
Relationship Between Intuition and Emotional Intelligence in Occupational Therapists in Mental Health Practice

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KEY WORDS

- decision making
- emotional intelligence
- intuition
- mental health services
- occupational therapy

OBJECTIVE. Clinical reasoning studies have acknowledged tacit aspects of practice, and recent research suggests that clinical reasoning contains intuition informed by tacit knowledge. Intuition also appears to be influenced by awareness and understanding of emotions. This study investigated the relationship between intuition and emotional intelligence among occupational therapists in mental health practice.

METHOD. We mailed a survey containing measures of cognitive style and of use of emotional competencies at work and demographic questions to 400 members of the national occupational therapy association; 134 occupational therapists responded.

RESULTS. A moderate relationship was found between intuitive cognitive style and emotional intelligence. Experienced therapists scored higher on the use of emotional competencies at work and reported a preference for an intuitive cognitive style to a greater extent than novices.

CONCLUSION. This study represents the first attempt to explore occupational therapists' preferred cognitive style and self-reported emotional intelligence. Findings suggest that exploring emotions through reflective practice could enhance intuitive aspects of clinical reasoning.

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Since Mattingly and Fleming's (1994) inaugural exploration of clinical reasoning, occupational therapy researchers and practitioners have been interested in the cognitive processes of practice. Clinical reasoning studies have identified the use of tacit knowledge as a contributor to practice (Fleming, 1994; Gibson et al., 2000; Hagedorn, 1996; Schell & Schell, 2008; Unsworth, 2001). In a recent grounded theory study of intuition among occupational therapists practicing in mental health, *intuition* was defined as knowledge that was immediate and accessed without a conscious awareness of reasoning (Chaffey, Unsworth, & Fossey, 2010). The study found that intuition was embedded in therapists' clinical reasoning and was informed by tacit knowledge. Moreover, the findings indicated that intuition had an affective component. Emotions were implicated in the use of intuition in the following ways: Therapists needed to be aware of and understand their emotions to access intuition, to trust their emotions to act on them, and to use their emotions in problem solving and decision making; therapists with more years of experience reported feeling more comfortable using intuition in clinical reasoning than those with less experience.

In Chaffey and colleagues' (2010) study, the use of emotions in intuition and clinical reasoning that therapists described resembles the construct of emotional intelligence (EI). *Emotional intelligence* is awareness and understanding of one's own emotions (Howe, 2008), including the propensity to allow emotions to drive cognition and action (Palmer & Stough, 2001). This

article reports the results of a subsequent study designed to investigate the relationship between intuition and emotional intelligence among occupational therapists in mental health practice.

Emotional Intelligence

A variety of theoretical frameworks have been used to describe EI. Although no agreement exists as to whether EI is an ability, noncognitive skill, capability, or competence, researchers concur that this construct involves awareness of one's own and others' feelings and emotional management (Akerjordet & Severinsson, 2007; Carblis, 2008; Zeidner, Roberts, & Matthews, 2008). Mayer, DiPaolo, and Salovey (1990) first presented the construct of EI; their four-branch model (Mayer, Salovey, & Caruso, 2000) conceptualized EI as comprising two areas of competence (Palmer & Stough, 2001)—accurate reasoning about emotions and use of emotions to enhance thinking (Mayer, Roberts, & Barsade, 2008)—and four separate abilities within these two competencies: (1) the ability to recognize and express emotions in oneself and others, (2) the ability to integrate emotion into thought, (3) the ability to understand and analyze emotions in oneself and others, and (4) the ability to regulate and manage emotions in oneself and others (Mayer et al., 2008). This model allows for the possibility of improvement in EI as abilities and skills improve.

Other models of the construct of EI share many characteristics of Mayer et al.'s (1990) four-branch model but differ in their inclusion of personality traits. Models by Bar-On (1996), Cooper and Sawaf (1997), and Goleman (1996) are referred to as *mixed models* because they propose that EI comprises emotion-related personality traits (such as optimism) in addition to the abilities described in Mayer et al.'s model (Palmer & Stough, 2001), a view Mayer and colleagues (2000) rejected.

