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SCALES FOR EXPERIENCING EMOTIONS: AWARENESS, APPRAISAL AND REGULATION OF ONE'S OWN EMOTIONS

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***Abstract*:** Experiencing, appraising and dealing with emotions reinforce mental health and interpersonal skills. The study (N =772) reports the development of a multidimensional test for the experience, evaluation and regulation of emotions. Based on the person-centred theory of personality and on concepts of emotional intelligence, seven construct-related factors of a preliminary study were replicated: bodily experience, overwhelming emotions, imagination, self-control, congruence, lack of emotions, and regulation of emotions. The seven scales, with a total of 42 items, show a satisfactory reliability and validity. Psychotherapy patients are emotionally more unbalanced than the random sample and women are more emotional than men. Overwhelming emotions and the regulation of one's own emotions proved to be more related to disorders than the theory suggests. The test could be useful for clinical and social psychological research, in practice during the initial phase of counselling and psychotherapy, and for outcome verification.

***Key words*:** Client-centred psychotherapy, Counselling, Emotion, Emotional intelligence, Personality

INTRODUCTION

The person-centred personality theory has developed a process model for the awareness and integration of emotions into the self-concept, where personal cognitions, values and the appraisal of emotional awareness are meaningful (Barret-Lennard, 1998; Rogers, 1957, 1959; Tausch & Tausch, 1990). In this model, the person appraises his or her own feelings. This substantially affects the process of

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awareness and is the point of departure for changes within the self-concept. In line with other major psychotherapy approaches, including psychodynamic, gestalt and experiential psychotherapy, the Rogerian method views a vivid and positive encounter with one's own emotions to correlate with mental well-being. In this *congruence* of emotions, cognitions and behaviour is the central construct of mental health (Behr, 2009; Hoyer, 1996; Speierer, 1998; Teusch, Boehme, Finke, & Gastpar, 2001). A congruent person perceives undistorted emotional experiences because the experience does not threaten his or her self-concept. The person does not devalue feelings; instead, feelings can be looked at from a meta-position. For instance, the person can say, "I'm ashamed because of that feeling" instead of turning inward and displaying a fit of temper. The meta-position allows for a clear and complete emotional awareness. It allows finding, for example, words, images or body sensations as symbols for the experience. The experience becomes symbolized within the self.

The new measure will include scales that gauge the appraisal-aspects and the symbolisation-process within emotional awareness. Thus, it is not grounded on ability models from concepts of emotional intelligence, but on a process model concerning how emotions are processed within an ever-changing gestalt of the self. This represents the person-centred paradigm that a positive appraisal of emotions is the precondition for all following processes and qualities of perception. In this respect, the new scales should also gain importance within the construct of emotional intelligence. The inclusion of the appraisal-and symbolization-aspect more effectively completes the definition of an emotionally intelligent and "fully functioning person" (Rogers, 1963).

The ability model of emotional intelligence includes a multiplicity of concepts, which describe competencies of awareness and management of emotions (Mayer, Caruso, & Salovay, 2000; Mayer, Salovey, & Caruso, 2002a, 2002b; Salovay & Mayer, 1990). Some parts of this model are described by similar concepts in other research areas, such as the model of multiple intelligence (Gardner, 1991) - particularly as constituent skills of social intelligence (Riggio, 1986), or more general constructs (Mayer, Salovey, & Caruso, 2008).

Salovay and Mayer (1990) first defined their model of emotional intelligence as the sum of five aspects: 1) awareness and expression of emotions, 2) empathy, 3) regulation of emotions with oneself and others, 4) use of emotion and 5) social skills. Initially, self-report instruments were developed (Mayer & Gaschke, 1988; Otto, Döring-Seipel, Grebe, & Lantermann, 2001; Salovay, Mayer, Goldman, Turvey, & Palfai, 1995) with the scales "attention of feelings," "clarity of feelings" and "mood repair." Lischetzke, Eid, Wittig, and Trierweiler (2001) differentiate the

concepts with the distinction between self-consciousness and emotional clarity. In contrast, the "Emotional-Awareness-Scale" (Lane, Quinlan, Schartz, Walker, & Zeitlin, 1990), mixes these aspects and is difficult to use in practice. Other than these self-report measures, the "Multifactor-Emotional-Scale" (MEIS) (Mayer et al., 2000; Mayer et al., 2002a, 2002b) is an objective performance test, which measures further sub-concepts based on reactions to stimuli like pictures, music, stories and imaginative inspiration. The sub-concepts are "perceiving," "assimilating," "understanding" and "managing" emotions. However, the concept of emotional intelligence describes such a broad spectrum of skills with low scale inter-correlations that there is no evidence of an underlying general factor (Mayer, Salovey, & Caruso, 2004). The sub-concepts seem to overlap with the concept of social intelligence, which is similarly broadly applied and difficult to distinguish from traditional concepts of intelligence (Riggio, 1986). Additionally, two reviews and theoretical propositions suggest reasons for inconsistent findings regarding how people experience emotions. They seem to expand the Rogerian concept "conditions-of-worth" (Rogers, 1959), which claims that internalized values modify the experiential process towards incongruent and contradictory experiences. Robinson and Clore (2002) suggest an accessibility model that implies that memory processes and different frames of reference lead to substantial differences in how people report on their feelings. Lambie and Marcel (2002) developed a model in which the focus of attention and the mode of valuing one's own emotions influences the levels of consciousness, and in this the person's experiential process. Both papers implicitly suggest to increase focus on the process of experience than on given emotional skills, and thus support the rationale of this study.

While constructs of emotional intelligence often represent an ability model their validation data of test developments nearly always support clinical concepts of emotion-focused therapies. They also claim that focusing on feelings and abilities such as awareness, clearness or management of emotions correlate with general functioning of the person and mental health. In particular, the work of Stanton (Austenfeld & Stanton, 2004) contradicts findings that suggested that in contrast, emotion-focused coping and experiential orientation would correlate with stress and mental disorders (Coyne & Racioppo, 2000). Stanton, Kirk, Cameron, and Danoff-Burg (2000) developed measures that claim to avoid confounding emotion-focused coping strategies with aspects of distress and self-deprecation. Their findings support the aforementioned correlation of experiential orientations and mental well-being.

