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# CHAPTER I Self-Awareness

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## OBJECTIVES

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After reading this chapter you should be able to

- Discuss the concept of self-awareness.
  - Demonstrate how your self-awareness can help you understand others.
  - Apply self-awareness to your practice.
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## Introduction

It could be argued that one of the characteristics that differentiate human from all other animals is our ability to think consciously in deliberate, complex, and abstract ways about ourselves (Leary & Buttermore, 2003). According to Vorauer and Ross (1999), individuals possess a wealth of self-knowledge based on their past behaviours and their inner thoughts, feelings, goals, and intentions. Moreover, much of this information is private and not readily available to others. One could add that some people may not even recognise their inner thoughts and feelings unless of course they make a conscious attempt to do so. Even then these may be too traumatic to assimilate into their system (this point will become clear as the chapter develops). The question Vorauer and Ross (1999, p. 416) posed is, “do people realize the extent to which their self-knowledge is ‘inside information’?” It could be said that perhaps a good majority don’t. This could mean that we don’t always use our ability to think consciously in what we

say or do. For example, we may have said or done things that on reflection we wish we hadn't. Exercise 1 offers an opportunity to self-reflect.



### EXERCISE 1

Reflect on one occasion when you said or did something that you would have otherwise preferred not to have said or done.

Information obtained from Exercise 1 could be used to guide future behaviour, as it would appear that there is a price to pay for not implementing our ability to think consciously. As a health care practitioner one cannot afford to behave in a manner that is likely to cause harm or distress to those one is meant to help. Awareness of one's behaviour is crucial to any interaction but perhaps more so where these interactions involve patients. As Rungapadiachy (1999) states, self-awareness is a prerequisite skill for health care delivery. The implication is that health care practitioners would be in a much better position to empathise with their patients or clients. Moreover, the National Occupational Standards in Mental Health (2003) identifies 'practise in a reflective manner' as one of the key roles for mental health professionals. This notion could be extended to include all health care professionals. With this in mind, this chapter explores the concept of self-awareness with particular emphasis on how it can be used to establish effective relationships with patients and clients.

### What is self-awareness?

According to Williams (2003), the use of the term self-awareness may be problematic in that each theorist and researcher may be focusing on a different construct when they refer to it. For example, self-awareness could be taken to mean 'a general self-knowledge (an ability to have insight into one's inner world and personality), but self-awareness has also been defined as a momentary state, such as self-consciousness' (Williams, 2003, p. 178). The momentary state of consciousness and its implication to care delivery will be discussed later in the section that deals with benefits and drawbacks of self-awareness. In an attempt to understand the concept of self-awareness, the notion of self is explored. However, the starting point is with an explanation of the word 'awareness'.

To be aware means to be conscious, sensitive, and alert. To be aware could also mean to know, recognise, and accept. According to Rawlins, Williams, and Beck (1993), awareness implies that an individual can focus his or her attention on a particular experience and promote 'individual "knowing" of that experience' (p. 30). Self-awareness therefore could be taken to mean focusing on self as well as, recognising, knowing, and accepting of self. An interesting point to note here is that people not only have an image of themselves but also know that this image is the object of the process of self-reflection (Hart & Fegley, 1994).

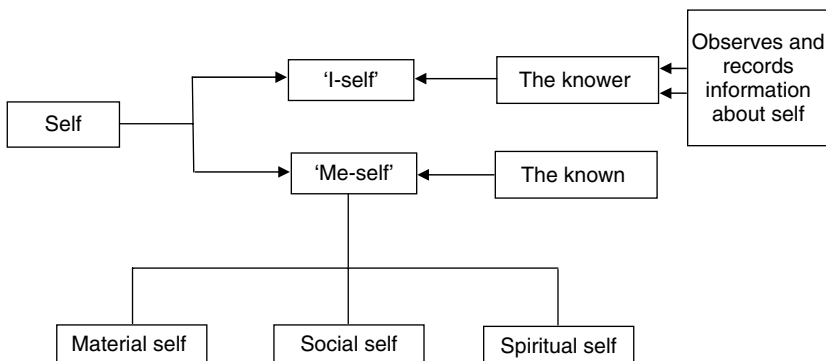
## What is self?

The construct of self consists of all those descriptions that individuals ascribe to themselves. For example, these could include all self-representations that reflect how people see themselves. The words that I would use to describe myself would give some indications as to my sense of self. For example, whom I think and feel I am, my physical attributes, things that I do, and the various roles that I occupy would all form part of my sense of self. It could be argued that there is a further dimension to self in that these descriptive characteristics can also serve to modify an individual's sense of self to transform this particular individual in the desired direction (Demetriou, Kazi, & Georgiou, 1999). The implication is that self is significant in that it influences people's actual behaviour, motivation to initiate or disrupt activities, and feelings about themselves. For example, we may see ourselves as 'caring', and therefore we behave in a 'caring' way; however, interaction is perceived to come before thinking and self-reflection (Ashworth, 2003). The implications as pointed by Ashworth (2003) are two fold:

1. Inner thoughts and external communications are basically the same. Thoughts can be easily translated into words, and symbols form part of the interaction.
2. The capacity to reflect on one's own actions is an avenue for the formation of one's self-concept. Moreover, perceived feedback from others contributes to the ability to self-reflect.

According to James (1890), self is a hierarchical and multidimensional construct (see Figure 1.1). The two hierarchical levels are as follows:

1. The 'I-self' which is the 'knower' and includes all the observation and self-recording processes that generate the knowledge about ourselves. The 'I-self' is also referred to as the Knowing Self. In this instance self assumes the role of subject.
2. The 'me-self' is that knowledge we have about ourselves and is described as the sum of all that we call ours. The 'me-self' has at least three dimensions. These are



**Figure 1.1** An overview of the hierarchical and multidimensional construct of self.

material self, social self, and spiritual self. The ‘me-self’ is also referred to as the known self and becomes the object.

Material self includes the representations of our bodies and possessions. The body is described as the innermost part of the material self. Moreover, certain parts of the body seem more intimately known to us than the rest (Hattie, 1992). Clothes, immediate family, homes, and possessions also form part of our material self. Social self is the recognition that we obtain from others such as friends and colleagues. According to James (1890), people generally have an innate tendency to get themselves noticed positively by others. Spiritual self is described as the inner or subjective being that contains the characteristics that are the most enduring and intimate parts of the self (Hattie, 1992). Spiritual self could be seen as reflective and involves people’s thinking about themselves. Hence, Descartes’ notion of ‘I think, therefore I am’. The concepts of material self, social self, and spiritual self would be easier to relate to by engaging in Exercise 2.



