a uniform. I think because you’re in their house and you’ve got –
‘who’s that on the wall, oh hello small baby, yes of course I will cuddle your grandchild
whilst talking to you!’ And things like that I think really help (build the relationship).”

(S1P-1-T) Occupational Therapist, 6 years’ experience, age range – 20s

In therapeutic relationships that therapists perceived as high-quality, the balance between
professional and personal use of emotion regulation strategies tended to shift toward the
personal end of the spectrum. In contrast, in therapeutic relationships perceived as low-
quality, the use of emotion regulation strategies tended to stay towards the professional end
of the spectrum. This was clear as therapists described high-quality therapeutic relationships
as having characteristics, such as authenticity and open communication, that are consistent
with a personal approach to interpersonal emotion regulation. Also, more intensely personal
interpersonal emotion regulation strategies, such as hugs and self-disclosure, were mainly
found in relationships that therapists perceived as high-quality, rather than those perceived as
low-quality. However, a more personal approach to interpersonal emotion regulation is not the key to having high-quality therapeutic relationships with all patients. Some patients may prefer a more distant and professional approach and respond to the therapist’s interpersonal emotion regulation strategies accordingly.

There were times when interpersonal emotion regulation strategy use did not develop within therapeutic relationships. This occurred in situations where there was no need to regulate emotions because the emotion was either desired (e.g., positive emotions) or not substantial enough to require regulation. This also occurred in situations where there was no need to alter how the emotion regulation strategies were being implemented because the strategies appeared to be effective.

While patients did not use as many interpersonal emotion regulation strategies as therapists, there was some evidence that some strategies that they used developed in a similar way to the therapist’s interpersonal emotion regulation strategies. However, it is not clear that at that moment the strategies were being used, they were specifically being used for emotion regulation purposes. For example, one patient discussed how her use of self-disclosure and humour developed during her relationship with her therapists.

“I think in the beginning it was testing. Just to get a feel for somebody, what they’re all about. It was like a sensor check kind of thing. Whereas now it is a genuine conversation I think… It’s completely open, there’s no kind of testing or anything like that. Feels so much more natural and normal now… I’d just say maybe at the beginning I was maybe just trying to sus him out a bit. Because you sort of build a character, don’t you, around it. So, my trust has grown over the time, the time has meant that my trust has grown. So, I don’t need that reassurance now. This is sort of, it’s a genuine conversation I would say rather than a…I think you get to know people’s boundaries.”

(1-2-P) Physiotherapy patient, profession – sales manager, age range – 40s

6.9 Discussion
This chapter sought to address two research questions: What type of turning points characterise high and low-quality therapeutic relationships? How do emotion regulation
strategies develop during the therapeutic relationship? The analysis indicated that turning points can be categorised as constructive and non-constructive to building high-quality therapeutic relationships. Using intrapersonal and interpersonal emotion regulation in response to each turning point, dyadic partners attempted to steer the quality of the relationship by influencing the emotional consequences of the turning points. Given that turning points typically trigger emotions that require regulation, I used them as markers to understand how emotion regulation strategies were used throughout the relationship. It has been shown that therapists progressively tailor their use of interpersonal emotion regulation to patients wants and needs. In particular, one of the main ways that therapists tailor their use of interpersonal emotion regulation strategies is from using a more professional approach to using a more personal approach.

This research makes an important contribution to the knowledge base on how therapeutic relationships develop. It differs from previous studies on therapeutic relationship development in that it incorporates both dyadic partners perspectives and it focuses on emotional processes that underlie the therapeutic relationship. This is important because the interpersonal aspect of therapeutic relationships has previously been underemphasised (Gelso & Carter, 1994). This is the first study to use a turning point analysis, a method commonly used to understand personal relationship dynamics, in the context of therapeutic relationships. Also, unlike studies that attempt to understand therapeutic relationship development using critical incidents and ruptures and repair (e.g., Safran, Muran, Eubanks-Carter, 2011), the longitudinal nature of this study provides a full picture of relationship developmental dynamics. This research also makes an important contribution to the knowledge base on emotion regulation, in that it answers calls for more research on temporal factors associated with emotion regulation (Gross, 2015; Sheppes & Gross, 2011). Lastly, this is the first study to consider emotion regulation in occupational therapy and physiotherapy therapeutic relationships. The remainder of this section places the findings in the context of relevant extant research.

This chapter has shown that interpersonal emotion regulation strategy use becomes increasingly tailored to the patient’s emotional response tendencies during therapeutic relationships. This finding is in line with Diefendorff and Richard (2008) conceptualisation of two types of display rules, prescribed and contextual. Prescribed display rules are general guidelines for emotional displays put forth by the organisation (Diefendorff and Richard, 2008). Contextual display rules refer to people’s perceptions of the emotional displays that
are appropriate given a specific set of circumstances (Richard & Converse, 2016).

Contextual display rules change over time, whereas prescribed display rules are more stable. People adhere to different display rules in different situations (Campos, Mumme, Kermoian & Campos, 1994; Fridlund, 1997) and how they choose which display rules to adhere to is influenced by situational cues, such as relationship closeness and quality (Campos, Mumme, Kermoian & Campos, 1994; Fridlund, 1997) and interaction context (Jones, Abbey & Cumberland, 1998). Therefore, in the beginning of the therapeutic relationship the therapist may adhere more to prescribed display rules due to lack of specific knowledge about the patient’s emotion response tendencies and the pre-mature status of the relationship. However, as therapists gets to know their patients, they increasingly utilise this understanding to tailor their interpersonal emotion regulation strategies to their patients.

As the therapeutic relationship develops, one of the main ways that therapists tailor their use of interpersonal emotion regulation strategies is from professionally-based use to personally-based use of strategies. This development pattern is consistent with the social penetration theory of relationship development (Altman & Taylor, 1973). Social penetration theory characterises relationship development in terms of changes in interpersonal communication, particularly self-disclosure, moving from shallow and superficial communication to deep and intimate communication (Altman & Taylor, 1973). Purely adhering to organisational display rules and therefore, using a more professional approach to interpersonal emotion regulation can be considered a shallow and superficial way to communicate emotions. Whereas, using a more personal approach to interpersonal emotion regulation, may be considered a more deep and intimate way to communicate emotional information. In the same way that the level of intimacy in self-disclosure is an indication of relationship development, the level of intimacy in emotional expression is an indication of relationship development.

Therapists use emotional boundaries as a gauge to achieve the appropriate level of authenticity and professionalism in their emotional display, as a way to control the emotional closeness between themselves and the patient. This was evident in the rationale that therapists gave for using emotion regulation strategies. Purely professional display of emotion can lead to interpersonal distance, lower social satisfaction, and less social support (Kernis & Goldman, 2006; Swann & Pelham, 2002). In contrast, more informal emotional displays, which are associated with a personal approach to interpersonal emotion regulation, can indicate openness and investment of emotional resources and is crucial in establishing emotional connection in relationships (Hayward & Tuckey, 2011; Reis & Patrick, 1996).
However, healthcare professionals whose approach to interpersonal emotion regulation is too personal may run the risk of becoming overly involved and crossing professional boundaries (Maytum, Heiman, Garwick, 2004). Researchers have described the ideal balance as being sufficiently emotionally involved to assist patients while retaining enough distance to maintain control (Smith, Taylor, Keys, Gornto, 1997; Watson, Kieckhefer, Olshansky, 2006). It is important to appreciate that the ideal balance between professional and personal approaches changes as relationship contextual factors change.

Hayward & Tuckey (2011) conceived emotional boundary manipulation as a form of emotion regulation in which workers take proactive and sometimes reactive control of their emotional space to enhance their adaptability to the work environment. Healthcare professionals manipulate emotional boundaries to promote personal and professional growth and development, to protect themselves, and to enable the achievement of work-related goals. It is an evolutionary process where healthcare professionals may initially distance themselves emotionally to strategically determining whether to remain distant or to engage emotionally with patients (Hayward & Tuckey, 2011).
Chapter 7 Conclusion

This research is focused on the role of emotion regulation in therapeutic relationships between occupational therapists/physiotherapists and their patients. The research was guided by three research questions: How do patients and therapists use emotion regulation strategies during therapeutic relationships? How does the use of these emotion regulation strategies evolve throughout the course of the therapeutic relationship? What type of turning points characterise relationships that are perceived as high-quality/low-quality? To address these questions, two studies using qualitative methods were conducted. In the first study, patients and therapists were asked to tell the story of a recent or current therapeutic relationship using semi-structured interviews. In the second study, patient-therapist dyads were observed during their encounters, and then at the end of the relationship a participant verification interview with each dyadic partner was conducted.

The rationale for this research was motivated by knowledge gaps in research literature on therapeutic relationships and emotion regulation at work. Research on therapeutic relationships has mostly ignored the role of emotion regulation. This is problematic because emotions are an important component in relationships that influence the trajectory of relationships and how we understand them (Planalp, 1999; Lawler & Thye, 1999). This area of research also often excludes one dyadic partner and focuses on one encounter rather than the many encounters that occur over the course of the relationship. While research on emotion regulation at work has been growing exponentially, this area of research is still working to develop a more nuanced understanding how people use emotion regulation in real life. Factors that hinder the ability of this area of research to understand real life use of emotion regulation is its tendency to focus on a limited range of emotion regulation strategies (Webb, Miles & Sheeran, 2012), only one emotion regulation strategy used at a time (Aldao & Nolen-Hoeksema, 2013), and its focus on the regulation of negative emotions to the virtual exclusion of the regulation of positive emotions (Heiy & Cheavens, 2014). This area of research also tends to focus on intrapersonal or interpersonal emotion regulation, even though people use these concurrently in real life (Kappas, 2013). Importantly, researchers have recently recognised the need for more research on how emotion regulation changes and develops during the course of social relationships (Niven, 2017).

This research is particularly important now given the current professional and policy context. Health policy in the UK is focused on cost containment while at the same time improving the
quality of services. These initiatives may exert competing pressures on therapists. For example, to contain costs therapists may feel pressured to spend less time with their patients and therefore spend less time building the therapeutic relationship. However, given that high-quality therapeutic relationships are an indication of service quality, therapists may also feel pressured to spend more time building the therapeutic relationship. Research that illuminates how therapist can most effectively use emotion regulation strategies to build therapeutic relationships may help therapist meet the challenges of providing high quality, compassion, and client centred services with less time and resources.

In this concluding chapter, the key findings in relation to three main themes are discussed. The first theme is focused on how therapists and patients use emotion regulation strategies. The findings in the second theme relate to how the use of emotion regulation strategies change as the therapeutic relationship develops. In the third theme, the factors that influence change in how patients and therapists use emotion regulation strategies during their interactions are discussed and an illustrative theoretical model is presented. The findings within each of these themes will be placed within the wider context of the current knowledge base and the theoretical contribution will be discussed. The methodological contributions, practical implications, and trustworthiness/limitations of the research are then considered. Finally, future research directions are proposed.