The EI and emotional competencies of health care professionals have received relatively little attention compared with those of professionals in business and management. Nevertheless, some attention has been given to EI in social work; Howe (2008) highlighted the importance of EI in suggesting that clinicians need to have knowledge of their own emotions and those of others to effectively empathize and communicate with their clients and regulate their own and others' affective states. This observation suggests that EI may be an element of what is described in the occupational therapy literature as therapeutic use of self.

Therapeutic use of self is a "practitioner's planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar &

Peloquin, 2000, p. 285). Taylor (2008) described the therapeutic use of self as a highly personal and subjective decision-making process that may be driven by intuition but is also grounded in rational and interpersonal guidelines. Taylor, Lee, Kielhofner, and Ketkar (2009) surveyed occupational therapists' attitudes toward and experiences of therapeutic use of self to examine its perceived importance in clinical reasoning. Of 568 respondents, 87% viewed therapeutic use of self as the most important aspect of their practice, and 80% reported that clinical reasoning should always include use of self. In terms of clinical reasoning, then, therapeutic use of self appears important in understanding oneself, including one's emotions, and may involve the use of intuition.

Relationship Between EI and Intuition

The relationship between EI and intuition has been investigated predominantly in business management. Downey, Papageorgiou, and Stough (2006) examined the relationship between EI, intuition, and leadership style in 176 Australian female senior managers from several industries, including health care, using the Swinburne University Emotional Intelligence Test (SUEIT; Palmer & Stough, 2001) to measure EI. Downey and colleagues found that the SUEIT subscales of Emotional Recognition and Expression and Emotions Direct Cognition significantly correlated with a preference for an intuitive cognitive style, indicating that senior managers who were able to recognize their emotions and use them in decision making were also likely to have an intuitive thinking style.

The relationship between EI and intuition has also been described and explored in a handful of studies in the health sciences. Akerjordet and Severinsson (2004) used a hermeneutic approach to explore seven Norwegian mental health nurses' experience of EI and intuition in their practice. All participants spoke of using intuition as a clinical tool to build relationships with clients and as a contributing factor in decision making. The authors concluded that intuition provided participants with emotional information about their practice, and EI was important in enabling them to interpret and communicate this information. Additionally, EI was implicated in interpersonal skills such as therapeutic use of self and critical reflection.

Smith, Thurkettle, and dela Cruz (2004) considered emotions, in the form of client relationships and connection, to be an integral part of nurses' intuition. The authors conceptualized *intuition* as a "non-linear process

of knowing, perceived through emotional and physical awareness or through the making of connections at the physical and/or spiritual level” (p. 615). They asserted that intuitive knowledge emerged from emotional feelings such as feelings of unease or excitement.

The impact of emotional states on decision-making strategies has been explored in the psychology literature, with a positive mood found to be associated with intuitive decision making (Bolte, Goschke, & Kuhl, 2003). Additionally, they found that people value the outcome of a decision more highly if their mood state matches the decision-making strategy. That is, people who make an intuitive decision while in a positive mood are more likely to value the outcome more highly than if they made an intuitive decision while in a negative mood (de Vries, Holland, & Witteman, 2008).

A core feature of intuition is that the process and source of information elude the person who is experiencing it, making it impossible to use self-reported measures about intuitive processes (Glockner, 2010). However, self-reported measures of the behaviors associated with the use of intuition, such as its influence on decision making, may be useful. Nursing researchers have sought to quantify intuition in this manner by developing a number of self-report tools including measures of nurses’ self-perception of intuition (Miller, 1993; Smith, 2006; Smith et al., 2004) and an instrument that aims to measure nurses’ intuitive and analytical decision making (Lauri et al., 2001). Although all of these tools were found to be valid and reliable, they also all strongly reflect nursing roles and tasks and are not easily transferable to other health professions. The Cognitive Style Index (CSI; Allinson & Hayes, 1996), used in Downey et al.’s (2006) study and in many studies of cognitive styles of managers and teams (e.g., Allinson & Hayes, 2000; Armstrong & Priola, 2001; Corbett, 2007), may be more useful with other professional groups.