## EXERCISE 2

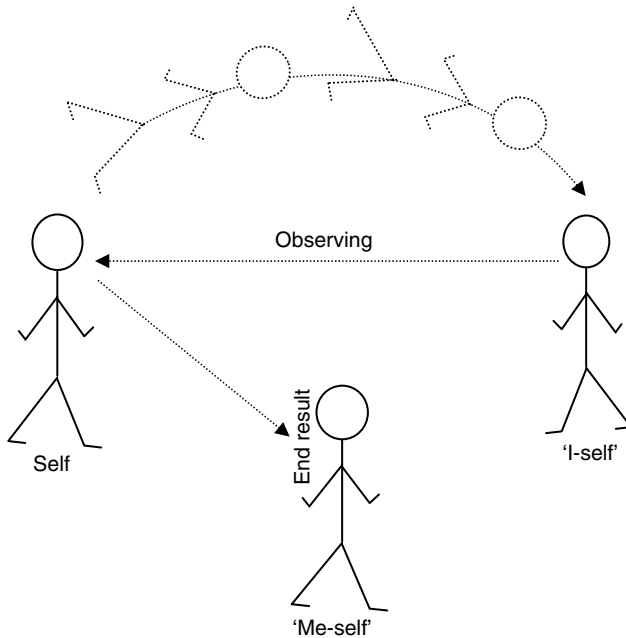
Make lists of your material, social, and spiritual selves.

The process of gaining knowledge about ourselves almost seems as though we step out of ourself to observe ourself (see Figure 1.2). The end result of this observation is the ‘me-self’. The act of stepping out of, looking at, observing, and recording oneself can be described as reflexivity. For Mead (1934), reflexivity means the turning back of one’s experience upon oneself. James (1890) would argue that self-awareness is the conclusion that the ‘I-self’ arrives at to form the ‘me-self’. In simple terms, if we are able to describe our material selves, our social selves, and our spiritual selves, we would, to some extent, be self-aware.

Self-awareness can be conceptualised both as a personality trait and a skill (Church, 1997). For example, Fletcher and Baldry (2000) state that trait self-awareness is found in a minority of individuals who could be described as being ‘naturally’ self-aware. This could mean that the majority of people would need to develop self-awareness as a skill. Self-awareness as a skill is related to factors influencing and biasing self-assessment. The implication is that learning to become self-aware would help to bring some element of objectivity in assessing oneself. The subjective self is therefore required to take on self as the object of one’s own attention and thought.

## Components of self-awareness

It could be said that there are at least three components to self-awareness and these are cognitive, affective, and behavioural. Cognitive refers to the mental process of comprehension. It includes memory, perception, past experience,



**Figure 1.2** 'I-self' is the observer and the 'me-self' becomes the end product of that observation.

expectation, appraisal, attribution, attitude, beliefs, and values. Moreover, these could be seen as the thinking aspect of an individual. Affective refers to the feeling aspect of self. Behavioural simply means the action that one engages in, and this could be verbal and/or non-verbal. There is a dynamic relationship between these three components in that thinking could affect feeling and behaviour, feeling could affect thinking and behaviour, and behaviour could affect thinking and feeling.

### Cognitive self

The cognitive self could be described as the representations that we each have in our own minds of the kind of person we think we are. Exercise 3 attempts to clarify this point.



#### EXERCISE 3

Make a list of the kind of person you think you are. For example, how are you in company of others? Are you easy to get on with? Do you really listen when people speak with you? What are your beliefs about politicians? What are your strengths and weaknesses? The list is endless.

The conclusion that you would have drawn from Exercise 3 would indicate the representations of your cognitive self. However, Salzen (1998) argues that self-awareness is achieved through introspection that in itself is a conscious cognitive process. The implication is that cognitive knowledge about self cannot be objective. It could be argued that this realisation may in itself be helpful in that an individual may be able to guard against cognitive self-serving bias (see Chapter 7). Self-serving bias suggests the tendency to attribute positive events to self and negative events to external factors. For example, if we pass our exams it is because we are knowledgeable, but if we fail it is always because we have been unfairly marked. It could be argued that there may be some unconscious dynamics at play in the phenomenon of self-serving bias. This could also imply that we function at various depth of consciousness.

### **Levels of consciousness**

According to Freud (1984), an individual has three levels of awareness and these are conscious, preconscious, and unconscious.

1. At a conscious level we have immediate access to materials. For example, at times we are aware that we are hungry. According to Epstein (1983), people have conscious theories of reality that include theories about themselves and the world.
2. At a preconscious level some thoughts and images are not in our immediate awareness, but we can access these with little or moderate effort. For example, we can try and bring to our awareness events of September 11, Tsunami, Live 8, and hurricane Katrina. Moreover, Epstein (1983) states that reactions at the preconscious level are often so automatic and fleeting that it may take special practice and training in order to be aware of certain preconscious thoughts and images. Epstein (1983) theorises that individuals use mental defence mechanisms<sup>1</sup> to shield them from awareness of their preconscious beliefs, thereby allowing them to deceive themselves into believing that their behaviour is more rational and less egocentric than is often the case.
3. At the unconscious level and ‘under normal conditions’ events are not available to our awareness. These may be for various reasons and one of which may be that such an event is morally unacceptable for the individual. Moreover, materials cannot be assimilated into the conscious system because they may be incongruous with that system. A typical example would be the repression of aggressive sexual impulses because of the incongruity between people’s conception of their actual selves and their morally acceptable selves.<sup>2</sup> ‘Expressed otherwise, not only do individuals repress, or dissociate, mental content because it contains taboo material that is guilt arousing, but they also dissociate mental content that threatens the stability or coherence of their overall conceptual systems’ (Epstein, 1983, p. 231).

In summary, the cognitive self involves all descriptions, implicit or explicit, that people make of themselves in relation to their mental functions, abilities, strategies, and skills. In other words the cognitive self serves to judge self, others, and self in relation to others. Exercise 4 is an attempt to personalise cognitive self.



#### EXERCISE 4

What do you think of the following groups of people?

Individuals who hear voices.

Individuals who are aggressive.

Individuals who harm themselves.

What you think of the above individuals will indicate to some extent your judgement about them and hence one aspect of your cognitive self.

#### Emotive self

According to Salzen (1998), subjective emotions, like feelings of sensori-motor pleasure and displeasure, involve minimal cognitive processing and as such are believed to produce the objective observable display of emotion. It would appear that 'emotions are central to the recognition and acceptance of its existence' (Salzen, 1998, p. 300). The implication is that self-feeling is self-transparent. For example, generally speaking, an individual knows when he or she is feeling sad or happy,<sup>3</sup> and it would seem difficult to self-deny these feelings at a conscious level. However, Duval, Silva, and Lalwani (2001) conclude that both positive and negative effect can potentially induce self-awareness. For example, we feel happy when we are praised, and we become aware of this happy feeling. Similarly, we feel angry when we are insulted, and in some situations (as this is not always the case) we will be aware of this anger feeling.

#### Behavioural self

Most literature on self-awareness deal with its cognitive and affective aspects and very few if any address awareness of behaviour per se. This, to some extent, could be because behaviour includes the components of thinking and feeling. For example, when someone says 'let me think', this implies seeking the opportunity to engage in intellectual information processing. Thinking, therefore, becomes an act and as such a behaviour. Emotion, however, has three behavioural characteristics and these are physiological, expressive, and experiential. The physiological aspect of emotion is believed to have its roots in the limbic system of the brain. For example, arousal of particular parts of the limbic system leads to changes in heart rate, blood pressure, and increase in sweating. The expressive aspect of emotion is related to facial expression, vocal cues, and body movements. The experiential aspect of emotion is believed to be crucial to daily functioning in that it may be responsible for motivating action. For example, fear may be the motivation for escape, anger for attacking, and disgust for vomiting (Scherer & Ekman, 1984).