7.1 Therapists and Patients Use of Emotion Regulation

Therapists used a full range of intrapersonal and interpersonal emotion regulation strategies during their therapeutic relationships, including those that are less prevalent in emotion regulation research, such as situation selection, situation modification, and overt emotion regulation strategies. They used these strategies in response to experienced and anticipated affective events that occurred or may occur during their interactions with patients. Therapists mostly sought to decrease their own and their patients’ negative emotions and increase positive emotions, but at times would use strategies to slightly decrease positive emotions. Intrapersonal and interpersonal emotion regulation strategies were often used simultaneously. At times therapists used intrapersonal emotion regulation strategies prior to patient interaction to prepare themselves emotionally and after patient interaction to regulate residual emotions. Therapists were motivated to use emotion regulation strategies for a
number of reasons, including to achieve rehabilitative goals, build and maintain the relationship, to feel competent in their work, and for altruistic reasons.

Patients used a full range of intrapersonal emotion regulation strategies. They regulated their negative emotions, but unlike therapists, they mostly did not feel the need to regulate their positive emotions. Like therapists, patients used intrapersonal emotion regulation strategies in preparation for their encounter or after their encounter to address residual emotions. Patients used interpersonal emotion regulation strategies to a lesser extent than therapists. This may be because the therapists typically did not display emotions that the patients deemed required regulation, and in general, the patients did not believe it was their responsibility to regulate their therapist’s emotions. The patients were motivated to use emotion regulation strategies to build a positive therapeutic relationship and to avoid awkwardness during their interactions with therapists.

Both therapists and patients used intrapersonal and interpersonal emotion regulation strategies proactively and reactively. Proactive emotion regulation refers to strategies used to address expected emotions. Reactive emotion regulation refers to strategies used to address experienced emotions. Most research on emotion regulation focuses on how strategies are used in response to emotions. In intrapersonal emotion regulation research, proactive strategies (e.g., situation selection and situation modification) have been studied less often than reactive strategies (e.g., cognitive change, attentional deployment, and response modulation) (Webb, Miles & Sheeran, 2012). Studies on interpersonal emotion regulation research, do not tend to draw a distinction between strategies used proactively and reactively (e.g., Tamminen & Crocker, 2013; Niven, Totterdell & Holman, 2009). Given that anticipated emotions may have more influence on self-regulatory behaviour than experienced emotions (Brown & McConnell, 2011), more research is needed regarding proactive intrapersonal and interpersonal emotion regulation.

Research on affective and empathetic forecasting is related to proactive and reactive emotion regulation, respectively. Affective forecasts are people’s predictions of how they expect they would feel in particular situations (Wilson & Gilbert, 2003). Empathic forecasts are people’s predictions on how others would feel in social interactions (Moons, Chen & Mackie, 2017). Studies that investigate the intersection between affective forecasting and emotion regulation are scarce (Loewenstein, 2007). One study on this topic investigated people’s affective forecasts regarding their ability to regulate a variety of different emotions in a variety of
contexts. The researcher concluded that reappraisal strategies were consistently seen as more effective and more likely to be used, compared to distraction and response modulation (Loewenstein, 2007). Research on empathetic forecasting and emotion regulation is also limited. However, one study demonstrated that people’s empathic forecasts led to forecasts-consistent non-verbal behaviour in social interactions that transmitted the emotional expectancy on the target person (Moons, 2009). Although this study did not specifically mention emotion regulation, it is likely some of the non-verbal behaviour was for emotion regulatory purposes.

My findings related to how patients and therapists use emotion regulation during therapeutic relationships are unique for a number of reasons. This is one of the few studies in healthcare that consider the emotion regulation behaviour of both dyadic partners over time. The finding that people use interpersonal and intrapersonal emotion regulation strategies both proactively and reactively highlights the need for more research that integrates affective and empathic forecasting and emotion regulation. In addition, there are a limited number of studies on emotion regulation in occupational therapy and physiotherapy contexts. These findings make an important contribution because emotion regulation is an important part of therapists’ job and both dyadic partners play a role in regulating emotions within the therapeutic relationship. The more knowledge researchers gain on the emotion regulation processes within therapeutic relationships, the more we are able to understand how emotion regulation can be used most effectively in this context.

7.2 Emotion Regulation Strategy Development During Therapeutic Relationships

An important theoretical contribution of this thesis is it explains how, through a learning process, the use of emotion regulation strategies develops during the course of the therapeutic relationship. While the use of intrapersonal emotion regulation strategies did not seem to develop over the course of the relationship, therapists tended to increasingly tailor their interpersonal emotion regulation behaviour to suit patients’ individual emotional needs and preferences as the relationship developed. They did this by learning about the patient’s emotional response tendencies through ongoing interactions. Patients also learned about their therapist’s interaction preferences through social cues but used interpersonal emotion regulation to a lesser extent than the therapists.
This finding is supported by the notion that people learn how their actions and behaviours affect their perception of their current situation/environment (Hershberger, 1990). In comparing these perceptions to their goals, people begin to understand which behaviours and actions are adaptive, and therefore facilitate achievement of their goals, and which are maladaptive. Those actions/behaviours that are adaptive will be used again in similar situations. Those actions/behaviours that are maladaptive will be extinguished (Hershberger, 1990). People learn from this type of positive and negative feedback and use this information to organise future behaviours, both within the current relationship and in similar subsequent relationships (Ormrond, 2015).

Research on how people learn to regulate their own and other’s emotions is mostly focused on how children learn to regulate emotions. Within this research there is a large body of evidence that indicates that the social environment plays an important role in the development of emotion regulatory skills (Marroquin & Nolen-Hoeksema, 2015). Given the importance of the social environment in learning emotion regulatory behaviour throughout childhood and adolescent development, it is likely that the social environment plays an important role in adults learning emotion regulation (Rime, 2009). This speculation is in line with research that highlights the importance of interpersonal cues in helping people understand the appropriateness of their emotion regulatory behaviour (Forsythe, 2015; Planalp, 1998). It is also supported by organisational based research that concluded the implicit rules of performing emotional labour are learned through informal socialisation with colleagues, managers, and customers (Seymour & Sandiford, 2005). This thesis makes a contribution to these studies by providing evidence regarding the impact of learning on adults use of interpersonal emotion regulation over a relatively intermediate time frame, the duration of a therapeutic relationship. This is an important contribution because understanding how people learn to use emotion regulation can lead to strategies aimed at helping people learn how to use emotion regulation more effectively.

Importantly, these findings also make a contribution to what is known about how emotion regulation use changes and develops over time. Numerous researchers have acknowledged the need for research to focus on how emotion regulation use changes over time (e.g., Sheppes & Gross, 2011; Gross, 2015), particularly over different time frames (Grimm, Ram & Hamagami, 2011) and in the context of social interactions (Niven, 2017). While there are many studies that focus on how emotion regulation abilities develop over time in childhood and adolescence (e.g., Kramer, 2014; Zhao, Zhang & Zhou, 2014; Gullone, Hughes, King &
Tongue, 2010), there are few that focus on how adults’ use of emotion regulation develops over time. Those studies that do focus on adults’ use of emotion regulation over time are mostly concerned with intrapersonal emotion regulation, as opposed to interpersonal emotion regulation and relatively short time frames, such as over the course of a day (e.g., Brans et al, 2013, Nezlek & Kuppens, 2008; Verduyn, Van Mechelen, & Tuerlinckx, 2011). My findings shine light on how interpersonal emotion regulation use develops over an intermediate time frame in therapeutic relationships. In this way, these findings contribute to a better understanding of how emotion regulation is used over time.

One way that therapists tailor their interpersonal emotion regulation strategies, as they learn about their patients’ emotional needs and preferences, is by adjusting their approach to emotion regulation on a spectrum ranging from professional to personal. A professional approach to interpersonal emotion regulation is more formal and is mainly guided by organisational display rules. A more personal approach to interpersonal emotion regulation is less formal and mainly guided by contextual display rules. Therapists use cues from social interaction to decide on and facilitate the ideal balance between a professional and personal approach.

This finding is in line with healthcare-based research on balancing professional and personal identities at work. Taking a professional approach has been described as presenting oneself in a way that lacks emotional depth (Cecil & Glass, 2015), utilises emotional control, and demonstrates relational detachment (Funk, Peters & Roger, 2017). In contrast, a personal approach has been described as a way to demonstrate care for another person (Funk, Peters & Roger, 2017), showing one’s humanity (Pruthi & Goel, 2014), and being authentic (Seno, 2010).

Healthcare-based research on balancing professional and personal identities at work is concentrated in the nursing professional context. For example, Hem and Heggen (2003) described this phenomenon as being professional and being human. They used an ethnographic research design to understand how nurses experience and interpret the demands of expressing their humanity while being professional. Another study, conducted by Funk and colleagues (2017), described this phenomenon as balancing caring and professional identities. They used semi-structured interviews with nurses and health aides to understand the appropriateness of grief display when working in palliative care and how that relates to their caring and professional identities. Both studies concluded that nurses and health aides
appreciate that at times it is beneficial to express authentic emotions, but they do so cautiously because such expression is also associated with being unprofessional.

Therapists use emotional boundaries as a gauge to achieve the appropriate balance between a professional and personal approach to interpersonal emotion regulation as a way to control the emotional closeness between themselves and their patients. Although, there is no ideal therapeutic relationship type, because not all patients prefer the same type of relationships with therapists, there is some evidence that more personal therapeutic relationships are more desirable than less personal therapeutic relationships, particularly in relationships that last over extended durations. In low-quality relationships therapists are likely to use emotional distancing strategies (Michaelsen, 2012), which are associated with a more professional approach to emotion regulation. One of the consequences of emotional distancing is the healthcare professionals do not get to know the patient well and therefore cannot give them the best service possible (Michaelsen, 2012). In contrast, people are more likely to show their true emotions or be authentic in high-quality relationships (Clark & Finkel, 2005; DePaulo & Kashy, 1998). Patient satisfaction is to some extent shaped by the client’s perception of the healthcare providers authenticity (Drach-Zahavy, Yagil & Cohen, 2017). Moreover, in new relationships patients’ expectations are focused on instrumental outcomes of the encounter but in established relationships patients expect their healthcare professional to also satisfy their emotional needs (Yagil & Shnapper-Cohen, 2016). Therefore, using a professional approach to interpersonal emotion regulation may be appropriate in the beginning of a therapeutic relationship, but as the relationship develops and customers/patients begin to rely more on the employee to satisfy their emotional needs, a more personal approach may be warranted.

