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Running head: POSITIVE EMOTION

Pepperdine University
Graduate School of Education and Psychology

EXAMINING THE OCCURRENCE OF VERBAL AND NON-VERBAL POSITIVE
EMOTIONAL EXPRESSION DURING DISCUSSION OF INTERPERSONAL TRAUMA IN
PSYCHOTHERAPY: A CASE STUDY

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Whitney A. Dicterow

June, 2011

Susan Hall, J. D., Ph. D. – Dissertation Chairperson

This clinical dissertation, written by

Whitney A. Dicterow

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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Janine Shelby, Ph.D.

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DEDICATION

This dissertation is dedicated first and foremost to my mother, who has been my biggest supporter throughout my life, but particularly throughout my long and arduous journey through the doctoral program. Without her love, support, and unwavering belief in me, I would not have made it through this process. This dissertation is also dedicated to my husband who is my source of sanity and comfort. Thank you for your constant patience, love, and acceptance. You inspire me every day and I am so blessed to be able to spend the rest of my life with you.

Additionally, I want to dedicate this dissertation to my amazing father, sisters, and brother who have always believed that I can achieve anything I put my mind to. They are my biggest fans, and their empathy and encouragement over the past few months has given me the strength to persevere through this difficult endeavor.

ACKNOWLEDGMENTS

I would like to acknowledge and thank all of those people who have helped contribute to the development and completion of this dissertation. First and foremost, I would like to thank my lab mates, Karina Campos, and Lauren Desjardins for their companionship, support, and humor throughout this process. Your friendship means so much to me, and I wouldn't have made it this far without you!

I also want to extend a special thank you to Dr. Susan Hall, my chairperson. I am touched by her passion and unwavering support and dedication to her students, as well as her tireless efforts to support and encourage me throughout this journey. She is an inspiration, and if I can be half of the mentor to others as she has been to me, then I will have succeeded. I am blessed to have her in my life both as a mentor and friend.

Additionally, I would like to thank Drs. Bryant-Davis and Shelby, my committee members, for sharing their knowledge and expertise in the area of trauma. I truly appreciate the time and effort you have dedicated to expanding my conceptualization of this vast topic, as it has added great depth to my dissertation project and to the psychology discipline as a whole.

Furthermore, I want to thank the five master's students who transcribed all videotaped sessions in this research study. Their hard work and dedication is greatly appreciated, and I wish them the best in their future careers in psychology.

Finally, I would like to thank my incredible friends. To Tessa, Lisa, Annie, Julie, and Max; your cards, videos, baked goods, and voice messages replenished my soul and made me feel so cared for in the most trying times of this process. To my psychology friends and colleagues: Anna Lock, Kerri Schutz, Katy Jakle, Shana Spangler, Alina Gorgorian, Quinn Negabauer, Ayala Ofek, and the remainder of my cohort, thank you for your smiles, laughter, and good times. A special thank you to Heejin Kim and Nikki Rubin. I love you girls and would not have made it through this doctoral program without your friendship.

VITA

Whitney A. Dicterow

EDUCATION

Sept 2007- May 2011 **PEPPERDINE UNIVERSITY GRADUATE SCHOOL OF
EDUCATION AND PSYCHOLOGY**

- Doctoral Student in Clinical Psychology in an APA-Accredited Psy.D. Program
- Anticipated Date of Graduation: Spring 2011
- Dissertation Title: “Examining the occurrence and type of positive emotion words expressed during disclosure of an interpersonal trauma in psychotherapy: A case study”
- Preliminary exams passed June, 2009
- Defended April 29th, 2011
- Dissertation chair: Susan R. Hall, Ph.D.

Jan 2006 – July 2007 **PEPPERDINE UNIVERSITY GRADUATE SCHOOL OF
EDUCATION AND PSYCHOLOGY**

- Master of Arts in Psychology

Sept 2000 – June 2004 **CARLETON COLLEGE**
Northfield, Minnesota

- Bachelor of Arts in Psychology

LANGUAGES SPOKEN

July- Aug 2008 **RANCHO DE ESPAÑOL**
La Guacima, Costa Rica

- Fluent in Spanish, written and spoken.
- Completed one month of intensive Spanish language courses focusing on language and vocabulary used in psychology.

Sept – January 2002 **SCHOOL OF INTERNATIONAL TRAINING
FALL SEMESTER IN ECUADOR**
Quito, Ecuador

- Participated in a home-stay with an Ecuadorian family.
- Completed three months of intensive Spanish language courses.
- Took a lecture series on culture and development in Spanish.
- Completed an internship and independent study in Spanish.

AWARDS

2007-2011 **PEPPERDINE COLLEAGUES GRANT
SCHOLARSHIP**

CLINICAL EXPERIENCE

Aug 2010-Aug 2011

SEPULVEDA AMBULATORY CARE CENTER

- *Intern*

Chemical Dependency Treatment Unit (CDTU) –supervised by Sylvia Boris, Ph.D., CDTU Program Director

- Provided individual and group therapy to veterans presenting with alcohol and drug dependence, in addition to co-occurring anxiety, mood, and personality disorders.
- Acted as group facilitator for the following groups: Relapse Prevention group, Emotions Management group, Aftercare workgroup, and Childhood Abuse group.

Outpatient Mental Health (OPMH)- supervised by Steven Ganzell, Ph.D., and David Schafer, Psy.D.

- Provided individual Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) therapy, and Acceptance and Commitment Therapy (ACT) for veterans presenting with Posttraumatic Stress Disorder and co-occurring mood and personality disorders.
- Provided treatment for couples dealing with PTSD using ACT.
- Acted as group facilitator for the following groups: ACT Sobriety and PTSD group, ACT for Couples group, ACT for Anxiety and Depression Group, CPT Alumni group; Vietnam Veteran group, and OEF/OIF group.

Health Psychology- supervised by Greg Serpa, Ph.D., and Alexis Kulick, Ph.D., ABPP/CN

- Facilitated groups in Primary Ambulatory Care and Specialty Clinics, including weight management clinic, cancer support clinic, sleep clinic, and stress management clinic.
- Provided individual therapy for veterans who have both psychological and physical health problems.
- Learned techniques for the assessment and treatment of individuals with primarily medical issues.

Neuropsychology Assessment – supervised by Steven Ganzell, Ph.D., and Alexis Kulick, Ph.D., ABPP/CN

- Conducted structured individual intake interviews for veterans with traumatic brain injury, seizure disorder, and dementia.
- Administered, scored, and interpreted neuropsychological test batteries.
- Completed norms, and full report for each test battery.

Psychodiagnostic Assessment – supervised by Sylvia Boris, Ph.D.

- Completed two psychodiagnostic assessments, including both objective and projective measures, for veterans with substance use disorders and co-occurring mood, anxiety, psychotic, and personality disorders.
- Scored and interpreted psychodiagnostic test results.
- Completed norms, interpreted findings, and wrote full report for each assessment.
- Determined appropriate treatment based on psychodiagnostic test results

Aug 2009-May 2010

**UNIVERSITY OF SOUTHERN CALIFORNIA
COUNSELING SERVICES**

- *Clinician*- Supervised by Elizabeth Reyes, Ph.D., Staff Psychologist.
- Provided individual and group therapy to undergraduate and graduate students presenting with anxiety, mood, adjustment, personality and substance use disorders.
- Conducted one intake per week.
- Participated in outreach efforts to students and faculty on campus.
- Led the Therapist in Training group

Sept 2008-July 2009

**HARBOR UCLA CHILD AND ADOLESCENT CBT AND
DBT PROGRAMS**

- *Clinician*- Supervised by Michele Berk, Ph.D., Assistant Professor and Director of the Adolescent CBT and DBT Programs.
- Provided individual, group, and family CBT and DBT treatment in English and Spanish for adolescent clients diagnosed with personality, mood, and anxiety disorders.
- Participated in weekly DBT team meetings.
- Attended a weekly didactic on evidence-based Cognitive Behavioral Treatments.
- Attended a weekly didactic on evidence-based Treatments for Trauma.
- Attended a weekly didactic on Dialectical Behavioral Therapy techniques.

Feb 2009-June 2009

**UCLA-ADRC NEUROPSYCHOLOGY LABORATORY
DAVID GEFKEN SCHOOL OF MEDICINE AT UCLA**

- *Pre-Doctoral Assessment Extern*- Supervised by Ellen Woo, Ph.D.
- Conducted individual intake interviews for adults with traumatic brain injury, seizure disorder, dementia, learning disabilities, ADHD, pervasive developmental disorders, language disorders, brain tumors, and other medical/forensic issues.
- Administered, scored, and interpreted one complete neuropsychological battery per week.
- Completed norms, and one full report per week.

July 2007-Aug 2010

**PEPPERDINE UNIVERSITY PSYCHOLOGICAL AND
EDUCATIONAL CLINIC**

- *Clinician* - Supervised by Aaron Aviera, Ph.D., Clinical Faculty and Clinic Director.
- Provided individual psychotherapy for a culturally diverse group of adults, adolescents, and children diagnosed with a variety of mental disorders including mood, anxiety, and substance use disorders.
- Participated and presented in weekly case conferences to discuss diagnosis and treatment of clinic clients.
- Carried emergency pager to provide emergency crisis intervention for all clients belonging to the clinic.
- Performed detailed intakes with clients.
- Administered, scored, and interpreted client measures

June 2006 - Aug 2006

AUTISM SPECTRUM THERAPIES

- *Behavior Therapist* – Supervised by Efi Pyladaki, M.A., BCBA.
- Provided behavior therapy for children with Autism in school and home settings.
- Implemented specific early intervention plans, based on data collection and program evaluation, to improve children's social, academic, and everyday living skills.

Jan 2005 - April 2006

CENTER FOR BEHAVIORAL, EDUCATIONAL, AND SOCIAL THERAPIES

- *Behavior Therapist* – Supervised by Shah Bahador, Psy.D., Clinical Director.
- Worked with four clients at school and in the home using behavioral intervention programs tailored to meet the individual needs of each child.
- Worked with children on developing academic, social, communication, and self-care skills.

SUPERVISORY EXPERIENCE

Sept 2010-Aug 2011

SEPULVEDA AMBULATORY CARE CENTER

- *Intern Supervisor*
- Supervised one pre-intern on all of his clinical cases.
- Reviewed clinical notes, reports, and audio-recorded therapy sessions.
- Attended weekly supervision for intern supervisors.

Sept 2009 – Aug 2010

PEPPERDINE UNIVERSITY GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY

- *Peer Supervisor*
- Supervised four first-year doctoral students on all of their clinical cases.
- Reviewed clinical notes, case presentations, reports, and video recorded therapy sessions.
- Attended weekly supervision for peer supervisors.
- Provided in-service instruction to first year doctoral students on emergency care and evidence-based treatments for suicidal behavior.

