2024

Integrating Clinical Intuition for a Whole Person Approach to Empowerment

Jennifer Sousa
Sofia University, Palo Alto, CA, USA

Integrating Clinical Intuition for a Whole Person Approach to Empowerment

Jennifer Sousa
Sofia University
Palo Alto, California

This paper is a summary of a study utilizing constructivist grounded theory to examine the process of accessing and applying clinical intuition in psychotherapy. Intensive interviews were conducted with 19 psychotherapists to explore their experiences with clinical intuition, including training on the topic, supportive conditions for accessing intuition, and decision making around its application in session. Engagement in an iterative process of data collection and analysis occurred to arrive at the constructed theory: integrating clinical intuition for a whole person approach to empowerment. The theory is comprised of the core categories (a) building trust and confidence to access and use intuition as a therapist, (b) practicing, and (c) empowering clients to connect with their own intuition.

Keywords: *clinical intuition, psychotherapy, ways of knowing, constructivist grounded theory, qualitative*

While there is a growing body of research on utilizing intuition in professional settings, such as business and nursing, there continues to be a dearth of research in the realm of psychotherapy and clinical intuition (Dane & Pratt, 2007; Holm & Severinsson, 2016; Jeffrey & Stone Fish, 2011). Moreover, most psychotherapists are not trained to recognize, interpret, and utilize their clinical intuition despite these professionals reporting employing it in their work and rating intuitive understanding and judgment above theoretical practices regularly (de Vries et al., 2010; Fox et al., 2016; Jeffrey, 2012; Jeffrey & Stone Fish, 2011). The lack of research and training in relation to clinical intuition may limit practitioners access to "clues about information the client is not expressing, the status of the therapeutic relationship, areas of needed inquiry, and warning signs related to the counseling process" (Jeffrey, 2012, p. 38).

One of the primary concerns with applying intuition is the difficulty of distinguishing it from bias and countertransference (Dane & Pratt, 2007; Hart, 1997; Jeffrey, 2012; Kahneman & Klein, 2009). This discernment process would greatly benefit from the support of clinical supervision or consultation (Jeffrey, 2012). Therefore, the present study pursued developing a theory regarding the process of using clinical intuition to enhance understanding for psychotherapists, contribute to the existing literature, and promote education and training for it given its consistent use among practitioners.

A contributing factor to the difficulty researching intuition is the lack of agreement on how to define intuition with over 40 definitions in the extant literature (Holm & Severinsson, 2016; Jeffrey, 2012; Shirley & Langan-Fox, 1996). Shirley and Langan-Fox (1996) explained intuition "as a feeling of knowing with certitude on the basis of inadequate information and without conscious awareness of rational thinking" (p. 564); whereas, Cook (2017) described intuition in more colloquial terms saying, "It is sometimes described as a sixth sense, or gut feeling, that is later proven correct" (p. 432). Bernstein (2005) characterized intuition as receiving accurate information about other people, places, or incidents which do not originate from stored memory or information accessed via physical sensations. Bernstein's definition runs counter to cognitive research viewing retrieval of stored memories as an underlying mechanism

of intuition (Hodgkinson et al., 2008; Langan-Fox & Shirley, 2003; Shirley & Langan-Fox, 1996).

The lack of consensus on how to operationalize intuition reflects the complexity of the concept, variations in how it is measured, and opposing views of its etiology (Dane & Pratt, 2007; Langan-Fox & Shirley, 2003). The variety of perspectives and approaches to intuition is ensconced in its historical underpinnings as well. Langan-Fox and Shirley (2003) noted that intuition "seems to have arisen from at least two sources: the mathematical idea of an *axiom*, a self-evident proposition that requires no proof, and the mystical idea of revelation, that is, truth that surpasses the power of the intellect" (p. 207). Langan-Fox and Shirley (2003) further outlined intuition's significance to Greek philosophers, including Pythagoras, and Christian philosophers, who considered it in relation to connecting with a higher power; whereas, Thomas Reid offered one of the initial theories of intuition as being part of the "human mind" (p. 208) in the 1700s. These divergent concepts continue to be evidenced in research on intuition taking on more of a parapsychological stance as in Bernstein's (2005) summary of the scientific findings over the past century on telepathy, precognition, remote viewing, and presentiment to Pilard's (2018) exploration of Jung's conceptualization of intuition evolving from the supernatural and pathological to a psychological type. Pilard (2018) acknowledged this range of experience by commenting, "For intuition to become fully accepted, our society needs to appreciate it, from its paranormal epiphanies to its normal occurrences" (p. 81).

The study summarized herein sought to answer the question: What theory explains psychotherapists' use of intuition in their therapeutic work? This researcher viewed intuition as "direct and embodied ways of knowing prior to conceptual or psychological interpretation" (Anderson & Braud, 2011, p. 19), and within the professional setting of psychotherapy, clinical intuition was understood as tacit knowing or an automatic perception of the client's state as experienced by the psychotherapist that can be applied in clinical decision making (Fox et al., 2016). However, constructivist grounded theory calls for examining the participants' implicit meanings and acknowledging how multiple social realities lend themselves to meaning making (Charmaz, 2014). The present participants were asked to share their definitions of intuition, which were categorized, to ground the findings in their conception of this complex term.

Review of the Literature

Research on intuition has taken several forms and emerged from various disciplines. For example, two tests identified as measuring intuition, Myers-Briggs Type Inventory (MBTI) and the Accumulated Clues Task (ACT), were speculated to be measuring different aspects of intuition. Langan-Fox and Shirley (2003) explained, "The ACT may be measuring the cognitive dimension of intuition . . . and the MBTI may be measuring the behavioral dimension of intuition or a person's tendency to respond in an intuitive manner" (p. 219). From an evolutionary perspective, "our emotional responses provide us with an immediate sense of whether we should approach or avoid particular objects or people before we are able to articulate why" (Cook, 2017, pp. 432–433). Bernstein (2005) summarized theories suggesting telepathic communication is transmitted through electromagnetic waves, and quantum entanglement may be involved in individuals' ability to engage in remote viewing. Other research has outlined the conditions in which intuitive decision making is most likely to be used consisting of when there are many possible solutions, less predictability, limited information or precedent, and the need to make a quick decision in the moment (Shirley & Langan-Fox, 1996).

Cognitive theories of intuition typically concentrate on using intuition to problem solve or make decisions. Delving into expertise, the naturalistic decision-making (NDM) perspective postulated accumulating enough tacit knowledge through experience to engage in more accurate intuitive decision-making (Klein, 2015). Implicit learning has been further implicated in the formation of intuition by some researchers, such as Bowers' two stages of intuition described as "clues to coherence [that] activate appropriate mnemonic and semantic networks within the individual, and eventually the level of activation is large enough to become conscious, resulting in a hunch or hypothesis" (Langan-Fox & Shirley, 2003, p. 209).