Expertise and Intuition

Although limited research has addressed the relationship between intuition and EI in occupational therapy, a small body of work has examined intuition and expertise. Dreyfus and Dreyfus (1996) asserted that experts use intuition more than novices, with experts appearing to have an intuitive understanding of a situation and the appropriate actions they should take. Explorations of expert occupational therapists’ clinical reasoning also indicated that they practice intuitively (Gibson et al., 2000; Unsworth, 2001).

Purpose

The aim of this study was to explore the preference of occupational therapists practicing in mental health for the use of intuition, as measured by the CSI, and EI, as measured by the SUEIT. Specifically, this study aimed to document levels of preference for intuition and levels of EI, compare preference for intuition and EI by gender and level of experience, and explore the relationship between intuition and EI.

Method

Research Design

A survey design was chosen to collect structured, self-reported data from a large sample of occupational therapists (Forsyth & Kviz, 2006). The Faculty of Human Ethics Committee, La Trobe University, approved the study in advance.

Sample

Participants were occupational therapists practicing in mental health who were registered with the national professional association in Australia and had previously agreed to participate in research activities through this association.

Instrument

The authors developed a self-administered questionnaire packet using Dillman’s (2000) tailored design method. The packet included demographic questions, a measure of intuition, the CSI, and the SUEIT. The developers of the CSI and the SUEIT granted permission to use their measures. The demographic questions concerned gender, years in occupational therapy practice, and area of mental health practice.

The CSI, designed specifically for professionals, was used to measure respondents’ preference for an intuitive versus an analytical cognitive style. The developers defined *intuitive style* as use of immediate judgments based on feelings and a global understanding of a situation and *analytical style* as use of judgments based on reasoning and a focus on detail.

The CSI consists of 38 trichotomously scored items, of which 21 indicate an analytical orientation (e.g., “I avoid taking a course of action if the odds are against its success”) and 17 an intuitive orientation (e.g., “I work best with people who are spontaneous”). Possible responses are *true* (score of 2), *uncertain* (score of 1), and *false* (score of 0); these scores were collated to provide an overall score between 0 and 76. Higher scores indicate an

analytical orientation, and lower scores indicate an intuitive orientation. Psychometric analysis indicated that internal consistency of the CSI is high. Cronbach's α ranged from .84 to .92 across the seven samples used in tool development (Allinson & Hayes, 1996), with similar findings found in further studies (Murphy, Kelleher, & Doucette, 1998; Sadler-Smith, Spicer, & Tsang, 2000). Construct validity ranged from $-.06$ to $-.81$ ($p < .001$) compared with five other instruments of cognitive style, which the developers considered good initial evidence of construct validity. Allinson and Hayes (1996) also found a test-retest coefficient of .90 ($p < .001$) for a sample of managers reassessed after a 4-week interval.

The SUEIT was used to assess respondents' EI. Given the differences in views about the construct of EI, there is little consensus regarding appropriate measurement. Palmer and Stough (2001) addressed this issue by identifying the most definitive dimensions of EI based on a factor analytic study with a sample of 310 people representative of the Australian general public involving six prominent measures of EI from the different theoretical models. The resultant tool, SUEIT, contains 64 items (e.g., "I can pick up on the 'emotional tone' of staff meetings"), with responses indicating the extent to which each statement is true of a respondent's typical reaction in the workplace on a 5-point Likert scale (1 = *never* to 5 = *always*). This tool assesses five areas of emotional competency:

1. *Emotional Recognition and Expression* refers to the ability to identify and express one's own emotions.
2. *Understanding Emotions, External*, refers to the ability to perceive and understand the emotions of others.
3. *Emotions Direct Cognition* refers to the extent to which one incorporates emotions into one's decision making and problem solving.
4. *Emotional Management* refers to the ability to repair negative moods and maintain positive moods in both oneself and others.
5. *Emotional Control* refers to the ability to control strong emotional states such as anger and frustration.