While research has been conducted on emotional boundaries and balancing professional and personal identities at work in nursing (e.g., Allan & Barber, 2005; Fegran & Helseth, 2009; Harris, 2014), researchers have not explored this topic in occupational therapy and physiotherapy. The closest area of research is focused on sexual professional boundaries between patients and physiotherapists (e.g., Ang, Cooper & Jenkins, 2010; Soundy, Stubbs, Jenkins & Cooper, 2013; Roush, Cox, Garlick, Kane & Marchand, 2015). My findings on this topic make an important contribution to the knowledge base because they highlight an understudied but consequential area in occupational therapy and physiotherapy practice that requires more investigation.
7.3 Factors that Influence Change in Identification, Selection and Implementation of Emotion Regulation Strategies

Emotion regulation has been described as a dynamic regulatory process that unfolds over the course of customer interactions (Gabriel & Diefendorff, 2015). Previous research has identified a number of relatively stable factors that influence how people identify, select and implement emotion regulation strategies ranging from personal factors like attachment style (Van Durme, Goossen, Bosmans & Grael, 2018) and emotional awareness (Boden & Thompsen, 2015) to environmental factors like culture (Miyamoto, Ma & Petermann, 2014) and level of organisational support (Mesmer-Magnus, DeChurch & Wax, 2012). My findings contribute to these studies by highlighting that the perception of display rules, perception of turning points in relationships, and whether the encounter is routine or non-routine are important dynamic factors that influence how patients and therapists use emotion regulation during therapeutic relationships. These emotion regulation strategies, through their influence on emotion, have an impact on how patients and therapists perceive their therapeutic relationship. The perception of the therapeutic relationship, in turn, impacts upon how dyadic partners perceive display rules, turning points, and encounters. Based on these findings, I have developed a model to illustrate how these factors influence the dynamic nature of how therapists and patients identify, select, and implement emotion regulation strategies throughout the course of the therapeutic relationship (see Figure 3).

Figure 3: Model of Factors that Influence the Dynamic Nature of How Therapists and Patients Identify, Select and Implement Interpersonal Emotion Regulation Strategies in Therapeutic Relationships.
The findings show that in the beginning of the therapeutic relationship therapists may refer to prescribed display rules, general guidelines for emotional display put forth by the organisation (Diefendorff and Richard, 2008). However, as therapists gets to know their patients, therapists may increasingly refer to contextual display rules, people’s perceptions of the emotional display that is appropriate given a specific set of circumstances (Richard & Converse, 2016) to tailor their emotion regulation approach to their patients’ specific tendencies and preferences. Patients demonstrate a similar pattern in that in the beginning of the relationship they seem to adhere to display rules based on normal social conduct and then use social cues to understand the most appropriate modes of interpersonal interaction, including emotion display, in the specific context. This finding represents an incremental contribution to the knowledge base for two main reasons.

Firstly, this finding is unique because of the way contextual and prescribed display rules are conceptualised. According to Diefendorff and Richard (2008), contextual display rules are subordinate to prescribed display rules. In other words, people follow prescriptive display rules until they notice that this approach is ineffective due to perceived discrepancies between the goal and the current situation. This discrepancy is then addressed by adapting the display rule to the particular context thereby, referring to contextual display rules.

My findings suggest that contextual display rules can be more usefully understood as an alternative to prescribed display rules. Meaning, in any situation the people can decide whether to refer to prescribed or contextual display rules. This is a more useful way of understanding the link between prescribed and contextual display rules because it introduces the possibility that utilising one set of display rules may be preferable to the other in certain contexts. For example, contextual display rules may be associated with decision making that is open to alternatives. Whereas, prescriptive display rules may be associated with decision making that is rigidly committed to given line of action (Tunguz & Carnevale, 2011). Since improved decisions and judgements are associated with openness to alternatives and detrimental decisions and judgements are associated with rigidity (Tunguz & Carnevale, 2011), referring to contextual display rules may be more adaptive than adhering to prescriptive display rules in certain circumstances. Conceptualising the relationship between prescribed and contextual display rules in this way also takes in account the learning that takes place through repeated interactions. As dyadic partners accumulate information about
each other, they can use this information to develop shortcuts in future interactions, thereby increasing the efficiency and effectiveness of interactions (Ford, 2001).

Secondly, these findings are novel in that they highlight the dynamic nature of people’s perceptions of display rules. Most studies on the topic focus on perceptions of prescribed display rules (Martinez-Inigo, Totterdell, Alcover & Holman, 2009; Diefendorff, Richard & Croyle, 2006; Diefendorff, Erickson, Grandey & Dahling, 2011), which are by definition more stable than contextual display rules (Diefendorff & Richard, 2008). Although a number of studies have identified contextual factors that influence individuals’ perceptions of display rules, including gender (Moran & Diefendorff & Greguras, 2013), professional or organisational affliction (Martinez-Inigo, Totterdell, Alcover & Holman, 2009), ethnicity (Hwang & Matsumoto, 2012), nationality (Mann, 2007), and relationship status (Fok, Hui, Bond, Matsumoto & Yoo, 2008), there are few studies that have empirically investigated people’s perceptions of contextual display rules at work (Richard & Converse, 2016; Diefendorff et al, 2010; Diefendorff & Greguras, 2009). Diefendorff and Greguras (2009) investigated employees perceptions of contextual display rules related to discrete emotions and specific work targets using hypothetical scenarios. Diefendorff and colleagues (2010) also used hypothetical scenarios to investigate employees’ perceptions of contextual display rules related to two interpersonal relationship dimensions, relative power, and solidarity. Both studies found that emotional display rules, when contextualised, are much more complex and nuanced than reflected in previous organisational research.

A more recent study by Richard and Converse (2016) extended these studies by examining employees’ real-time perceptions of contextual display rules during the course of a typical day, thereby using real and naturally occurring scenarios. They used an experience sampling methodology to survey employees four times a day, over five days. The participants were asked to describe their most recent interaction including their momentary affect, how they regulated their affect, perception of contextual display rules and target characteristics. They found certain target characteristics, solidarity and relative power, and momentary affect, particularly pleasantness and activation, were predictors of both contextual display rule perception and deviation from those display rules. My study extends these studies by exploring employees’ and patients’ perception of contextual and prescriptive display rules in service relationships over time.
This contribution is important because it takes a step in the direction of understanding the complexity and dynamic nature of emotion display rules at work. Specifically, how one’s perception of the appropriateness of display rules may change over time within workplace relationships. Since display rules have been found to be associated with determinants of employee health and wellbeing, such as job satisfaction (Diefendorff & Richard, 2003) and emotional burnout (Brotheridge & Grandey, 2002), and the direction of the correlation is determined by the context of the display rules (Martinez-Inigo, Totterdell, Alcover & Holman, 2009), learning more about the details of specific contextual display rules will help researchers understand how we can improve employee wellbeing at work. Also, since developing a better understanding of contextual display rules may be a way that organisations can provide services that are more tailored to customers’ needs, gaining knowledge in this area may present opportunities for organisations to gain competitive advantages.

7.3.2 Turning Points and Emotion Regulation

Turning points are significant events that influence each dyadic partner’s ongoing perception of the relationship. They often have emotional consequences that provoke the use of intrapersonal and interpersonal emotion regulation strategies. The effectiveness of emotion regulatory processes has an important influence on dyadic partners perception of the quality of the therapeutic relationship. Turning points can be broadly categorised as constructive and nonconstructive. Constructive turning points are those that help dyadic partners develop high-quality therapeutic relationships. Non-constructive turning points are those that hinder dyadic partners from achieving high-quality therapeutic relationships. While constructive turning points were concentrated in high-quality relationships and non-constructive turning points were concentrated in low-quality relationships, both types of turning points were present in high and low-quality relationships.

Patients and therapists perceived different but corresponding turning points within their relationships. Therapists identified turning points that fit into six main categories: progress towards goals, set-backs in progress towards goals, interpersonal affective bonding with patients, interpersonal problems with patients, positive feedback, and negative feedback. Patients identified turning points that fit into five main categories: progress towards goals, set-backs in progress towards goals, interpersonal affective bonding with therapists, agreement with therapist, and change in treatment.
This is the first study to explore therapeutic relationship dynamics by identifying the turning points that occur over time from a dyadic point of view. The findings extend previous studies in psychotherapy and nursing on ruptures and repairs, critical incidents, and hassles/uplifts because these studies mostly explored one event during a relationship rather than the many events that occur over time in a relationship. Also, unlike the current study, many of these studies only explore one dyadic partners point of view (e.g., Tejero, 2016; Bedi, Davis & Williams, 2005; Safran & Muran, 2006).

Although interpersonal events are considered an important aspect of therapeutic relationships (Taylor, 2008), occupational therapy and physiotherapy research on events that are influential in therapeutic relationship development is lacking. Instead, research on therapeutic relationships in occupational therapy and physiotherapy contexts has mainly focused on understanding essential aspects of therapeutic relationships. These studies imply the importance of certain events in therapeutic relationship development. For example, Miciak and colleagues (2018) identified therapists and patients being themselves or being genuine during interactions as a necessary condition for building therapeutic relationships. Similarly, Finaret and Shor (2006) concluded that a necessary element involved in therapeutic relationship development is instances where the professional/personal boundary shifts to some degree towards the personal end of the spectrum. Shifting this boundary towards the personal end of the spectrum was aided by open communication, careful self-disclosure, and informal work settings, for example working in the client’s home (Finaret & Shor, 2006). These two studies imply that instances where dyadic partners are being transparent or disclosing information about themselves may be important interpersonal events within therapeutic relationship development.

My findings extend these studies by taking a more direct and in-depth approach to understanding the characteristics and consequences of events or turning points that influence participants’ emotion regulation strategies and perceptions of relationship quality. The findings are unique because the turning points are categorised, include both constructive and non-constructive turning points, and consider both the patient’s and therapist’s perception. These findings are important because a better understanding of the nature of these influential events within therapeutic relationships can lead to a better understanding of how therapists can navigate such events successfully.
7.3.3 Routine and Non-Routine Encounters and Emotion Regulation

Routine and non-routine encounters have an important impact on therapists’ emotion regulation behaviour. Routine encounters feature commonly encountered affective events and emotions in terms of level of intensity. The reoccurring nature of routine encounters may enable therapists to become increasingly adept at dealing with these situations. As a result, the therapist may navigate these encounters in an increasingly effortless and efficient manner. Also, the common nature of the emotions and affective events in these routine encounters led the therapists to anticipate them, and as a result, at times attempt to regulate them proactively. Non-routine encounters feature uncommonly experienced and therefore, unexpected affective events and emotion intensity levels. The lack of commonality in affective events and resulting emotions made it necessary for therapists to use a trial and error approach to emotion regulation in order to navigate these situations. Therefore, in non-routine encounters, therapists regulated emotions in a less efficient and more effortful manner.