Alternatively, heuristic theories view intuition as coming from heuristics, such as fast and frugal heuristics (FFH), which "can arise from individual learning, from social learning, and from phylogenetic learning . . . and result in general purpose tools such as Take The Best" (Klein, 2015, p. 164). Heuristic theories stressed issues with heuristics being used to make inaccurate decisions because they do not apply to the present conditions or there is a better alternative, such as using the heuristic of representativeness over statistical prediction in a question related to probability (Kahneman & Tversky, 1973). It is easy to see how bias and stereotypes can factor into decisions arising from heuristics. However, Kahneman (2002) stated, "Most behavior is intuitive, skilled, unproblematic and successful" (p. 483) but cautioned for the need to be aware of the pitfalls of intuitive judgments and make corrections where needed. Additionally, Kahneman and Klein (2009) addressed differences between heuristics and biases (HB) and NDM research by outlining discrepancies in how they approach their studies, such as using laboratory as opposed to field settings and comparing participants' performance to peers versus the most applicable model to solve a problem or make a prediction.

The neuroscience literature adds yet another layer by exploring the possible neurology behind intuition. Hodgkinson et al. (2008) underscored neurological studies adopting dual-process cognitive theories, which focus on intuitive and analytical cognitive processes. Research conducted by Lieberman and colleagues using functional magnetic resonance imaging (fMRI) supported a two-system model with the X-system, intuition, being *reflexive*, quick, and engaged in parallel processing but *slow learning* and the C-system, analysis, being *reflective*, slow, and engaged in serial processing but *fast learning* (Hodgkinson et al., 2008). The X-system included the "ventromedial prefrontal cortex, basal ganglia, amygdala, and lateral temporal cortex" (Lieberman et al., 2004, p. 424). Additionally, emotional experience could play a role in intuition with one possibility being the amygdala appraising negative affective stimuli and the basal ganglia assessing the positive (Hodgkinson et al., 2008; Lieberman, 2000; Lieberman et al., 2004). While this research has contributed many substantial findings, such as exploring intuition's etiology and possible benefits and drawbacks of its use, it also demonstrates the diversity and complexity of studying intuition in general and lack of research specifically in the area of clinical intuition. These challenges may be underlying hesitance to research, train, or discuss clinical intuition due to a need for more clarity and specialized studies.

When reviewing the limited research pertaining to intuition and psychotherapy, the existing studies have started to examine the psychotherapists' experience of clinical intuition, how it is used in decision making, and possible guidelines for applying it in therapy. Jeffrey and Stone Fish (2011) studied clinical intuition by conducting a qualitative phenomenological study using semi-structured interviews with eight marriage and family therapists (MFT). Participants reported a variety of ways to experience intuition, such as via images, thoughts, and bodily sensation, and they described preparing to receive intuitive information, including being present and attentive to their own experience (Jeffrey & Stone Fish, 2011). However, participants also spoke to the lack of guidance and acceptance for clinical intuition within the field. Participants stated it would be helpful to have clinical intuition addressed in supervision and training, and some participants shared not disclosing use of clinical intuition due to worry of being disregarded since it was perceived to still be a taboo subject (Jeffrey & Stone Fish, 2011).

In relation to decision making, Fox et al. (2016) analyzed the responses of 44 mental-health clinicians to watching 39 two-minute video clips of clients talking in therapy and asked to rate the appropriateness of different pre-identified clinical interventions for each clip. Fox et al. found the results clustered into a common response, which they related to clinical intuition since participants were required to make quick clinical judgments versus the more time-consuming, analytical processing. In the de Vries et al. (2010) study, 80 students in a clinical psychology program were asked to read two descriptions of complex clinical cases, and then,

participants in the conscious-processing condition were directed to consider the cases for 4 minutes while participants in the unconscious-processing condition worked on a word-finding puzzle during that time (de Vries et al., 2010). Subsequently, all participants provided two diagnoses per case, and the unconscious processing condition resulted in more correct diagnoses than the conscious-processing condition (de Vries et al., 2010).

The merit of further researching and utilizing clinical intuition beyond these studies on decision making may be conceived in Hart's (1997) description of the related experience of transcendental empathy in session. Hart (1997) stated, "In these moments my feelings, images, and thoughts did not seem to be my own but instead seemed to be coming directly from the client" (p. 246). Hart went on to cite research noting psychotherapists preparing to enter a state of receptivity to attune to their clients by engaging in centering and relaxation practices prior to session. Likewise, the 12 therapists interviewed in Siegel's (2013) study on spiritual resonance reported engaging in their own spiritual practices leading to expanded awareness and intuitive understanding applied in their therapeutic work.

Jeffrey's (2012) proposed guide to assist counselors with self-reflection in using clinical intuition only strengthens the argument for the additional nuance and need for understanding involved in clinical intuition. The guide specified the three key elements to clinical intuition being a trusting therapeutic alliance, attunement to the client, and the therapist's own self-awareness, and it provided six steps, including "attunement, experience, interpretation, decision making, action, and evaluation" (Jeffrey, 2012, p. 39). Jeffrey explained that attunement involved self-awareness about therapists' own personal well-being and being present to their internal experience and the therapeutic dynamic in session to access intuition and distinguish it from personal triggers. These accounts of creating optimal internal conditions to access clinical intuition and the guidelines outlined by Jeffrey indicate that support and training is beneficial in the application of clinical intuition given its reported regular use and intricacy

Method

Constructivist grounded theory was the applied research method for this study. Grounded theory was established to advocate for "*developing* theories from research grounded in qualitative data rather than *deducing* testable hypotheses from existing theories" (Charmaz, 2014, p. 5). It is suitable for researching phenomena that have not been widely investigated and can serve as a basis for future empirical research. Some predominant facets of grounded theory are concurrent data collection and analysis, codes and categories emerging from the data, memo writing, and theoretical sampling (Charmaz, 2014).