VOLUNTEER EXPERIENCE

July 2008

EL RANCHO DE ESPANOL
La Guacima, Costa Rica

- Worked with Spanish professors to translate and culturally adapt Mindfulness exercises.
- Designed and provided presentations on Mindfulness practices in Spanish to members of the local community and staff of El Rancho de Español..
- Designed take home materials in Spanish on Mindfulness practice for members of the local community.
- Participated in activities with students at a local parochial school for orphaned girls ages 11-18 with histories of physical, emotional, and sexual abuse.

Sept 2003 - June 2004

HOPE CENTER
Northfield, Minnesota

- *Advocate*- Supervised by Regina Prenzel-Guthrie.
- Participated in eight hours a week of intensive training in crisis intervention and support counseling.
- Provided information to callers about options for survivors, help with protection planning, assistance with systems, and referral to other resources for survivors and secondary victims.
- Worked six hours a week taking crisis calls and implementing emergency crisis intervention to physically and emotionally abused women.

June - Aug 2003

ELMHURST HOSPITAL PSYCHIATRIC WARD
Elmhurst, New York

- *Assistant to Psychiatrist* – Supervised by Andeia Harris, M.D.
- Worked as an assistant to a psychiatrist with patients who had a variety of mental disorders including Schizophrenia, Bipolar Disorder, Delusional Disorder and Dissociative Identity Disorder.
- Observed therapy sessions, assisted therapists in counseling patients, and led psycho-educational group therapy sessions.

PROFESSIONAL AND RESEARCH EXPERIENCE

Sept 2008 – June 2009

PEPPERDINE UNIVERSITY

- *Research Assistant*
- Principal Investigators: Susan Hall, Ph.D. and Kathleen Eldridge, Ph.D.
- Assisted in gathering and entering data on specific clinical issues and decisions facing graduate student therapists, their supervisors, and clients in order to address gaps in the current research base.

Sept 2006 - April 2007

UCLA MARRIAGE AND FAMILY LAB

- *Research Assistant*
- Principal Investigator: Thomas Bradbury, Ph.D.
- Assisted in research studying the way in which marriages and families form, develop, change, improve, and deteriorate.
- Coded behavior of children whose parents were experiencing marital discord.

TEACHING EXPERIENCE

May 2008

USC KECK SCHOOL OF MEDICINE
Plastic Surgery Residency Program

- *Guest Lecturer*
- Title of Presentation: “Working Sensitively and Effectively with Latino Patients and Their Families: Practical Techniques to Increase Cultural Competency with Trauma Related Injuries”

Sept 2008- May 2009

**PEPPERDINE UNIVERSITY
PSYCHOLOGY DEPARTMENT**

- *Teaching Assistant*- Assisted professor Dr. Keatinge in Doctoral level Cognitive and Personality Assessment courses.
- Tutored students in administration of the WAIS-III, WAIS-IV, WISC-IV, and Rorschach.
- Hand-scored the WAIS-III, WAIS-IV, WISC-IV, RAVLT, Bender Gestalt, FAS, Trails A, Trails B, VMI, MMPI, and Rorschach.

TRAININGS

June-July 2010

**ACCEPTANCE AND COMMITMENT THERAPY
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- *Facilitated by Adria Pearson, Ph.D.*
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PROFESSIONAL ASSOCIATIONS

2009-2010 Association for Behavioral and Cognitive Therapies (ABCT), Student Affiliate
 2007-present Psi Chi National Honor Society in Psychology, Member
 2007-present American Psychological Association (APA), Student Affiliate

CONFERENCES

November 2010

**ABCT ANNUAL CONVENTION - Cognitive Behavioral
Therapy: Unifying Diverse Disciplines With a Common
Thread**

- Workshop Leaders: Edna Foa, Ph.D., Albert Bandura, Ph.D., James Prochaska, Ph.D., Helen Mayberg, M.D.

November 2009

**ABCT ANNUAL CONVENTION:
Universal Processes**

- Workshop Leaders: David H. Barlow, Ph.D., Aaron T. Beck, Ph.D., Christopher G. Fairburn, Ph.D., Marsha Linehan, Ph.D., Robert L. Leahy, Ph.D., Joseph LeDoux, Ph.D.

April 2009

AWAKENING TO MINDFULNESS

- Workshop Leaders: Marsha Linehan, Ph.D.; Steven Hayes, Ph.D.

April 2009

**DIALECTICAL BEHAVIOR THERAPY:
Treating Adolescents with Multiple Problems**

- Workshop Leader: Alec Miller, Ph.D.

February 2008

**RECONSIDERING TRAUMA: Treatment Advances,
Relational Issues, and Mindfulness in Integrated Trauma
Therapy**

- Workshop Leader: John Briere, Ph.D.

January 2009

**APPLYING THE SCIENCE OF POSITIVE
PSYCHOLOGY TO IMPROVE SOCIETY**

- Hosted by Claremont Graduate University's School of Behavioral and Organizational Sciences.

ABSTRACT

Recent theories of positive emotion, including the broaden and build theory, propose that positive emotion can broaden one's range of thoughts and actions, and build long-lasting personal resources (Folkman & Moskowitz, 2000; Fredrickson & Levenson, 1998). However, little research exists on how positive emotion is expressed in the context of discussing interpersonal trauma in psychotherapy. The current study explored the expression of positive emotion during discussions of interpersonal trauma over the course of an individual case of psychotherapy as related to the broaden and build theory.

The client-participant in this single-case study was a 28-year-old African American female who presented to treatment reporting difficulties in relationships and work problems. The course of therapy was 21 sessions, 15 of which were videotaped, with 6 of the videotaped sessions containing discussions of childhood sexual abuse (CSA) and workplace psychological harassment (WPH). In these 6 sessions, the Linguistic Inquiry and Word Count (LIWC; Pennebaker, Chung, Ireland, Gonzales & Booth, 2007) was used to identify positive emotion words; smiles and laughter were coded to identify expression of positive affect; and assessment measures and qualitative themes were analyzed to better understand the context and course of therapy.

The findings of the current case study supported previous literature in that positive emotion was expressed during discussion of trauma. Results were also consistent with the broaden and build theory of positive emotion in that the client-participant demonstrated patterns of emotional expression that were consistent with the theoretical components of broadening; although other variables may have contributed to this result.

Limitations included the LIWC's potential inability to identify all of the positive emotions that the client-participant expressed verbally and its lack of consideration of cultural context in verbal expression of emotion. Yet, the findings of this study not only provide potential ways to operationally define/ identify broaden and build constructs, but also can inform therapists

working with trauma survivors that the expression of positive emotion during discussion of trauma may occur more often than not, and could be normative, an indication of avoidance, or a sign of strength or resilience, which could help to promote quality of life and possibly flourishing (Keyes & Lopez, 2005).

Chapter I. Introduction and Literature Review

Psychological research on trauma has generally focused on the negative effects of traumatic events on individuals' psychological functioning (Tedeschi & Calhoun, 2004). However, research within positive psychology has shifted that focus to examine some of the positive aspects related to experiencing trauma. For example, while survivors of trauma often experience distressing emotions in response to a traumatic event, some may also simultaneously experience growth (Calhoun & Tedeschi, 2006). Research on coping, resilience, and posttraumatic growth has looked at ways in which human beings are able to manage stressful life events, resist their negative effects, and positively change in response to them (Bonanno, 2004; Schnider, Elhai, & Gray, 2007; Tedeschi & Calhoun, 2004). Positive emotion has been identified as a factor that promotes healthy coping, resilience, and posttraumatic growth in the wake of a trauma (Bonanno, 2004; Calhoun & Tedeschi, 2006; Zautra, Johnson, & Davis, 2005). It has been suggested that positive emotions both contribute to an individual's ability to achieve efficient emotion regulation, and to one's ability find meaning in aversive events (Fredrickson, Mancuso, Branigan, & Tugade, 2000; Tugade & Fredrickson, 2004). Accordingly, the literature on positive emotions may have implications for clinical work with individuals who are working through trauma and its effects.

This dissertation involved observing the occurrence of positive emotion words during a client's disclosures of a traumatic event(s) in the therapeutic environment. The literature review, therefore, begins with a description of trauma with special attention to sexual and workplace trauma experienced by African American women, and growth and trauma. Then, the historical context of positive psychology as well as its fundamental tenets and critiques is briefly reviewed. Next, resilience is defined and discussed, followed by a discussion of five general forms of coping. The disclosure of emotion and trauma is then discussed, including benefits and disadvantages of disclosure. This chapter next outlines important theories of positive emotion,

and describes four distinct positive emotions, and reviews common measures of positive emotion. It concludes a description of the purpose of the current study and research questions.

Trauma and Positive Psychology

Trauma definitions. In the literature, trauma has been defined as both the negative events that create distress as well as the distress itself (Briere & Scott, 2006). According to Briere and Scott, the original meaning of the term trauma refers to a major event that is psychologically overwhelming to the individual. According to the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (American Psychiatric Association, 2000), extreme traumatic stressors involve direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (p. 463)

Trauma events can be divided into two different categories: interpersonal and non-interpersonal (Sparta, 2003). Non-interpersonal traumas can include accidental injuries, chronic or severe illnesses, and catastrophes (Hall & Sales, 2008). Interpersonal traumas generally refer to physical or sexual maltreatment, witnessing domestic violence or spousal murder, hate crimes, community violence, war, school shootings, kidnapping, and traumatic loss (sudden or violent deaths of a loved one; Hall & Sales, 2008). Racial, sexual, emotional, and psychological harassment are other forms of interpersonal trauma that can contribute negatively to an individual's psychological well-being (Brotheridge & Lee, 2010; Buchanan & Fitzgerald, 2008; Crashaw, 2009). This dissertation focused on the interpersonal traumas of child sexual abuse (CSA) and workplace psychological harassment (WPH) experienced by an African American woman.

African American women, in particular, are in a unique position, as they are members of multiple minority groups and are therefore at increased risk for harassment (Berdahl & Moore,

2006). Findings suggest that 40 to 70% of ethnic minority employees experience at least one unwanted race-based behavior within a period of 1 to 2 years, and one half of female employees report at least one unwanted sex-related behavior (Buchanan & Fitzgerald, 2008). Additionally, it has been found that sexual harassment and racial harassment are associated with increased rates of work withdrawal, desire to quit, decreased productivity, and posttraumatic stress (Avina & O'Donohue, 2002; Buchanan & Fitzgerald, 2008; Langhout, Bergman, Cortina, Fitzgerald, Drasgow, & Williams, 2005). Individuals who have experienced past trauma are especially vulnerable to these effects, as exposure to multiple forms of trauma is associated with increased distress when compared to exposure to only one type of trauma (Green et al., 2000).