SUEIT results are presented individually for the five subscales and together as an overall score. The SUEIT is psychometrically sound (Palmer & Stough, 2001); the reliability coefficients (α) for overall EI and each of the subscales range from .63 to .88. Correlations between each subscale vary, ranging from .16 (Emotions Direct Cognition and Emotional Control) to .57 (Emotional Management and Emotional Control). According to the developers, the differing sizes of correlations indicate that the subscales are distinct yet related facets of EI. The test-

retest reliability for the overall and subscale scores ranged from .83 to .95 for a 1-month period.

Procedure

We piloted the questionnaire with two occupational therapists, and no changes were required. The national association distributed the survey packet to 400 members from their database of 700 members who practiced in mental health. Respondents were asked to return the completed surveys within 3 weeks, and those who did so received book vouchers to thank them for their time.

Data Analysis

SPSS Version 17.0 software package for Windows (SPSS, Inc., Chicago) was used to analyze the data. After initial exploratory data analysis, we transformed years of occupational therapy practice to levels of experience guided by the literature on experience and expertise (Dreyfus & Dreyfus, 1996; Unsworth, 2001): 0–5 yr = novice clinician, 5–10 yr = intermediate clinician, and >10 yr = experienced clinician.

Two analyses were undertaken to examine for differences between SUEIT and CSI scores by gender and level of experience. Mann-Whitney U tests (z ; Portney & Watkins, 2008) were used to compare CSI and SUEIT scores between genders. Kruskal-Wallis tests (H ; Portney & Watkins, 2008) were applied to compare SUEIT and CSI scores by level of experience. Post hoc Mann-Whitney U tests were used to determine statistically significant differences in level of experience; the level of experience with the lowest mean rank was individually compared with the other two levels.

Two-tailed Spearman rank correlation coefficients were used to determine the association between overall SUEIT score and CSI score and between individual subscale scores of the SUEIT and CSI. Portney and Watkins's (2008, p. 525) guidelines for measuring the strength of correlation were used in this study: little or no relationship = .00–.25, fair relationship = .25–.50, moderate to good relationship = .50–.75, and good to excellent relationship = >.75.

Results

One hundred and thirty-eight questionnaires were returned, of which 3 were returned unopened and 1 was incomplete. Therefore, 134 of the mailed 400 questionnaires were included in the analyses, representing a 33.5% response rate. This is considered a realistic return rate for a postal survey (Portney & Watkins, 2008).

Thirty-five percent of respondents practiced in adult community mental health, 16% in private practice, 12% in child and adolescent mental health, 11% in adult inpatient services, 6% in mental health services for older adults, and 4% in nongovernmental support services. Seven additional areas of mental health practice were represented by up to three respondents each. The mean number of years respondents had practiced as an occupational therapist was 14.89 yr ($SD = 10.42$), with a range between 3 wk and 43 yr; years of practice was transformed into levels of experience (see Table 1), and all subsequent analyses were undertaken with levels of experience rather than years of practice. Mean scores on the CSI and SUEIT by gender are provided in Table 1.

Table 2 presents the mean scores on the CSI and SUEIT from the study and normative samples. The CSI mean was close to the theoretical mean of 38.00, indicating an absence of response bias. There was a positive skew in the distribution of all SUEIT scores, with the exception of the Emotional Control subscale, which had a negative skew.

No statistically significant difference was found between the scores of male and female respondents, $z = -0.13$, $p = .898$, indicating that preferred cognitive style as measured on the CSI is not dependent on gender. However, few men were among the study sample, which may have influenced this result. The difference between male and female respondents in mean ranking of the total SUEIT score approached significance, $z = -1.83$, $p = .068$, indicating a possible difference in EI between genders; again, this result may have been influenced by the small number of men in our sample. Subsequent data analysis assumed a homogenous sample with no difference by gender.