Charmaz (2014) described introducing constructivist grounded theory to address the perspective in grounded theory that the researcher is a neutral observer. Constructivism is the "assumption that social reality is multiple, processual, and constructed [and] the researcher's position, privileges, perspective, and interactions [must be] taken into account" (Charmaz, 2014, p.13). Constructivism's acknowledgment that researchers do not conduct studies as blank slates affords them the opportunity to engage in reflexivity. Charmaz (2014) explained,

> Your grounded theory journey relies on *interaction*—emanating from your world-view, standpoints, and situations, arising in the research sites, developing between you and your data, emerging with your ideas, then returning back to the field, and moving on to conversations with your discipline and substantive fields. (p. 321)

The co-construction of data and findings built on interactions respects the concept of multiple social realities and still derives from the intention of developing a theory (Charmaz, 2014). These principles inherent in constructivist grounded theory made it a natural fit for studying the process of accessing and applying clinical intuition. The recognition of multiple social realities matched the complexity of meaning making regarding clinical intuition, and the interpretive tradition allowed for the construction of a theory to better understand this process. The intensive interviews, normally used

in grounded theory, had the advantage of creating "an interactional space in which the participant can relate his or her experience" (Charmaz, 2014, p. 57). Furthermore, this author's insider status due to the author's experience as a therapist utilizing clinical intuition made it essential to select a research approach that provided the framework to take into account the author's subjectivity and role in co-constructing the findings and proposed theory.

A purposive sample of 19 psychotherapists, ranging in years of clinical experience from 5 to 47 years with an average of 21 years, reported using clinical intuition and participated in intensive video interviews individually with this researcher for a duration between 30 to 60 minutes each. Two participants engaged in 15-minute follow-up video interviews for the purposes of theoretical sampling and member checking. Participants were somewhat heterogeneous in regard to their clinical theoretical orientations and populations served, and in terms of location, 10 participants practiced in Washington, four in California, three in Minnesota, one in Pennsylvania, and one in New Mexico. Sixteen of the participants hold a master's degree and three hold a Ph.D. degree as their highest level of education. Participants noted a variety of religious or spiritual affiliations, and one participant identified as atheist and three participants noted no religious or spiritual affiliation. Unfortunately, while attempting to recruit a diverse sample, the resulting sample was homogenous in terms of all the participants identifying as Caucasian, 18 participants identifying as cisgender women and one cisgender man, and 18 identifying as heterosexual and one participant as demisexual.

This researcher recorded and transcribed the interviews for analysis, and pseudonyms were used to protect participants' anonymity. During the interviews, participants were given the option of reviewing their transcripts to check for accuracy before coding occurred. Fifteen participants requested a copy for review, and of those participants, 10 responded with six making edits and/or adding comments and four stating no changes were needed.

In the iterative process of constructivist grounded theory, data collection and analysis occurred concurrently, and as a result, questions were added based on the analysis from the initial nine interviews to reflect the emerging codes. Also, theoretical sampling is an opportunity to follow up with participants to be able to compare their responses to initial data and refine or examine the relevance of tentative theoretical categories (Charmaz, 2014). The participants, Morning Star and Szanda, engaged in subsequent interviews with this researcher to fill the gaps related to the core category: empowering clients to connect with their own intuition, and they were presented with the tentative theory for member checking, which they reported being aligned with their experience of clinical intuition.

In constructivist grounded theory, data analysis commonly involves open coding, focused coding, axial coding, and theoretical coding (Charmaz, 2014). During open coding, transcripts were coded line by line using single words or phrases that were largely in vivo or gerunds to capture the participants' voices and the active process associated with clinical intuition (Lyons & Coyle, 2016). Focused coding was used to code initial codes, compare them, and give them meaning in order to organize similar codes into more prominent codes (Charmaz, 2014). The codes were saturated to form categories, and during axial coding, the categories were compared and grouped. This process aided the researcher in organizing categories and their subcategories (Charmaz, 2014). Cluster charts, memo writing, and comparative analysis were employed to organize the codes, subcategories, and core categories culminating in the formation of a theory.

Results

The constructed theory—*integrating clinical intuition for a whole person approach to empowerment*—encompasses the theoretical core categories (a) building trust and confidence with using intuition, (b) practicing, and (c) empowering clients to access their own intuition. These categories represent the arc of participants' developing trust with intuition and practicing using it lending itself to facilitating this process for their clients. However, this process is not linear and can fluctuate, especially depending on participants' identified conditions that help and hinder use of

clinical intuition. Participants' responses to their definitions of intuition were also categorized as the following: unconscious, guidance and awareness, information, an accumulation of prior experience, centered, knowingness, taking place in the right brain, deep listening, and embodied/felt sense. Their definitions were categorized to capture the participants' meaning making surrounding intuition.

The first core category of building trust and confidence with intuitive information touched on the participants' personal and professional development of recognizing and building trust with using their intuition. The second core category of practicing described the subcategories involved in the process of accessing and applying clinical intuition, such as decision making and its clinical uses. Given the context of the study being conducted during the COVID-19 pandemic, participants were also asked about how the pandemic affected their use of clinical intuition. The last core category of empowering clients to connect with their own intuition delved into (a) the purpose for doing so, (b) the roles of the client, therapist, and therapeutic relationship in this process, and (c) therapeutic approaches that foster intuition.

Building Trust and Confidence Within Self as Therapist and Intuition

The core category involving building trust and confidence was at the foundation for using clinical intuition. Its subcategories include *personal and professional development of intuition*, *mutually building trust and confidence within self as therapist and intuition*, *cultivating trust of intuition via discernment*, and *allowing utilization of intuition*. Participants described feeling their intuition was always present but second-guessing intuitive inklings potentially interfering with trusting and acting on the intuitive information. Jennifer described having to build confidence with using intuition as, "It would start off really small, and the more I would lean into it, the more confident. It grew into the confidence I have now to use it." Isabel touched on the roles of trust and confidence in the following, "Lack of confidence, I think affects my intuition . . . part of that is trusting my intuition, and I know it's grounded in who I am . . . Knowing when to share and when not to and other things to utilize." Practice applying their clinical intuition in session led to greater trust in their intuition and their ability to utilize it effectively.

Personal Development of Intuition

The subcategory, *personal development of intuition*, explored the influence of participants' personal experiences on their intuition and how it supported their use of clinical intuition as psychotherapists. In terms of intuition, Steve noted, "You know, it was more personal. Now, as a clinician, it's like I'm bringing that out to meet where the client is." Most participants reported having noticed intuition since their youth. Manatee shared, "I think it just kind of started when I was younger. I was always intuitive, and I was always empathic."

Some participants parsed out experiences in association with intuition, such as trauma exposure and emerging psychic capacity. Morning Star described her experience as a person, who had adverse childhood experiences.

> I work with trauma survivors a lot, and trauma survivors are very intuitive. Actually, you know, they've had to be. And while I wouldn't call myself a trauma survivor, I would say that I am a child of adverse childhood experiences . . . there was mis-attunement going on. When there's mis attunement, I think kids start listening to something else. They start listening for something else.

Two participants commented on experiencing some psychic capacity, and Annie shared, "Sure, back in the early 2000s, I started developing psychic capacity . . . What precipitated that was my own hitting a really hard place, and I started having visions that were really dramatic."