In comparison with this array of research on emotional intelligence, the clinical perspective does not put equivalent effort into empirical research concerning the

experiential process and the process of symbolization. Research more often focuses on therapy outcome: statements about therapy results are collected through self-reports of clients - for example, regarding the decline of symptoms, increased interpersonal skills and personality traits. However, the underlying personality theory of emotion-focused therapies assumes that such change processes basically emerge through a person's modification of emotional organisation (process of experience, more congruence and intuition, awareness, regulation and positive validation of feelings). Thus, it may be useful both for practical work and for research to measure these constructs directly, which is the rationale of this study.

A similar attempt was already undertaken by the "Personal Orientation Dimensions" and by the "Feelings, Reactions, and Beliefs Survey" (FRBS). The "Personal Orientation Dimensions" (Knapp, Shostrom, & Knapp, 1977; Shostrom, Knapp, & Knapp, 1976) are derived from the person-centred theory and survey basic attitudes toward life and life-orientations. Aspects of emotional awareness are of less relevance. These aspects are more relevant in the "Feelings, Reactions, and Beliefs Survey" (FRBS) of Cartwright, DeBruin, and Berg (1991; Höger, 1995). Because of the poor test statistic scores, Cartwright et al. and Höger recommend to avoid using this instrument for individual evaluations, but rather for group surveys. Although the alexithymia-scale by Taylor, Ryan, and Bagby (1986) was developed out of a clinical and deficit-orientated standpoint, it measures constructs that are similar to the concept of emotion-focussed therapies and to the concept of emotional intelligence. The subscales are "ability to identify and distinguish between feelings and bodily sensations," "ability to describing feelings," "daydreaming," and "externally-oriented thinking." A similar instrument is the "Toronto Alexithymie Scale" by Ritz and Kannapin (2000) with the following subscales: "identification, differentiation and description of emotions", "inadequate importance of emotions" and "pragmatic attitude". Clinical studies with these instruments report high correlations of alexithymia and mental-health problems, which prove the notable significance of emotional awareness and positive emotional appraisal. The study of Lovett and Sheffield (2007) supports such findings, even with regards to children.

Implications for test design

The appraisal aspect is essential for the process of symbolisation (the emergence and taking-shape) of emotions within the self-concept. The concepts of emotional intelligence do not explain this process. In the person-centred model the process of becoming aware of an emotion is described as a process of symbolisation: a manifest

experience arises in the person, and a corresponding word, sentence, image, taste, bodily sensation, etc. is found. This process facilitates undistorted and complete awareness. Beyond putting experiences into words, there exists today differentiated concepts like imagination (e.g., focusing, catathym-picture-experiences, dream-work) and body experience (e.g., focusing, diverse body therapies), which are able to foster the process of emotional awareness. However, the issue of inter-subject differences with regard to the preferences or permeability of these approaches has not been conceptualized. Therapeutic practice suggests that it may be valuable to investigate these differences. A practical consequence, for example, could be the earlier undertaking of differentiated therapy planning in psychotherapy processes.

Self-control and emotional regulation have recently been pointed out as a central theme in emotion-centred therapy concepts (Greenberg, 2002; Greenberg & Bolger, 2001). They are understood as a consequence of congruence or incongruence within the experience. Thus, another goal of test development is to assess these abilities as well by short self-evaluation-scales.

Purpose and intention of test development

The intention of the present study was to develop scales in the field of emotional appraisal and awareness that distinguishes modes of appraisal and symbolization of emotions. The goal was to develop a fully standardised, easy-to-handle and practicable instrument. The person and his or her helper may get a distinct assessment of their approach to emotions. Thus, interventions to foster awareness can be better attuned to many fields of psychotherapy, psychosocial counselling and staff-promotion. The scales shall verify changes in psycho-structural variables within psychotherapy-outcome research: the structural development of the self and the development of emotional awareness and appraisal. Furthermore, the scales shall achieve a clarification of variance in many research issues ranging across personality, social, clinical and educational psychology.

The hypothesis was that out of a large item pool that represents the aforementioned constructs, scales could be constructed that comply with test-statistic requirements and that are equally attuned to theoretically relevant and practicable constructs. In this way, our methodology is deductive in drawing item-wordings out of diverse concepts for emotional competences and Rogerian constructs that all proved to be relevant for the subject of this test development. However, the final test construction is inductive in nature. Test scales and variables are constructed as a result of explorative factor analysis and thus derived from a broad range of empirical data concerning the issue in question.

METHOD

Studies for test construction and generation of the item pool

Table 1 lists the steps of the test construction. While test construction normally starts with a large item pool that is reduced due to theoretical and statistical criteria, two smaller pre-studies initially led to the most significant stages with a practicable version in study 3 and a replication and optimisation of that version in study 4. Throughout all studies the item pool was created by the authors and by cooperating psychotherapists. Statements were formulated in a wording, which psychotherapy clients and participants of encounter-groups would use when they talk about their feelings and about themselves, or which friends would use when they talk intimately or share their experiences. Several times the item pool was presented to colleagues working in the fields of research and psychotherapy with the request to propose necessary revisions and supplementation. With some of those colleagues, most of them psychotherapists, the existing material was discussed in individual meetings.

In Study 1 (Behr, Doubek, & Holl, 2002), items related to the themes of emotional awareness and appraisal were formulated. Among them are also items about insufficient or overwhelming emotional experience as a central element of the person-centred theory of personality, as well as items about awareness and bodily experiences. The 32 items were discussed and improved upon in teams. Afterwards, a pre-test with 35 participants was arranged.

Table 1. Studies for the test development SEE

Study Nr.	Purpose of Study	*N*	Sample	No. of Items
1	Prestudy 1: Item wording and Test of Acceptance	35	Teachers	32
2	Prestudy 2: Item Wording and Selection	276	Students	72
3	Scale Construction and Validation	456	Convenience Sample general population and Students 1	106 / reduced to 46
4	Replication and Revision of Scale Construction/ Validation/ Test-retest Reliability/ Norms	772 + 443	Convenience Sample general population and Students 2	55 / selected to 42
5	Validation Study	67	Psychotherapy Clients	42

In Study 2 the item pool was expanded to 72 items. Again, the guideline was to relate to the above mentioned theoretical constructs and to create a wording similar to that which is found in intimate conversations between friends. Another pre-test with 276 participants yielded only a partially satisfying factor-structure and to some extent an insufficient consistency of the scales.