Based on Freud's (1984) notion of unconscious level of awareness it would seem that there are certain aspects of our behaviour that we are not aware of. This is evidenced in mental defence mechanisms that normally refer to unconscious

strategies that we adopt in our attempt to deal with emotional conflicts. Mental defence mechanisms do not resolve conflicts as such, but they change the way we perceive or think about them. According to Smith, Nolen-Hoeksema, and Fredrickson (2003), mental defence mechanisms involve an element of self-deception. The basic and perhaps most important of all defence mechanisms is repression.

### *Repression*

The essence of repression lies in turning something away, and keeping it at a distance, from the conscious. For example, memories and impulses that are too frightening, painful, and can evoke shame, guilt, or self-deprecation are often excluded from conscious awareness. Early evidence of repression is seen in Freud's notion of Oedipus (in boys) and Electra (in girls) complex. Freud believed that all young boys and girls have feelings of sexual attraction towards their opposite sex parent and feelings of rivalry and hostility towards their same sex parent. However, these impulses are blocked from consciousness in order to avoid the painful consequences of acting on them. In later life or adulthood people may repress feelings that are incongruous with their moral expectation and duty. For example, feeling of intense hate towards an intimate partner with murderous intention may be excluded from conscious awareness. It needs to be pointed out that repression is itself an unconscious act. Other defence mechanisms include suppression, regression, rationalisation, denial, projection, reaction formation, displacement, and introjection.

### *Suppression*

Unlike repression, suppression is the conscious process of self-control where impulses and desires are kept at bay. This could be temporarily pushing aside memories that are likely to cause pain and/or discomfort. In its simplistic form a typical example could be putting one's financial problem aside while on holiday.

### *Regression*

This is unconsciously adopting a behaviour that is appropriate to an earlier stage of development. Stage theorists like Freud (1973), Erickson (1963), and Piaget (1952) believe that an individual's personality develops in a series of stages from birth to maturity. From Freud's perspective, each stage of development brings with it some element of frustration and anxiety. If the levels of frustration and anxiety become too much, normal development may be temporarily or permanently halted. The child may remain fixed at the current stage. However, the intensity of frustration could be such that the resulting anxiety pushes that child into an earlier stage of development. For example, the child may revert back to thumb sucking or bed-wetting.

### *Rationalisation*

One of the simplest explanations of rationalisation is through Aesop's fable of the fox and the sour grapes. The real reason the fox rejected the grapes was because it could not reach them but instead said that they were sour. The moral of this particular fable is that it is easy to despise the things that we cannot get.

Rationalisation is the unconscious process whereby a false but acceptable reason is offered for behaviour that has in fact a much less acceptable motive. Smith, Nolen-Hoeksema, and Fredrickson (2003) state that rationalisation serves two purposes. For example, it eases our disappointment when we fail to reach our goals and it provides us with acceptable motives for our behaviour. The overall aim is to place our behaviour in a more favourable light.

### *Denial*

This is believed to occur when individuals are faced with an external reality that is too unpleasant to accept, for example the loss of an intimate partner or of a child. Denial and disbelief are often classed as the initial stage of bereavement (Kübler-Ross, 1969).<sup>4</sup> There would seem to be an unconscious refusal to accept that the loss has taken place or is imminent. Less severe forms of denial are seen in people who consistently ignore advice or whose marriage is failing but ignore all the signs.

### *Projection*

In terms of projection 'I don't like you' becomes 'you don't like me'. When one's own unacceptable feeling is attributed to someone else, projection is said to be at play. For example, the child who dislikes his or her father may say 'my father hates me'.

### *Reaction formation*

Adopting a behaviour opposite to that which reflects the individual's true feelings and intentions is seen as reaction formation. For example, an individual who may have negative feelings towards people of different ethnic origins campaigns actively for their rights. Similarly, someone who harbours sexual feeling for a member of the same sex may protest against homosexuality.

### *Displacement*

This involves the transferring or shifting of emotion from a situation or object with which it is truly related to another target. Displacement is used when the real target is perceived as too threatening to confront directly. For example, our superior tells us off and we in turn take it out on our subordinates. Kicking the door is perhaps the simplest example.

### *Introjection*

This is a process whereby an individual takes on the values or personal attributes of a significant other and behaves as though these are really his or her own. For example, we may have no qualms about sex before marriage but our parents condemn it. This leads to a conflict of values. However, because of our emotional ties and not wishing to displease them, we take on their values and behave as though we too condemn sex before marriage. Exercises 5 and 6 help to develop the concept of defence mechanism as applied to self and others.



**EXERCISE 5**

Using a similar format as in Table 1.1, identify an appropriate example (from personal experience) in each of the mental defence mechanisms listed below.

**Table 1.1** Defence mechanisms as related to self

Defence mechanism	Self
Repression	
Suppression	
Rationalisation	
Denial	
Projection	
Reaction formation	
Displacement	
Introjection	



**EXERCISE 6**

Identify an appropriate example in each of the mental defence mechanisms listed below from your observation of patients (for example, how might patients exhibit relevant defence mechanisms).

**Table 1.2** Defence mechanisms as related to patients

Defence mechanism	Others as in patient
Repression	
Suppression	
Rationalisation	
Denial	
Projection	
Reaction formation	
Displacement	
Introjection	

**Forms of self-awareness**

According to Neisser (1997), self-awareness is based on five distinct forms of information and these are as follows.

**Ecological self-awareness**

Ecological self-awareness suggests that individuals have to have the ability to process information regarding their immediate physical environment. According to Leary and Buttermore (2003), as individuals move through their environment, they experience visual, auditory, and other cues that are intimately linked to their bodily positions and movements. They would thus conclude that they are in the here and now and engaging in a specific activity.

**Interpersonal self-awareness**

Interpersonal self-awareness refers to people recognising that they are in fact interacting with others at a particular place and time. Neisser (1988) argues that the nature, direction, timing, and intensity of people's interaction with one another shows that they have a sophisticated knowledge about themselves and their ongoing behaviour that allows them to self-regulate effectively in ongoing social encounters. Interpersonal self-awareness therefore could be taken to mean knowing how to behave in social situation. Social intelligence would encapsulate interpersonal self-awareness and will be discussed later in the chapter.

**Extended self-awareness**

Extended self-awareness consists of thoughts about oneself in the past and in the future. For example, 'I am today the same person who did thus-and-so last year or who will do this-or-that next week' (Leary & Buttermore, 2003, p. 368). The extended self-awareness allows the individual to think about himself or herself in other times and places. This involves the act of reflection and forward thinking.

**Private self-awareness**

Private self-awareness as the phrase suggests involves processing private, subjective information including thoughts, feelings, intentions, and other states that are not available to other people. Private self-awareness allows people to reflect on their subjective experience. The resulting information is used to anticipate personal reaction to future events with the knowledge that other people are not privileged to that information. According to Leary and Buttermore (2003), private self-awareness may underlie people's ability to infer other people's states. For example, in order to understand and predict other people's reactions we may make reference to our own inner states. 'We infer others' feelings, intentions, and attitudes, for example, by extrapolating from our own (with adjustments based on knowledge about the other person), thus requiring the capacity for private self-reflection' (Leary & Buttermore, 2003, p. 381).