Personal healing work was also addressed by participants and involved engagement in healing modalities that helped participants to attune to themselves, participate in their own self-care and healing, understand their parts, and experience being the client. These foundational experiences supported their self-awareness, self-care, presence, and empathy needed to notice and use clinical intuition professionally. A. Oakley elaborated on the experience via metaphor.

> I think of myself as the tractor. I'm a tool, and I have to keep my tractor working well. I do all

> those regular self-help things like going to analysis . . . So, that's invaluable to me as a human being and even more so as a psychologist. For me to do my own work and to experience what it's like on the other side to be a client.

Several participants reported different spiritual trainings or exposure, including studying chakras, reading spiritual texts, and working with a spiritual mentor. Beth noted, "So, when I lived in the yoga community . . . we always talked about listening to your body, higher self, and intuition. I mean everything I read was geared towards that whether it was Buddhist or Hindu, Kabbalah." Grace relayed her experience working with a Native American medicine woman.

> It is such a foundational piece that it's almost like I couldn't pull out which pieces came from that training versus not. Because it's probably informed a lot of the work that I do . . . it helped me personally. And then, it just ripples out into how I show up as a professional.

Professional Development of Intuition

Professional development of intuition consisted of the participants' experiences with helpful and unhelpful education, training, and clinical supervision in relation to clinical intuition. Supportive educational experiences encouraged self-care, acknowledged that past experiences do inform clinical work, and had faculty knowledgeable about clinical intuition. Szanda described her experience in an existential phenomenology program, "I think that it allowed a lot of space for growing both intellectually and intuitively to understand that our past experiences do inform us." Unsupportive education did not foster the use of clinical intuition, provide information about it, or discuss or respect it. Participants mentioned more of a focus on traditional theories. Morning Star shared, "It wasn't in my schooling . . . I think it depends on the school of therapy that people are doing or the modality. But I think it's missing for sure." Grace acknowledged, "It's not really something that's talked about, and it might not even be that respected, I would think."

In terms of trainings, participants mentioned examples of helpful training for clinical intuition nurturing participants' awareness and connection to their bodies, promoting a whole person approach, fostering attunement to the client and self, and/or teaching Jungian or existential approaches. Ajax noted her experience with the Diamond Approach stating, "[I engaged in the] Diamond Approach . . . because it brings psychology and the body and spirit together." Dr. Mary reported the following about being trained as a Jungian analyst and using intuition:

> [Jungian theory] totally honors this part of the psyche, and Jung paid attention to it and von Franz did . . . I think that's why Jungian therapy is so rich and deep . . . I feel really lucky that I had those supervisors, those analysts, those teachers.

Unhelpful trainings for clinical intuition led participants to note the absence or lack of training on the topic. Healing Presence reported, "It's not something that's talked about enough in the therapy training world or even in workshops."

As participants disclosed their experiences with supervision, some participants stated selecting supervisors, who were able to address clinical intuition. Isabel relayed, "I think that I chose a path of learning that mostly cultivated my use of intuition . . . I've chosen to work with people over the years that would be congruent with my beliefs about this work." Jenny reported having a clinical supervisor, who supported her with listening to her gut, stating, "It started with, when you feel an intense emotion, what's happening? What's happening in your body . . . she helped me understand that process, and I in turn help other up-and-coming therapists understand it as well."

Participants identified qualities and behaviours displayed by supportive supervisors, such as being knowledgeable, authentic, present, gentle yet honest, and concerned with building rapport with the supervisee. Sue shared, "So, probably the doing the work and a great supervisor helped me to learn how to do it and use intuition, although it was not spoken in that way." Helpful guidance regarding clinical intuition included modelling the process, providing support with distinguishing it from countertransference, and giving participants permission to use their intuition

and take risks. Jennifer relayed what her supervisor, advised, "I want you to just be silent and listen to your inner voice about something, and try to lean into that and try to offer that in sessions and see what happens." On the other hand, unhelpful supervision did not address clinical intuition or align with the participants' clinical approach.

Mutually Building Trust and Confidence Within Self as Therapist and Intuition

The subcategory, *mutually building trust and confidence within self as therapist and intuition,* spoke to many participants reporting their level of trust and confidence getting stronger with experience and practice. Morning Star described the link between practice and confidence.

> There was a lot of mistrust of my own intuition, and I find this a lot with women. . . I always say to people awareness is only half the work, practice is the other. Practice is following the intuition, even if there's self doubt. That's how I think it's developed because then you get evidence. You get the sense of that worked. And then, the self-confidence in that builds.

Dr. Mary shared her development experience.

> When I started, it was just terrible probably because I was paying so much attention to doing it right, saying the right thing that I wasn't related at all. I mean I was related to my textbook. It was like I was not even looking at my patient. So, it just is a question of becoming comfortable and sort of mutually building trust within myself and with the intuition.

Cultivating Trust of Intuition Via Discernment

Cultivating trust of intuition via discernment described the process of practicing differentiating countertransference, bias, and projections from intuition and the client's experience. Participants addressed helpful practices and warning signs of bias and countertransference to distinguish it from intuition. Helpful practices were taking time to reflect on the intuitive material or countertransference, consulting with peers or supervisors, and slowing down to self soothe rather than react to the client in the moment in session. Participants reported many warning signs for countertransference entailing the session material staying with them after the session, experiencing judgment towards the client and no longer being curious, having an emotional response, and recognizing their attachment to a treatment agenda versus following the client's lead. They also noted knowing their own personal buttons to be aware of being triggered when those topics arise in session. A. Oakley explained, "So, when I am more distracted by my own issues that seem to be echoing here, I'm pretty sure that inhibits intuition because I'm over here thinking rather than being as receptive." While distinguishing triggering emotions, Morning Star shared,

> Intuition sometimes speaks to me in a different voice, if you will, than ego. Because it's kind of a calm, a piece of information that comes. An ego wants something to happen, right? So, I try to get a sense of, "Is this just my stuff wanting to spill out, over?" or "Is this really coming to me?" . . . I think that's a distinguishing factor. I think countertransference is always charged. There was always the surge of emotion. Even if it's subtle, it's still a surge of emotion.

Allowing Utilization of Intuition

Lastly, *allowing utilization of intuition* addressed being receptive and open to intuitive material. Whereas, not giving oneself permission to use it and doubt interfered. Isabel clarified,

> If I allow it to be okay, which is not always easy in our field in my opinion. But if I allow it to be okay to tap into this and utilize it, it's more of a natural process . . . But I would say throughout my career, I've had lapses in utilizing my intuition, but it's always been there.