Thereupon in Study 3, initially conceptual categories were set up and items were classified based on these categories (Behr & Becker, 2002). Categories were derived from the person-centered theory of personality, especially regarding the process of symbolization and experiencing. This also included the identification of bodily experiences based on the concept of focusing and on body psychotherapy approaches, and the role of dreams and daydreams: a) positive evaluation of feelings, b) experience of excessive feelings, c) insufficient experience of feelings, d) recognition of bodily experiences as useful, e) different cognitions about feelings, f) acknowledgement of daydreams as useful, g) acknowledgement of dreams as useful, h) feeling the ability to curb feelings and reactions, i) ability to regulate feelings, j) experience of intuition. These categories play an important role in psychodynamic thinking and experimental models of emotional awareness, as well as in the current research on emotion regulation. Every category consisted of six to 14 items, whereby in bigger categories repetitive groups of items and in smaller categories missing items were identified. Appropriate supplementary items were then formulated. So far, the theoretical approach had been deductive. It has now shifted to an inductive process: although these item categories describe the item pool, it was not assumed that they would necessarily correspond with the later received factor-structure, as consistent evidence about the relation of those concepts exists neither on the theoretical nor on the empirical level.

On the basis of a sample of 456 participants, seven scales with altogether 46 items out of this item pool were obtained with an eigenvalue distribution of 7.7 - 5.8 - 3.3 - 2.3 - 2.0 - 1.8 - 1.5 (cut-off value) - ... - 1.3, and an explained variance of 53%. The scale construction succeeded satisfyingly both in terms of plausible construct building and alpha scores. The scales were validated with different measures for personality traits and measures of interpersonal communication (Behr & Becker, 2002).

In the Studies 4 and 5, the 46 item version was supplemented with nine items and therefore work continued with a 55 item version. These studies aimed at the replication of the factor-structure and validation with a random and a clinical sample. Further aims were the reduction of the number of items and the substitution of the seven-point rating with a five-point rating scale (disagreement, little agreement, moderate agreement, fairly strong agreement, and strong

agreement). In addition, norms were generated (Behr & Becker, 2004) and scale scores and factor structure were examined within another culture and language (Watson & Lilova, 2009). The present instrument with 42 items is the result of Studies 4 and 5. Study 4 with a random sample and Study 5 with ambulant and stationary psychotherapy clients were conducted at the same time.

Item selection and scale construction

Item selection. The procedure of Studies 3 and 4 was executed according to the criteria of Rost and Schermer (1986). Items with a difficulty smaller than .20 and larger than .80 were removed so as not to endanger the reliability of scales that contain only a few items. Then an explorative main-component-analysis was conducted. With the random sample of study 3, the Scree-Test was not well-defined and suggested six to eight factors. The underlying theoretical constructs were portrayed best with a seven-factor analysis. In the continuing process, more items were removed with the aim to increase the homogeneity of the scales and maximize the instrumental reliability. The result corresponded widely with the intention to construct a short questionnaire with few items (Behr & Becker, 2002).

Scale construction. The scale-construction of study 4 was carried out the same way as in study 3. The factor analysis (main-component-analysis with varimax rotation) with 55 items replicated the factor-structure. After removing further items, like in study 3, a factor solution arose from the factor analysis (main-component-analysis with varimax rotation) with the remaining 42 items (eigenvalue of the first 8 factors: 7.05, 5.26, 2.85, 2.07, 1.89, 1.46, 1.36, 1.08) with an explained variance of 55.2%.

Sample for test construction

The test consisted of 772 participants: 253 men, 490 women, age average = 34.7 years (SD = 14.4). All of them volunteered to take part. Statistics for the convergent and discriminant validity were not carried out with the whole sample.

Instruments

The following instruments were used for validation in Studies 4 and 5:

1. NEO FFI: Five Factor Inventory (Borkenau & Ostendorf, 1993; Costa & McCrae, 1992)
2. FPI: Freiburg Personality Inventory: scales measuring life satisfaction, stress and somatisation (Fahrenberg, Hampel, & Selg, 1989)

3. FSKN: Frankfurt Self-Concept-Scales (Deusinger, 1986)
4. MMPI Saarbrücken: scales measuring 'antisocial practices' and 'low-self-esteem' (Hathaway & McKinley, 1972)
5. SAF: Questionnaire for the measurement of dispositional self-consciousness (Merz, 1986)
6. STAI: Trait-Stait-Anxiety Inventory (Laux, Glanzmann, Schaffner, & Spielberger, 1981)
7. ADS: General Depression-Scale (Hautzinger & Bailer, 1993)
8. TMMS: Trait-Meta-Mood-Scale, scales measuring clarity of emotions, emotional suggestibility, attention to emotions (Otto, Döring-Seipel, Grebe, & Lantermann, 2001; Salovay, Mayer, Goldman, Turvey, & Palfai, 1995)
9. TAS: Toronto Alexithymie Scale (Kupfer, Brosik, & Braehler, 2001)
10. IIP: Inventory of Interpersonal Problems (Horowitz, Strauss, & Kordy, 1994)
11. RDAS: Revised Dyadic Adjustment Scale (Busby, Crane, Larson, & Christensen, 1995)
12. BSI: Brief Symptom Checklist (Franke, 2000)

Not every questionnaire was given to the whole sampling. With instruments No. 1 to No. 7 the relationship between SEE scales and different personality-measures are studied. Instruments No. 8 and No. 9 assess constructs similar to the SEE scales concerning emotional awareness. Instruments No. 10 and No. 11 examine relationships among aspects of interpersonal communication. Instrument No. 12 measures the relationship of various mental disorder symptoms.

RESULTS

Factor structure and its coherence with theoretical models

The first factor, named *experiencing overwhelming emotions*, is defined over items that illustrate the experience of too many feelings. This factor describes people who suffer from a flood of feelings. Sample item: "I'm so full of emotions that I can often hardly stand it."

The items of the second factor, named *bodily symbolisation of emotions*, correspond to bodily sensations that are indications of mental processes and feelings. The awareness of bodily sensations is related to a possible mental meaning. Sample item: "My body often reflects my feelings."

The third factor, named *accepting one's own emotions*, includes items that refer

to a positive valuation of one's own feelings. Sample item: "I feel what I feel and that's ok."

The fourth factor, named *imaginative symbolisation of emotions*, consists of items where fantasies and dreams are looked upon as useful to deal with different problems. They address a valuation of imaginative processes. They are regarded as a tool to understand oneself and be able to handle stress. Sample item: "My dreams clarify my feelings."