Mean ranks of CSI scores differed significantly by level of experience, $H(2) = 12.12$, $p = .002$. Post hoc analysis indicated the following differences: novice and intermediate, $z = -1.5$, $p = .135$; novice and experi-

enced, $z = -2.59$, $p = .01$; and intermediate and experienced, $z = -1.36$, $p = .175$. The only significant difference in CSI scores was between novice and experienced therapists. Similarly, mean ranks of SUEIT scores by level of experience showed significant differences, $H(2) = 7.50$, $p = .023$. Post hoc analysis indicated the following differences: novice and intermediate, $z = -1.84$, $p = .066$; novice and experienced, $z = -2.6$, $p = .008$; and intermediate and experienced, $z = -0.13$, $p = .90$. The only significant difference was between novice and experienced therapists.

Lower CSI scores were associated with higher overall SUEIT scores, $r = -.56$, $p = .000$, indicating that higher EI is associated with an intuitive cognitive style. Table 3 presents the correlations of CSI scores and SUEIT subscale scores for respondents. The weakest association between CSI and the SUEIT subscales was for Emotional Control, $r = -.24$, $p = .005$, and the strongest was for Emotions Direct Cognition, $r = -.56$, $p = .000$.

Discussion

With the exception of the subscale Emotions Direct Cognition, SUEIT scores in our sample were higher than the developers' normative data (Palmer & Stough, 2001). This finding suggests that occupational therapists may exhibit higher levels of emotional competency and management in the workplace than workers in general. The mean score on the CSI was close to the theoretical mean, indicating a lack of bias in responses.

Comparisons of Intuition and EI by Gender and Experience

Our study found no statistically significant difference in CSI scores between male and female respondents, a finding that should be interpreted with caution because of the small number of male respondents. Research by the tool developers has produced inconsistent results for gender

Table 1. CSI and SUEIT Scores, by Gender and Level of Experience ($N = 134$)

Variable	<i>n</i>	%	CSI Scores			SUEIT Scores		
			Mean	<i>SD</i>	Median	Mean	<i>SD</i>	Median
Gender								
Male	6	4.5	37.33	12.16	37.00	213.00	18.01	211.50
Female	124	92.5	37.16	15.03	37.50	229.65	30.93	228.50
Missing	4	3.0						
Level of experience								
Novice	26	19.4	45.71	12.63	43.50	219.85	16.01	217.50
Intermediate	24	17.9	38.79	15.48	41.00	231.51	22.73	229.50
Experienced	83	61.9	34.07	14.34	32.00	231.98	21.51	230.00

Note. CSI = Cognitive Style Index; *SD* = standard deviation; SUEIT = Swinburne University Emotional Intelligence Test.

Table 2. CSI and SUEIT Scores, Including Subscales (N = 134)

Scale	Current Study		Normative Sample ^a	
	Mean	SD	Mean	SD
CSI	37.14	14.81		
SUEIT overall score	229.51	21.11	221.75	17.25
SUEIT subscales				
Emotional Recognition and Expression	39.65	5.26	38.51	4.90
Understanding Emotions, External	78.46	8.24	76.17	6.64
Emotions Direct Cognition	38.03	6.19	39.05	5.00
Emotional Management	41.41	5.31	41.35	4.72
Emotional Control	31.97	4.40	31.66	3.94

Note. CSI = Cognitive Style Index; SD = standard deviation; SUEIT = Swinburne University Emotional Intelligence Test.

^aPalmer & Stough, 2001.

differences (Allinson & Hayes, 2000; Hayes & Allinson, 2004).

The significant difference in CSI scores by level of experience supports the view that experience is associated with the use of intuition (Dreyfus & Dreyfus, 1996). Allinson and Hayes (2000) suggested that experience may support the development of intuition. In their study, managers had lower CSI scores than business students, which they attributed to the fact that the managers had gained tacit knowledge from their experience, leading to a more intuitive style than less experienced students.