Practicing

Practicing outlined the process of using clinical intuition in the participants' clinical practices. This core category contained the subcategories, *practices that support access to intuition, helpful and unhelpful conditions to access and use intuition, experiencing intuition, decision making, accurate and effective and inaccurate and ineffective application of intuition, sharing use of intuition,* and *telehealth*. Practices supporting intuition involved engaging in self-care activities, self-help or self-

development, attuning to self, internal quieting practices, and practices in relation to session. The benefits of engaging in certain practices were maintaining good boundaries, facilitating an internal state conducive to intuition, and being able to be present to self, client, and the therapeutic dynamic. Examples of practices in relation to session were engaging in morning practices and setting intentions prior to session, creating a transitional space at the of start session, such as beginning a session with breathwork, and clearing the space and creating a boundary between work and personal life at the end of the day. Jennifer shared actions after a session,

> I smudged. Took a hot Epsom bath . . . part of preparation is repairing from what you did that day too . . . That's how I see it because I think it's a muscle in a way. Then, the more you use it, the stronger it becomes.

Helpful and Unhelpful Conditions to Access and Use Intuition

Similarly, while considering helpful conditions for clinical intuition, participant responses were engaging in self-care, having a safe/peaceful environment, being present or mindful towards self and client, and having supportive consultation about intuition, and some participants commented on setting intentions, being authentic, and a spiritual connection to the therapeutic alliance. Self-care in this context conjured reports of prioritizing one's own needs, ensuring the working conditions match the practitioner's capacity, and managing stress. Safe and peaceful environment entailed considering how to limit or adapt to distractions, choosing or creating a peaceful space, and noticing one's sensitivity to energy in the surroundings. Sue noted, "Having no clutter. It just reflects how the mind needs to be peaceful and quiet to have an intuition . . . It just calms the mind because the mind is so easily drawn into this or that." Unhelpful conditions for using clinical intuition included noisy environments, stress, fatigue, distractions, therapist attachment to a treatment agenda or client progress, and client resistance. Morning Star stated the following about clients,

> The more a client has a symbolic life, the better they are able to reflect and drop in into themselves, then I'm going to be doing that. You know, it's like, "Is my unconscious and their unconscious speaking to one another?" . . . So, the more a client is attuned, the better.

Participants were also asked if meeting with more than one client in session impacted their access or application of intuition, and participants expressed mixed perspectives from it having no effect to being different or more challenging. Isabel explained her experience of it affecting intuition by stating, "Yes, I think that there's divided attention, and for me, a little bit more anxiety can come up wanting to make sure that I'm taking care of everybody's needs." Reported obstacles to using clinical intuition in family counselling was divided attention due to multiple people in session, therapist feeling more emotional, and the need to be more strategic, and some participants noted the need to be more strategic in couples counselling as well as there being more psyche in the room and the goals being different from individual therapy.

Group counselling elicited different responses in comparison to family or couples counselling as participants spoke of the "synergy" once group members got to know each other and settled in, as stated by Ajax. Marita explained this process as:

> Psychodynamic theory, they call it the mother. The group soul becomes the mother . . . we're collaborating, creating something that's holding us . . . Being present with what already is and tapping into it, I think is the accessing the field of coherence . . . So, yeah, I would say those are all helpful resources for me to tap into my intuition and knowing I'm not alone.

Experiencing Intuition

Intuition was experienced through feeling energy, images, hearing, dreams, thoughts, reading body language, a knowingness, and via the body. Some participants noted feeling an empathetic response, channelling, and synchronicity. Grace reported experiencing intuition via thought and somatic confirmation, "It's almost like I get an idea in my head, and then, my body gives me this really subtle kind of somatic confirmation of like,

'Oh, I think this is where they're going with that.'" In relation to hearing, Beth shared, "I'm pretty auditory. So, I might hear guidance," and in terms of a knowingness, Annie stated,

> I think sometimes it is just a sense of knowing where to go next . . . it is just a feeling of movement of like going towards versus the other feeling, which would be the absence of an intuitive yes or feeling of wanting to pull back or a kind of stopping.

Intuition experienced through the body, such as bodily sensations and a somatic response, was reported by most participants. Dr. Mary shared, "Then to notice what happened in my body . . . I mean it was probably unconscious mirroring of what they're feeling, but just as a way to know. So, I guess body's the main channel if it's intuition in the session."

Decision Making

Decision making associated with clinical intuition application was reported to be a conscious process based on the therapeutic alliance and several deciding factors. Jennifer spoke to it being a conscious process, "Just because something comes to you, doesn't mean you share it. It's not an impulsiveness . . . The very careful, quick decision you have in a session . . . of what you're going to do with it." Relationally, participants discussed building rapport first and attuning to the client to know if they would use clinical intuition and how to apply it. The identified deciding factors were using their intuition to discern whether to share intuitive information, the intuition feeling strong or relevant, if the client was receptive to intuitive material, whether there was a need to gather more information, if it was ethical and appropriate, client presentation and history, timing, and client goals. Jenny offered an example of determining if clinical intuition is appropriate to use.

> This doesn't work with clients who are delusional or paranoid, and it just makes it worse. And it feeds into their, "Somebody is controlling me. Somebody is using some sort of like Jedi mind tricks on me.". . . It's not everybody's going to be able to handle the intuitive body, visceral approach to therapy.

The stated uses for clinical intuition were utilizing the intuitive material to determine the next intervention, choose where to focus or gather more information, support case conceptualization, name something for the client, or engage in reflection of feelings. Additionally, some facilitators of decision making for using clinical intuition were practicing applying it, engaging in reflection, and being okay with putting off addressing the intuitive material in order to consider if and how to use it. Marita reported, "I think slowing down and really listening helps with that discernment process both in what's mine or theirs, in when do I name something and reflect it, or when do I hold it?"

Accurate and Effective and Inaccurate and Ineffective Application of Intuition

While exploring accurate and effective application of clinical intuition, participants shared examples of using the information to ask a question, apply a useful intervention, engage in dreamwork, or share the intuitive material with the client. Isabel stated an example of sharing an image with a client.

> The image was of standing at the edge of a cliff . . . There being a sense of like, "Am I going to go over this cliff?" What came strongly was the word, choice . . . the image was very clear and strong that there's a choice here. That went well. There was a lot of resonance with the image, and it was useful.

Participants described recognizing the application of clinical intuition was accurate or effective by the client's verbal and nonverbal response, movement or progress in treatment, and having a sense. Manatee reported, "Generally, they'll say it, but you can also see that like aha moment on their face, just you know by their facial expression." Likewise, client responses were often to verbalize whether the intuition resonated per participants, but they also displayed an emotional response. Jennifer noted, "You share what's coming to you with the client, and they go like, 'Wow.' They have a sense of relief. [It] happens 80% or 90% of the time, that would be the case."