**Conceptual self-awareness**

Conceptual self-awareness (seen as synonymous with the symbolic self) involves labels, traits, categories, and roles that we use to conceptualise ourselves, for example lecturers and students (Leary & Buttermore, 2003). However, conceptual self-awareness also has an evaluative function. The implication is that people may categorise themselves as good or bad and effective or ineffective.

Conceptual self-awareness serves to provide an individual with an identity and self-concept.

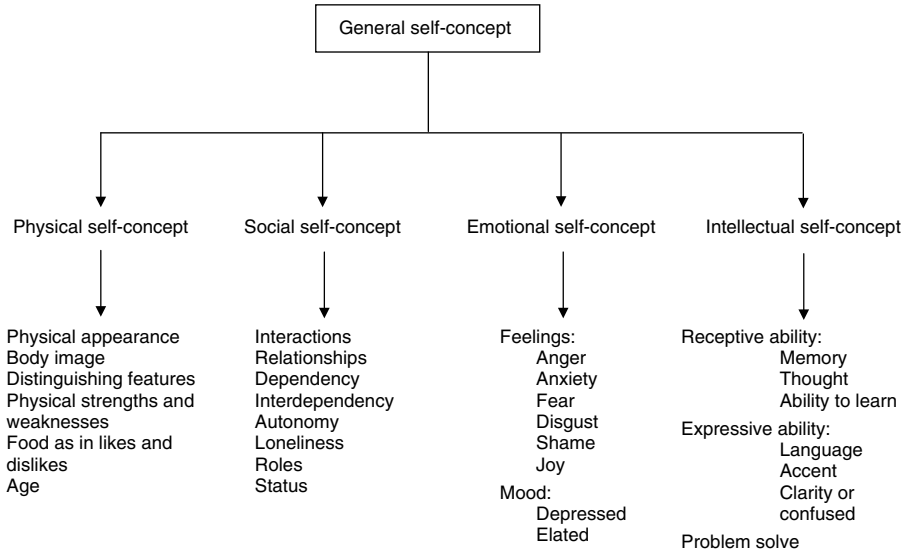
### **Self-concept**

According to Hattie (1992), self-conceptions are individuals' cognitive appraisals of their attributes. However, these are the more private aspects of themselves. Self-concept refers to a particular cluster of ideas and attitudes that we have about ourselves at any given moment. The implication is that self-concept is not static, and it can change. According to Adler (1963), self-concept is both the artist and the picture. This suggests that individuals are able to self-reflect in order to know that they know what they know about themselves. However, some people have more reflexivity than others. Hence, some know more about themselves than others. It could be argued that self-concept is not merely what we know about ourselves but involves the relationship between what we know and how we behave. For example, our self-concept may guide our behaviour (this point will be discussed later). According to Hamacheck (1992), self-concept has at least four components and these are physical, social, emotional, and intellectual. These components are displayed in the way we describe ourselves. For example, we may feel and think that

- our nose is too big (physical self-concept)
- we are approachable and friendly (social self-concept)
- we are happy (emotional self-concept)
- we are knowledgeable (intellectual self-concept).

These four components are interrelated in that conclusions drawn from one will influence the others. For example, 'big nose' implies that we are not happy with it and perhaps wish to have a smaller nose. We may as a result feel depressed and our approachability and friendliness may disappear. We may even see ourselves as less intelligent. The implication is that these clusters (physical, social, emotional, and intellectual) contribute to form a general self-concept, and for this reason self-concept is described as hierarchical (Shavelson, Hubner, & Stanton, 1976) (see Figure 1.3).

On closer analysis two principal sub-themes seem to emerge from these clusters. These are self-image and self-esteem. It is worthwhile noting that in some instances self-concept and self-image have been used interchangeably (Petersen, 1981). However, in the context of this chapter self-image is taken to mean a view of what one looks like on the outside, for example, one's body image. These sub-themes are evaluated against the self that we would like to be, that is our ideal self. This result is in our self-esteem.



**Figure 1.3** The hierarchical nature of self-concept.

## Body image, ideal-self, and self-esteem

It could be argued that one of the key features of physical self-concept is our body image. Described as a multifaceted psychological experience of embodiment, especially but not exclusively one's physical appearance (Cash, 2004), body image is significant to one's general self-concept. For example, our life experiences are influenced by the body we happen to occupy. Our body is also seen as the tool for actions and interactions. The attitude we hold towards our body will reflect our identity and the way we present ourselves to others. Appearance matters to most of us; moreover, 'Individuals' own subjective experiences of their appearance were often even more psychologically powerful than the objective or social "reality" of their appearance' (Cash, 2004, p. 1). However, it could be argued that it is not what we look like that matters but instead the way we think and feel about our looks. The implication is that body image has two distinct poles and these are positive and negative. Exercise 7 serves to personalise the concept of body image.



### EXERCISE 7

What do you like and dislike about your physical appearance?

It is possible to work out whether you have a positive or negative body image based on your answer in Exercise 7. It could be said that our interpretations

of our physical appearances are sometimes dependent on our interpretation of others. For example, we may think our noses are too big but we may also feel that it is not as big as the next person. In this instance, we may take comfort that there is someone worse off than us. This could mean keeping the negative evaluation of our physical attributes in check.



### EXERCISE 8

Describe your thoughts and feelings relating to the following:

1. Imagine you are in your swimming clothes on a beach with numerous other people, some of whom you are acquainted with, others you are not.
2. You are at a party and your friends and colleagues comment on how great you look.
3. You are watching a programme on television relating to weight problems.

Emerging issues for discussion in Exercise 8 relate to who you are and how you feel about your body. Evidence suggests that obese and overweight people are more likely to have a negative body image (Cash & Roy, 1999). However, it would seem that the more we accept and like our bodies, the more secure we will feel and the less anxious we are likely to be. However, if the gap between our self-image and ideal self (the self or attributes that we would like to possess) is wide and unbridgeable this could lead to a low self-esteem. For example, if we see ourselves completely different to the person we would like to be (or the attributes that we would like to have) and we are not able to change, we may suffer mental health problems characterised by low self-esteem. Self-esteem can be described as the value one holds of oneself, and this is contingent on one's successes and failures. Success in one's life may contribute to high self-esteem, whereas failure may result in low self-esteem.