Research that investigates the influence of the familiar encounters on emotion regulation behaviour is sparse. One such study was conducted by Gabriel and colleagues (2015) and investigated how customer’s familiarity with the employee and service provided influenced the impact of the employee’s positive emotional display on the customer’s perception of the service performance. They found that the impact of employees’ positive emotional displays on customers’ perception of service performance matters more in situations where the customer is not familiar with the employee or the service, than in situations where the customer is familiar with the employee or the service. The researchers reasoned that when the customer is familiar with the employee and service, the customer has more information about the employee upon which to base their perceptions of performance and are therefore, less dependent on non-verbal cues. In contrast, when the customer is unfamiliar, they place more weight on the information gained through non-verbal cues that indicate relational motives, such as positive emotional displays. The findings in this thesis contribute to this limited area of study by demonstrating that therapists’ level of familiarity with a particular type of encounter has an influence on their emotion regulation behaviour. For example, if a patient cries every time a therapist interacts with him, the crying will become a familiar aspect of their encounter. As such, the therapist will over time learn how to best use emotion regulation strategies to navigate such encounters within this relationship and may also be able to generalise their learned skills to similar encounters outside of the relationship.
My finding regarding the influence of routine and non-routine encounters on emotion regulation behaviour also have implications for researchers understanding of the effort associated with emotion regulation at work. A primary idea behind Grandey and Melloy’s (2017) model of emotional labour as emotion regulation is that emotional labour is best defined as the effort performed by the employee rather than the work role requirements or expressive display (Grandey & Melloy, 2017). Researchers have concluded that certain emotion regulation strategies require more effort than others. In particular, surface acting requires more effort than deep acting because while deep acting changes the agent’s emotions to make the expression of emotions and actual felt emotions congruent, surface acting only changes the agent’s expression of emotion and therefore requires attentional monitoring from the agent to ensure the true feelings do not slip out (English & John, 2013; Webb, Miles & Sheeran, 2012). Both deep and surface acting are more effortful than authentic displays of emotion because when displaying authentic emotions, the agent does not need to expend energy or resources to use emotion regulation strategies (Grandey & Melloy, 2017).

My findings suggest that more than just the type of emotion regulation strategy utilised determines the level of effort required. In particular, the therapist’s level of familiarity with the affective event and resulting emotions has an impact on the amount of effort expended in regulating the emotion. More effort is required when using emotion regulation in response to non-routine versus routine emotions and affective events because in unfamiliar situations the agent requires more trial and error use of emotion regulation strategies. Also, routinely encountered affective events and emotions allow people to develop emotion regulation routines (Eder, Rothermund & Proctor, 2010) that can become increasingly automated. Automated use of emotion regulation requires less effort because it utilises less cognitive and physiological resources (Christou-Champi, Farrow & Webb, 2015). This is an important contribution because the amount of effort expended can lead to interpersonal resource depletion. Resource depletion can affect one’s ability or willingness to utilise emotion regulation to adhere to display rules (Dahling, 2017). An employee’s deviation from display rules can trigger negative reactions from customers and may be harmful to the organisation (Dahling, 2017). Therefore, this contribution to the knowledge base on the source of effort in emotion regulation at work can lead to a better understanding of how to manage the effort associated with emotion regulation at work.

These findings regarding the emotion regulatory effort expended in routine versus non-routine encounters also has implications for research on affective events theory. Affective
events theory postulates that people experience negative and positive events at work that have consequences in terms of the employee’s emotions and moods. These events are referred to as affective events. The employee’s emotions and moods impact upon their job satisfaction and performance. Research on affective events theory has sought to identify factors that moderate the relationship between affective events, emotions, and job performance. These researchers have mainly focused on personal disposition factors, such as self-efficacy, work engagement, positive/negative affectivity, and trait anger (e.g., Glaso, Vie, Holmdal & Einarsen, 2011; Junca-Silva, Caetano & Lopes, 2017; Glaso, Vie, Holmdal & Einarsen, 2011). Since routine encounters may require less emotion regulatory effort and therefore cause less resource depletion than non-routine encounters, the familiarity of the affective event may be an important moderator of the relationship between affective events, emotions, and job performance that has yet to be investigated.

7.3.4 Emotion Regulation and the Therapeutic Relationship

Patients’ and therapists’ use of emotion regulation, through its effect on emotion, has an impact on their perception of the relationship quality. Patients and therapists used intrapersonal and interpersonal emotion regulation strategies in response to emotions stemming from affective events. The impact of those strategies on both dyadic partner’s emotions shaped their perceptions of the relationship quality on an ongoing basis. Generally, in instances where the patient or therapist felt negative emotions, their relationship quality rating went down. Similarly, in instances where they felt positive emotions their relationship quality rating went up.

While emotions are considered an important aspect of therapeutic relationships in occupational therapy and physiotherapy environments (Nicholls, 2013; Taylor, 2008), research on the emotional aspects of occupational therapy and physiotherapy are limited (Healey, 2017). However, in the last five years, there has been an increase in research on emotion related topics in occupational therapy and physiotherapy contexts including, emotion management (Healey, 2017), emotional intelligence (Andonian, 2013; Gribble, Ladyshewskey & Parsons, 2017; McKenna & Mellson, 2013), and emotional burnout (Fischer et al, 2013; Du Plessis, Visagie & Mji, 2014).

Only two studies have investigated occupational therapists and physiotherapists emotion management at work. Fosters and Sayers (2012) used in-depth interviews with
physiotherapists in private practice to understand the range of emotions they experience in context and the self-management techniques they use in response to the emotions. They found that therapists experience a wide range of negative and positive emotions including anger, annoyance, pride, hope, and excitement. They experienced these emotions in all aspects of their job including social relationships, in treating their patient, developing new skills and in coping with organisational limitations. They used a number of self-management strategies including identifying communication barriers, digging deep within oneself and seeking support (Foster & Sayers, 2012). They did not consider how these self-management techniques impacted upon the therapeutic relationship.

The second study set out to understand how occupational therapists simultaneously manage the practical and emotional aspects of their work in psychiatric occupational services (Weiste, 2016). Using conversation analysis of videotaped patient/therapist encounters, the researchers sought to understand how occupational therapists use formulations to manage client’s emotional states. Formulations are conversational actions that propose an altered version of the client’s expression of emotion (Heritage & Watson, cited in Weiste, 2016) and are central to practices that professionals use for managing talk on client’s emotion. The researcher found two types of formulation sequences that therapists use to manage talk related to the client’s emotional states. In the first type of sequence, the client expresses a positive emotional state or experience, and the therapist endorses that perspective by directing the patient’s attention to their competence. The second sequence of formulation involves the client expressing a negative emotional state or experience and the therapist attempting to redirect the client’s attention away from the topic (Weiste, 2016). Both sequences could be categorised as altering attention in Williams (2007) taxonomy of interpersonal emotion regulation strategies. Although this study did not explore any links between the use of formulations and the therapeutic relationship, the researcher noted a previous study that suggested a positive association between the use of formulations in psychotherapy and improved therapeutic relationships (Thompson, cited in Weiste, 2016).

This thesis makes a contribution to this growing area of knowledge in that it is the first study to explore emotion regulation as an underlying mechanism that steers therapeutic relationship development in the occupational therapy and physiotherapy professional context. As such it clarifies the emotion regulatory role that both dyadic partners play in therapeutic relationship development. This contribution is important because emotion regulation is a tool that therapists use to tailor their interpersonal behaviours to meet organisational goals.
(Diefendorff, Richard & Croyle, 2006). Since interpersonal behaviours are a key aspect of service performance (Stouten & De Cremer, 2010), understanding how therapists use emotion regulation and how patients respond to these strategies can lead to a better understanding of how therapists can improve their overall service performance.

7.3.5 Therapeutic Relational Factors that Influence Emotion Regulation

Dyadic emotion regulation is likely to rely on relational processes that draw on intrapersonal mechanisms of affect and cognition, vary among relationships and change within relationships over time (Marroquin & Nolen-Hoeksema, 2015). The findings in this thesis support this notion. Therapeutic relationships influence how patients and therapists understand display rules, turning points, and the familiarity of encounters. Therapists and patients use relational cues to understand the appropriate display rules at any point in time. The status of relationships provides the context in which turning points are interpreted. The way dyadic partners interact during their relationship establishes what type of encounters become routine within the relationship.

Researchers have sought to understand how relational factors influence emotion regulation. For example, Marroquin and Nolen-Hoeksema (2015) conducted three quantitative studies to understand how relationship status, social connectedness, and relationship characteristics (levels of intimacy and trust), and the use of adaptive and maladaptive emotion regulation strategies are associated with depressive symptoms. They found that maladaptive emotion regulation strategies had weaker associations with depressive symptoms among more socially connected people and people in close relationships than among more socially isolated people and single people, respectively. Among people in romantic relationships, the association between their use of maladaptive emotion regulation strategies and depressive symptoms depended on levels of intimacy and trust within their relationships. They also found that being socially connected or in a close relationship was positively linked with the use of adaptive emotion regulation strategies and negatively linked with use of maladaptive emotion regulation strategies. The influence of maladaptive and adaptive emotion regulation strategies on depressive symptoms seemed to be either diluted or amplified by social and relationship resources. Overall, they concluded that romantic relationships operate as both the social contexts in which individuals deploy emotion regulation strategies and social influences on how individuals regulate emotion (Marroquin and Nolen-Hoeksema, 2015).
In organisational studies there are a few studies that investigate the influence of relationships or relational factors on emotion regulation. For example, a recent study investigated the impact of leader-member exchange in the relationship between emotional labour and burnout in nursing (Lee & Ji, 2018). Another study investigated the impact of how well customers know the employee on how the customers perceive the employee’s emotional displays (Wang & Groth, 2014). Other studies have considered how employees perception of emotion display rules is influenced by relationship status (Fok, Hui, Bond, Matsumoto & Yoo, 2008) and interpersonal relationship dimensions, power and solidarity (Diefendorff, Morehart & Gabriel, 2010). This thesis makes an incremental contribution to the knowledge base on social influences on dyadic emotion regulation by specifying how relational factors impact on dyadic partners perception of display rules, turning points and routine/non-routine encounters. This is an important contribution because emotions and relationships at work influence important factors, such as employees health and wellbeing (Fredrickson & Joiner, 2002; Marroquin, 2011), job performance (Bolton, 2000), and customer satisfaction (Beattie et al, 2002).

7.4 Methodological Contribution

This is the first study to use turning point analysis to understand therapeutic relationship development. Turning point analysis has long been used to understand how interpersonal relationships develop. Previous studies on therapeutic relationship development used critical incidents, ruptures and repairs, and hassles and uplifts. While these types of studies are similar to turning point analysis, they typically only consider negative affective events and/or one encounter during the course of the relationship. Turning point analysis, on the other hand, includes an examination of constructive and non-constructive turning points that occur over the course of the relationship. For this reason, turning point analysis may be a useful method to use in future studies on therapeutic relationship dynamics.

Also, this study was able to gain unique access to observe therapeutic relationship development from when the patient and therapist first met, to when the patient was discharged. I observed most, if not all of the interactions between the patient and therapist throughout the duration of their therapeutic relationship. This enabled me to gain intimate first-hand knowledge of the relationship, which I used to ask informed questions during the interview at the end of the relationship. Using observation to understand how interpersonal
interaction develops over time is a novel approach in research on therapeutic relationships that provides a rare opportunity to understand interactional dynamics within these relationships. Few studies on relationship development utilise a longitudinal design due to the difficulty in getting access (Baxter & Montgomery, 1996).

Lastly, this study makes a unique methodological contribution to emotion regulation research in that it has avoided imposing unnecessary limitations on the scope of focus. In particular, this study includes the use of intrapersonal and interpersonal emotion regulation; most studies on this topic focus on either interpersonal or intrapersonal emotion regulation. Also, this study asked participants to describe which emotion regulation strategies they use without limiting the emotion regulation options available. Another unique feature is this study also includes the perspective of both dyadic partners. Most emotion regulation studies only include the perspective of one dyadic partner, usually the employee. In addition, unlike most studies, this study focused on the regulation of both positive and negative emotions. Lastly, the longitudinal nature of this study in the context of workplace relationships is also an uncommon approach. In avoiding such limitations, this study provides a more complete picture of how emotion regulation strategies are used and experienced at work.