While addressing inaccurate or ineffective application of clinical intuition, many participants stated difficulty remembering an example, there

being a risk with sharing intuitive material, learning from errors being part of the process, and recognizing mistakes occur all the time. Beth acknowledged, "Oh that happens all the time. That's part of the process . . . It is not about me reading them. It is about them getting the tools to read themselves. So, I always check in." The reported issues were ignoring the relevant clinical data that may contradict the intuition, being disconnected from the client due to the therapist's ego or agenda, assuming things were going well versus checking in with the client, timing being off for applying clinical intuition, and desiring to push or advise the client.

Participants recognized an issue had occurred through their intuition or a sense, feeling the client's anger, or the client's verbal response, and when the application of clinical intuition was off, participants described clients feeling uncomfortable, angry, or triggered, presenting as confused or disengaged, and discontinuing treatment in some cases. In these instances, therapists' responses were to check in with the client, try to repair the rupture, or use it as an opportunity to have the client connect with their own intuition. Participants noted owning the mistake, apologizing to the client, and letting go of the intuition. A. Oakley explained the usefulness of repairing ruptures being the client sees the therapist is not perfect.

> We have those ruptures, which is part of being a human being and being interactive.Then, the recovery from those is incredibly important. Without any ruptures, it's not a real relationship . . . Occasionally, I just make a blunder, and [the client] lets me know. I always say, "I'm sorry, and I hear that was painful for you." So, that's the biggest thing is to listen, listen, listen, listen and receive whatever the person is saying.

Isabel addressed using it as an opportunity for clients to connect with their own intuition.

> I would respond with complete acceptance that that's not something that is useful, or I might also ask if they have any feeling or image or memory that comes up. So, sometimes, it can actually become like, even if it falls flat, it can become like a model for how they can check into their own inner knowing.

Sharing Use of Intuition

Sharing use of clinical intuition with clients led to participants identifying a couple of discerning variables and how they communicate it in the moment. The discerning variables were the client's worldview and the practitioner's own vulnerability with sharing their use of intuition. Grace explained,

> So, I've also learned to, at some point, just ask the other person, "Do you consider yourself intuitive?" And that helps me know how much it's going to come up in our sessions versus not . . . what's most important in the session is maintaining their worldview.

In relation to sharing intuitive information in the moment, participants discussed framing it as something coming up for them and asking the client if it resonates. Jennifer shared this example, "I might say, 'You know, I just want to offer something that's coming up for me around this particular topic . . . Would you be interested in hearing about it?'"

Telehealth

When asked if the COVID-19 pandemic affected their use of clinical intuition, participants reported clinical intuition was still available during telehealth even though it was different. Participants spoke to their ability to be connected with their clients despite not being in the same physical space. Grace commented on a conversation with a friend, "We were just talking about quantum entanglement and how all of us have these fields that don't necessarily require physical proximity."

Participants described the benefits of telehealth, including increased physical comfort sitting naturally due to their bodies not being observed by the client, a physical boundary, and potential for clients to be more open. Susan stated,

> I just sort of went all in and I find it to be just as effective. And more effective in some ways maybe because people, on the other side of the screen, feel safer . . . they're more open. So, I find that's true sometimes . . . but the zoom has not stopped the intuition flow for me at all.

The drawbacks included inability to see the client's body language, screen fatigue, loss of a private office space, and shift in being able to utilize

physical tools and resources. Reflecting on the pandemic led to participants commenting on the collective trauma of the pandemic, their increased vulnerability being in their homes, and greater need for self-care. Marita noted,

> I think I kind of got thrown off and needed to learn a new way to get in touch with my intuition. I don't know if that's so true or not. I think there was a lot happening . . . So, it required a lot of prayer and a lot of internal work for my own self and my self-care more than anything . . . I kept moving around, and for me, I needed to be grounded to get in touch with my intuition.

Empowering Clients to Connect With Their Own Intuition

Empowering clients to connect with their own intuition emerged as a core category given participants consistently touching on the collaborative dynamic of clinical intuition and value in clients recognizing their own intuitive material. Additionally, to fill the gaps of this category, Morning Star and Szanda participated in follow-up interviews. The subcategories were *purpose, therapeutic relationship, therapist role, client role,* and *therapeutic approaches that foster intuition*. The *purposes* of supporting clients with connecting with their own intuition were cultivating client's inner authority, building client's trust in their own intuition, reconnecting them with recognizing intuition, and supporting the therapeutic process and healing. Morning Star addressed inner authority and connecting with intuition as a feminist issue:

> This has to do with women's way of knowing. Now, I'm talking about women, but how often that knowing and that voice is shut down by the patriarchy or the family, or the boss, or the doctor. So, it's really about authority in a way. One of the ways I work with people is I tell them, "It's important that we withdraw our projections, and one of the projections that we have is we project our authority outside of us." As soon as we can withdraw that projection on the system or from the, I don't know, the priest or whoever. We withdraw it; then, it's my own authority. Now, I can trust. Otherwise, I'm looking outside for other people to make decisions for me.

The *therapeutic relationship* hit on the cocreation of intuitive space in therapy and client feedback. Isabel shared, "It's the space that we create together. So, I don't think, I mean, intuition can come, but I think there's certainly more access to it if that space is there. If that energy and that connection is there." The *therapist's role* in this process involved being present, teaching skills or practices, such as meditation and relaxation strategies, framing sharing of intuitive information as collaborative, checking in with the client regularly, modelling, guiding embodied awareness, and facilitating exploring beyond the surface level of an issue and accessing their intuition. Szanda reported teaching clients about felt sense.

> They're waiting to feel if it's right in their body, and it's called the felt sense . . . Many people already have it, and you just tap into that. You say, "Oh, I'm noticing this shift, and the felt sense is what we're talking about." And then, I name it . . . If people don't do it, then I teach it to them.

The client's role was to identify what intuition meant for them and direct the timing and pacing of exploring or using it in session. Grace exemplified this point in the following statement,

> Well, when you talk about intuition . . . I do think it means different things. I think people use it differently. And so, whenever talking about it, it's really important to understand either what I mean by it or what my client might mean by it.

A. Oakley described following the client, "So, present in the moment is the thing that is conducive to intuition. [To] not do so much planning ahead, but to be with the client and follow the client rather than impose on the client."

The subcategory, *therapeutic approaches that foster intuition*, was organized by how the approaches facilitated intuition for clients consisting of (a) fostering client's self-attunement, (b) presence, (c) connection to unconscious or spiritual self, and (d) meaning making via existential approaches. Self-attunement was comprised of attunement to body,

mindfulness, parts work, and conjuring client material or symbolic life, and connection to unconscious or spiritual self entailed the use of transpersonal psychology and Jungian approaches. Isabel stated, "Anything I draw from transpersonal psychology I feel supports the efficacy of utilizing intuition."