### Factors influencing self-concept formation

It could be said that self-concept is learned and that its development emerges out of an individual's interaction with significant others. Significant others include parents, teachers, friends, and peers. Therefore, self as such does not exist at birth. According to Rogers (1959), newborn babies perceive all their experiences as a unitary whole and do not have the capacity to differentiate between themselves and the environment. The process of self-concept formation starts the moment infants are able to distinguish between themselves and the external world. For Piaget (1952), self-concept formation begins during the first phase of development known as the sensorimotor stage. It becomes clear that the initial

years of development are crucial to the formation of self-concept. Moreover, parents have the greatest impact on the developing self-concept for preschool children (Burns, 1982). However, Rogers (1951) argues that one of the factors influencing self-concept formation is the universal need for positive regard. The implication is that everyone has a desire to be loved and accepted by significant others. Rogers (1951) argues that a child's self-concept is governed by his or her organismic valuing process, whereby each new experience is evaluated in terms of whether it facilitates or impedes his or her psychological growth and development. For example, the experience of hunger, thirst, cold, pain, and loud noises hinder growth, whereas food, water, security, and love promote it. However, the need for love and acceptance is so intense that children are generally prepared to sacrifice their organismic valuing process to satisfy their need for positive regard (see Chapter 9). Hence, they unconsciously employ the mental defence mechanism of introjection. Moreover, children also learn that certain types of behaviour lend themselves to positive regard and other types do not. Positive regard that are dependent on good behaviour are called conditions of worth. When positive regard is dependent on conditions of worth, this is called conditional positive regard. Rogers (1951) argues that both conditions of worth and conditional positive regards are detrimental to a child's psychological growth and development. It could be said therefore that positive self-concept emerges out of unconditional positive regard. The implication is that people should be praised for who they are and not on whether what they do pleases us.

### **Becoming and developing self-awareness**

Reflecting on Hamachek's (1992) sentiment, if we want to know ourselves, then we need to observe what others are doing. If we want to understand others, then we need to search within ourselves. However,

Most of us are inclined to do exactly the opposite. We observe the other person to understand him or her, and we probe within ourselves to understand ourselves better. Normally, we look at the other person objectively; we behold their flaws, weaknesses, self-deceptions, and even their prejudices masquerading as principles. When we probe within ourselves, however, we are not inclined to see the same personal distortions. What we "see" are our good intentions, our noblest ambitions, the fine deeds we have performed, and the sacrifices we have made.

(Hamachek, 1992, p. 318)

The implication is that we use one pair of glasses to look at ourselves and a different pair to look at others. We also seem to be much more critical of others than we are of ourselves. The reason as Hamachek (1992) says is that it may not be so much that we are deliberately setting out to deceive ourselves but instead we are trying to view a picture from inside the frame. A point that has already been made is that in order to see ourselves as we truly are, we need to step out of and observe ourselves. Although a start, however, we are not guaranteed to see all there is to see. 'We can meditate for hours or analyze ourselves for weeks and not progress an inch farther—any more than we can smell our own breath or laugh when we tickle ourselves no matter how hard

we try' (Hamachek, 1992, p. 318). This suggests that reflexivity on its own is not adequate for self-understanding. One possible solution rests with Adler's (1964) notion of social feeling. Possessing social feeling implies that one has gone beyond one's own private experiences, motives, and thoughts in order to understand the needs and goals of others. The principal sentiment here is to be less self-preoccupied and more attentive to what others are going through. This would serve as an avenue for self-knowledge. For example, it may never have dawned on us that someone needs help until we see our neighbours running to help. Similarly, a person saying 'I wish my partner would do more in the house' could serve as a cue for us to realise that we should pull our weight. Other ways of self-knowledge could be through what has been described as the dynamics between trust-disclosure-feedback (see Rungapadiachy, 1999, Chapter 18). The argument is that the more able we are to trust someone, the more we will self-disclose and the more objective the feedback will be when we ask for it. In summary, we could enhance our self-awareness skills by

- reflexivity
- keeping journals
- observing what others do
- listening to what others are saying
- trust-disclosure-feedback
- instructions to focus on personal thoughts and feelings as in the exercises suggested throughout this chapter. This could also be seen as guided memory recall.

### **Benefits and drawbacks of self-awareness**

According to Duval and Wicklund (1972), when people are self-aware their consciousness is focused on their thoughts and feelings, their personal history, their body, or other personal aspects of themselves. Being self-aware in principle means that we should be more calculated in what we do. For example, if we are aware that what we do is offensive to some people, then we may think twice before exhibiting such behaviour. It could be argued therefore that self-awareness serves as an adaptive function principally in the form of self-control. According to Salzen (1998), 'the function of self-awareness then, at the full cognitive level, is not to allow the luxury of introspection but as a mechanism or device for the integration of personal and social behaviour into a single learned self-controlling system' (p. 308). For example, being aware of a socially unattractive mannerism such as farting or scratching one's private parts in the company of others should in theory contribute to their eradication. Moreover, Gallup (1998) calls this a sense of personal agency that emerges as a result of interacting and informally experimenting with both animate and inanimate features in our environment. For example, we learn that what we do, when we do it, and how we do it has an influence on the outcome.

According to Vorauer and Ross (1999), people should be more inclined to see their own actions as conveying information congruent with their personal attributes and attitudes when they are self-aware. For example, I would come to see myself as a confident lecturer in the way I deliver my lectures. Outside, observers are expected to see this as well. This suggests an element of deliberate communication. Leary and Buttermore (2003) argue that deliberate communication requires the communicator to infer how the audience is likely to react to various communicative acts. The implication is that self-awareness may underpin our ability to infer other people's states. Moreover, as Leary and Buttermore (2003) state, there seems to be no way to understand and predict other people's reaction except with reference to our inner states. 'We could, in effect, imagine what it's like to be them, because we know what it's like to be ourselves' (Humphrey, 1986, p. 71). Vorauer and Ross (1999) found that increased self-awareness is associated with feelings of transparency. The notion of transparency suggests our beliefs about the extent to which our personal qualities can be accurately perceived from our behaviour. However, dwelling on ourselves as objects can make us aware of how we fall short of our ideals thus leading us to conclude negative views of ourselves (Duval & Wicklund, 1972). Moreover, this may explain why according to Maslow (1968) some people are reluctant to engage in self-awareness activities.

Interestingly, being self-aware is not without its drawbacks. For example, verbal disfluencies among stutterers have been attributed to self-awareness (Mullen, Migdal, & Rozell, 2003). The implication is that stutters are compounded by self-awareness. One argument is that the more aware individuals are of their stutters the more pronounced the stutters become. Moreover, Williams and Hill (1996) found that when novice therapists were aware of their own negative self-talk, they also reported feeling more negative about their overall therapeutic performance and about their clients' reactions. Williams (2003) found that momentary states of heightened therapist self-awareness may be hindering the process of therapy. For example, the more anxious the therapists were before a session, the more they focused on themselves during the session. Therapist momentary self-awareness was negatively related to clients' perception of therapists' helpfulness. Williams (2003) suggests that higher amounts of momentary self-awareness in therapists may be distracting to the helping process. Similarly, the more aware we are of our anxieties, for example, before presenting at a conference, the more exaggerated our anxieties may become.