In our study, however, the only statistically significant difference in CSI was between novice and experienced therapists; the CSI scores of therapists at the intermediate experience level did not differ significantly from those of therapists at either of the other experience levels. Rassafiani (2009) investigated the relationship between occupational therapists' length of experience and level of expertise by reanalyzing their treatment recommendations for hypothetical clients with cerebral palsy from two previous

studies. He found no significant association between years of experience and expertise and concluded that the development of expertise is multifaceted and includes reflection, observation of expert practice, and opportunities for feedback. Thus, in our study participants at an intermediate level of experience may have been exposed to other factors influencing intuition, resulting in differing levels of expertise within the group.

SUEIT scores also differed significantly between novice and experienced respondents. According to Mayer et al.'s (2000) four-branch model, EI can improve over time as emotional skills develop. Staff retention may also explain this finding, however. Akerjordet and Severinsson (2007) suggested that higher EI provides nurses with better ability to cope with stress, leading to a more productive working life. Occupational therapists with higher EI may cope better with workplace stress than those with lower EI, stay in practice longer, and gain more experience.

Relationship Between Intuition and EI

The significant moderate negative correlation we found between reported CSI and SUEIT scores indicates that a preference for the intuitive cognitive style was associated with higher levels of self-reported emotional competence in the workplace. This finding confirms those of the previously reported grounded theory study (Chaffey et al., 2010). The following paragraphs discuss the relationship of each SUEIT subscale to the CSI to illustrate how EI influences the use of intuition.

A core element of Mayer et al.'s (2000) model of EI is the ability to recognize emotions in oneself and others. Although the relationships between the CSI scores and SUEIT scores indicating an understanding of one's own emotions (Emotional Recognition and Expression, $r = -.33$) and those of others (Understanding Emotions, External, $r = -.29$) were significant, the probability

Table 3. Correlation Coefficients for CSI Scores, Overall SUEIT Score, and SUEIT Subscale Scores (N = 134)

	CSI Total Score	Overall SUEIT Score	Emotional Recognition and Expression	Understanding Emotions, External	Emotions Direct Cognition	Emotional Management	Emotional Control
CSI total score							
Overall SUEIT score	-.56*						
SUEIT subscales							
Emotional Recognition and Expression	-.33*	.70*					
Understanding Emotions, External	-.29*	.80*	.49*				
Emotions Direct Cognition	-.56*	.60*	.34*	.39*			
Emotional Management	-.49*	.75*	.37*	.44*	.30*		
Emotional Control	-.24*	.51*	.29*	.27*	.001	.62*	

Note. CSI = Cognitive Style Index; SUEIT = Swinburne University Emotional Intelligence Test.

* $p < .01$.

levels were only fair. This fair relationship suggests that Smith and colleagues' (2004) assertion that emotional awareness is one of the core aspects of intuition may not provide a complete picture of the role of EI in intuition, at least for occupational therapists in mental health practice.

Recognizing emotions appears to be the first step in the use of intuition, with the next step being interpretation of these feelings, which Mayer and colleagues (2000) referred to as the ability to *integrate emotion in thought*. This ability is represented in the SUEIT subscale Emotions Direct Cognition. This subscale had a moderate negative correlation with the CSI ($r = -.56$), with high scores on this subscale linked to an intuitive thinking style. This finding is not surprising, given the nature of the measures used. Emotions Direct Cognition assesses a person's ability to use emotions in reasoning, and a high score indicates an intuitive, emotion-based decision-making style. The CSI assesses a person's propensity to use either an intuitive or an analytical cognitive style; a low score indicates an intuitive thinker. Downey and colleagues (2006) also found a correlation between this SUEIT subscale and the CSI in their study of senior managers. Our finding supports Akerjordet and Severinsson's (2004) assertion that EI is important in interpreting and acting on intuitive feelings. These authors found that their participants experienced intuitive feelings but also needed an awareness of emotions to interpret and act on these feelings. Moreover, this result supports Smith and colleagues' (2004) other component of intuition: knowledge arising from emotional feelings. Our findings suggest that merely recognizing emotions in oneself and others does not necessarily result in the use of intuition, but using these emotions to drive cognition is important in the use of intuition.