Workplace psychological harassment (WPH) is distinct from sexual or racial harassment in that it is not overtly specific to race, gender, or a social group (Hershcovis & Barling, 2010). It often involves forms of social exclusion, gossiping, yelling, and rude behaviors, which communicate to the victim, that he/she is of low status, is disliked, does not belong, or is not welcome in the workplace (Hershcovis & Barling, 2010). It can involve one or more perpetrators and targets, occur at varying degrees of severity and frequency, be intentional or unintentional, and can be observed through an array of unacceptable behaviors in response to various precipitants (Crawshaw, 2009). Research on psychological harassment in the workplace has used various terms (e.g., workplace bullying, mobbing, psychological abuse, and/or harassment) to describe this phenomenon (Crawshaw, 2009). While the term workplace abuse encompasses all forms of abuse in the workplace including sexual harassment, discrimination, workplace violence, unsafe working conditions, and nonphysical aggression, the term workplace psychological harassment (WPH) identifies the common denominator among the above subcategories of workplace abuse, including bullying, verbal abuse, and aggression, and excluding discrimination and sexual harassment (Crawshaw, 2009; Fox & Stallworth, 2005; Raver & Nishii, 2010). Since the client-participant's experience in the workplace did not include sexual or racial harassment, the term workplace psychological harassment (WPH) is used for the purpose of this study to

describe the client-participant's experience with her boss. Additionally, workplace bullying may be used interchangeably with workplace psychological harassment throughout the study as it refers to, "ill-treatment and hostile behavior toward people at work, [ranging] from the most subtle, even unconscious incivilities to the most blatant, intentional emotional abuse" (Fox & Stallworth, 2005, p. 439).

WPH is a general manner in which aggression is acted out, and is, "less likely than sexual harassment to be perceived as an attack on a minority characteristic" (Hershcovis & Barling, 2010, p. 276). In terms of the emotional consequences of WPH on the target of harassment, Hershcovis and Barling (2010) propose that victims of WPH, unlike targets of sexual or racial harassment, are unable to protect their self-concept by citing a minority characteristic (Hershcovis & Barling, 2010). Results of the authors' study demonstrated that targets of WPH are more likely to make internal attributions and take the mistreatment personally than targets of sexual harassment, and may therefore demonstrate stronger adverse outcomes than targets of sexual harassment (Hershcovis & Barling, 2010). Furthermore, targets of WPH demonstrate both inward-focused (sadness, restlessness, tiredness, and confusion) and outward-focused (anger) negative emotions (Brotheridge & Lee, 2010). Inward-focused negative emotions are usually experienced if targets evaluate the bullying from the perspective of their own contribution to the interaction (Brotheridge & Lee, 2010). Specifically, low self-esteem, self-blame, and helplessness are inward-focused emotions that are commonly experienced by targets of WPH (Brotheridge & Lee, 2010). Additionally, outward-focused emotions, such as anger, are experienced by targets of bullying in the workplace when the events are assessed as violating one's expectations, threatening, harmful, or thwarting one's objectives (Brotheridge & Lee, 2010; Lazarus, 1991). This experience of anger may be accompanied by the behavioral response of assertiveness, protest, or counterattack (Brotheridge & Lee, 2010; Roseman, Wiest, & Swarts, 1994), which could potentially exacerbate the conflict in the workplace.

Childhood sexual abuse (CSA) is another form of interpersonal trauma that was experienced by the participant in this study. According to Fergusson and Mullen (1999),

childhood sexual abuse (CSA) can be divided into two different types of occurrences, the first being acts that involve forced or coerced sexual actions imposed upon a child, and the second being acts that include sexual activity between a child and an older person, irrespective of whether or not the child was coerced. Studies indicate that African American women are especially vulnerable to severe forms of child abuse, such as vaginal, anal, or oral penetration (Shaw, Lewis, Loeb, Rosado, & Rodriguez, 2001; West, 2002).

In a study using a community sample of Los Angeles residents, it was found that 29 percent of African American women had reported at least one incident of childhood sexual abuse, a figure that did not significantly change over a 10 year time period (Wyatt, Loeb, Solis, Carmona, & Romero, 1999). Furthermore, a national sample of the general population found that 23.4% of African American women had experienced some kind of sexual assault over the course of their life (Zinzow et al., 2010). Another national study examining prevalence rates of sexual assault of African American women suggested that approximately 3 per 1,000 women were sexually assaulted (Rennison & Welchans, 2000; Tillman, Bryant-Davis, Smith, & Marks, 2010). Although some research suggests that there are higher prevalence rates of sexual assault among African American women than among Caucasian women, other research suggests that there is no significant difference between African American and Caucasian women in the prevalence of childhood and adult sexual abuse (Temple, Weston, Rodriguez, & Marshall, 2007; Ullman & Filipas, 2005), or in the severity or manifestation of PTSD symptoms (Hood & Carter, 2008).

Sexual abuse has also been categorized as intrafamilial, where the abuse occurs at the hands of a family member, or extrafamilial, where the abuse is committed by an adult outside of the survivor's family (West, 2002). According to Levine and Kline (2007), the most common source of childhood trauma takes place within the child's home at the hands of family members or trusted adults. This is particularly devastating for the child, as the betrayal and shame from being sexually or physically abused by someone they trusted tends to be overwhelming (Levine & Kline, 2007). The devastation due to intrafamilial abuse is evident in the finding that African

American women abused by a family member are more likely to report a multitude of mental health symptoms than survivors who were victims of extra familial abuse (Banyard, Williams, Siegel, & West, 2002).

Other researchers have found that interpersonal traumas tend to result in more intense and complicated responses in adults than compared to non-interpersonal traumas (Briere & Scott, 2006). Again, sociocultural context may be one reason for this finding. Briere and Elliott (2003) described how hurricane or earthquake survivors may be seen by some people as less at fault for or more worthy of sympathy than survivors of rape. For example, African American women identified negative attitudes toward sexual assault victims, such as blaming the victim for the assault, doubting the integrity of the victim, or minimizing the sexual assault as barriers to disclosure (Neville & Pugh, 1997). Other reported barriers to disclosure that are culture specific to African American women include fear of blame due to stereotypes of African American women as promiscuous, sexual/economic oppression, and the perception that African American male perpetrators are protected from blame of sexual assault (McNair & Neville, 1996). Survivors of interpersonal trauma may not receive the same level of social support, a factor that has been found to reduce the intensity of posttraumatic stress, as do survivors of non-interpersonal trauma (Briere & Elliott, 2003).

Trauma can also be defined as reactions to, the effects of, and/or the distress caused by, a very stressful or disturbing event (Hall & Sales, 2008; Yeager & Roberts, 2003). For example, African American females who experienced penetration were more likely to be rated as withdrawn and were more likely to experience attentional difficulties than Hispanic females (Shaw et al., 2001). Furthermore, Briere and Elliott (2003) state that the primary impacts of childhood sexual abuse and neglect on later functioning in adulthood include negative preverbal assumptions and relational schema, conditioned emotional responses to abuse-related stimuli, memories of the abuse, narrative memories of maltreatment, suppressed cognitions related to abuse, and inadequate affect regulation skills. Childhood sexual abuse has also shown to have

mental, spiritual, and psychological effects on African-American women, such as impaired psychosocial functioning, depression, anxiety, dissociation, impaired sense of self, lowered self-esteem, PTSD, substance use, suicidality, distrust of others and sexual concerns (Banyard et al., 2002; Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010; Tillman et al., 2010; West, 2002; Wyatt & Riederle, 1994).

Furthermore, Hall and Sales (2008) note that some define trauma by the symptoms and disorders it creates. The disorders associated with traumatic events include, but are not limited to, Complicated or Traumatic Grief (not codified in the DSM-IV, but found among individuals exposed to events that result in death or major loss), Major Depression, Generalized Anxiety Disorder, Panic Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, Dissociative Disorder, Somatization Disorder, and Borderline Personality Disorder (Briere & Scott, 2006). Posttraumatic Stress Disorder is one of the disorders most commonly equated by some with trauma. The three characteristic symptoms of PTSD are persistent re-experiencing of the traumatic event (through thoughts, recollections, images or perceptions), avoidance of stimuli associated with the traumatic event (including thoughts, places, situations, people, and memories), and physiological arousal (including hypervigilance, exaggerated startle response, irritability, and difficulty sleeping).

However, this approach to defining posttraumatic stress disorder excludes other responses to trauma including helplessness, shame, grief, loss of connection with one's spirituality, and disruption of one's ability to hope and trust (Briere & Scott, 2006; Hall & Sales, 2008; Joseph, Williams, & Yule, 1997). Also, Kraus and Roth (2010) echo Janoff-Bulman's (1992) assertion that survivors' general positive view of the self is shattered following a trauma. They proposed that female survivors of childhood sexual abuse would endorse self-evaluations informed by rigid standards about women, including stereotypes about "good" women versus "bad" women. Findings from their study supported their hypothesis, in that women who identified as Caucasian, African American, Asian, Hispanic, and "Other" and reported sexual

abuse in childhood were more likely than women who did not experience childhood sexual abuse to endorse beliefs about women as manipulative, sexual teases, debilitated by men, and less intelligent than men (Kraus & Roth, 2010). They interpret these findings as suggesting that experiences of childhood sexual abuse may be associated with cognitive polarization of the sexes, including a tendency to see women as inherently manipulative and vulnerable (Kraus & Roth, 2010).

Posttraumatic growth. However, responses to traumatic events do not always result in negative outcomes. For example, research in the area of posttraumatic growth shows that some individuals who have experienced trauma also experience positive changes in their perception of themselves, experiences of relationships with others, and philosophy of life as a result of their struggle with trauma (Calhoun & Tedeschi, 2006). More specifically, Tedeschi and Calhoun (2004) identified five domains of posttraumatic growth. The first domain is greater appreciation of life and a changed sense of priorities, in which individuals seem to find greater meaning in their everyday lives and begin to place importance on the things in their lives that they previously took for granted (Sheikh, 2008; Tedeschi & Calhoun, 2004). The second domain identified by the authors is more intimate relationships with friends and family, with an ability to distinguish between meaningful versus superficial relationships, which leaves the individual time to devote more time and energy to those who are truly important in his/her life (Sheikh, 2008; Tedeschi & Calhoun, 2004). The third domain identified by Tedeschi and Calhoun is a sense of increased personal strength. Individuals often feel that their ability to cope with their trauma gives them the strength and ability to cope with any life challenge. The fourth domain identified within posttraumatic growth is a sense of new possibilities for the individual's life, which may be due to a shift to more fulfilling priorities and values (Sheikh, 2008; Tedeschi & Calhoun, 2004). Finally, the fifth domain identified by the researchers is spiritual growth, where individuals seem to connect with something greater than themselves, regardless of what that greater thing is (e.g., God, nature, the universe; Sheikh, 2008; Tedeschi & Calhoun, 2004).