### **Self-awareness and engaging with patients**

It could be argued that the benefits of being self-aware far outweigh its drawbacks. It is worth noting that self-awareness on its own cannot not guarantee effective engagement. However, self-awareness in the hands of a skilled practitioner would significantly improve the quality of engagement. For example, Schwebel and Coster (1998) suggest that self-awareness is a fundamental characteristic in a well-functioning practitioner. Moreover, self-awareness is also one of the primary principles of ethical practice (Rubin, 2000). As McLeod (2003) states, caring for patients involves empathic listening and awareness of the needs

and feelings of the patient as well as one's own. 'Too often we lead unbalanced lives in terms of work, relationships, play, and personal time. We frequently strive for perfection, deny our needs and feelings, assume total responsibility for the patients, and are altruistic to the point of self-denial' (McLeod, 2003, p. 2135). It seems clear from literature that health care practitioners' self-awareness is central to care delivery. For example, Severinsson (2001) posits that the degree to which practitioners are aware of their views of human beings and of a caring philosophy can be crucial for the care provided. What seems obvious is that self-awareness does contribute positively to health care delivery. In order to explain how self-awareness can be applied to health care practice we would need to revisit the five distinct areas of awareness: ecological, interpersonal, extended, private, and conceptual. The principal sentiment that can be deduced from these is that one has sensory acuity of one's physical environment, interactions with others, thoughts (as in past, present, and future), much more private and subjective feelings and thinking, and who one is. Once we are equipped with these areas of awareness, we would then have to extrapolate how it feels to be someone else but more specifically how it must feel to be in need of health care services. Successful engagement with patients is underpinned by three prerequisite skills that would enable practitioners to use self as agents of therapeutic interventions and these are empathic understanding, social intelligence, and emotional intelligence.

### **Empathic understanding**

According to Nelson-Jones (2000), empathic understanding is another term for empathy. Empathy can be described as a form of emotional knowing or the experiencing of another person's feeling. Moreover, Rogers (1957) states that empathy is the sensing of another person's private world *as if* it were one's own, but without losing the 'as if' quality. The implication is that the practitioner would need to 'get into the shoes' of their patients in order to understand their private subjective world. Raskin and Rogers (1989) suggest that when 'empathy is at its best, the two individuals are participating in a process which may be compared to that of a couple dancing, the client leading, the therapist following: the smooth, spontaneous back-and-forth flow of energy in the interaction has its own aesthetic rhythm' (Raskin & Rogers, 1989, p. 157). However, Raskin and Rogers warned that if one thinks empathy is just about repeating the client's words, one is horribly mistaken. Empathy is seen as an interaction in which the practitioner is a warm, sensitive, respectful companion in the typically difficult exploration of the client's emotional world. Rogers (1959) argues that empathic understanding takes place when the practitioner is able to capture the patient's feelings, emotions, and thoughts through his or her words and action. Moreover, based on the practitioner's own experiences, thoughts, and feelings he or she communicates to the clients those feelings that were verbally expressed by the latter. In summary, when practitioners are able to demonstrate their ability to appreciate their patients' phenomenological world, they would be described as having 'empathic understanding'. Exercise 9 helps to clarify your own position about the notion of empathy.



### EXERCISE 9

Is it possible to empathise with another person? If so how might you achieve this?

According to Berlo (1960), one school of thought argues that there is no such thing as empathy. The implication is that one could never truly empathise with another person. This argument is based on the notion that it is impossible to ‘get into’ another person’s world, feel it, and sense it just as the other person would. From a personal perspective, I feel it may be difficult to empathise with another person but not impossible. As Berlo (1960) states, the development of empathy requires a special kind of talent. One could argue that effective listening, attending, and responding could help practitioners to develop empathic understanding. However, it does mean that practitioners would have to do their homework, and this would involve getting to know patients’ personal and medical history and listen to what they have to say. Most importantly, ask yourself the following question. ‘How might it feel to be, for example, depressed or anxious?’ Therefore, another prerequisite for the caring process is for practitioners to have a good understanding of patients’ complaints. This would serve as an avenue to attempt to enter the patient’s world. Exercise 10 may help to enhance the use of self-awareness in your clinical practice.



### EXERCISE 10

Imagine what it must feel like to

1. Sleep in a hospital bed in a room of strangers.
2. Be feeling anxious with a low self-esteem.
3. Suddenly find that you have a serious heart problem that is incapacitating.
4. Be a patient whose first language is not English and experiencing difficulty to understand others and be understood by them.

This type of reflection could be linked with extended self-awareness, for example, imagining oneself in a different time and environment with different health status. This would serve to create a much more genuine relationship when engaging with patients. Moreover, it could be argued that using one’s own experience to make inferences about the experiences of others could also serve to reinforce one’s ability to become socially and emotionally intelligent.

### **Social intelligence**

Social intelligence can be described as a by-product of self-awareness (Gallup, 1998), hence the need for introspection and reflection in order to understand one's intrapersonal and interpersonal dynamics. Social intelligence has its origin in the work of Thorndike (1920), who describes it as one's ability to understand and manage relationships with others. According to Vernon (1933), to be socially intelligent means to possess the ability to get on with people in general as well as in social situation. This implies that one must have knowledge of social matters and have insight into the temporary moods or underlying personality traits of people. For Egan (1977), social intelligence means knowing what to do in interpersonal situations. Implicit within any definition of social intelligence is the essence of being able to evaluate with reasonable accuracy the social responses and expectations of others. One could argue that the skill to predict other people's social responses is an integral part of daily living. In fact, according to the social intelligence hypothesis the need to cope with complex social relationships, acquire and manage social knowledge in order to predict responses of group members was 'a decisive factor in the evolution of human intelligence' (Dautenhahn, 1998, p. 577). It would be erroneous to assume that every human being is socially intelligent just the same as it would be incorrect to believe that we are all cognitively intelligent. However, as agents of health care delivery, being socially intelligent is a prerequisite. Moreover, practitioners must develop a 'natural feel' for people. For example, when interacting with patients, practitioners would need to show understanding, sensitivity in their interaction, as well as respecting the needs and wishes of the former. According to Sternberg (1985), implicit within social intelligence is the concept of managerial intelligence. The implication is that health service practitioners not only need to understand others but they must also know how to cope with their patients' behaviour. In summary, the principal characteristics of social intelligence include being aware of and sensitive to the needs of patients as in demonstrating empathic understanding and engaging in effective interpersonal communication. For example, we need to know **WHAT** to say, **WHEN** to say it, **WHERE** to say it, **HOW** to say it, and **WHOM** to say it.

### **Emotional intelligence**

Coined by Salovey and Mayer (1990) the concept of emotional intelligence was initially defined as 'the ability to monitor one's own feeling and emotions, to discriminate among them, and to use this information to guide one's thinking and actions' (p. 189). Reflecting on this and other definitions, Mayer and Salovey (1997) feel that emotional intelligence is much more than how it was first conceptualised. They revised their original thoughts to incorporate four principal themes in their definition and these are perception, appraisal, and expression of emotion; emotional facilitation of thinking; understanding and analysing emotions as well as employing emotional knowledge; and reflective regulation of emotions to promote emotional and intellectual growth. The attributes of each of the four themes are highlighted below.