The fifth factor, named *experiencing self-control*, contains items that describe people who are able to control their emotional impulses. Sample item: "I've always got myself under control."

The sixth factor, named *experiencing regulation of emotions*, contains items that address the ability to regulate emotions and moods. Sample item: "If I want to, I can easily manipulate my emotions."

The seventh factor, named *experiencing a lack of emotions*, consists of items that describe people who say about themselves that they do not feel a lot of emotions, that they are cut off from their bodily experiences and that they regret this. Sample-item: "I don't often feel my inner world."

The scale *accepting one's own emotions* represents the construct of "congruency" from the person-centred approach. The items clearly describe characteristic features of the experience of people whose self-concept stands in conformity with the experienced feelings. This is exactly postulated in the theoretical model: congruency as conformity of organismic experiences and self-concept, which is related with high estimation of one's own emotional experiences. This construct has a fundamental importance in the person-centred theory and therefore this scale will be listed first in this test.

The scale *experiencing a lack of emotions* and parts of the scale, *experiencing overwhelming emotions* correspond with the same issue. Incongruence in the person-centred approach describes a condition in which a person experiences parts of his or her feelings and organismic experiences as a distortion or not at all. The person may also have a low estimation of his or her own feelings. The person experiences the self being partly split off from emotions. The items of the scale *experiencing a lack of emotions* rewrite such an assessment. The low or non-existent estimation of one's own emotions, the lack of emotional integration, and the lack of emotional clarity are contained in the scale *experiencing overwhelming emotions*. It is connected to the opinion that one has too many feelings and that this is a strain. This characteristic feature is described less in the person-centred approach but more in concepts of emotional intelligence; although, as the validating data shows, it is clinically of high importance.

The items of the scales *bodily symbolisation of emotions and imaginative symbolisation of emotions* describe processes of awareness and clarification of feelings.

In the person-centred approach these processes are termed "symbolisation". The scales represent the theoretical idea that body experiences or spontaneous imaginative activities open pathways to emotions. This is also conceptualised in the model of "focussing" (Gendlin, 1978, 1996). Psycho-dynamic treatment also uses dreams, daydreams and spontaneous imaginative activity. These scales describe central concepts of psychodynamic, experience and body related-therapies.

The scales *experiencing self-control and experiencing regulation of emotions* correspond to concepts of ability, as they are described in the field of emotional intelligence and emotion psychology. The scale *self-control* distinguishes between people who regret and are ashamed of their lack of self-control and people who are able to control themselves especially well. The items of the self-control scale address a person's ability to behave in a controlled manner, uninfluenced by emotional needs. Emotional regulation is described as a general ability to change emotions in oneself, especially to stimulate or calm oneself down.

Scale correlation

Table 2 reports the inter-correlations between the scales. The highest coefficient is .46, the second highest is .42, and all the others are under .40. The mean is .20. The inter-correlations are low enough to regard the scales as independent from one another. In addition, scale inter-correlations correspond to theoretical expectations: acceptance of one's own emotions, a "healthy" personality characteristic, as well as correlating positively with emotional regulation and negatively with scales that represent disorders, such as emotional excess and emotional deficiency. Emotional regulation correlates with self-control. Correlations between bodily and imaginative symbolisation are expected because both are based on non-verbal mental processes; however, the score of .46 is remarkably high.

Table 2. Inter-correlations of SEE scales

Scale	1	2	3	4	5	6	7
1. Accepting one's own emotions	--						
2. Experiencing overwhelming emotions	-.42**	--					
3. Experiencing lack of emotions	-.24**	.20**	--				
4. Bodily symbolisation of emotions	.16**	.29**	-.21**	--			
5. Imaginative symbolisation of emotions	-.01	.33**	-.06	.46**	--		
6. Experiencing regulation of emotions	.29**	-.23**	-.14**	.12**	.08*	--	
7. Experiencing self-control	.17**	-.36**	-.02	-.16**	-.18**	.39**	--

$N = 723$, * $p < .05$, ** $p < .01$ (two-tailed)

To investigate higher-order connections, an explorative factor-analysis on the seven scales was carried out. The eigenvalue-progression yielded two factors, which explain 54% of the variance. The first factor includes the scales, acceptance of one's own emotions, experience of emotional regulation, experience of self-control, experience of overwhelming emotions (reversed) and experience of emotional deficiency (reversed). The second factor contains body related symbolisation of emotions, imaginative symbolisation of emotions, as well as the experience of overwhelming emotions and experience of self-control (reversed). The first factor is defined by scales, which in a broader sense show mental stability versus instability. The second factor thus describes openness towards processes of symbolisation, which is associated with little control of inner processes.

Test-theoretical findings

Operative, performative and interpretative objectivity. The objectivity of the procedure with regard to all three category groups can be taken for granted. This so-called paper-and-pencil procedure has to be filled out independently by the participants after a standardised - and occasionally only written - set of instructions. The evaluation follows simple mathematical rules and can be also done by assistants. The interpretation is based on the measures of the deviation from the random-sample-average.

Reliability. *Consistency.* Table 3 reports the scale statistics. Although the scales only consist of four to nine items, all the scales show a satisfactory homogeneity and reliability. With a Cronbach's ± between .70 and .86, only two scales range near the lower end of an acceptable level.

Stability. With five parts of the samples, replicate tests were made to survey stability. They report test-retest reliability for time ranges from 2, 3, 4, 10 and 14 weeks. The scores in table 4 demonstrate the high stability of the scales also over a longer period of

Table 3. Scale Statistics of the SEE - Whole sample and broken down according to gender

Scale	No. of Items	Variance explained %	*M* Whole Sample	*SD* Whole Sample	Cron-bach's α all	Discrim inatory power r_{it} all	Cron-bach's α men	Discrim inatory power r_{it} men	Cron-bach's α women	Discrim inatory power r_{it} women
1. Accepting one's own emotions	6	8.3	22.02	4.36	.82	.43	.79	.38	.84	.46
2. Experiencing overwhelming emotions	7	9.4	19.70	6.06	.86	.46	.85	.45	.85	.44
3. Experiencing lack of emotions	5	5.6	11.72	3.54	.70	.32	.66	.28	.71	.33
4. Bodily symbolisation of emotions	8	8.6	25.68	5.53	.80	.33	.81	.34	.77	.29
5. Imaginative symbolisation of emotions	6	8.2	15.50	5.28	.82	.44	.82	.42	.82	.42
6. Experiencing regulation of emotions	4	5.6	11.93	2.82	.70	.37	.71	.38	.67	.34
7. Experiencing self-control	6	6.6	18.97	4.34	.76	.35	.76	.35	.75	.34