7.5 Practical Implications

The findings discussed in this thesis have practical implications for occupational therapists, physiotherapists, other healthcare professionals, healthcare organisations that employ them, and educational organisations that train them. Patients experience a wide range of emotions prior to, during, and after their encounters with therapists. For this reason, therapists should focus on addressing patients’ emotions not only during the treatment session but also before and after the treatment sessions. Prior to the encounters, patients mainly reported anxiety due to not knowing what to expect. Therapists may address this by sending an informational leaflet to patients prior to the first treatment session to inform them of what to expect. Alternatively, therapists could adapt a practice of contacting the patient via telephone prior to the first treatment session to provide information and therefore, alleviate the patient’s anxiety. After the therapy session, patients, particularly those who experienced pain during the session, may experience negative emotions, such as anger and frustration. To address this, therapists could practice ensuring the treatment session ends on a high note. They could end the treatment session with something that is soothing like a therapeutic massage or with a
task that the patient can do with little difficulty. They may also end the session with positive feedback on the patient’s progress and more information about the ongoing treatment process.

My findings demonstrate that emotion regulation is a skill that occupational therapists and physiotherapists use to build and steer the quality of therapeutic relationships. Given the importance of the therapeutic relationship on patient satisfaction and outcomes (Beattie, Pinto, Nelson & Nelson, 2002; Hall et al, 2010), therapists should be supported in developing these skills. Therefore, training programs to help therapists learn to use intrapersonal and interpersonal emotion regulation during their interactions with patients are needed. Such programs would benefit from utilising constructive and nonconstructive turning points in role playing exercises where therapists or student therapists can practice navigating each scenario. Practicing addressing emotions and turning points can enable therapists to put plans in place for how to address these happenings in real life. This may improve their effectiveness and fluency in addressing such happenings in real life.

These practical implications may be relevant to all healthcare professionals who have direct contact with patients. Healthcare professionals, such as doctors, nurses, and speech and language therapists work in similar settings, so their organisational display rules are similar. They also work with identical patient populations, so they may experience many of the same emotional challenges at work. In addition, the function of the therapeutic relationship is constant within each of these professional contexts.

Lastly, the findings highlight the importance of organisations promoting cultural norms that encourage authenticity and flexibility in emotional display rather than rigid adherence to display rules. Organisations should encourage authenticity because patients and therapists identified it as an indication of high-quality therapeutic relationships. Organisations should encourage flexibility because one approach to emotion regulation is not ideal for every situation. Cultural norms can be changed through the organisation’s messaging on the topic. They can use a number of strategies to promote such messages including, signage in the office space, orientation materials, and in-service training. They can also hire leaders who exemplify an authentic and flexible approach to emotion regulation.
7.6 Trustworthiness and Limitations

Trustworthiness refers to the degree of confidence in the quality of the data collection, analysis, and interpretation (Polit & Beck, 2014). A number of strategies were used to ensure the trustworthiness of this research. Methodological triangulation was used to cross verify the data collected. Pilot studies were used to fine-tune the data collection process. Theme-maps were completed in conjunction with participants to ensure that my understanding of their experiences was in line with their perceptions. This was used as a form of member checking. Regarding the data collection, I took notes during the interview and recorded my reflexions on the interview directly afterwards. I was careful to be sure that the participants understood the questions being asked by using layman’s terms and inviting questions. Prompts were used to ensure that omissions were intentional rather than by accident. During the data analysis, I went over the data and recoded it numerous times to ensure that I captured all that the data has to offer. As I developed my interpretations, I looked for disconfirming evidence in the data. An emergent design was employed to utilise learning from each successive cycle of data collection and analysis. Also, the context is described in detail, which adds to readers’ ability to understand the transferability of the research (Polit & Beck, 2014).

Reflexivity is a valuable strategy for improving the quality of research (Darawsheh, 2014). A researcher’s values and thoughts play a role in shaping the research process and therefore needs to be explicit (Holloway & Wheeler, 2010). I have been an occupational therapist for more than 20 years. My professional indoctrination has led me to understand that it is the therapist’s responsibility to develop and maintain high-quality therapeutic relationships. I have experienced both high-quality and low-quality therapeutic relationships. My experience of therapeutic relationships helps me understand affective events and emotion display rules from a therapist’s point of view. My research skills have developed during my doctoral studies and this has influenced all phases of the research process and knowledge generation.

I used reflexivity as a tool to limit the influence of my subjectivity throughout the research process as suggested by Darawsheh (2014). To do this, I utilised a reflexive journal to record my assumptions, actions, and rationale for those actions. Since I recorded my assumptions, I was prepared to question my interpretation of the data if it were to be consistent with those assumptions. Recording my actions and rationale for those actions added transparency to the research process. I also recorded problems that I was having, the things that went well, and
how my ongoing learning influenced the research process. In appendix 10, I have included illustrative excerpts from my reflexive journal.

As with all studies, there are limitations that must be acknowledged. While semi-structured interviews are a useful way to access participants perceptions, the information gained may be limited by participants memory, understanding of the topic, or their willingness to disclose information. The use of observation combined with participant verification interviews in the second study mitigated some of these limitations since I could ask questions based on my observations that might jog their memory or compensate for any deficits in their understanding. However, using observation introduced additional limitations since participants may act differently when being watched. Also, the very nature of some emotion regulation strategies makes them difficult to observe but through observation I could gain an understanding of the context and happenings that enabled me to ask informed questions about emotion regulation during the participant verification interviews. Lastly, as with all qualitative research, the generalisation of the results is limited to the specific context in which the research was conducted.

7.7 Future Research Directions
A fertile direction for future research is testing the findings on how interpersonal emotion regulation strategies develop in workplace relationships. Observation and participant verification interviews were useful in this research but utilising videotaped encounters would improve the trustworthiness of future studies. The findings should be tested in the context of occupational therapy and physiotherapy and in the context of other healthcare professions, such as doctors and nurses. The findings could also be applied to other professional service relationships, such as lawyer-client, teacher-student, and financial planner-client. It would be interesting to know if interpersonal emotion regulation develops in the same way in business to business relationships. Research in this area would fine-tune our understanding of how emotion regulation strategies develop within relationships.

As previously mentioned, this research can inform current and future emotion regulation training programs for healthcare professionals and other professional service workers. Therefore, a second potentially fruitful direction for future research would be to investigate the impact of these training programs on patient/client and employee outcomes. This
research can be conducted using randomised control trials or cohort studies. The independent variable would be emotion regulation training provided to healthcare professionals. The dependent variable would be patient or employee outcomes, such as patient functional gains, adherence to treatment, job satisfaction, stress, or organisational citizenship behaviours. Research in this area would complement research on emotional intelligence training in the workplace, since little scientific evidence has been provided to show the effectiveness of such training (Wong, Foo, Wang, Wong, 2007). This research would improve our understanding of the impact of training programs.

A third potentially productive area of research may focus on emotion and therapeutic relationships. Emotion is a key ingredient in relationships that has been missing from research on therapeutic relationship development. My research demonstrated that patients and therapists experience a wide range of emotions and that positive emotions are more associated with high-quality therapeutic relationships and negative emotions are more associated with low-quality therapeutic relationships. There is a lack of empirical studies that demonstrate that therapists can deliberately improve their interpersonal relationships with patients (Gelso & Silberberg, 2016). Therefore, research that focuses on how therapists promote their patients to have positive emotions and avoid negative emotions and how these efforts impact on the quality of therapeutic relationships could shine light on how therapists strategically work to improve their relationships with patients. It would be especially interesting to know the degree to which particular strategies are used in response to specific turning points and how this links to high and low-quality relationships. This research would complement extant research on emotion-oriented care (e.g., Finnema et al, 2005; van der Kooij et al, 2013). It would also be interesting to understand how organisations can work to promote positive emotions in therapists and patients and how these efforts affect the quality of therapeutic relationships.

A related research area could consider how certain demographic groups of therapists differ from others in their use of emotion regulation strategies and the associated outcomes. For example, since workers with more experience may be more familiar with routine and non-routine encounters in a particular work environment than workers with less experience, it would be important to understand the differences in how each group uses emotion regulation strategies during both types of encounters. Also, since the age of service workers may impact on the appropriate selection and success of emotion regulation strategies (Johnson, et al,
2017), it would be interesting to know how older and younger workers use emotion regulation strategies in response to particular turning points.

Lastly, my findings on how therapists and patients use emotion regulation strategies can spur a number of research questions that can continue to fine-tune our understanding. For example, it would be interesting to know the antecedents and consequences of proactive interpersonal emotion regulation strategies. It would also be useful to investigate if there are certain cocktails of interpersonal and intrapersonal emotion regulation strategies that lead to better outcomes. Another worthwhile area of research stemming from my findings may be to investigate whether emotion regulation in routine encounters versus non-routine encounters has a moderating effect on the link between health and wellbeing in emotional labour. These research questions represent potentially rich future research directions.

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Appendices

Appendix 1: PhD Interview Schedule

Stage 1 Interview for Patients/therapist

1. Broad / Funnelling down questions on emotions felt at work
   a. How do you want your therapists/patients to feel when working with you? (show list of emotions)
   b. How do you want to feel when working with your therapists/patients? (show list of emotions)
   c. Describe the ideal emotional appearance of a therapist.
   d. Describe the ideal emotional appearance of a patient.
   e. What are the main positive emotions that you experience when working you’re your therapist/patients? (show list of emotions)
      i. Prompt: satisfaction, hopefulness, compassion, happiness, optimism, contentment
      ii. Do you show these emotions or not and why?
   f. What are the main negative emotions that you experience when working you’re your therapist/patients? (show list of emotions)
      i. Prompt: frustration, anger, sadness, regret, embarrassment, anxiety
      ii. Do you show these emotions or not and why?
   g. Describe the qualities of a good therapeutic relationship.
   h. Describe the qualities of a poor therapeutic relationship.
      i. How do you build a therapeutic relationship with therapists/patients?

2. Think about a therapist/patient with whom you had a good/bad relationship (within the last month).
   a. Tell me about this therapist/patient (describe)
   b. Tell me about the first time you saw this therapist/patient
   c. How long did you see them?
   d. How long ago did you work with this therapist/patient?