- **Perceive accurately, appraise, and express emotion:** This theme implies that emotionally intelligent individuals have the ability to recognise their own and those of other people's emotions through physical states as well as feelings (physical sensations) and thoughts. For example, given that we are emotionally intelligent, we should be able to recognise by facial expressions, how sad, happy, or angry patients look like. Similarly, we should be able to recognise the physical sensations that we are feeling. Mayer and Salovey (1997) state that the emotion and feeling as experienced by self can be generalised onto others through imaginative thinking. You would have already had a flavour of the notion of imaginative thinking in Exercise 10 where you are asked to imagine how it must feel to be, for example, anxious. The argument here is that being already aware of how it feels to be anxious you would use this feeling as a template to recognise when other people are anxious. The ability to recognise false or manipulative expression of emotion in others is a further characteristic of emotional intelligence.
- **Access and/or generate feelings when they facilitate thought:** The implication in this theme is that emotions prioritise thinking by directing attention to important information (Mayer & Salovey, 1997). Emotionally intelligent people would not allow their worries to spoil the day. Instead, they would actively address the issue. For example, knowing that one has to meet a deadline, one would not sit and worry about it. Instead, one would start prioritising what needs to be done and set about doing it. Emotionally intelligent individuals will therefore engage in a problem-solving approach. Moreover, emotions are readily accessible and serve as a template to help in evaluating feelings. For example, we may know from personal experience how changes affect us. Therefore, we can choose whether or not to engage in events that require us to make changes. In this instance we would have used our past emotional experience to direct future behaviour. Implicit within this theme is the ability to recognise that one's mood influences one's perspective on objects or events. Mayer and Salovey (1997) call it mood congruent judgement. The implication is that good mood leads to optimism (there is light at the end of the tunnel) and bad mood to pessimism (no, it's an on coming train). Moreover, emotional states dictate the strategy that one adopts in solving problems. For example, we would behave differently when we are in a good mood in comparison to when we are in a bad mood.
- **Understand and analyse emotions and employ emotional knowledge:** This theme deals with the understanding of emotion and application of emotional knowledge in future behaviour. The development of emotional recognition starts in childhood where the child learns to label emotions through interaction with significant others. Mayer and Salovey (1997) state that parents teach children about emotional reasoning by linking emotions to situations. For example, the child learns that a frustrating situation can lead to anger; loss leads to sadness; and so on. The implication is that emotionally intelligent individuals should be able to recognise and understand the relationship between events and emotional expression. Moreover, they should recognise the complexity of the experience of emotion in that it is possible

to experience more than one emotion at the same time, for example, anger and anticipation, fear and surprise, sadness and relief, and so on. The employment of emotional knowledge in future behaviour could be in the form of 'an individual who feels unlovable might reject another's care for fear of later rejection' (Mayer & Salovey, 1997, p. 14).

- **Reflective regulation of emotions to promote emotional and intellectual growth:** The implication for emotionally intelligent practitioners is that they should be able to accept the expression of emotions regardless of whether these are pleasant or unpleasant. In fact, Mayer and Salovey believe that emotional reaction should be welcomed. However, one needs to know when to withdraw from an emotionally charged situation. Moreover, emotionally intelligent practitioner should have the ability to monitor and manage emotions in self and in others. It could be argued that emotional growth can only take place when negative emotions are moderated and pleasant ones are enhanced without any attempt to repress or exaggerate the information that they communicate.

## Summary

Possessing and recognising a wealth of self-knowledge is the key to the making of an effective health practitioner. The importance of self-awareness on the part of health care practitioners and its pivotal role need to be acknowledged. Self, as was discussed, is made up of the 'I-self' (the knower) and the 'me-self' (the known). The implication is that the 'I-self' becomes the observer of self and the end product is the 'me-self'. Awareness is the consciousness of an event and in the context of this chapter, this relates to cognitive, affective, and behavioural aspects of self. Five distinct forms of self-awareness are highlighted as ecological, interpersonal, extended, private, and conceptual. Conceptual self-awareness contributes to the formation of one's identity and self-concept. Self-concept was described as consisting of at least four themes highlighted as physical, social, emotional, and intellectual. Self-concept formation is said to be learned and that its development occurs as a result of interaction with significant others. Moreover, parents are reported to have the greatest impact on the developing child's self-concept. One of the key ingredients for the development of a positive conception of self rests with the notion of unconditional positive regards. The implication is that the developing child would not have to go to the extreme of displaying introjection in order to be praised. The principal sentiment that is conveyed throughout is that self-awareness is a prerequisite for health service delivery. Some practitioners may possess the trait of self-awareness; however, most of us need to learn to be self-aware and one of the ways is through reflexivity. Interestingly, being self-aware does have some drawbacks but one would still maintain that these are few and far between. From what has been presented so far, the common element between the three core skills for a helping relationship (that is, empathic understanding, social intelligence, and emotional intelligence) is self-awareness. For example, empathic understanding suggests possessing knowledge of the

feeling of the other person as well as conveying this knowledge to him or her (see Chapter 9, perceived empathic understanding). Social intelligence means to know the what, when, where, and how of interactions. Emotional intelligence is having the ability to monitor one's own feeling and emotions, to discriminate among them, and to use this information to guide one's thinking and actions. In order to be able to do these one needs to be self-aware. Social intelligence has already been described as a by-product of self-awareness. The same could be said for both empathic understanding and emotional intelligence.

## References

- Adler, A. (1963). *Understanding Human Nature*. Translated by Walter Béran Wolfe. London: Allen & Unwin.
- Adler, A. (1964). *Social Interest: A Challenge to Mankind*. New York: Capricorn Books.
- Ashworth, P. (2003). The origins of qualitative psychology. In J. A. Smith (ed.), *Qualitative Psychology: A Practical Guide to Research Method* (pp. 4–24). London, Thousand Oaks, and New Delhi: Sage Publications.
- Berlo, D. K. (1960). *The Process of Communication: An Introduction to Theory and Practice*. New York: Holt, Rinehart, and Winston.
- Burns, R. B. (1982). *Self-Concept Development and Education*. London: Holt, Rinehart, and Winston.
- Cash, T. (2004). Body image: past, present, and future. *Body Image*, 4(1), 1–5.
- Cash, T. F. and Roy, R. E. (1999). Pounds of flesh: weight, gender, and body images. In J. Sobal and D. Maurer (eds.), *Interpreting Weight: The Social Management of Fatness and Thinness* (pp. 209–228). Hawthorne: Aldine de Gruyter.
- Church, A. H. (1997). Do you see what I see? An exploration of congruence in ratings from multiple perspectives. *Journal of Applied Social Psychology*, 27, 983–1020.
- Dautenhahn, K. (1998). The art of designing socially intelligent agents: science, fiction, and the human in the loop. *Applied Artificial Intelligence*, 12, 573–617.
- Demetriou, A., Kazi, S., and Georgiou, S. (1999). The emerging self: the convergence of mind, personality and thinking styles. *Developmental Science*, 21(4), 387–422.
- Duval, T. S., Silva, P., and Lalwani, N. (2001). *Self-Awareness and Causal Attribution: A Dual Systems Theory*. Boston: Dordrecht and London: Kluwer Academic Publishers.
- Duval, S. and Wicklund, R. A. (1972). *A Theory of Self-Awareness*. New York: Academic Press.
- Egan, G. (1977). *You & Me: The Skills of Communicating and Relating to Others*. Monterey: Brooks/Cole Publishing Company.
- Epstein, S. (1983). The unconscious, the preconscious, and the self-concept. In J. Suls and A. G. Greenwald (eds.), *Psychological Perspectives on The Self* (Vol. 2, pp. 219–247). Hillsdale and London: Lawrence Erlbaum Associate Publishers.
- Erickson, H. (1963). *Childhood and Society*. New York: Norton.
- Fletcher, C. and Baldry, C. (2000). A study of individual differences and self-awareness in the context of multi-source feedback. *Journal of Occupational and Organizational Psychology*, 73, 303–319.
- Freud, S. (1973). *Introductory Lectures on Psychoanalysis*. London: Penguin Books.
- Freud, S. (1984). *On Metapsychology*. London: Penguin Books.
- Gallup, G. G. (1998). Self-awareness and the evolution of social intelligence. *Behavioural Processes*, 42, 239–247.
- Hamachek, D. (1992). *Encounters with Self*. Fort Worth, New York, London, Sydney, and Tokyo: Harcourt Brace Jovanovich College Publishers.