N = 723

Table 4. Retest-Reliability: Correlations at different time intervals with five different samples

Scales	Interval				
	2 weeks $n = 30$	3 Weeks $n = 53$	4 Weeks $n = 33$	10 Weeks $n = 38$	14 Weeks $n = 33$
1. Accepting one's own emotions	.88 **	.75 **	.84 **	.67 **	.60**
2. Experiencing overwhelming emotions	.85 **	.75 **	.74 **	.76 **	.80 **
3. Experiencing lack of emotions	.63 **	.60 **	.79 **	.72 **	.47 **
4. Bodily symbolisation of emotions	.62 **	.70 **	.85 **	.80 **	.52 **
5. Imaginative symbolisation of emotions	.73 **	.78 **	.90 **	.82 **	.73 **
6. Experiencing regulation of emotions	.58 **	.71 **	.78 **	.81 **	.24
7. Experiencing self-control	.73 **	.82 **	.82 **	.77 **	.79 **

** $p < .01$ (two-tailed)

time. This corresponds clearly to the theory-compatible interpretation of the grounding constructs as personality attributes. Detailed statements toward the change-sensitivity cannot yet be made because so far no outcomes from SEE in the context of intervention studies have been made. According to the test's concept, we expect only a change-sensitivity with regard to structural changes of valuing patterns and emotional processes.

Convergent and discriminant validity. An indicator of convergent validity exhibits the relationship among conceptually similar instruments. An indicator of discriminant validity shows the nonexistent relationship among conceptually different constructs.

Convergent validity. Extensive coherences arose, as was theoretically expected. Table 5 reports SEE correlations with some other personality measures. Table 6 reports coherences with the self-concept, table 7 reports coherences with different emotional measures, and table 8 reports coherences with measures of interpersonal relations. Indicators of convergent and discriminant validity arose through the following correlations:

Based on the person-centred theory, we expect for the scale *acceptance of one's own emotions* correlations with all measures that stand for mental health, as well as for openness towards experiences, a positive self-concept and positive relations with other people. Of course, the scale should also correlate with other measures of beneficial awareness and emotion management. These hypotheses were largely validated, especially with regard to the measures of mental health (Table 5). Here you can find in column 1 significant negative correlations with neuroticism, depression, fear and low self-confidence and a positive association with contentment with life. Table 6 shows that the acceptance of one's own emotions correlates on average positively with almost all aspects of self-concepts. Table 7 displays high correlations with the TMMS measures that stand for emotional intelligence. Contrary to the theory, only a very low correlation can be found with the NEO-FFI-Scale openness to experiences (Table 5). Some ambiguities can also be found in the range of interpersonal relations: Table 8

Table 5. Correlations of SEE scales with other personality measures

Personality Scales	1. Accepting one's own emotions	2. Experiencing overwhelming emotions	3. Experiencing lack of emotions	4. Bodily symbolisation of emotions	5. Imaginative symbolisation of emotions	6. Experiencing regulation of emotions	7. Experiencing self-control
NEO-FFI							
Neuroticism [a].	-.40**	.61**	.12	.13	.22**	-.28**	-.30**
Openness for Experience [a]	-.17*	.35**	-.02	.23**	.30**	-.09	-.22**
FPI							
Life Satisfaction [b]	.35**	-.53**	-.20**	-.14**	-.26**	.22**	.26**
Stress b	-.22**	.34**	.17**	.15**	-.01	-.17**	-.16**
Psychosomatic Disorders [b].	-.11*	.35**	-.04	.32**	.25**	-.09	-.15**
ADS Depression [c]	-.32**	.46**	.22**	.20**	.25**	-.26**	-.26**
STAI Trait-Anxiety [d]	-.42**	.54**	.17*	.23**	.24**	-.32**	-.27**
MMPI [e]							
Antisocial Behaviour	-.11	.18	.15	-.10	-.10	.12	-.15
Low Self-esteem	-.33*	.43**	.34*	.00	.05	-.16	-.28
Private Self-consciousness [f]	-.07	.28**	-.29**	.16	.36**	.03	-.11

NEO-FFI=Five Factor Inventory, FPI = Freiburger Personality-Inventory, ADS = General Depression Scale, STAI = Stait-Trait Anxiety Inventory, MMPI=Minesota Multiphasic Personality Inventory
a: $n = 216$. b: $n = 442$. c: $n = 228$. , d: $n = 226$, e: $n = 47$, f: $n = 64$, * $p < .05$, ** $p < .01$ (two-tailed)

shows an average negative correlation with most of the interpersonal problems. Congruent people experience significantly fewer problems with other people, but they do not experience their partner relationships in a better way. Within the RADS very little connection exists. All together, these results impressively support the validity of the scale and the underlying construct of the person-centred theory. People who experience congruency are more satisfied with their lives, are conscious of their feelings and suffer less from disorders, stress and interpersonal problems.

For the scales *experiencing overwhelming emotions* and experiencing a lack of emotions we expect negative connections with the scale *accepting one's own emotions* because they stand for an unbalanced way of experiencing and the subsequent negative valuation of the experience by the person. Both should correlate with measures of mental impairment and low self-confidence. This is especially to be expected for the scale *experiencing a lack of emotions*, because person-centred theory claims that emotions, which were not formerly perceived or perceived only in a limited way, cannot be symbolised in oneself because significant others and thus the person do not accept them. With other measures of emotional awareness and interpersonal experience there should, however, still be oppositional correlations