3. Turning points refer to points in time that mark what you perceive as noteworthy moments in your partnership with your therapist. These points can be subtle or very significant and alter the relationship either negatively or positively. Talk me through the turning points in this relationship. (prompt: show example)
a. Next, please plot on the graph how the probability of this relationship becoming good, bad or somewhere in the middle changed according to each event. In considering the chances of the relationship becoming good or bad, please consider your own feelings regarding the quality of the relationship and your impression of your therapists feelings regarding the quality of the relationship.

b. Did you do anything else to manage your emotions or your therapist’s/patient’s emotions?
   1. Interpersonal: humour, touch or self-disclosure, body language, facial expression,
   2. Intrapersonal: ignore, rethink the situation, savour, dampen, exercise, vent, share positive experience

4. How do Emotion Regulation Strategies Develop?
   a. You used X intrapersonal emotion regulation strategy here on time line and the same strategy later on timeline. Does the way you use this strategy change from when you used it earlier vrs later.
   b. You used X interpersonal emotional regulation strategy at the end of the relationship. Would you have used it in the same way in the beginning of the relationship if this turning point happened there? Why or why not?

5. Contextual Questions
   a. Profession and years of experience?
   b. Ethnic background (not asked but noted)
   c. Nationality?
   d. Gender (not asked but noted)
   e. Approximate age (20’s, 30’s, 40’s, 50’s, 60’s)
   f. Where recruited from?
   g. Why are you seeing a therapist?
   h. Is this your first time seeing OT or PT?
   i. Was the therapist/patient the same or different race or culture?
   j. What were your expectations regarding the type of relationship you would have with your therapist/patient?
   k. What were your expectations regarding your outcome of therapy?
   l. How long since treatment?
Appendix 2: Observation data collection and participant verification interview

<table>
<thead>
<tr>
<th>Therapist:</th>
<th>Demographics of therapist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient:</td>
<td>Age:</td>
</tr>
<tr>
<td>Session number:</td>
<td>Ethnicity:</td>
</tr>
<tr>
<td>Date:</td>
<td>Years of experience:</td>
</tr>
<tr>
<td>Time:</td>
<td>OT / Physio:</td>
</tr>
<tr>
<td>Audio Folder / File number:</td>
<td>Male / Female:</td>
</tr>
<tr>
<td>Next Session Date/Time:</td>
<td>Demographics of patient:</td>
</tr>
<tr>
<td></td>
<td>Age:</td>
</tr>
<tr>
<td></td>
<td>Ethnicity:</td>
</tr>
<tr>
<td></td>
<td>Profession:</td>
</tr>
<tr>
<td></td>
<td>Male / Female:</td>
</tr>
</tbody>
</table>

**Emotion observed and evidence (Therapist /Patient)**

1.  
2.  
3.  
4.  
5.  

**Potential turning points**

1.  
2.  
3.  

**Strength of emotion on 0-10 scale**

1.  
2.  
3.  
4.  
5.
4.

5.

**Observed emotion regulation strategy and context**

1.

2.

3.

4.

5.

**Questions to Inform Discharge Questions**

1. How do you think the therapist/patient felt when_______________________________________

2. What emotions did you feel when ____________________________________________________

3.

4.

5.

**End of Treatment Session Reflexion**

Quality of therapeutic relationship on 0-10 scale (Based on impression of how each other made the other feel)

Significance of turning point/s 1-5 scale

Degree to which ruptures were resolved 1-5 scale

Impression of interaction

Comment on resolution of negative turning points and effect of positive turning points

Change in emotion regulation strategies use since last session?
Questions to Use at Discharge

6. Broad / Funnelling down questions
   a. How do you want your therapist/patient to feel when working with you? (show list of emotions)
      i. Did you do anything to try to get them to feel that way prior to the session, during the session or after the session?
   b. How do you want to feel when working with your therapist/patient? (show list of emotions)
      i. Did you do anything to try to get them to feel that way prior to the session, during the session or after the session?
   c. What positive emotions did you experience when working your therapist/patient? (show list of emotions)
      iii. Prompt: satisfaction, hopefulness, compassion, happiness, optimism, contentment
      iv. Did you show these emotions or not and why?
   d. What negative emotions did you experience when working with your therapist/patient? (show list of emotions)
      i. Prompt: frustration, anger, sadness, regret, embarrassment, anxiety
      ii. Did you show these emotions or not and why?

7. Turning points refer to points in time that mark what you perceive as noteworthy moments in your partnership with your therapist. These points can be subtle or very
significant and alter the relationship either negatively or positively. Talk me through the turning points in this relationship. (prompt: show example)

a. What emotions did you experience at each turning point and what was the strength of that emotion on a 0-10 scale?

b. What did you do with those emotions (e.g., did you show, hide, fake etc)? Why?

c. What emotions do you think your therapist/patient felt at each turning point and what do you think was the strength of that emotion on a 0-10 scale?

d. Did you do anything to influence or change the way they felt? Why?

e. Questions derived from observation (e.g., how did you feel with X happened; it appeared that you used X strategy to regulate your emotions; was this a turning point in your relationship)

i. ________________________________________________________________

ii. ______________________________________________________________

iii. ______________________________________________________________

iv. ______________________________________________________________

v. ______________________________________________________________

vi. ______________________________________________________________

vii. ______________________________________________________________

viii. ______________________________________________________________

ix. ______________________________________________________________

x. ______________________________________________________________

xi. ______________________________________________________________

f. Next, please plot on the graph how the probability of this relationship becoming good, bad or somewhere in the middle changed according to each turning point. In considering the chances of the relationship becoming good or bad, please consider your own feelings regarding the quality of the relationship and your impression of your therapists/patients feelings regarding the quality of the relationship.

g. Did you do anything else to manage your emotions or your therapist’s/patient’s emotions?

1. Interpersonal: humour, touch or self-disclosure, body language, facial expression,

2. Intrapersonal: ignore, rethink the situation, savour, dampen, exercise, vent, share positive experience

8. How do Emotion Regulation Strategies Develop?
a. You used X strategy to influence your own emotions here on timeline and the same strategy later on timeline. Does the way you use this strategy change from when you used it earlier vrs later.

b. You used X strategy to influence your therapist’s/patient’s emotions at the end of the relationship. Would you have used it in the same way in the beginning of the relationship if this turning point happened there? Why or why not?

c. You used this emotion regulation strategy here in the relationship, would you use it the same way in a different place in the relationship?

d. Why did you use this emotion regulation strategy like this? And not with less or more intensity?

e. If you were going to give your patient/therapist a hug/ risky joke/ stern critique where in the relationship would you be likely to do it and why?

f. Would you have used this strategy this way at a different point in the relationship?
Appendix 3: Beginning Template (Therapists and patients)

PhD: Beginning Template

1. Demographics
   a. area of practice
   b. how long work with patients
   c. like job
   d. patients a day
   e. years of experience
2. doing job affects both persons emotions
3. Emotion regulation development
4. emotional events
   a. agreement
   b. breaking bad news
   c. cant fix problem
   d. complaints
   e. compromise
   f. disagreement
   g. discharge
   h. fix problem
   i. home visit
   j. insensitivity
   k. introduction
   l. lack of communication or misunderstanding
   m. not getting along
   n. patient angry outburst
   o. patient doesnt want to work
   p. patient status setback
   q. setbacks in the system or process
   r. uncovered problem
5. How you build relationship
6. Ideal emotional appearance
7. Interpersonal emotion regulation strategies
   a. accept tea
b. acknowledging issue
c. adapting communication styles
d. apologising
e. assist with cognitive reappraisal
f. communicate compassion and understanding
g. distract
h. empowering with information
i. encouraging
j. facial expression body language
k. fix the problem
l. give in
m. hide emotions fake emotions
n. humor
o. modulate expression of emotion
p. pacing
q. patience
r. positioning
s. self disclosure
t. show emotion
u. touch

8. Intrapersonal emotion regulation strategies
   a. attentional deployment
   b. cognitive change
c. desensitised
d. eat
e. exercise and leisure
f. fix the problem
g. ignore
h. plan ahead
i. situation modification
j. situation selection
k. supervision
l. suppression
m. switch off
n. take a break
o. vent
p. work life balance

9. Negative emotions experience
   a. anger
   b. anxious or tense
   c. concerned
   d. creepy
   e. disheartened
   f. disliking
   g. feel bad
   h. frustration
   i. overwhelmed
   j. sad
   k. take home bad feelings

10. Other focused emotional goals
    a. calm
    b. comfortable
    c. confident or trust
    d. dignity
    e. empowered and informed
    f. enthusiastic
    g. like
    h. not upset with therapist
    i. satisfaction with service

11. Positive emotions experienced
    a. confident
    b. feel good
    c. happy
    d. hopeful anticipation
    e. relief
    f. satisfaction

12. Qualities of bad relationship

13. Qualities of good relationship
14. Self-focused emotional goals
   a. comfortable
   b. competent
   c. happy
   d. successful in achieving goals
   e. true to self
Appendix 4: Final Template (Therapists)

**PhD: Final Template (Therapist)**

1. Emotion regulation development
   - Will show neg emotions when at end of tether
   - contradiction
   - Support for social penetration theory
   - will use if appropriate

2. Ideal emotional appearance patient
   - enthusiastic
   - little anxiety
   - relief
   - no ideal appearance

3. Ideal emotional appearance therapist
   - enthusiastic
   - hopeful
   - optimistic
   - friendly
   - relaxed

4. Negative emotions experienced
   - anger
   - annoyance
   - anxious or tense
   - apprehensive
   - concerned
   - creepy
   - disappointed
   - disheartened
   - disliking
   - embarrassment
   - exasperation
   - feel bad
   - frustration
   - insecurity
   - irritation
   - jealous
   - overwhelmed
   - panic
   - rage
   - regret
   - rejection
   - resentment
   - sad
   - sympathy
   - take home bad feelings
   - worried

5. Positive emotions experienced
   - all mentioned
   - cheerfulness
   - compassion
   - confident
   - contentment
   - enjoyment
   - enthusiasm
   - excitement
   - feel good
   - happy
   - hope
   - hopeful anticipation
   - joy
   - liking
   - love
6. Other focused emotional goals
   - at ease
   - calm
   - caring
   - cheerful
   - comfortable
   - compassionate
   - confident or trust
   - contentment
   - dignity
   - empowered and informed
   - enthusiastic
   - excitement
   - happy
   - hopeful
   - like
   - no negative but realistic
   - not upset with therapist
   - optimistic
   - relief
   - satisfaction with service
   - triumphant

7. Self-focused emotional goals
   - caring
   - cheerfulness
   - comfortable
   - compassion

8. Qualities of bad relationship
   - Poor communication
   - Lack of understanding
   - Dishonesty
   - Negative emotions
   - Lack of empathy
   - Lack of clinical knowledge
   - Lack of compassion and caring
   - Distrust
   - Not having time
   - Lack of engagement in therapy
   - Lack of patient satisfaction

9. Qualities of good relationship
   - Patient satisfied
- Patient and therapist willing to learn
- Open communication
- Honesty
- Time to listen
- Bilateral trust
- Humour
- Combination of professional and personal interactions
- Empathy

10. Constructive Turning Points
   - Progress Towards Goals
   - Interpersonal Affective Bonding with Patients
   - Positive Feedback

11. Non-constructive Turning Points
   - Set-backs in Progress Towards Goals
   - Negative Feedback
   - Interpersonal Problems with Patients