Role of Intuition in Therapy

Participants were also asked the question, "What do you think is the role of intuition in therapy?" The responses were separated to form its own category. The subcategories consisted of *the core of the process being self-trust, attunement to self and client in session to access intuitive material, being a relational process with client, needing both the left and right brain,* meaning using both intuitive and analytical processing in session, and *purpose*. These subcategories parallel the core categories in noting trust, characteristics of practicing, and the purposes being using clinical intuition to tailor therapy to the client's needs in the moment, it being the crux of healing, and helping clients be alive to themselves and their own inner knowing. Marita explained,

> I think it could be the crux of healing, personally. I think generally the role of intuition in therapy . . . I think intuition allows us that inner wisdom and higher level of knowing, not higher in a hierarchical kind of way but in a spiritual way, that holds and guides the container of the whole process. So, I think it can be at the crux and core of healing, and I think the practice is for each of us to get out of our way to connect with that.

Discussion

The intention to develop a theory regarding the process of using clinical intuition led to core categories denoting the significance of establishing confidence and a foundation of trust with intuition and the aspiration of being able to support clients with connecting with their intuition as well. The findings of this study are aligned with most of the prior research cited concerning engaging in personal development work to increase self-awareness, practicing discernment, receiving minimal to no training regarding clinical intuition, and modeling, acceptance to openly discuss intuition, and guidance from more experienced staff in this area facilitating development of clinical intuition (Arnd-Caddigan, 2022; Dane & Pratt, 2007; Holm & Severinsson, 2016; Jeffrey, 2012; Jeffrey & Stone Fish; 2011; Langan-Fox & Shirley, 2003; Laub, 2006; Shirley & Langan-Fox, 1996).

Some participants report of viewing intuition as an accumulation of knowledge or experience may be aligned with the implicit learning theories of intuition (Langan-Fox & Shirley, 2003; Shirley & Langan-Fox, 1996), and participants' noting that intuition was mainly calm versus countertransference being emotionally charged matches research stating positive mood supports intuition (Ambady, 2010; Dane & Pratt, 2007; Lieberman, 2000). Likewise, engaging in practices to quiet the mind to be more present and receptive to self and client has been reported by participants in prior research (Arnd-Caddigan, 2022; Hart; 1997; Jeffrey & Stone Fish, 2011; Siegel; 2013), and other research participants have experienced intuition as thoughts, images, a knowingness, bodily sensations, somatic symptoms, feeling or emotional awareness, noticing verbal and nonverbal cues, and shifts in energy (Cook, 2017; Holm & Severinsson, 2016; Jeffrey & Stone Fish, 2011; Siegel, 2013).

In concordance with the present findings, Arnd-Caddigan (2022) specified the benefit of teaching and supporting clients' intuition in enhancing their self-confidence and trust, self-healing, sense of well-being, and integration of parts. Additionally, Arnd-Caddigan (2022) stated the transpersonal benefit of intuition as supporting "the sense of belonging to the universe, help[ing] expand consciousness, and help[ing] people perceive transpersonal dimensions of experience" (p. 119); this sentiment corresponded to some participants reporting a connection between intuition and spirituality or energetic dimension between client and therapist.

The present study's limitations included a mostly homogenous participant sample in regard to race, gender, sexual orientation, present clinical setting, and practice location: Caucasian, cisgender women, heterosexual, outpatient, and practicing within the United States. Future research would benefit from a diversified sample to be representative

rather than simply meet theoretical saturation. The purposive sample also limited the participant pool to English speaking, licensed psychotherapists with at least 10 years of clinical experience for 16 of the 19 participants. While the present study sought participants with enough experience to claim domain expertise, given personal development of intuition reports, future studies with participants with a variety of years of clinical experience may clarify the relevance of domain expertise to clinical intuition (Nalliah, 2016). As Holm and Severinsson (2016) reported newer nurses were more likely to use intuition if they had the social support, personal experience with hospitalization, and were older. This researcher's insider status and exposure to the extant literature prior to data collection and analysis further contributed to preconceived notions about intuition. However, constructivist grounded theory allowed for this researcher to engage in reflexivity and constant comparative analysis. Additionally, the study relied on the quality of participants' memories, and in at least one example, participants displayed difficulty recalling examples of inaccurate or ineffective application of clinical intuition.

Other considerations for future research could be examining the role of the sociopolitical climate on level of trust in intuition given the link to feminist issues mentioned in this study. Arnd-Caddigan (2022) stated in regard to intuition, "Given that it is normal and natural, the need to develop the capacity may be a function of the degree to which one has suppressed it due to cultural constraints" (p. 133). Future research could consider how many providers are explicit or open about their use of clinical intuition and if they received any training or education regarding clinical intuition since many participants reported it was seldom directly addressed. Since this study only interviewed psychotherapists, future research is needed on clients' experience of clinical intuition and if it improves treatment outcomes. Empirical research based on this study's constructed theory would further clarify and inform practitioner development and application of clinical intuition.

At the heart of this study and prior research is the acknowledgment practitioners do use clinical intuition (de Vries et al., 2010; Fox et al., 2016; Jeffrey & Stone Fish, 2011). Intuition is a natural process utilized in conditions in which there is limited information requiring quick decision making, and feedback informed care improves its application (Nalliah, 2016). Clinical intuition is essential to tailoring therapy in the moment-to-moment interactions with clients whereas analytical processing has been supportive of intellectual tasks with objective criteria, such as implementing structured interventions, indicating both are needed and utilized (Dane & Pratt, 2007).

Unfortunately, unsupportive education, supervision, and professional experiences discourage clinical intuition's application, comfort openly speaking about it, and opportunities to develop clinical intuition by not addressing it or discounting it in favor of conventional approaches to treatment (Jeffrey & Stone Fish, 2011; Klein, 2015; Shirley & Langan-Fox, 1996). Given the complexity of recognizing and applying clinical intuition, disregarding its use means psychotherapists may be utilizing it without the benefit of training, guidance, and support around helpful practices, discerning it from bias and countertransference, and how to respond to clients when the application is ineffective along with several other variables addressed in this study. Most regrettably, clients may not receive the benefit of having their intuition valued and supported if the practitioner has not done this work themselves. Continued research is needed to not only better educate and support providers with clinical intuition but to normalize and validate its use.