Additionally, growth often co-occurs with the discomfort and distress produced by the tragedy and/or loss that an individual has experienced (Calhoun & Tedeschi, 2006). For example, individuals who have experienced traumatic events often report feelings of vulnerability when they have not been able to control or prevent their own suffering. However, these same individuals may also develop the sense that they have the capacity to survive and prevail in the face of adversity (Tedeschi & Calhoun, 2004). Linley and Joseph (2005) elucidated the co-occurrence of growth and distress when they stated that,

[p]ositive accommodation of the traumatic material and development of meaning as significance may not make people 'happier' in terms of their SWB [subjective well-being]...Growth may leave them sadder, but almost inevitably wiser, in recognition of the vicissitudes of the human condition. (p. 273)

Other psychosocial factors that may facilitate growth include: (a) the degree of inconsistency between the individual's previous assumptions of the world and the new information he/she receives from the trauma; (b) the extent to which the individual has experienced satisfaction of basic psychological needs (i.e., needs of autonomy, competence, and relatedness); (c) effortful appraisal; and (d) a social environment that promotes basic psychological needs (Linley & Joseph, 2005).

Posttraumatic growth does not solely occur in one population, as it has been observed to occur in males and female individuals of all ages, and in a wide array of cultures, including refugee, Latina, Israeli, German, American, and British individuals (Sheikh, 2008). Although no studies were found that specifically focused on PTG and adult African-Americans, a meta-analysis found that in studies whose samples had a larger percentage of ethnic minority participants, benefit finding (operationally defined by the authors as the positive effects that result from a traumatic event) was more strongly associated with less depression, positive affect, and reduced distress (Helgeson, Reynolds & Tomich, 2006). Moreover, ethnic minority participants were more likely to engage in benefit finding than Caucasian participants. The authors concluded

that benefit finding might be more adaptive to people from an ethnic minority background, as people from an ethnic minority background may experience greater adversity (possibly due to racism and prejudice), which may lead them to be more capable of deriving the good from the bad (Helgeson et al., 2006). Furthermore, the authors state that if this is the case then people who have experienced a great deal of stress and trauma should be more likely to experience posttraumatic growth (Helgeson et al., 2006). Further research is required to test out these claims.

Positive psychology. Research on trauma within the field of psychology has generally focused on maladaptive behaviors and symptoms that result from traumatic events (Calhoun & Tedeschi, 2006). One reason for a focus on trauma symptoms is due to clinicians' desire to help clients who seek therapy for negative emotions and distressing symptoms return to their previous levels of functioning (Calhoun & Tedeschi, 2006). A second reason is that therapists may play a role in assessing or treating the clients involved in the criminal justice system as a result of traumatic experiences (Hall & Sales, 2008). Third, the field of psychology has a history of being linked to an illness ideology and the medical model. Since World War II and the creation of the Veterans Administration, psychology became a medically-oriented discipline that focused on psychopathology (Seligman & Csikszentmihalyi, 2000). Psychology practitioners were historically trained in psychiatric hospitals where they worked as psycho-diagnosticians supervised by psychiatrists trained in medicine (Joseph & Linley, 2008). In addition, the National Institute of Mental Health, established in 1947, focused all of its energy and resources on treating mental illness (Joseph & Linley, 2008).

Quite the opposite, the goal of positive psychology is to seek a more balanced view of humans by focusing on strengths and virtues rather than solely on pathology, weakness, and damage (Seligman & Csikszentmihalyi, 2000). Instead of dealing with the dichotomous concepts of illness and health, positive psychology considers a more complex picture of human life, which includes work, education, insight, love, growth, and play among other aspects of life (Seligman & Csikszentmihalyi, 2000). The positive psychological vision is that scientific research and interest

in general should attempt to understand the range of human experience from illness, suffering, and distress to health, thriving, fulfillment, and contentment (Linley, Joseph, Harrington, & Wood, 2006).

There are three pillars supporting the field of positive psychology (Seligman & Csikszentmihalyi, 2000). At the first subjective level, positive psychology focuses on valued subjective experiences such as: “(a) well-being, contentment, and satisfaction in the past; (b) hope and optimism for the future; and (c) happiness in the present” (p. 5). On the second individual level, positive psychology focuses on positive traits such as “courage, interpersonal skills, forgiveness, wisdom, and perseverance” (p. 5). On the third group level, positive psychology, “examines institutions that foster responsibility, altruism, tolerance and civility” (p. 5). This dissertation focused on the first two pillars of positive psychology: valued subjective experiences (positive emotion) and positive traits (resilience).

One of the domains of focus within positive psychology relevant to this dissertation is clinical psychology. According to Maddux, Snyder, and Lopez (2004), there are four assumptions of positive clinical psychology. The first assumption is that positive clinical psychology is invested in people’s everyday problems and their subjective and psychological well being just as much as it is invested in more extreme problems such as psychopathology and the alleviation of subjective distress and maladaptive functioning (Maddux et al., 2004). Second, human functioning falls along a continuum, such that psychopathologies, clinical problems, and clinical populations only differ in degree from everyday problems and non-clinical populations (Maddux et al., 2004). Third, psychological problems are the result of problems that exist between the person and his/her environment (i.e., between the individual and other people as well as between the individual and the larger culture) and not necessarily solely caused by biological or medical diseases (Maddux et al., 2004). Finally, the role of the positive clinical psychologist is to promote psychological health through recognizing human strengths during assessment and therapy and instilling hope (Maddux et al, 2004; Pedrotti, Edwards, & Lopez, 2009). For example, the

empowerment model of trauma treatment takes a strengths-based perspective by assuming that clients are capable of solving their own problems and are the experts at what solutions will work best for them (Dass-Brailsford, 2007). Janoff-Bulman (1992) believes that empowerment and recognition of strength and resilience is particularly beneficial for trauma survivors whose experiences often leave them feeling helpless and weak.

While positive psychology has many supporters, it also has critics. For instance, Lazarus (2003) proposed a number of fundamental critiques of positive psychology. His first criticism was that positive psychology relies heavily on cross-sectional research, which assumes that emotions are the potential cause of health and well-being. Since a cross-sectional design does not determine causation or direction, using such data to prove the hypothesis that positive emotion causes health or well-being is inherently flawed (Lazarus, 2003). Csikszentmihalyi (2003) responds to this criticism by stating that: (a) no meaningful longitudinal research can be conducted in a short time; and (b) that this criticism applies to psychology as a whole, not just positive psychology.

Additionally, Lazarus (2003) found a tendency to categorize emotions into two groups and to assign valence (i.e., positive vs. negative) to discrete emotions problematic. He stated that emotions are seen as “positive” when they subjectively feel good, when they are brought about by favorable events, and when they result in a desirable personal or social outcome. In contrast, emotions are seen as “negative” when they feel negative subjectively, when the emotion is based on unfavorable circumstances, and when the emotion has negative personal or social consequences (Lazarus, 2003). Lazarus asserted that the use of both subjective and contextual aspects to assign a valence to emotions creates the problem that one person’s happiness may be another’s sadness and that emotions are constantly occurring within contexts, which is an important and overlooked part of their production.

A related concern is Lazarus’ (2003) criticism of positive psychology for its tendency to overgeneralize findings on individuals to groups of people. Because societal and cultural contexts greatly affect identity development, life goals, and happiness, cultural rules and norms often

dictate what is considered a strength versus a weakness (Pedrotti et al., 2009). Therefore, research in positive psychology should continue to consider cultural and societal contexts. In the current study, the researcher discussed how the client-participant's cultural and societal contexts may have affected her expression of positive emotion during disclosure and discussion of trauma. Furthermore, the researcher also discussed how the researchers' cultural and societal context may have affected the findings of the current study.

Finally, Lazarus (2003) along with other researchers hold a general critique of positive psychology that positive psychologists take a "polyanna" view of the world, only focusing on the positive and ignoring the negative sides of life (Held, 2004; Lazarus, 2003). There are some common responses to the critique that positive psychology takes a "polyanna" view of the world. For example, Seligman and Csikszentmihalyi (2000) state that the goal of positive psychology is to seek a balanced view of humans, not to focus solely on weakness or strength. Gable and Haidt (2005) clarify that the goal of positive psychology is not to erase or replace work on pathology, distress, and dysfunction, but to increase what is known about human resilience, strength, and growth in order to balance the existing knowledge about pathology and distress.

Trauma, Resilience and Coping

Although most people will experience at least one trauma in their lifetime, people differ in the way they respond to these highly aversive events (Bonanno, 2004). According to Janoff-Bulman (1992), the experience of a trauma in adulthood destroys four basic assumptions the individual has about him/herself and the world: the assumption that one is invulnerable (i.e., the general belief that bad things one happen to the individual), the general positive view of the self, the assumption that there is order in the world (i.e., things happen for a reason), and the assumption that other humans are inherently good. These shattered assumptions leave the individual feeling helpless and weak in a disorganized and dangerous world (Janoff-Bulman, 1992). Janoff-Bulman asserts that the individual must resolve the dissonance between his/her preexisting beliefs that no longer describe his/her current world, and his/her new beliefs that are

overwhelmingly negative and threatening.

For young children who have experienced chronic early trauma and have never known trust and safety (e.g., chronic child abuse by parents), the traumatic experience is likely to become fully integrated into the child's inner world, and will define the child's assumptions of him/herself and the world (Janoff-Bulman, 1992). For these children, "[t]he trust and optimism, the sense of safety and security, the feeling of relative invulnerability that are afforded the person with positively biased assumptions are absent in [their] psychological world..." (p. 86) Adults and children who have experienced trauma must not only deal with shattered assumptions, but also with the psychological effects of the trauma that were mentioned earlier in this review. Given the positive psychology lens of this dissertation, this section focuses on how adults respond to trauma in terms of resilience and coping.

Resilience. Resilience is generally defined as the ability to maintain psychological stability following a highly stressful or negative event (Vaughan, Fredrickson, & Taylor, 2008). Resilience communicates the idea that individuals can evade negative outcomes despite confrontation with significant risk factors in the environment (Staudinger, Marsiske, & Baltes, 1995). Some people may have acute responses and slowly return to their previous level of functioning; others will have fleeting responses and quickly return to their former levels of functioning (Bonanno, 2004).

Although denial and premature resolution are sometimes associated with resilience, they are different constructs/concepts. Some individuals who demonstrate a rapid return to previous levels of functioning (premature resolution) may be using denial as a means to cope with traumatic events (Mancini & Bonanno, 2006). Denial involves the repression or compartmentalization of traumatic memories, which allows the individual to live each day without the conscious perception of the repressed event (Scaer, 2005). When denied, memories resurface in response to environmental cues, disrupting the individual's psychological and physical functioning (Scaer, 2005; Bonanno, 2004). Conversely, resilience does not involve the

repression of traumatic memories or a disruption in psychological or physical functioning (Bonanno, 2006). It is characterized by a return to stable psychological and physical functioning despite the experience of the traumatic event and its related memories (Bonanno, 2006).