Table 6. Correlations of SEE scales with self concept measures

Personality Scales	1. Accepting one's own emotions	2. Experiencing overwhelming emotions	3. Experiencing lack of emotions	4. Bodily symbolisation of emotions	5. Imaginative symbolisation of emotions	6. Experiencing regulation of emotions	7. Experiencing self-control
Self Concept Scales of **FSKN**							
General Performance	.26**	-.25**	-.20*	.04	-.05	.38**	.19
General Problem Solving	30**	-.43**	-.24*	-.03	-.13	.45**	.41**
Confidence in Behavior and Decision-making	.37**	-.59**	-.27**	.05	-.13	.47**	.37**
Self Esteem	.35**	-.34**	-.18	-.03	-.07	.30**	.19
Sensitivity and Mood	.20*	-.37**	-.03	-.26**	-.09	.32**	.21*
Assertiveness in Groups and with Significant Others	.37**	-.44**	-.09	-.13	-.13	.38**	.20**
Social Contact	.34**	-.27**	-.17	.06	-.11	.30**	.27**
Feeling Valued by Others	.17	-.21*	-.17	.04	.02	.08	.13
Low Irritation through Others	.30**	-.19*	-.13	-.05	-.09	.23*	.04
Positive Feelings and Relations with Others	.17	-.12	-.21*	.10	.03	.21*	.17

FSKN = Frankfurt Self-concept Scales, $N = 216$, * $p < .05$, ** $p < .01$ (two-tailed)

between both scales. Actually, the scales are in line with the theory in almost all measures for mental problems. Columns 2 and 3 from Table 5 especially show correlations of overwhelming emotions with neuroticism, psychosomatic disorders, depression, fear and low self-confidence. *Experiencing a lack of emotions* correlates similarly, but noticeably weaker. This is also the case for the reported negative correlations with self-concept aspects in Table 6. Table 7 shows the expected correlations with other emotional measures: *experiencing overwhelming emotions* and *experiencing a lack of emotions* both correlate positively with problems of identification with feelings (TAS) and negatively with clarity of emotions (TMMS). However, only the scale *experiencing a lack of emotions* correlates negatively with a *lack of attention* to emotions (TMMS). Columns 2 and 3 of Table 8 show a different pattern of correlation. While participants who experience a lack of emotions are more aggressive, competitive, repellent, cold, introverted and socially evasive when in contact with others (IIP), participants who experience overwhelming emotions see themselves as caring, friendly, expressive and intrusive when in contact with other individuals (IIP). These findings clearly support the validity of both scales.

Table 7. Correlations of SEE scales with measures of emotional competencies

Emotional Competencies Scales	1. Accepting one's own emotions	2. Experiencing overwhelming emotions	3. Experiencing lack of emotions	4. Bodily symbolisation of emotions	5. Imaginative symbolisation of emotions	6. Experiencing regulation of emotions	7. Experiencing self-control
TAS							
Difficulties in Identifying Feelings [a]	-.27**	.41**	.55**	-.01	-.07	-.19*	-.15
Low Importance of Emotions [a]	-.14	-.04	.16	-.38**	-.36**	-.21*	-.04
Externally Orientated Thinking [a]	-.03	.10	.03	.14	.00	-.07	-.17
TMMS							
Clearness of Emotions [b]	.47**	-.42**	-.47**	-.01	-.11	.53**	.24
Attention to Emotions [b]	.35**	-.06	-.30*	.53**	.45**	-.27*	-.38**
Regulation of Emotions [b]	.59**	-.06	-.17	.29*	.12	.25	.05

TAS= Toronto Alexitymie- Skala, TMMS = Trait Meta Mood Scale,
a: $n = 132$; b: $n = 56$, * $p < .05$, ** $p < .01$ (two-tailed)

For the scales *bodily symbolisation of emotions* and *imaginative symbolisation of emotions*, hypotheses can be derived from the person-centred approach that they correlate with, openness towards experiences (NEO-FFI) and attention to emotions (TMMS), as well as the importance of emotions (TAS). The scales should not correlate to other measures because only a specific mode of access to emotions is registered. Actually, the expected theory-compatible connections appear as well, which support their validity. Table 7, however, shows a low correlation with regard to *externally orientated thinking* (TAS) and a high correlation with attention to emotions (TMMS). Additionally, Table 5 exhibits a very low correlation concerning psychosomatic troubles (FPI), depression, and fear. Table 8 displays, as well, little correlation with a number of interpersonal problems.

Emotional regulation and self-control are seen as positive skills in the concept of emotional intelligence, both in the area of self-management and interpersonal relationships. Moreover, emotional regulation is being discussed more and more in the clinical field as a meta-skill, which correlates negatively with some disorders. Both scales should, in this way, correlate negatively with measures of mental disorders and positively with good self-concepts. There should also be a correlation with identification of emotions and attention to emotions because this clearly shows a precondition for regulative processes. Actually, the hypothetical connections can especially be seen in clinical measures and therefore support validity. Table 5 shows

Table 8. Correlations of SEE scales with measures for interpersonal relations

Scales for Interpersonal Relations	1. Accepting one's own emotions	2. Experiencing overwhelming emotions	3. Experiencing lack of emotions	4. Bodily symbolisation of emotions	5. Imaginative symbolisation of emotions	6. Experiencing regulation of emotions	7. Experiencing self-control
RDAS							
Consensus [a]	.14*	-.11	-.07	.04	.06	-.01	.03
Happiness [a]	.09	-.06	.01	.05	.12*	-.06	-.02
Bond [a]	.02	.16**	-.03	.18**	.12*	-.01	-.04
IIP							
Too authoritarian / dominant [b]	-.13	.10	.10	-.03	.07	.03	-.19**
Too argumentative / competitive [b]	-.26**	.11	.23**	-.02	.05	-.18**	-.15*
Too reserved / cold [b]	-.26**	.05	.33**	-.12	-.04	-.13	-.11
Too introverted / antisocial [b]	-.33**	.20**	.29**	-.02	.10	-.15*	-.13
Too unsure of oneself / deferential [b]	-.23**	.38**	.25**	.18**	.16*	-.27**	-.22**
Too submissive / compliant [b]	-.13	.37**	.24**	.19**	.15*	-.15*	-.17*
Too thoughtful / friendly [b]	-.16*	.45**	.18**	.27**	.21**	-.18**	-.26**
Too expressive / intrusive [b]	-.12	.32**	.11	.22**	.20**	-.12	-.29**
IPP- Total value [b]	-.31**	.39**	.34**	.14*	.18**	-.23**	-.29**

RDAS = Revised Dyadic Adjustment Scale, IPP = Inventory of Interpersonal Problems;
a: $n = 282$. b: $n = 216$; * $p < .05$, ** $p < .01$ (two-tailed)

a lower negative correlation with neuroticism, depression and fear, as well as a positive correlation with life satisfaction. The negative correlation with interpersonal problems (Table 8) is also low. However, there is a medium negative correlation with attention to emotions (TMMS, Table 7) and in some parts towards openness for experiences (Table 5), which maybe also point out unfavourable aspects of those constructs.