The SUEIT subscale Emotional Management also had a statistically significant but fair relationship with the CSI, $r = -.49$. This subscale measures a person's ability to maintain a positive mood. Bolte and colleagues (2003) found that a person is better able to make intuitive decisions when in a positive mood. De Vries and colleagues (2008) elaborated on Bolte et al.'s idea, suggesting that a person values the decision outcome more if the decision strategy was congruent with mood. Our finding that the ability to manage emotions to maintain positive moods is associated with the propensity to use intuition supports this literature regarding mood and decision style.

The SUEIT subscale Emotional Control had no or little relationship with the CSI, $r = -.24$. Unlike the Emotional Management subscale, which assesses the ability to regulate and manage moods in oneself and

others on a daily basis, the Emotional Control subscale assesses the impact of strong emotional reactions to events on a person's ability to work effectively. Our results indicate that this aspect of EI is not related to a preference for a particular cognitive style.

Our findings thus indicate that the key EI factors influencing the use of intuition are the ability to recognize and interpret emotions in oneself and others and the ability to use these emotions in driving action and decisions. This interpretation is in keeping with Mayer and colleagues' (2000) view of EI as being a set of abilities that are amenable to improvement over time. It also suggests that enhancing EI may help occupational therapists use intuition in practice more effectively over time.

Limitations of the Study

A potential limitation of this study is the imbalance in gender distribution in the sample; 92% of respondents were women. We do not believe this imbalance to be a substantial threat to the validity of the data. The fact that 93% of the occupational therapy workforce in Australia consists of women (Australian Institute of Health and Welfare, 2006) indicates that our sample was representative of the population in question, ruling out a coverage error (Dillman, 2000). The return rate of 35% could also be considered a limitation, and further investigations with larger and international samples are warranted.

Implications for Occupational Therapy Practice

Our findings have the following implications for occupational therapy practice:

- This study found that experienced therapists had a greater preference for an intuitive cognitive style than did novice therapists. Understanding the need for time to develop a pattern library and adequate tacit knowledge may assist occupational therapy supervisors with tempering the use of intuition by novice therapists.
- Developing abilities associated with EI, either individually or in supervision, could enhance practice by encouraging occupational therapists to make effective use of intuition within clinical reasoning. It may also contribute to the therapeutic use of self.
- Supervision for occupational therapists could be enhanced if it focused not only on practice issues but also on understanding and using emotions within practice.
- Including education on EI in occupational therapy course curricula could be beneficial because novice therapists could develop improved skills more quickly by analyzing and articulating their intuitions.

Future Research

The scope of this study was limited to occupational therapists in mental health practice. Although there is no reason to believe that results from other areas of occupational therapy practice would be different, investigations in a wide variety of practice settings would be useful to better investigate the use of emotional intelligence and intuition in practice. Examining the role of EI in therapeutic use of self may enable clinicians to enhance this important aspect of practice. Future studies are also needed to explore the influence of specific mental health settings on EI and the use of intuition.

Conclusion

Building on previous findings that intuition was embedded in clinical reasoning (Chaffey et al., 2010), the current study represents the first attempt to use the SUEIT and the CSI to investigate emotional competencies in the workplace and the preferred cognitive style of occupational therapy practitioners. It confirmed a moderate relationship between EI and preferred cognitive style of intuition by occupational therapists in mental health practice, as measured by these instruments. This study suggests that developing occupational therapists' abilities associated with EI, either individually or in supervision, could enhance practice by encouraging the effective use of intuition in clinical reasoning. ▲

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