Another related but different concept is thriving. Although resilience refers to a homeostatic return to a previous condition after a traumatic event, thriving denotes the experience of being better off after a traumatic event (Carver, 1998) or a tendency to function at a higher level than before the occurrence of the adverse event (Vaughn et al, 2008). Other closely related constructs are growth, which refer to “behaviors involved in reaching higher levels of functioning or adaptive capacity...in the face of a new contextual challenge or a loss in potential” (Baltes, 1997, pp. 369-370), and posttraumatic growth, which refers to the positive psychological changes individuals experience in response to struggling with highly challenging life circumstances that disrupt their perceptions of the world and their place in it (Tedeschi & Calhoun, 2004).

Fergus and Zimmerman (2005) posit that there are two integral conditions of resilience: (a) the presence of risks; and (b) the existence of promotive factors that facilitate positive outcome or help reduce negative outcomes. Promotive factors can be divided into assets and resources (Fergus & Zimmerman, 2005). Fergus and Zimmerman define assets as positive factors that exist within the individual such as competence, coping skills, and self-efficacy.

Similarly, Vaughn and colleagues (2008) refer to resilience as a stable and enduring internal psychological trait that allows people who possess it to exert appropriate and dynamic self-regulation, whereas those individuals considered to be low ego-resilient under or over self-regulate. Internal resiliency factors also include spiritual or motivational characteristics (cognitive capabilities or belief systems that increase motivation and give individuals a point of focus for their efforts), cognitive competencies (cognitive abilities that allow individuals to accomplish their goals/dreams), behavioral/social competencies (social skills or talents that help individuals to attain their goals/dreams), emotional stability and emotional management (happiness vs. depression, recognition of feeling, emotional management skills and ability to control anger and

depression, ability to restore self-esteem, and hopefulness), and physical well-being and physical competencies (Kumpfer, 1999). Other internal psychosocial factors that have been found to promote resilience and buffer against the development of posttraumatic stress disorder include, but are not limited to, positive or action-oriented coping styles (versus avoidant coping styles), an internal locus of control (i.e., feeling as though one has control over one's life circumstances), and perceived social support and family cohesion (Hoge, Austin, & Pollack, 2007).

In contrast, resources are positive factors that are external to the individual that promote resilience (Fergus & Zimmerman, 2005). External or environmental resiliency factors include safe social environments (environments in which an individual is able to disclose in confidence to others and receive social support), and social capital (resources innate in social relationships such as mutual trust, reciprocity, and community participation; Lepore & Revenson, 2006).

When considering internal and external resources and positive factors, forms of coping and sources of support may differ depending on cultural context (Bryant-Davis, 2005; Pedrotti et al., 2009), including for clients who have experienced and been exposed to violence (Bryant-Davis, 2005). For example, black adolescent females growing up in U.S. inner cities exposed to violence may perceive a lack of sustained support from institutions that are usually viewed by society as protective, such as schools (Brown & Gourdine, 2001). Instead, internal resiliency factors such as spirituality and creativity, and external resiliency factors like activism and kinship ties, may be more likely to lead to successful coping (Bryant-Davis, 2005).

Another internal resiliency factor that may lead to successful coping for African American women after experiencing a traumatic event is possessing an internal locus of control (Hood & Carter, 2008). While PTSD is common following childhood sexual abuse, one study found that African American women who had a history of both childhood and adult abuse had fewer and less severe PTSD symptoms than African-American women who had a history of adult abuse only (Hood & Carter, 2008). The authors hypothesized that African American women who experience both childhood and adult abuse may become more resilient to severe PTSD reactions

(Hood & Carter, 2008). They discovered that African American women demonstrated a higher sense of internal locus of control (i.e., perception that they have personal control over their environment and perceive the world as more controllable) than Caucasian participants in previous studies (Hood & Carter, 2008). This finding seems counterintuitive given that individuals who perceive the world as highly controllable would typically experience a shattering of their worldview after an experience of physical or sexual trauma (Kushner, Riggs, Foa, & Miller, 1992). However, Hood and Carter (2008) postulate that due to African American women's lifelong experiences of discrimination, crime, and other hardships, being assaulted may not alter their control-related beliefs. Furthermore, African American women who experience both child and adult trauma may be more resilient to psychological symptoms, such as those that occur within PTSD, that follow adult trauma (Hood & Carter, 2008). This finding is consistent with previous research, which suggests that lower perceived control is significantly related to more reexperiencing and arousal symptoms, as well as overall PTSD severity (Kushner et al., 1992).

Coping. A key aspect of the protective assets (internal resiliency factors) that promote resilience after experiencing a stressful life event are coping skills and styles (Bonanno, 2004; Fergus & Zimmerman, 2005). The way in which an individual responds or copes with stress and trauma can have an effect on the individual's emotional state (Billings et al., 2000; Blalock, DeVellis, & Giorgino, 1995; Coifman, Bonanno, Ray, & Gross, 2007).

Although most researchers agree the study of coping is imperative to understanding the way in which individuals are affected by stress, they do not agree on how to conceptualize coping or coping strategies (Skinner, Edge, Altman, & Sherwood, 2003). This is perhaps because coping is not a specific behavior, but rather an organizational construct used to encompass the many ways that people deal with stressful events (Skinner et. al., 2003).

According to Folkman and Moskowitz (2004), researchers generally group coping responses rationally through the use of theory-based categories, empirically through factor analysis, or by using both rational and empirical techniques. As an example of theory-based

categories, Aldwin and Yancura (2004) identified four fundamental theoretical and methodological approaches to coping in the literature: psychoanalytic approach (focus on defense mechanisms), personality approach (focus on individual coping styles), coping process approach (focus on environmental demands and influences), and daily coping process approach (focus on coping strategies used throughout the day). This subsection focuses on the coping process approach because the role of environmental stressors is a key variable when examining coping within the context of trauma (Aldwin & Yancura, 2004). For example, African American individuals cope with violence in a variety of contexts, including their schools and neighborhoods (Bryant-Davis, 2005).

The coping process approach is based on the cognitive behavioral perspective, and views coping as a dynamic process that is reactive to both the environment and to individual differences (Aldwin & Yancura, 2004). Furthermore, this approach examines how individuals cope with particular stressors rather than focusing on general coping styles (Aldwin & Yancura, 2004). Similarly, Lazarus and Folkman (1984) argue that coping is a response to the appraisal of the environment as threatening or harmful. They define coping as a process aimed at managing specific stressful encounters perceived as straining or exceeding the individual's resources, and the physiological and psychological effects of those encounters (Lazarus & Folkman, 1984). Lazarus and Folkman identify these perceptions of stress as stress appraisals, and assert that stress appraisals coupled with the emotions that follow, trigger coping responses.

Five main types of coping responses or strategies have been identified in the coping process approach: problem-focused coping (information-seeking and resource generation), emotion-focused coping (expressing emotion, denial, and positive reappraisal), social support (asking for advice, concrete aid, community support), religious coping (praying), and meaning making (reinterpretation of the event and context; Aldwin & Yancura, 2004; Bryant-Davis, 2005; Folkman & Moskowitz, 2004). Additional coping strategies can be seen to fall within the coping-process approach. For example, African American individuals have been found to cope with a

violent past by using activism (helping others make sense of their trauma), creativity (use of art to explore themes related to trauma), humor (viewing one's experience as amusing to improve mood), and confrontation (talking to the perpetrator about the trauma to increase emotional well-being; Bryant-Davis, 2005).

Problem-focused coping. Generally, problem-focused coping takes place when a person appraises his or her environmental conditions as changeable and engages in behavioral or cognitive attempts to manage stress (Lazarus & Folkman, 1984; Moskowitz, 2001). These attempts are aimed at defining the problem, creating alternative solutions, weighing the costs and benefits of the solutions, choosing a solution, and acting (Lazarus & Folkman, 1984). Problem-focused coping strategies also include those that are directed inward such as motivational or cognitive changes like changing ones goals, finding alternative ways of attaining gratification, or learning new skills (Lazarus & Folkman, 1984).

Emotion-focused coping. Contrastingly, Lazarus and Folkman (1984) state that emotion-focused coping strategies occur when the individual appraises that he/she can do nothing to change the harmful or threatening environment, and engage in behaviors aimed at decreasing emotional distress. Emotion-focused coping can include strategies such as avoidance, minimization, distancing, selective attention, positive comparisons, and finding positive value in negative events (Lazarus & Folkman, 1984). Some of these emotional coping strategies (e.g., positive reappraisal; accepting responsibility) change the way in which the situation is interpreted or reappraised (Bryant-Davis, 2005; Folkman & Moskowitz, 2004; Lazarus & Folkman, 1984). By reappraising the situation, the individual reduces the environmental threat (Lazarus & Folkman, 1984). Other emotional coping strategies, such as engaging in distracting activities, using alcohol or drugs, and seeking emotional support, do not involve reappraisal but instead involve screening out certain aspects of the situation or engaging in activities that distract the individual from threatening environment (Lazarus & Folkman, 1984). Whatever strategy is used,

emotion-focused coping strategies are used as attempts to decrease emotional distress (Lazarus & Folkman, 1984).

Seeking social support. Seeking social support strategies utilize aspects of both problem-focused and emotion-focused coping (Aldwin & Yancura, 2004). In terms of problem-focused social support seeking, an individual can seek social support for instrumental reasons, which includes seeking the advice, assistance of, or information from others (Carver, Weintraub, & Scheier, 1989). In contrast, an individual can seek social support for emotional reasons, such as receiving moral support, sympathy, or understanding, which is associated with emotion-focused coping strategies (Carver et al., 1989).

Religious coping. Similarly, religious coping utilizes features of both problem-focused and emotion-focused coping (Aldwin & Yancura, 2004). Coping using religion and spirituality entails “the use of one’s faith in a higher being or in the universal order of things (i.e., karma or an afterlife) to make sense of the trauma or increase one’s feeling of efficacy in handling the effects of the trauma” (Bryant-Davis, 2005, p. 411). This type of coping includes prayer, which is generally considered to be emotion-focused. However, praying also may include asking for advice or receiving concreted aid, which is more associated with problem-focused coping. In a study on religious coping, Pargament, Smith, Koenig, and Perez (1998) identified other religious coping strategies and grouped them into positive and negative categories. Positive religious coping strategies were religious forgiveness, seeking spiritual support, collaborative religious coping, spiritual connection, religious purification, and benevolent religious reappraisal (Pargament et. al., 1998) . Negative religious coping strategies were spiritual discontent, punishing God reappraisals, interpersonal religious discontent, demonic reappraisal, and reappraisal of God’s powers (Pargament et. al., 1998).