Discriminant validity. In addition to the correlation with conceptually similar constructs, the discriminant validity of the scales becomes clear through its lack of correlation with conceptually different constructs. No correlation between SEE and the NEO-FFI scales agreeableness and conscientiousness is expected since connections cannot be postulated based on theories or on the level of evidence. Actually the scales are definitely uncorrelated (with one exception). Surprisingly, there are also no significant correlations towards the scale *extroversion*. Here, significant correlations were expected under the assumption that a positive valuation of one's own emotions would promote the expression of these feelings vis-à-vis others. It was also anticipated

that people experiencing a lack of emotions are more reserved in the expression of their emotions, and therefore, a negative correlation would exist. However, these constructs do not seem to be fundamentally linked. Further research will examine this more closely. The findings concerning convergent and discriminant validity from Study 3 (Behr & Becker, 2002) have been consistently replicated with these results.

Criteria-validity. *Findings with psychotherapy clients: Psychotherapy clients versus general population.* To further verify the validity of SEE, patients, who at the time of the inquiry were in ambulant or stationary psychotherapy, were examined with respect to their SEE results and compared with data out of the random sample. The sample of stationary psychotherapy patients was drawn from three institutions of adult and adolescent psychiatry. The ambulant psychotherapy clients came from five different psychotherapists.

The average-value and significant average-value-differences of the three groups are listed in Table 9. The outcomes are consistent with the theoretical considerations throughout the results. It was expected that psychotherapy clients in all scales, except the two scales of symbolisation, would show more unfavourable data than the random sample and that clients of stationary psychotherapy would rank again even more unfavourably than clients of ambulant psychotherapy. For the scales of symbolisation we did not expect this because they only cover the person's preferred approaches towards emotions. Actually, these hypotheses were verified: people without psychotherapy show a higher amount of acceptance of their own emotions and greater emotional regulation compared to people in ambulant or stationary psychotherapy. With regard to the experience of self-control, they differ significantly from people in ambulant psychotherapy, but not from people in

Table 9. Psychotherapy-clients: Significant mean differences in SEE scales among client groups

	General Sample (without Psychotherapy) $N = 1094$		Ambulant Psychotherapy $N = 42$		Psychotherapy in Clinic $N = 25$	
Scales	*M*	*SD*	*M*	*SD*	*M*	*SD*
1. Accepting one's own emotions	3.68 [a]	.76	3.28 [b]	.92	2.93 [b]	.99
2. Experiencing overwhelming emotions	2.83 [a]	.86	3.21 [b]	1.03	3.61 [b]	.71
3. Experiencing lack of emotions	2.33 [a]	.69	2.41 [a]	.76	2.90 [b]	.74
4. Bodily symbolisation of emotions	3.19 [a]	.68	3.33 [a]	.72	3.03 [a]	.61
5. Imaginative symbolisation of emotions	2.65 [a]	.87	2.42 [a]	.86	2.61 [a]	.92
6. Experiencing regulation of emotions	3.02 [a]	.69	2.68 [b]	.71	2.54 [b]	.63
7. Experiencing self-control	3.19 [a]	.73	2.87 [b]	.88	2.93 [a b]	.70

Scores with same index within one scale do not differ significantly. (Scheffé - Test), * $p < .05$ (two-tailed)

stationary psychotherapy. This result could arise from the soothing, structured stationary setting. In comparison with the other two groups, people not in psychotherapy still feel significantly less overwhelmed by their emotions. They also experience less of a lack of emotions. As expected, simply from the scales *bodily symbolisation of emotions* and *imaginative symbolisation of emotions*, no differences can be determined among the three groups.

Connections of SEE with the Brief-Symptom-Inventory

We hypothesised that at the symptom-level of psychotherapy patients, connection patterns could be replicated, which arose from the random sample with correlations of SEE and the clinically relevant personality measures fear, depression, neuroticism, stress, life satisfaction, and the self-concept measures. These connections did emerge (see Table 10). Here, negative to high-negative associations of the BSI-general index with the scales *acceptance of one's own emotions*, *experience of emotional regulation* and *self-control* arose. The three scales also show a consistently negative correlation with the BSI-subscales, whereas these negative correlations were at their highest level with the scale *accepting one's own emotions*. The scales *experience of overwhelming emotions* and *experiencing a lack of emotions* show positive connections

Table 10. Correlations of SEE scales with the experience of symptoms of psychotherapy clients

Symptoms	1. Accepting one's own emotions	2. Experiencing overwhelming emotions	3. Experiencing lack of emotions	4. Bodily symbolisation of emotions	5. Imaginative symbolisation of emotions	6. Experiencing regulation of emotions	7. Experiencing self-control
BSI (SCL-90 short form)							
Somatization	-.38**	.33*	.20	-.05	.10	-.15	-.25
Obsessive Compulsive	-.32*	.27	.30*	-.17	.09	-.23	-.19
Fragility in Social Contacts	-.62**	.45**	.21	-.16	.01	-.38**	-.23
Anxiety	-.59**	.46**	.27	-.04	-.06	-.27	-.19
Depression	-.47**	.32*	.32*	-.27	.01	-.31*	-.13
Aggression/ Hostility	-.42**	.45**	.28*	-.01	.06	-.26	-.36**
Phobic Fear	-.40**	.13	.27	-.16	-.18	-.07	.02
Paranoid Thinking	-.38**	.38**	.27	-.04	.09	-.19	-.39**
Psychoticism	-.49**	.47**	.41**	-.11	-.03	-.30*	-.22
Global Severity Index	-.55**	.44**	.34*	-.14	.01	-.30*	-.25

BSI = Brief Symptom Inquiry (Short Version of SCL 90)
$N = 52$, * $p < .05$, ** $p < .01$ (two-tailed)

in both the BSI-general-index and the BSI-subscales. These results show that acceptance of one's own emotions, emotional regulation and self-control as they are surveyed by the SEE, have less bearing on symptom experiences in the group of psychotherapy patients. The experiences of overwhelming emotions and a lack of emotions are linked with symptom strain, as was expected against the backdrop of the person-centred approach.