References

Ambady, N. (2010). The perils of pondering: Intuition and thin slice judgments. *Psychological Inquiry, 21*, 271–278. https://doi.org/10.1080/1047840x.2010.524882

Anderson, R., & Braud, W. (2011). *Transforming self and others through research: Transpersonal research methods and skills for the human sciences and humanities*. State University of New York Press. https://doi.org/10.1353/book2591

Arnd-Caddigan, M. (2022). *Intuition in therapeutic practice: A mind-centered depth approach for healing*. Routledge. https://doi.org/10.4324/9781003090816

Bernstein, P. (2005). Intuition: What science says (so far) about how and why intuition works. In R. Buccheri, A. C. Elitzur, & M. Saniga (Eds.), *Endophysics, time, quantum, and the subjective: Proceedings of the ZiF interdisciplinary research workshop* (pp. 487–506). World Scientific. https://doi.org/10.1142/9789812701596_0026

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). SAGE.

Cook, L. L. (2017). Making sense of the initial home visit: The role of intuition in child and family social workers' assessments of risk. *Journal of Social Work Practice*, *31*(4), 431–444. https://doi.org/10.1080/02650533.2017.1394826

Dane, E., & Pratt, M. G. (2007). Exploring intuition and its role in managerial decision making. *Academy of Management Review, 32*(1), 33–54. https://doi.org/10.5465/amr.2007.23463682

De Vries, M., Witteman, C. L. M., Holland, R. W., & Dijksterhuis, A. (2010). The unconscious thought effect in clinical decision making: An example in diagnosis. *Medical Decision Making, 30*(5), 578–581. https://doi.org/10.1177/0272989x09360820

Fox, J., Hagedorn, W. B., & Sivo, S. A. (2016). Clinical decision-making and intuition: A task analysis of 44 experienced counselors. *Counseling and Psychotherapy Research, 16*(4), 244–255. https://doi.org/10.1002/capr.12084

Hart, T. (1997). Transcendental empathy in the therapeutic encounter. *The Humanistic Psychologist, 25*(3), 245–270. https://doi.org/10.1080/08873267.1997.9986885

Hodgkinson, G. P., Langan-Fox, J., & Sadler-Smith, E. (2008). Intuition: A fundamental bridging construct in the behavioral sciences. *British Journal of Psychology, 99*, 1–27. https://doi.org/10.1348/000712607x216666

Holm, A. L., & Severinsson, E. (2016). A systematic review of intuition: A way of knowing in clinical nursing? *Open Journal of Nursing, 6*, 412–425. https://doi.org/10.4236/ojn.2016.65043

Jeffrey, A. (2012). The clinical intuition exploration guide: A decision-making tool for counselors and supervisors. *The Family Journal: Counseling and Therapy for Couples and Families, 20*(1), 37–44. https://doi.org/10.1177/1066480711425469

Jeffrey, A., & Stone Fish, L. (2011). Clinical intuition: A qualitative study of its use and experience among marriage and family therapists. *Contemporary Family Therapy, 33*, 348–363. https://doi.org/10.1007/s10591-011-9161-7

Kahneman, D. (2002). Maps of bounded rationality: A perspective on intuitive judgment and choice. In T. Frangsmyr (Ed.), *Nobel Prizes 2002: Nobel Prizes, presentations, biographies, & lectures,* 449–489. The Nobel Foundation. https://doi.org/10.1036/1097-8542.902002

Kahneman, D., & Klein, G. (2009). Conditions for intuitive expertise: A failure to disagree. *American Psychologist, 64*(6), 515–526. https://doi.org/10.1037/a0016755

Kahneman, D., & Tversky, A. (1973). On the psychology of prediction. *Psychological Review, 80*(4), 237–251. https://doi.org/10.1037/h0034747

Klein, G. (2015). A naturalistic decision-making perspective on studying intuitive decision making. *Journal of Applied Research in Memory and Cognition, 4*, 164–168. https://doi.org/10.1016/j.jarmac.2015.07.001

Langan-Fox, J., & Shirley, D. A. (2003). The nature and measurement of intuition: Cognitive and behavioral interests, personality, and experiences. *Creativity Research Journal,15*(2–3), 207–222. https://doi.org/10.1207/s15326934crj152&3_11

Laub, L. (2006). Intuitive listening. *Modern Psychoanalysis, 31*, 88–101.

Lieberman, M. D. (2000). Intuition: A social cognitive neuroscience approach. *Psychological Bulletin, 126*(1), 109–137. https://doi.org/10.1037/0033-2909.126.1.109

Lieberman, M. D., Jarcho, J. M., & Satpute, A. B. (2004). Evidence-based and intuition-based self-knowledge: An fMRI study. *Journal of Personality and Social Psychology, 87*(4), 421–435. https://doi.org/10.1037/0022-3514.87.4.421

Lyons, E., & Coyle, A. (2016). *Analyzing qualitative data in psychology* (2nd ed.). SAGE.

Nalliah, R. P. (2016). Clinical decision making: Choosing between intuition, experience, and scientific evidence. *British Dental Association, 221*(12), 752–754. https://doi.org/10.1038/sj.bdj.2016.942

Pilard, N. (2018). C. G. Jung and intuition: From the mindscape of the paranormal to the heart of psychology. *Journal of Analytical Psychology, 63*(1), 65–84. https://doi.org/10.1111/1468-5922.12380

Shirley, D. A., & Langan-Fox, J. (1996). Intuition: A review of the literature. *Psychological Reports, 79*, 563–584. https://doi.org/10.2466/pr0.1996.79.2.563

Siegel, I. R. (2013). Therapist as a container for spiritual resonance and client transformation in transpersonal psychotherapy: An exploratory heuristic study. *The Journal of Transpersonal Psychology, 45*(1), 49–74.

About the Author

Jennifer Sousa, PhD, is a licensed mental-health counselor in the states of Washington and Florida and a licensed professional clinical counselor and marriage and family therapist in the state of California. She graduated in 2008 with her master's degree in counseling psychology from Boston College, and she has experience counseling in a variety of settings, including adolescent substance abuse treatment, home-based counseling services, and inpatient and outpatient eating-disorder treatment. She earned her Ph.D. in psychology with a concentration in transpersonal psychology from Sofia University. Correspondence concerning this article should be addressed to Jennifer Sousa, P. O. Box 811, Langley, WA 98260, United States. Email: jsousa.mft@gmail.com

About the Journal

The *International Journal of Transpersonal Studies* is a Scopus listed peer-reviewed academic journal, and the largest and most accessible scholarly periodical in the transpersonal field. IJTS has been in print since 1981, is published by Floraglades Foundation, sponsored in part by Attention Strategies Institute, and serves as the official publication of the International Transpersonal Association. The journal is available online at www.transpersonalstudies.org, and in print through www.lulu.com (search for IJTS).

\