Meaning-making. The meaning making strategy of coping is also relevant in the context of trauma because individuals who have experienced trauma are attempting to integrate their negative experiences with their previous more naïve views of the world (Aldwin & Yancura,

2004; Janoff-Bulman, 1992). By identifying the values and beliefs that they once held, and that the trauma destroyed, trauma survivors “reconstruct a system of belief that makes sense of their undeserved suffering” (Herman, 1997, p. 178). Making meaning consists of using cognitive strategies to reconstruct a view of reality that accounts for the individual’s victimization without creating an overwhelmingly threatening view of the world (Janoff-Bulman, 1992). These strategies include reorganization of existing cognitive-motivational structures and reinterpretation of the event and the context, which can lead to posttraumatic growth (Aldwin & Yancura, 2004).

Discussion of Trauma

Disclosure is an elusive concept, as its meaning varies among individuals and within individuals as a function of context (Farber, 2006). Pennebaker, Zech, and Rimé (2001) consider disclosure as verbalizations of emotional experiences and events. Jourard (1971) defined disclosure as the sharing of deeply held thoughts and beliefs with others. Similarly, social-sharing is a term that has more recently been used when referring to the sharing of emotional experiences and events or of deeply held thoughts and beliefs (Pennebaker et al., 2001). Social-sharing refers to the “reevocation of an emotional experience in a socially shared language with some addressee, the latter being present at least at the symbolic level” (Pennebaker et al., p. 3). Help-seeking is similar to social sharing (and disclosure in some contexts) but can be differentiated in that it often refers to the distressed person’s efforts to contact formal and informal institutional sources of help, and may or may not lead to disclosure (Coker et al., 2002; Rogler & Cortez, 1993; Ullman & Filipas, 2001).

Within the child abuse field, disclosure is often defined more narrowly as the accidental, purposeful, or prompted/elicited first report to another person about the abuse (Alaggia, 2004). However, in his study of disclosure among adult survivors of childhood sexual abuse, Alaggia found that many disclosure patterns described by participants did not fit into these categories (Alaggia, 2004). Therefore, Alaggia recommended that the conceptualization of disclosure be expanded to include behavioral and indirect verbal attempts, disclosures intentionally withheld,

and disclosures that were triggered by recovered memories.

Although there is no one agreed upon definition of disclosure in the literature, many researchers believe that its process (including disclosure of traumatic events like abuse) is a dynamic rather than static event that can be circular and interactive, and may involve many different stages and cycles (Alaggia, 2005; Jourard, 1971; Lindbald, 2007). For the purpose of this dissertation, disclosure of trauma will be broadly defined as any discussion/sharing of a traumatic event or events, or the emotions, thoughts, and beliefs associated with the traumatic event, not limited to the first telling or reporting of the event, to both informal support systems (e.g., disclosure of trauma to friends and/or family) and formal support systems (e.g., police, physicians, and/or mental health providers; Ullman & Filipas, 2001).

Discussion of emotion. One way that people cope with, and potentially alleviate, distressing emotions connected with a variety of events is to share those emotions with others. These shared emotions include both positive and negative emotions (Rimé, Philippot, Boca, and Mesquita, 1992). Rimé and colleagues found in their review of eight independent studies that 90 to 96.3% of participants discussed emotional episodes with another person regardless of the basic type of emotion or the valence of the emotion (negative or positive). It was also found that participants shared their emotional episodes multiple times typically with parents, close family members, best friends, and/or a spouse or companion (Rimé et al., 1992).

Research also exists on the effects of discussing emotions. Rimé, Noël, and Philippot (1991) found that when sharing an emotional episode with others, participants reported experiencing vivid mental images of the episode, marked bodily sensations, and intense subjective feelings. Such re-experiencing is not always a negative process. Pennebaker and colleagues (2001) reported that 89 % of participants ($N=1024$) in one of their studies experienced talking about an emotional episode as relieving. Furthermore, they reported that in six of their eight studies, residual emotional feelings about an emotional event were associated with the need to discuss those feelings with another person (Pennebaker et al., 2001). Their data, however, did

not support the conclusion that sharing one's emotion leads to emotional recovery from a negative emotional event (Pennebaker et al., 2001).

Discussion of trauma. Discussion of interpersonal traumatic experiences specifically may be more difficult than discussion of emotions generally or of neutral events. Janoff-Bullman (1992) believes that as distressing emotions associated with intrusive memories from interpersonal trauma increase and become intolerable, avoidance of the memories may increase, making discussion less likely. Research illustrates this proposition in findings that 30-80 % of individuals who have experienced childhood sexual abuse purposefully do not report or discuss that abuse with others (Alaggia, 2005). Furthermore, research examining the delay between the occurrence of sexual abuse and first telling of that abuse reveals a large delay in discussion of the incident(s) ranging from 3-18 years (Alaggia, 2005). Factors that may play a role in a wide range of the above numbers include obedience to grown-ups, mistrust of people, fear of social rejection, and fear of the criminal justice system (Somer & Szwarcberg, 2001). Furthermore, when the trauma violates a cultural taboo (e.g., rape of an unmarried woman), cultural beliefs and practices may make the discussion of the trauma "culturally indigestible" (Stamm & Friedman, 2000, p. 79).

There are a number of factors that influence whether an individual will discuss a trauma. Both contextual and individual characteristics may interact to either hinder or facilitate discussion of the trauma. These factors include relationship to the perpetrator, age, gender, cultural issues (e.g., cultural/family values, consequences for the victim, and cultural inappropriateness of discussing one's personal matters in public), family dynamics, availability of social support, and environmental receptivity (Alaggia, 2005; Tyagi, 2002). Furthermore, intrapsychological consequences of abuse such as fear of intimacy, inadequate capacity for trusting, low self-esteem, depression, and strong feelings of shame and guilt may hinder adults from seeking and using social support (Cole & Putnam, 1992; Jonzon & Lindblad, 2004). In addition, approach and avoidance factors have also been proposed to influence one's decision to discuss traumatic events

(Omarzu, 2000). If an individual feels there are more risks to discussing his/her trauma than benefits, he or she will be less likely to share (Omarzu, 2000). If an individual assesses the risks of sharing to be greater than rewards, discussion of the traumatic event will be avoided (Alaggia, 2005).

Neuropsychological factors have also been found to contribute to one's ability to discuss traumatic material (Glaser, 2000; Harris, 2009; Pitman, Shin, & Rauch, 2001). PET measurement of regional cerebral blood flow in individuals with PTSD has revealed greater deactivation of Broca's region (an area of the brain involved in the production of speech) in response to trauma-related stimuli (Pitman et al., 2001). The deactivation of Broca's area can impair both language production and the encoding of conscious memory for traumatic events, interfering with the development of coherent narratives that may be integral to processing the experience (Cozolino, 2006). Additionally, there is some evidence that memories of traumatic experiences are stored in the right hemisphere of the brain, which is recognized as pre- or non-verbal (Glaser, 2000; Harris, 2009). These neuropsychological factors may make it more difficult for individuals who have lived through traumatic events to speak about what they have experienced.

A central assumption of most schools of or approaches to psychotherapy is that talking about one's emotions and experiences is beneficial, and that discussion and processing of a traumatic event are key to the client's healing and growth (Pennebaker, 1995). Although some researchers believe that discussing trauma is beneficial to physical health and can help people cope with stressful and traumatic experiences (Janoff-Bulman, 1992; McAdams, 1996; Pennebaker, 1995, 1997), others believe that sharing of traumatic material can have adverse effects on psychological well being and that suppression of negative thoughts and emotions can actually lead to reduced distress (Bonanno, Keltner, Holen, & Horowitz, 1995; Stroebe, Schut, & Stroebe, 2005).

The psychological effects of discussing traumatic experiences may vary depending on whether the trauma survivor shared with informal (e.g., friends and/or family) or formal (e.g.,

police, physicians, and/or mental health providers) support networks, and on the race/ethnicity of the individual (Ullman & Filipas, 2001). For example, Ullman and Filipas found that white women who told only informal support sources received more emotional support than if they told both informal and formal support sources. Contrastingly, ethnic minority women (not operationally defined by the authors) who discussed their trauma with informal support sources received less emotional support than those who shared with informal and formal support sources (Ullman & Filipas, 2001). Finally, it was found that ethnic minority women received more emotional support from mental health professionals and medical doctors than from other supports (Ullman & Filipas, 2001).

Benefits of discussing trauma. According to Pennebaker (1995), there are a number of ways in which discussion of trauma is believed to facilitate healing after trauma. Sharing one's traumatic experience can facilitate learning more about the actual event and about one's reactions to the event; it can change the way in which the event is mentally represented and remembered; and it can facilitate habituation to the event (Pennebaker, 1995). Furthermore, Jannoff-Bulman (1992) and McAdams (1996) assert that people create self-narratives in order to make sense of who they are in the world as they change over time. Discussion could allow people to explain and organize distressing life events, and could lead to repairs in a damaged sense of self and to a more resilient self-concept (Pennebaker & Keough, 1999; Pennebaker et al., 1997).

Additionally, Hemenover (2003) found that among individuals who disclosed about a traumatic event, those that demonstrated an increase in their use of insight words over three writing sessions showed an increase in autonomy and a decrease in interpersonal sensitivity (Hemenover, 2003). These findings suggest not only that discussing trauma can be beneficial, but also that the use of insight words may be linked to a more resilient self-concept (Hemenover, 2003). Moreover, gaining insight into the meaning of a traumatic event may lead to a more resilient self-concept (Pennebaker et al., 1997).

Evidence has supported these theories by demonstrating that short-term discussion of adverse events can be associated with improved psychological adjustment, including decreased levels of distress, improved academic performance, and improved negotiation of life transitions (Hemenover, 2003; Lutgendorf & Antoni, 1999). Furthermore, Hemenover found that participants who discussed traumatic material demonstrated an increase in mastery, personal growth, and self-acceptance, and a decrease in depression, interpersonal sensitivity, anxiety, and somatization.

Disadvantages of discussing trauma. Although many theories of coping stress the importance of discussing the trauma to overcome its negative effects, there is some evidence that suggests discussion, in certain contexts, could be maladaptive (Coifman et al., 2007; Horowitz, 1986). After experiencing a traumatic event, individuals often experience alternating cycles of intrusive re-experiencing and avoidance (Horowitz, 1986). Avoidance is a mechanism used to protect the individual from overwhelming emotions, thoughts, and memories (Horowitz, 1986), and involves avoiding people, places, situations, and discussions that may activate memories or thoughts about the trauma. Therefore, there may be a significant worsening of symptoms around the time of discussion due to intense negative affect and cognitions being confronted (McNulty & Wardle, 1994). Denial is another defensive mechanism that may be used to cope with traumatic experiences. Denial is a form of avoidance in which the individual acknowledges the traumatic event; however, he/she creates an explanation for or way of viewing the situation that reduces the perceived threat associated with the event (Briere & Scott, 2006).