Gender, age and educational differences

Gender differences. Earlier research in this subject area showed gender differences in some emotional and social domains. It was reported that women express their emotions more than men (Gross & John, 1998, 1995; Riggio, 1986), show higher measures of impulsiveness (Gross & John, 1998), are socially and emotionally more sensitive, and control their emotions less (Riggio, 1986). In inventories of fear and depression, women perform worse. Because of the present research, it can be hypothesised that significant gender differences are evident in all the scales for the experience of emotions. Women should have lower data on the scale *acceptance of one's own emotions* because of the unfavourable strain of fear and depression. They should feel more overwhelmed by emotions and be less able to control and regulate themselves as compared with men. Moreover, they should have higher data in the scales *bodily and imaginative symbolisation of emotions*. These hypotheses were clearly verified, except for one (Table 11): regarding the acceptance of one's own emotions, men and women do not differ significantly.

Age differences. Because of the present research, no hypotheses concerning age differences can be formulated. In our random sample only a small effect can be

Table 11. Gender differences with the SEE scales

	Male $n = 332$		Female $n = 727$		
Scales	*M*	*SD*	*M*	*SD*	*t*
1. Accepting one's own emotions	3.73	.69	3.65	.73	1.71
2. Experiencing overwhelming emotions	2.58	.84	2.99	.86	7.27***
3. Experiencing lack of emotions	2.49	.71	2.25	.68	5.34***
4. Bodily symbolisation of emotions	2.97	.73	3.31	.63	7.63 ***
5. Imaginative symbolisation of emotions	2.39	.88	2.74	.86	6.14***
6. Experiencing regulation of emotions	3.16	.72	2.91	.65	5.65 ***
7. Experiencing self-control	3.41	.71	3.08	.69	7.17 ***

***$p < .001$ (two-tailed)

seen, whereby older participants accept their emotions more, $r = .12, p < .001$, have less imaginative symbolisation of emotions, $r = .21, p < .001$, and experience less overwhelming emotions, $r = .13, p < .001$.

Educational differences. There are no relevant connections. The highest rank correlation is -.13 ($p < .001$) with the scale *experiencing lack of emotions.*

DISCUSSION

The scales tap meaningful constructs of the person-centred approach and emotion-focused therapy approaches. The scales proved to be independent from one another; they show a satisfactory to good consistency and a good to very good stability. A wide range of correlations support the validity of the instrument. As a short and fully standardised self-report inventory with only 42 items, it can be set up quickly and easily in the aforementioned areas of practical work and research.

The scale *accepting one's own emotions* supplements the distinction developed by Salovey et al. (1995), Otto et al. (2001) and especially Litschetzke et al. (2001) between the attention to emotions and emotional clarity in terms of the valuation aspect of one's own emotions. A moderating effect could be on hand: in research for emotional self-awareness, awareness correlates with negative existential orientation and emotionality. Lischetzke et al. (2001) found in their studies a negative correlation with neuroticism as well, but all together inconsistent results for it. The scale *accepting one's own emotions* correlates in the present study positively, not only with the awareness scales, but also with the clarity of TMMS, and in particular, it correlates negatively with all measures of disorders. This supports the paradigm of all emotion-centred therapy theories in which focusing on one's own emotions predicts well-being if the person values his or her emotional experiences. Less convincing with regard to the interactive character of the person-centred personality theory are the moderate to low correlations with positive inter-personality, which seem to be too low in the area of interpersonal experiences for the self-concept in this personality theory context.

Who suffers more: the person who experiences a lack of emotions or the person who feels overwhelmed by emotions? The divergent correlation patterns of the two scales with the measures for clinical disorders suggest an extension of the person-centred personality theory. The scale *experiencing overwhelming emotions* represents a pattern of individual experiences, which is not directly described through a construct of the person-centred theory. The person-centred theory describes instead a person who is not in contact with feelings (*experiencing a lack of*

emotions) and how this person can become aware of his or her feelings through a process of self-directed symbolisation (Rogers, 1951, 1957). This illustrates a basic concept of all experience-orientated psychotherapies (Greenberg, 1993). Tables 10 and 11 show a conformity with this theory, that these persons, who do not feel in contact with their emotions, are unhappy, ambiguous about their feelings and are not in contact with other people. If you now look at these instruments - which measure mental disorders in a more clinical way, like neuroticism, stress, psychosomatic disorders, fear or depression, for example, you see that they have the strongest relation with the scale *experiencing overwhelming emotions*. These correlations correspond in part with the results of Gross and John (1998, pp. 180-183), who have also reported about significant, but somewhat lower correlations between neuroticism and their "Impulse Intensity Scale." Furthermore, they correspond with the results of Greenberg, Rice and Elliot (1996). The results point out the significant importance of patients' experiences of overwhelming emotions. They suggest a rethinking of the person-centred theory in that area.

Another interesting aspect for the personality-model concerning the experiential focus on emotions arises. Imaginative and body-related emotional experiences correlate low with fear, depression and psychosomatic disorders. This supports an aforementioned inconsistent finding: the connection of emotional self-awareness and negative mood, which again may suggest moderating variables. However, in the present clinical sample these connections were not found.

Three of the seven scales of SEE are concerned with too much emotion and its mastery: overwhelming emotions, self-control and emotional regulation, which points out a salient meaning of this complex. Present research outcomes and experiences of psychotherapy practitioners have supported the use of items that take the aspect of regulation into account. Of course, the factor structure is determined by the items that are used at the beginning. Still, it was not expected that this aspect would carry such weight in the factor structure. Also, emotional regulation and self-control predicted consistent well-being. With regard to stress, traumata, clinical disorders and overwhelming emotions, this aspect seems to deserve much more attention.

Concerning counselling practice, the results suggest that the diverse forms of how emotions are experienced and symbolised from the very beginning should be taken into account. Applying the SEE scales during the initial contact with a client may help counsellors to immediately adjust interventions to the structures of the person's emotional experience.

For outcome research, the scales open up the option of assessing those constructs that form the basis of the personality-model. The scores of these scales

should change as a result of person-centred interventions. This introduces the possibility of going beyond symptom measurement and theory-unspecific personality traits to a level of verifying immanent therapy-form models of change.

The outcomes to date point out that the experience of emotions is connected with variables like mental health, experience of stress, self-concept, interpersonal skills and life satisfaction. The scales indicate a high level of explained variance within questions of social, clinical, personality and educational psychology.

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