- Hart, H. and Fegley, S. (1994). Social imitation and the emergence of a mental model of self. In S. T. Parker, R. W. Mitchell, and M. L. Boccia (eds.), *Self-Awareness in Animals and Humans: Developmental Perspectives*. Cambridge: Cambridge University Press.
- Hattie, J. (1992). *Self-Concept*. Hillsdale: Hove. L. Earlbaum Associates.
- Humphrey, N. (1986). *The Inner Eye*. London: Faber and Faber.
- James, W. (1890). *Principles of Psychology*. Chicago: Encyclopaedia Britannica.
- Kübler-Ross, E. (1969). *On Death and Dying*. London: Routledge.
- Leary, M. R. and Buttermore, N. R. (2003). The evolution of the human self: tracing the natural history of self-awareness. *Journal for the Theory of Social Behaviour*, 33(4), 365–404.
- Maslow, A. H. (1968). *Towards a Psychology of Being*. New York: Van Nostrand.
- Mayer, J. D. and Salovey, P. (1997). What is emotional intelligence? In P. Salovey and D. J. Sluyter (eds.), *Emotional Development and Emotional Intelligence* (pp. 3–31). New York: Basic Books.
- McLeod, M. (2003). The caring physician: a journey in self-exploration and self-care. *The American Journal of Gastroenterology*, 98(10), 2135–2138.
- Mead, G. H. (1934). *Mind, Self and Society: From the Standpoint of a Social Behaviourist*. Chicago: The University of Chicago Press.
- Mullen, B., Migdal, M., and Rozell, D. (2003). Self-awareness, deindividuation, and social identity: unravelling theoretical paradoxes by filling empirical lacunae. *Personality and Social Psychology Bulletin*, 29(9), 1071–1081.
- National Occupational Standards in Mental Health (2003). *Unit A1: Develop your own Knowledge and Practice*. Available at <http://www.skillsforhealth.org.uk/page/competences/completed-competences-projects/list/mental-health?id=62>.
- Neisser, U. (1988). Five kinds of self knowledge. *Philosophical Psychology*, 1, 35–59.
- Neisser, U. (1997). The roots of self-knowledge: Perceiving self, I, it, and thou. In J. G. Snodgrass and R. L. Thompson (eds.), *The Self Across Psychology* (pp. 19–33). New York: New York Academy of Sciences.
- Nelson-Jones, R. (2000). *Six Key Approaches to Counselling and Therapy*. London and New York: Continuum.
- Piaget, J. (1952). *The Origins of Intelligence in Children*. London: Routledge and Kegan Paul.
- Petersen, D. M. (1981). The development of self-concept in adolescence. In M. D. Lynch, A. A. Norem-Bebeisen, and K. J. Gurgun (eds.), *Self-Concept: Advances in Theory and Research* (pp. 191–218). Cambridge: Ballinger.
- Raskin, N. J. and Rogers, C. R. (1989). Person-centered therapy. In R. J. Corsini and D. Wedding (eds.), *Current Psychotherapies* (pp. 155–194). Itasca: F. E. Peacock Publishers, Inc.
- Rawlins, R. P., Williams, S. R., and Beck, C. K. (1993). *Mental Health Psychiatric Nursing: A Holistic Life-Cycle Approach*. St. Louis, London, Sydney, and Toronto: Mosby Year Book, Inc.
- Rogers, C. R. (1951). *Client-Centred Therapy: Its Current Practice, Implications, and Theory*. Boston: Houghton Mifflin Company.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.
- Rogers, C. R. (1959). A theory of therapy, personality and interpersonal relationships, as developed in the client-centered framework. In S. Koch (ed.), *Psychology: A Study of Science* (pp. 184–256). New York: McGraw Hill.
- Rubin, S. (2000). Differentiating multiple relationships from multiple dimensions of involvement: therapeutic space at the interface of client, therapist, and society. *Psychotherapy: Theory, Research, Practice, Training*, 37, 315–324.
- Rungapadiachy, D. M. (1999). *Interpersonal Communication and Psychology for Health Care Professionals: Theory and Practice*. Oxford: Butterworth/Heinemann.
- Salovey, P. and Mayer, J. D. (1990). Emotional Intelligence. *Imagination, Cognition, and Personality*, 9(3), 185–211.

- Salzen, E. (1998). Emotion and self-awareness. *Applied Animal Behaviour Science*, 57, 299–313.
- Scherer, K. R. and Ekman, P. (1984). *Approaches to Emotion*. Hillsdale and London: L. Erlbaum Associate.
- Schwebel, M. and Coster, J. (1998). Well-functioning in professional psychologists: as program heads see it. *Professional Psychology: Research & Practice*, 29, 284–292.
- Severinsson, E. I. (2001). Confirmation, meaning and self-awareness as core concepts of the nursing supervision model. *Nursing Ethics*, 2001, 8(1), 36–44.
- Shavelson, R. J., Hubner, J. J., and Stanton, G. C. (1976). Self-concept: validation of construct interpretations. *Review of Educational Research*, 46, 407–441.
- Smith, E. E., Nolen-Hoeksema, S., and Fredrickson, B. (2003). *Atkinson and Hilgard's Introduction to psychology*. Belmont and London: Wadsworth.
- Sternberg, R. J. (1985). *Beyond IQ*. New York: Cambridge University Press.
- Thorndike, E. L. (1920). Intelligence and its uses. *Harper's Magazine*, 140, 227–235.
- Vernon, P. E. (1933). Some characteristics of the good judge of personality. *Journal of Social Psychology*, 4, 42–57.
- Vorauer, J. D. and Ross, M. (1999). Self-awareness and feeling transparent: failing to suppress one's self. *Journal of Experimental Social Psychology*, 35, 415–440.
- Williams, E. (2003). The relationship between momentary states of therapist self-awareness and perceptions of the counselling process. *Journal of Contemporary Psychotherapy*, 33(3), 177–186.
- Williams, E. and Hill, C. (1996). The relationship between self-talk and therapy process variables for novice therapists. *Journal of Counselling Psychology*, 43, 170–177.

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