Research done by Coifman and colleagues (2007) supports the idea that avoidance or repressive coping may lead to improved psychological functioning. The researchers found that people who used repressive coping were found to have fewer psychological symptoms, better adjustment, fewer somatic complaints, and less significant medical history than those who did not exhibit repressive coping (Coifman et al., 2007). Thus, therapists should recognize avoidance and repressive coping when working with individuals who have experienced a trauma, so as not to

remove these coping mechanisms too soon, which may lead to adverse psychological effects (Sano, Kobayashi, & Nomura, 2003).

Psychosocial factors are other aspects of context to consider when assessing the advantages and disadvantages of discussing traumatic experiences in allaying the effects of trauma (McNulty & Wardle, 1994). Particularly, the reactions of others to discussions of trauma may play a significant role in the successful coping and adjustment to trauma (Ageton, 1983). In a study investigating discussion of victimization by adult survivors of sexual assault, Ullman (1996) found that negative social reactions (e.g., attributions of responsibility or blame to victims) were strongly related to increased psychological symptoms. Also, cultural and familial values have been found to prevent discussion of incest, including family loyalty, not wanting to dishonor one's family, needing to maintain a "good" face within the community, the value of privacy, and the value of virginity (Tyagi, 2002).

Furthermore, the need to share emotion with others may vary across cultures due to differences in practices and beliefs (Wellenkamp, 1995). For example, the presence of cultural practices surrounding death can assist bereaved individuals in adapting to their loss, hence reducing the need for later discussion (Wellenkamp, 1995).

Although discussion of traumatic material often involves the expression of negative emotion, research has shown that bereaved individuals often express positive emotion when discussing and coping with their losses (Bonanno & Keltner, 1997; Pennebaker et al., 1997). Additionally, Bonanno, Colak, and colleagues (2007) found that late-adolescent and young adult women with documented histories of childhood sexual abuse expressed specific positive emotion (i.e., smiling and laughter) when asked to talk about "the most distressing event of their lives" with an interviewer associated with the research study. The following section reviews positive emotion generally, and then discusses specific theories of emotion that pertain to coping and resilience.

Positive Emotion

Positive emotion has not been very well defined in the literature (Fredrickson, 1998; Frijda, 1999). In fact, there is no one agreed upon definition of emotion in general, but rather many theories regarding the function of emotion (Ekman, 1992; Fredrickson, 1998; Frijda, 1986; Izard, 1977). Therefore, this section first reviews the major theories of emotion, and how positive emotion fits into those theories and differs from other related states. Next, this section reviews the broaden-and-build model of positive emotion, including the benefits of positive emotion and the undoing effect. It ends with a review of commonly used measures of positive emotion, as this dissertation specifically examined the expression of positive emotion during disclosure of trauma.

Lazarus (1991) was one of the first psychologists to assert that cognition plays a key role in emotions. He conceptualizes emotion as containing the following functions: relational, motivational, and cognitive components. Relational refers to the person-environment interaction, in which there is the potential for harm or benefit, yielding positive and negative emotion respectively (Lazarus, 1991). Motivational refers to the fact that within every person-environment interaction, a goal is activated by the demands, constraints, and resources within the environmental context (Lazarus, 1991). The cognitive component involves the appraisal of what is happening in the person-environmental interaction (Lazarus, 1991). In other words, the individual evaluates the personal significance of what is occurring in his/her encounter with the environment (Lazarus, 1991). In order for a positive emotion to occur, therefore, the individual must appraise the environmental interaction to have some benefit to his/her well-being (Lazarus, 1991).

Although Lazarus' theory focuses on appraisal and motivation as key to the generation of emotion, Frijda's (1986) theory focuses more on the actions and physiological changes triggered by the environment, which according to his theory, result in emotions. There are five central components to Frijda's theory of emotion: (a) a valenced appraisal of the environment, (b) a valenced feeling state, (c) an action tendency, (d) a specific pattern of physiological change, and

(e) a change in cognition (Lucas, 2007). Frijda builds on Lazarus' theory that "emotion[s]...[are] to a large extent awareness of action tendency-of desire to strike or to flee, to investigate or to be with" (Frijda, p. 71). Frijda defines action-tendency as the urge to perform an expressive behavior prior to its actual performance. In other words, emotions are associated with urges to act in specific ways (Fredrickson, 1998). This theory is built on the idea that specific action tendencies made emotion evolutionarily adaptive, as they allowed people to escape from life or death circumstances (Fredrickson, 1998).

Similarly, Ekman (1992) theorized that emotions evolved for their adaptive value in managing important life tasks. He asserts that emotions allowed people to adapt to recurring situations such as fighting and escaping predators, and that the primary function of emotion is to mobilize the individual to act quickly in response to his/her environment (Ekman, 1992). In terms of positive emotional states, Izard (1977) asserts that there are wider-ranging action- or response-tendencies toward more general goals such as affiliation and exploration.

However, Fredrickson and Cohn (2008) argue that one cannot fit positive emotion into these theories of emotion, as they presume the action-tendencies associated with emotion were intended to make it so early humans would be able to get themselves out of dangerous situations (Fredrickson, 1998). Although these models of emotion were also meant to include positive emotions, descriptors of the action tendencies associated with individual positive emotions within the research are very vague in contrast to action-tendencies associated with negative emotions (Fredrickson, 1998). Ekman (1992) acknowledged that positive emotions do not fit into these general theories of emotion. He stated that all positive emotions, while distinct from one another, share the same Duchenne smile, and theorized that this is because positive emotions were not important for survival (Ekman, 1992). Fredrickson (1998) proposes that rather than try and "shoe-horn" positive emotions into general theories of emotion, a separate theory of positive emotions should be created (Fredrickson & Branigan, 2005). Fredrickson's theory of positive emotion will be reviewed later in this section.

Another reason that defining emotion may be particularly difficult is the fact that people often mean different things when referring to emotions (Lucas, 2007). For example, positive emotion, positive mood, positive affect, and sensory pleasure are often used interchangeably (Fredrickson & Cohn, 2008; Fredrickson & Losada, 2005; Lucas, 2007). However, Fredrickson and Cohn assert that these terms can, and should be differentiated from one another.

Positive emotion can be differentiated from sensory pleasure, in that it is conceptualized as multi-component response tendencies that include, but are not limited to, muscle tension, hormone release, changes in cardiovascular activity, facial expressions, attentions, and cognitions that occur within a short time interval (Fredrickson & Cohn, 2008). However, sensory pleasure and emotion often co-occur (Fredrickson & Cohn, 2008). For example, the sensory pleasure obtained through a massage can also lead to feelings of contentment and gratitude (Fredrickson & Cohn, 2008). While sensory pleasure and positive emotion both include pleasant subjective feelings, unlike sensory pleasure, positive emotion requires the appraisal of the meaning of environmental stimuli or social interactions (Fredrickson & Cohn, 2008; Lazarus, 1991).

Fredrickson and Cohn (2008) also differentiate positive emotion from positive mood, in that emotions are about a personally meaningful event, are on the surface of conscious awareness, and are short in duration (Fredrickson & Cohn, 2008). Moods, on the other hand, do not commonly occur in response to anything specific, are long in duration, and are in the background of one's conscious (Fredrickson & Cohn, 2008). Fredrickson and Cohn point out that this distinction is based in theory, not in empirical evidence, and that studies use identical means to induce both positive emotion and positive mood.

Affect, in contrast to emotion and mood, has been defined as the “expression of a range of positive and negative evaluative sentiments and attitudes” (Fredrickson & Losada, 2005, p. 678). Furthermore, Fredrickson and Losada state that we use affect to, represent this spectrum of valenced feeling states and attitudes, with *positive affect* and *positivity* interchangeably representing the pleasant end (e.g., feeling grateful, upbeat; expressing

appreciation, liking) and *negative affect* and *negativity* representing the unpleasant end (e.g., feeling contemptuous, irritable; expressing disdain, disliking... (p. 678)

However, positive affect may not always communicate positive emotion (Ekman & Friesen, 1982). Smiles can often conceal and distract an observer from discovering an individual's true feelings (Ekman & Friesen, 1982). Not only can smiles mask true emotion, but they can also convey incorrect information to others when necessary (Ekman & Friesen, 1982). Ekman and Friesen (1982) distinguish between felt smiles and false smiles, stating that felt smiles include, "all smiles in which the person actually experiences, and presumably would report, a positive emotion," whereas false smiles are described as, "deliberately made to convince another person that positive emotion is felt when it isn't" (Ekman & Friesen, 1982, p. 244). The authors also distinguish between two types of false smiles: (a) phony smiles, and (b) masking smiles. They state that phony smiles occur when no particular emotion is felt but the individual attempts to appear as though they are experiencing positive feelings, while masking smiles occur when a strong negative emotion is being experienced and the individual is attempting to conceal his/her negative feelings by seeming as though they are having positive feelings (Ekman & Friesen, 1982). Ekman and Friesen also discuss the miserable smile, in which people do not attempt to appear as if they are experiencing positive emotion, but rather acknowledges that they are unhappy, while communicating to themselves and others that they can contain their response to their negative emotions. The different roles that positive affect plays in the expression of emotion may be particularly important information for therapists working with clients who have experienced trauma, as positive affect may be used for reasons other than to express positive emotion.

Four distinct positive emotions. This subsection will focus on the four distinct positive emotions of happiness, interest, hope, and contentment, which were chosen for this section because they differ maximally from one another, are recognizable across cultures, and may play a

key role in the coping process based on their action tendencies (Fredrickson, 1998; Moskowitz, 2001).

Happiness/Joy. According to Lazarus (1991) happiness and joy largely overlap and refer to nearly the same state; however, joy refers to a more intense emotional reaction to a more specific event than happiness. Although happiness can occur as a result of many diverse causes, the core theme of happiness is that the individual is able to gain what he/she desires out of his/her interaction with the physical/social environment (Lazarus, 1991). From this viewpoint, if the individual feels as if he or she has either made progress toward or realized his/her goals, he/she will experience happiness.

Lazarus (1991) proposes that the action-tendency associated with happiness consists of a sense of pleasure and security, which is then manifested in expansiveness and outgoingness. In other words, happiness results in the action-tendency to approach the physical/social environment. Happiness is a readiness to engage with one's world and, in particular, in the enjoyments of that world (Frijda, 1986). This readiness to engage and to approach can contribute to affiliative behavior as well as the strengthening of social relationships (Izard & Ackerman, 2000). In turn, these social bonds create a social support system which can be a highly adaptive mechanism in people's development (Izard & Ackerman, 2000).