12. Proactive Interpersonal emotion regulation strategies (ERS)

13. Interpersonal ERS in response to positive emotion

14. Interpersonal ERS in response to negative emotion
   - Altering the Cognitive Meaning of a Situation (dampening)

15. Intrapersonal ERS in response to negative emotion
   - Altering the Situation
   - Altering Attention
   - Altering the Cognitive Meaning of a Situation

16. Intrapersonal ERS in response to positive emotion
   - Response-focused
   - Just experienced and expressed naturally

17. Overt intrapersonal ERS

18. Intrinsic interpersonal emotion regulation
Appendix 5: Final Template (Patients)

**PhD: Final Template (Patients)**

1. emotion regulation development
   a. Will show neg emotions when at end of tether
   b. contradiction
   c. Support for social penetration theory
   d. will use if appropriate

2. ideal emotional appearance patient
   a. anger is not OK to show
   b. anxiety
   c. comfortable
   d. negative emotions in certain circumstances
   e. no sadness
   f. sadness is OK to show
   g. there is no ideal emotional appearance

3. ideal emotional appearance therapist
   a. cheerful
   b. compassionate
   c. happy
   d. neutral
   e. no anger
   f. No negative emotions
   g. not anxious
   h. pleasant
   i. pleased
   j. professional and confident

4. Negative emotions experienced
   a. anxiety
   b. embarrassment
   c. frustration
   d. disappointment
   e. anger
   f. upset
   g. annoyed
   h. fear
   i. none

5. positive emotions experienced
   a. cheerfulness
   b. comfortable
   c. confident
   d. contentment
   e. enthusiasm
   f. fondness
   g. happiness
   h. hopeful
   i. optimism
   j. relief
   k. satisfaction
   l. surprised

6. Other-focused emotional goals
   a. caring
   b. cheerfulness
   c. comfortable
   d. compassion
   e. contentment
   f. empathetic
   g. enthusiasm
   h. happiness
   i. hopeful
j. joy  
k. no negative emotions  
l. optimistic  
m. pleased  
n. pride  
o. relaxed  
p. satisfaction  

7. self-focused emotional goals  
a. at ease  
b. cheerful  
c. comfortable  
d. enthusiasm  
e. hopeful  
f. liking  
g. optimism  
h. pleased  
i. relief  
j. satisfaction  

8. qualities of bad relationship  
a. bad hygiene  
b. negative expressions or emotions  
c. no caring  
d. no honesty  
e. no rapport  
f. no time  
g. poor communication  

9. qualities of good relationship  
a. be encouraging  
b. calm  
c. can talk to each other  
d. caring  
e. empathy  
f. friendly  
g. good communication  
h. honesty  
i. making progress  

10. Constructive turning points  
a. Progress Towards Goals  
b. Interpersonal Affective  
c. Bonding with Therapists  
d. Agreement with Therapist  
e. Change in Treatment  

11. Nonconstructive turning points  
a. Set-backs in Progress Towards Goals  
b. Change in Treatment  

12. Proactive Interpersonal ERS  

13. Interpersonal ERS in response to positive emotion  

14. Interpersonal ERS in response to negative emotions  
a. Altering the situation  

15. Interpersonal ERS in response to negative emotions  
a. Altering attention  

16. Intrapersonal ERS in response to negative emotion  
a. situation selection  
b. situation modification  
c. cognitive reappraisal  
d. attentional deployment  
e. response-focused  
f. overt intrapersonal ERS  
g. express  

17. Intrapersonal ERS in response to positive emotion  
a. Attentional deployment
b. Express naturally

c. intrinsic interpersonal
Appendix 6: Consent form

CONSENT FORM

Study Title: The Development and Validation of an Unfolding Model of Emotion Regulation in Therapeutic Relationships

The participant should complete the whole of this sheet him/herself

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<th>Please initial the appropriate box</th>
<th>YES</th>
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Who have you spoken to?

Do you understand that you will not be referred to by name in any report concerning the study?

Do you understand that you are free to withdraw from the study:

- at any time
- without having to give a reason for withdrawing
- without penalty

I agree be interviewed and for the interview to be recorded.

I agree to allow the researcher to contact me via telephone or email within 1 – 3 months after the interview to discuss themes arising from the analysis of my interview.

I agree that the words I say may be used as anonymous quotations when the study is written up or published.

I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give permission for these individuals to have access to
Do you agree to take part in this study?

**Signature of Research Participant:**
**Date:**

**Name in Capitals:**

**Name of researcher:**

**Signature of researcher:**
I am satisfied that the above named has given informed consent.

**Witnessed by:**
**Date:**

**Name in Capitals:**

The St George University Hospital Trust local collaborator for this study is Megan Blakeway.

Her contact details are as follows:

Megan Blakeway, Clinical Specialist - Hand Therapy
0208 725 1038
megan.blakeway@stgeorges.nhs.uk
Appendix 7: Participant information form for study 1:

The Development and Testing of an Unfolding Model of Emotion Regulation in Therapeutic Relationships

Research Participant Information Sheet (Patient Stage 1)

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information on the purpose and procedure of the research and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Who will conduct the research?

The research is being conducted by Ayana Horton Ifekoya, a PhD (Doctor of Philosophy) student at the University of Manchester and lecturer at Brunel University.

Title of Research

The Development and Testing of an Unfolding Model of Emotion Regulation in Therapeutic Relationships

Purpose of the Study
The purpose of the study is to develop a better understanding of how patients/clients and occupational therapists/physiotherapists manage their emotions when they work together. This research is being undertaken by Ayana Horton Ifekoya to fulfil the requirements for a PhD degree.

**Why Have I Been Asked to Participate?**

You have been asked to participate because you are receiving or have received occupational therapy services or physiotherapy service and this research requires the researcher to gather patients’ perspectives on emotion within the therapeutic relationship.

**Do I Have to Take Part?**

As participation is entirely voluntary, it is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form, of which you will receive a copy. You have the right to withdraw at any time from the project. Your decision whether or not to participate will not have any impact on your occupational therapy/physiotherapy services or any healthcare services.

You will be given this information sheet to keep. If you are unsure if you want to participate you can take some time to think about it and if you decide to participate you can contact the researcher using the contact details (for Ayana Horton Ifekoya) listed on this form.

**What Will Happen to me if I Take Part?**

You will be interviewed one time, which will entail you being asked questions regarding your relationship with your therapist. Two examples of interview questions are as follows:

- How do you want your therapist to feel when you work with him or her?
- How do you try to make him or her feel that way?

The interview will last about an hour. Although the researcher will take some notes during the interview, an audio recorder will be used to ensure all information is captured. The interview will take place at a convenient time and place for you.
after the data are collected and analysed (within 1-3 months) the researcher would like to contact you via telephone or email to discuss the accuracy of the researcher’s interpretations of what you communicated in the interview. This discussion should take no more than 10 minutes.

What Do I Have to Do?

The only thing that you have to do if you decided to participate is answer the questions posed by the researcher.

What are the Possible Disadvantages and Risks of Taking Part?

Because the topic of the interview deals with emotions and your relationship with your therapist, you may feel a little exposed or embarrassed after talking about your feelings. If you feel this way, please let the researcher know so your feelings can be addressed appropriately.

What are the Possible Benefits of Taking Part?
The Development and Testing of an Unfolding Model of Emotion Regulation in Therapeutic Relationships

Research Participant Information Sheet (Therapist Stage 2)

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information on the purpose and procedure of the research and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Who will conduct the research?

The research is being conducted by Ayana Horton Ifekoya, a PhD (Doctor of Philosophy) student at the University of Manchester and lecturer at Brunel University.

Title of Research

The Development and Testing of an Unfolding Model of Emotion Regulation in Therapeutic Relationships

Purpose of the Study
The purpose of this study is to develop a better understanding of how patients/clients and occupational therapists/physiotherapists manage their emotions when they work together. This research is being undertaken by Ayana Horton Ifekoya to fulfil the requirements for a PhD degree.

Why Have I Been Asked to Participate?

You have been asked to participate because you are an occupational therapist, or a physiotherapist and this research requires the researcher to gather therapists’ perspectives on emotion within the therapeutic relationship.

Do I Have to Take Part?

As participation is entirely voluntary, it is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form, of which you will receive a copy. You have the right to withdraw at any time from the project. Your decision whether or not to participate will not have any impact on your job status.

You will be given this information sheet to keep. If you are unsure if you want to participate you can take some time to think about it and if you decide to participate you can contact the researcher using the contact details (for Ayana Horton Ifekoya) listed on this form.

What Will Happen to me if I Take Part?

You will be observed during your therapy session on 2 to 5 occasions. You will not have to do anything. The researcher wants to observe the way you and your patient build the therapeutic relationship. Although the researcher will take some notes, an audio recorder will be used to ensure all information is captured. The observation will only take place in the clinic. After the data are collected and analysed (within 1-3 months) the researcher would like to contact you via telephone or email to discuss the accuracy of the researcher’s observations. This discussion should take no more than 10 minutes.

What Do I Have to Do?
The only thing that you have to do is participate in the therapy session as normal.

**What are the Possible Disadvantages and Risks of Taking Part?**

Because you are being observed, you may feel a little exposed or embarrassed. If you feel this way, please let the researcher know so your feelings can be addressed appropriately.

**What are the Possible Benefits of Taking Part?**

The information gained from this research can help therapists better understand how to build and maintain therapeutic relationships with patients. The benefit of taking part in this research is the satisfaction that comes from playing a role in enabling this research.

**What if Something Goes Wrong?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher, who will do her best to answer your questions. If the researcher is unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on the following telephone numbers or email address:

- 0161 275 7583
- 0161 275 8093
- research-governance@manchester.ac.uk

**Will My Taking Part in This Study be Kept Confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the hospital premises will be kept in a locked briefcase and stored in a locked cabinet in the researcher’s office. If you disclose information that indicates an intention to harm yourself or others or malpractice the researcher is required to alert the appropriate authorities.
What Will Happen to the Results of the Research Study?

The information gained from this research will be written up in a report and disseminated via publications and professional conference presentations within the next 3 or 4 years. You can obtain a copy of any publication of this research by contacting the researcher, Ayana Horton Ifekoya. Her contact details are listed below.

Who is Organising and Funding the Research?

This is a self-funded study that is being organised by the researcher, Ayana Horton Ifekoya, and supported by the University of Manchester.

What are the Indemnity Arrangements?

Indemnity insurance is provided by the University of Manchester.

Who Has Reviewed the Study?

This research has gained ethical approval from the NHS, Brunel University and the University of Manchester.

Who Can I Contact for Further Information?

Thank you for taking the time to read this information. If you have further questions please contact the researcher, Ayana Horton Ifekoya. Her contact details are as follows:

Post: Mary Seacole Building

Brunel University

Uxbridge UB8 3PH

Email: ayana.ifekoya@brunel.ac.uk

Tel: 0189526878
Appendix 9: Theme-map

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-timeline-
Appendix 10: Excerpts from Reflexive Journal

December 28, 2012

I’m in the midst of analysing the data for the pilot study. I’m really glad I did this because there are loads of changes that I’m making because of what I found. The main findings and changes are as follows:

- Emotion regulation strategies do not change according to a timeline anchored on the stages of the therapeutic relationship. I found that people were using the same strategies throughout. However, due to my most recent reading I’m seeing that although the emotion regulation strategies may not change, the content of the strategies used may change and I found the social penetration theory that is basically explaining relationship content goes from shallow and impersonal to deep and intimate. So, I think maybe the use of emotion regulation strategies follow that pattern.
- Griffin’s model is not doing anything in terms of coming out of the data. But I still think E tasks are important to my research.
- This is really asking how do therapists build therapeutic relationships and I think that I can answer that questions by saying what ER strategies are used, how emotion regulation strategies develop and what are the emotion stirring events that give a need for emotion regulation. This answers the question because emotion is an integral part of relationships. It defines relationships. And emotion regulation is a tool that steers relationships.

Some of the findings that I jotted down as I went along as follows:

- The question when I ask them to tell a story gives insight on how the relationship changes or what factors changed in the relationship. It is good and it also helps to get specific rather than general information from them.
- This process has enabled me to see if some of my prompts were leading and that is good to help me make on the spot questions that are not leading in the future.
I should be asking, “this relationship, how do you think the way you managed your emotions (or how does your used of specific ER strategies change) and you patients emotions changed as you worked with the patient”

After talking about extrinsic emotion regulation I should talk about intrinsic emotion regulation only because that is being left in the shadows.

I need to define proactivity, adaptivity and proficiency for emotional tasks. Maybe the definition of these for emotional tasks is not appropriate. Because with technical tasks you either do it or not and you can see that. With emotional tasks you can avoid doing it and still the task gets done. Maybe there is not proactivity or adaptivity for emotional tasks. Maybe its just either you do not give of yourself and just do the technical stuff or you give of yourself and go the extra mile. Maybe some of the patients’ emotions that come up is expected and so your response to these would be proficiency. Such as the automatic smile that you give when interviewing a patient. Then all the emotions that come up from the patient that are unexpected you have to adapt to. You have to notice it and respond and that can be adaptivity. But then the difference between adaptivity and proactivity is a question of intensity or proactivity can be the things that therapists do to prevent certain emotions in patients or to encourage certain emotions in patients. OK, I like it.

- So with extrinsic ER proficiency is not in response to a patients emotion but the automatic things that you do because you are supposed to like smiling when doing an interview.
- Adapvity is in the response to patients emotions
- Proactivity is to promote an emotion in patients
  - So questions I need to ask in interview are:
    - What automatic things do you do to make your patients feel a certain way when working with them (proficiency)
    - When a patient has this emotion what do you do (adaptivity)
    - How do you try to make your patient feel this way (proactivity)

Im noticing that therapists have to keep their emotional display within certain boundaries and they strive to keep their patients emotions within certain boundaries (judged by the patients emotional display). They want patients to like them but not too affectionate. They want patients to be realistic(sense of acceptance) but not pessimistic (sad). I think therapists intrinsic ER wouldn’t have as strict boundaries on
the positive end of the spectrum but maybe even more strict boundaries for the negative end of the spectrum.

- The ‘emotions’ that the therapists are talking about are not emotions they may be affect or feelings. So should I explore how these things develop or only the emotions? – David said I should talk about emotions but used the interviewees language.

- If the emotion task is affective I think emotion regulation develops according to the situation and the relationship built. If the emotion regulation task is relational I think ER develops according to the situation and the level on getting to know each other.

- I don’t think the question on ideal therapist and ideal patient is useful and for that reason I didn’t code it.

- In emotional tasks node I separated it into affective and relational and other. The problem with this is there is overlap between affective and relational. For example if you make someone feel good it has an effect on your relationship.

- From looking at the data, I don’t think that intrinsic emotion regulation changes as the relationship develops except maybe you have better understanding so your assessment of emotional triggers may be more accurate but why would the methods change? I do think that extrinsic emotion regulation changes but not according to time, but according to context. What’s in the context – patient status, relationship status, current mood, environment, ect.

- I needed new nodes like ‘ER not stage specific’

- What are the factors that determine the strategies you use to manage your patients emotions? That is a question I should be asking.

- One of the problems that I am seeing is I don’t see much scope in the data to run queries. For example, I could run a query to see if people use certain emotion regulation strategies during good therapeutic relationships versus bad therapeutic relationships but to find this I would have needed to ask people to tell me about a good and a bad therapeutic relationship. Similarly, I might want to do a query to find out if emotional goal would affect the emotion regulation strategy used. But I think that all the emotional goals for everyone are pretty much the same even if they don’t say it.

- I think this is really asking how do therapists build therapeutic relationships and I know that is something that has not been found out yet.
• Its interesting that they described a good and bad therapeutic relationship in terms of how it made them feel.
• I need to read stuff that try to take note of all the factors that go into relationship development and then I need to see where emotions and feelings fall into that and how they study these things. If I understand emotion development within relationships I can understand emotional regulation within relationships.
• If this book is saying (Parkinson et al 2005) that the emotional dynamics of a relationship are established grossly at the beginning and only tweaked towards the end I could test that.
• Difficulty in pulling out adaptivity, proactivity and proficiency
• Some nodes have not been used and others have too many categories within them. Do I need a simplified template and do the analysis again?
• OT is such a homogeneous group I don’t see how demographics will play a role.
• When a person is faking it, I'm having difficulty deciding whether they are talking about extrinsic or intrinsic because there is a little of each in that. So what node do I put it in?

I used this information and the discussion that I had with David and Karen to change the interview schedule and research questions. I change the interview questions so much that I just renamed them as 2013 Interview Schedule. The research questions also have associated objectives now. They are as follows:

• How does emotion regulation develop within therapeutic relationships?
  o Which intrinsic and extrinsic strategies are used?
  o Do these strategies develop according to social penetration theory?
• How do therapeutic relationships develop from the therapist’s and patient’s point of view?
  o What emotional events change the status of the relationship and characterise good and bad therapeutic relationships
  o How do therapists and patients understand the therapeutic relationship in terms of emotion?
• What are the emotional tasks associated with OT work?
  o What are therapists and patients emotional goals for self and dyadic partners?
  o How do emotional tasks fit into current job performance models?
August 5, 2014

I understand now how important it is to be clear on why I have made certain decisions regarding my interview schedule. Below I have put my interview schedule and some notes as to why I put certain things in certain places. I do think the schedule is ready to go. Before I wasn’t sure what I was going to get from the questions I asked. Now I think I know exactly the type of information I’m going to get. I will also be using a list of emotions so I can ensure the participants are only talking about emotion and an example of the graph with the turning points so the participants have a better idea of what I’m trying to do. I think these two additions will help keep the participants on the right track. Previously they were using words that were not always emotions and I was looking for ways to translate what they said into emotions.

The ‘theme-map’ has been improved upon by the RIT and turning points. I understand now that I need to ask every question on the list and not skip or go out of order. I understand now that the demographics are important because I need to report that in any papers I write based on this. It’s important anyway to let the reader fully understand the research.

In my funnelling down questions I took out any question that asked how the manage emotions that was not attached to the story of a relationship. I found that the answer is always ‘it depends’ when you ask such a question outside of the confines of a particular instance in a particular relationship. I ask for top 5 emotions to try to get participants to aim high. In section 3 I have questions meant to jog participants memory of the patient/therapist and the relationship. This section was influenced by cognitive interviewing. I will make sure to ask about a good and a bad relationship because that was something that I wish I did when I started analysing the data in the pilot study.

I’m referring to turning points rather than emotional events because I think it is easier to understand. There is a large amount of literature that points out that relationships develop along turning points. I used the same explanation of turning points in my schedule as they used in (Pitts & Miller-Day, 2007) Upward turning points and positive rapport-development across time in researcher-participant relationships). In section 4 that is influenced by RIT and
at each turning point I am getting the what emotion was generated, the strength of the emotion, which interpersonal and intrapersonal emotion regulation strategy was used in response (in the pilot one of the problems was that I wasn’t getting enough intrapersonal emotion regulation strategy info), the resulting outcome related to how the emotion was managed and quality of the relationship and the emotional event is the turning point. All of this is within a particular instance within a particular relationship. This makes it so the person can be specific instead of saying ‘it depends’.

In section 5 I added that because I really wanted to get at the heart of how ERS develop. From the pilot study I have an inkling as to how this happens. I think these questions are good because they do not lead the participant but they do squarely ask how ERS change and why did you used this ERS this way at this time and would you use it the same way at a different point in the relationship. Also, in section 5 I will attempt to use the information learned in section 2 and section 4 to ask questions that are specific to the interviewees emotion regulation goals and the relationship being discussed. Section 6 is the contextual stuff that Gail suggested. I really do think that this interview schedule will get all the information needed to answer the research questions. I’m so excited! Also, my plan is to basically to make the patient interview the same as the therapist interview with small changes as needed. Below is the just about final interview schedule.

November 14, 2016

So Im just about done with transcribing the 1st 4 dyadic discharge interviews. My plan for data collection is as follows:

- Pull off the turning points and the emotion regulation strategies from the theme-map
- Code the transcripts
- Listen to the audio of the interactions for examples of the use of emotion regulation strategies in particular if they said they used strategy x more than once I need to find the example of how they used it, audio code it and then see if I can see any changes in the level of risk in the way the strategy was used.
- Lastly, I think I need to find some way of analysing the interaction but Im not clear on how to do this.
My initial impression is that I won’t see very much development of the emotion regulation strategies because the relationships were not out of the ordinary. There wasn’t much emotion to be regulated because the positive and negative emotion that was present was not at extremes. What does this tell me:

- The use of emotion regulation strategies develop in the way that they are used over the course of relationships typically from risk adverse to intrepid use of strategies.
- No or minimal development of strategies are found in relationships that are average. This may be because there are not many emotions that require regulation. Maybe since these are standard encounters the people know how to regulate the emotion so no development is needed. (the development is a symptom of trying to find what works and if you already know what works you use it and no development is needed.)
- Emotion regulation strategy use develops because people are trying to use what works. That is why you don’t see emotion regulation development in intrapersonal emotion regulation over the course of short or medium term relationships.
- So emotion regulation strategy use don’t necessarily develop during the course of a relationship unless there is a reason to and the reason to develop is to improve the effectiveness of the strategy.

The question is does my research show this. It shows some development in strategy use in both stages, Im expecting. Does it need to show why the development happens or is it enough for me to theorise. For me to be able to say this is why this strategy developed like it did, I need to find how the strategy developed and then ask the people why they used it this way in this instance and another way in another instance. This is something I can talk to D&G about.

April 6, 2017

I am going over all of the data again and recoding it because I need to do that for stage 2 but I want stage 1 to be fresh in my mind when I do stage 2. I am noticing that as I look at the data I have a tendency to discount in my mind contradictions to social penetration theory when I asked the participants directly about the development of an emotion regulation strategy. As a result, I am being very careful to code any contradiction without reasoning about whether or not it is valid.
Appendix 11: Visual Aid – 135 Positive and Negative Emotions
Appendix 12: Visual Aid – Graph of Turning Points in Romantic Relationship

FIG. 1 An example of a graph of changes in the probability of marriage.