Interest. Izard and Ackerman (2000) describe interest as a positive emotion that regulates attention by allowing people to focus on one particular object, person, situation or task rather than on the other stimuli in the environment. Interest is said to contain the affective states of interest, curiosity, wonder, and the behavioral urge to explore and discover (Izard & Ackerman, 2000). Thus, it is theorized that people who are healthy and are in a safe and comfortable environment experience interest more often than other positive emotions (Izard & Ackerman, 2000). Furthermore, Izard (1977) posits that interest is experienced frequently in contexts that offer novelty, change, and possibility.

Accordingly, the action-tendency associated with interest is exploration, which is aimed at increasing one's knowledge and experience with the object of interest. More specifically, interest is accompanied by the urges to investigate, incorporate new information, become involved with, and gain experiences with the person, topic, or object of interest (Izard, 1977). Finally, interest is a key factor in intrinsic motivation and activates personal growth, creativeness, and intelligence (Deci, 1992; Izard, 1977).

Hope. Hope is a positive emotion that has been described as difficult to conceptualize (Lazarus, 1991). Although it shares conceptual space with yearning and desire, it differs in that it requires a belief in the possibility of a positive outcome (Lazarus, 1999), even if it is unlikely to occur (Lazarus, 1991). This requirement adds a cognitive component to the concept of hope, and therefore, according to Lazarus (1999), differentiates it from motivation.

Others believe that motivation is an integral part of hope. Snyder's widely-used theory defines hope as a "positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)" (Snyder, Irving, & Anderson, 1991, p. 287). Agency thinking refers to the perceived capacity to begin and maintain movement toward a desired goal, while pathways thinking is the perceived capacity to create effective methods to attain a desirable goal (Snyder et al., 1991). Lazarus' (1999) model of hope is slightly different in that it involves both positive and negative judgments as to one's ability to attain a goal (agency). As such, a person's belief in the possibility of a favorable outcome may stem from underlying anxiety and fear about the present and future, a concern about what is going to happen, and/or a belief that there will be change for the better (Lazarus, 1999).

In terms of action tendency, hope is associated with an approach response (Lazarus, 1991). Common sources for supporting hopefulness include family relationships, friendships, and religious beliefs (Raleigh, 1992). It has been found to be negatively correlated with emotional distress, depression and anxiety, and positively correlated with active reframing, social support coping strategies, physical health, and psychological adjustment (Klausner, Snyder, & Cheavens,

2000; Lazarus, 1991; Snyder, 2002). Furthermore, studies on client hope in psychotherapy have found that hope is related to perceived social support, therapeutic alliance, satisfaction with life, recovery from illness, pain tolerance, and psychotherapeutic improvement (Horton & Wallander, 2001; Irving et al., 2004; Snyder, Ritschel, Rand, & Berg, 2006).

Contentment. People experience contentment when they are in situations they appraise as safe, where they have a high degree of assurance, and when they feel a low need to expend effort (Ellsworth & Smith, 1988). This finding is consistent with Lazarus' (1991) theory of emotion, which states that emotion has a cognitive component involving the appraisal of what is occurring in the environment. In order for contentment to occur, one must appraise the environmental interaction as having some benefit to his/her well-being (e.g, safety; Lazarus, 1991).

Research has shown that contentment is associated with an action-tendency to appreciate one's current life situation and recent successes, to feel connected to one's environment and the people within that environment, and to incorporate recent experiences into one's self-concept (Izard, 1977). Although Frijda (1986) has associated contentment with inactivity, Fredrickson and Branigan (2001) argue that contentment broadens one's views of self and the world, and involves openness to, and integration of moment-to-moment experiences into a new sense of self and environment. This argument could have potential implications for individuals coping with trauma, as they work toward integrating information from the trauma and its effects to create a new sense of self and worldview and heal from their experiences (Janoff-Bulman, 2002).

The broaden and build theory. A central assumption of many theories of emotion is that they are, by definition, associated with action tendencies. Negative emotions are usually associated with urges to act in specific ways that are evolutionarily adaptive. For example, anger creates the urge to attack and fear, the urge to escape (Frijda, 1986; Lazarus, 1991). Conversely, the action-tendencies associated with positive emotions are vague and non-specific, and do not appear to be as evolutionarily adaptive (Fredrickson, 1998). However, Fredrickson argues that instead of serving the purpose of immediate survival, positive emotions lead to personal growth

and development by broadening people's momentary mindset to include a broader range of thoughts and actions, which ultimately helps to build personal resources. In this open state, people feel the urge to contemplate new ideas, develop alternative solutions to problems, reinterpret situations, reflect on behaviors, and initiate new courses of action (Fredrickson, 1998). These new ideas, solutions, reinterpretations, and reflections build lasting physical, intellectual, social and psychological resources (Fredrickson, 1998). In other words, Fredrickson proposes that positive emotions are adaptive over the long-run, in that people who gain cognitive psychological, social, and physical resources are more likely to effectively manage life's challenges, take advantage of opportunities, and more likely to experience increases in well-being (Fredrickson & Branigan, 2005; Fredrickson & Cohn, 2008).

There are multiple criticisms of Fredrickson's (1998) theory. One criticism is that Fredrickson does not adequately define the term broadening and its descriptors encompass too many wide-ranging ideas to make it an effective theoretical tool (Lyubomirsky, 2000). Furthermore, Fredrickson does not specify whether positive emotions lead to broadening relative to the narrowing that occurs due to negative emotions, or whether positive emotions cause broadening relative to a neutral state of being (Lyubomirsky, 2000). In addition to problems within the definition of broadening, Lyubomirsky also presents problems within the concept of broadening. She posits the question of whether it is possible that negative emotions could lead to broadened thinking and positive emotions narrowed thinking, and whether neutral emotions can lead to the building of personal resources (Lyubomirsky, 2000). Additionally, Rathunde (2000) makes the point that research has demonstrated that people who demonstrate creativity (a characteristic that Fredrickson associates with broadening) broaden and narrow their thinking behavior depending on the task that is presented. In conclusion, it seems that there are a number of conceptual weaknesses in Fredrickson's theory that need to be fine-tuned. Further research in this area will hopefully answer some of the aforementioned questions.

Benefits of positive emotion in the broaden and build theory. Despite criticisms, emerging research supports Fredrickson's theory. Regarding the Broaden theory, Fredrickson and Branigan (2005) found that participants experiencing positive emotion exhibited broader scopes of attention in a global-local visual processing task than did participants experiencing no particular emotion. Also participants experiencing positive emotions demonstrated more numerous thought-action urges on a self-report measure in which they were asked to describe the strongest emotion they felt while viewing a film (meant to elicit either amusement, contentment, neutrality, anger, or anxiety) and when listing all the things they wanted to do while concentrating on that emotion, as compared to participants experiencing neutrality, anger, or anxiety (Fredrickson & Branigan, 2005).

Furthermore, research has demonstrated that people experiencing positive emotion make a broader range of associations to neutral words, show an increase in verbal fluency, and display improved performance on tasks testing creative problem solving (Isen, Daubman, & Nowicki, 1987). Studies also indicate that positive emotions lead people to include others in their self-concept, increase trust in others, lead people to initiate conversations with others, and predict greater enjoyment of social activities (Cohn & Fredrickson, 2006; Dunn & Schweitzer, 2005; Isen, 1970; Lucas, 2001). According to Fredrickson (1998) these broadening tendencies in response to positive emotions will build long lasting physical, psychological, social, and intellectual resources.

Fredrickson (1998) also proposes that the experience of positive emotion helps to *build* enduring personal resources (i.e., the Build theory). Although positive emotions are often perceived as the product of optimal well-being, studies show that positive emotions are often the precursors of long-lasting increases in physical, intellectual, social, and psychological resource (Cohen & Pressman, 2006; Fredrickson et al., 2000; Fredrickson & Joiner, 2002; Tugade & Fredrickson, 2004).

Evidence suggests that positive emotions are beneficial to physical health (Cohen, Doyle, Turner, Alper, & Skoner, 2003; Danner, Snowdon, & Friesen, 2001; Zautra et al., 2005). In a study testing the influence of emotional style on health, adults scoring low on positive emotional style were three times more likely to become sick than those with high positive emotional styles (Cohen & Pressman, 2006). In addition, positive emotional style was associated with better health practices and lower levels of stress-related hormones (Cohen & Pressman, 2006). Results from a study done on positive emotions in early life and longevity demonstrated a very strong association between the positive emotional content of autobiographies and longevity 6 decades later (Danner et al., 2001). Furthermore, there is evidence that positive emotion may reduce the experience of physical pain. In their study on the effect of positive and negative emotions on pain experienced by chronic pain patients, Zautra, and colleagues (2005) found that those demonstrating more positive affect were less likely to experience an increase in pain over the duration of the study. While these studies suggest there is some relationship between positive affect and physical health, causality cannot be inferred. Other confounding variables could account for these associations.

Positive emotions have also been shown to increase intellectual resources. Bryan, Mathur, and Sullivan (1996) found that second-grade students with learning disabilities performed significantly better on a learning task when experiencing positive emotion than second-grade students with learning disabilities who were experiencing neutral emotion. Similarly, 4-year-old children who recalled a positive emotional memory were able to more rapidly master a task compared to 4-year-old children recalling neutral and negative emotional memories (Masters, Barden, & Ford, 1979). In particular, the positive emotion of interest has been identified as an important motivator for learning in both children and adults (Hidi & Baird, 1986; Schiefele, 1991). Specifically, interest has been linked to increased conceptual understanding, higher levels of academic achievement, and decreased rates of withdrawing from

school (Deci, Vallerand, Pelletier, & Ryan, 1991). These findings suggest that positive mood may play an integral role in learning and task performance.

Regarding social resources, it is well known that social support is vital to survival, as well as to psychological well-being (Cohen & Wills, 1985; Ell, Nishimoto, Mediansky, Mantell, Hamovitch, 1992; Holahan, Moos, & Rudolf, 1981). Fredrickson (1998) asserts that positive emotions can increase and sustain social relationships, which, in turn, increases social well-being. Studies on gratitude, a positive emotion, indicate that people act prosocially simply to express their gratitude towards others, which, over time, creates new social bonds, strengthens already existing social bonds and friendships, and makes people more likely to feel loved and cared for by others (Emmons & Shelton, 2002; McCullough, Kilpatrick, Emmons, & Larson, 2001). Furthermore, positive emotion has been shown to increase the quality of close relationships (Gable, Gonzaga, & Strachman, 2006). These social bonds are considered resources because they can be used as social support during difficult times (Fredrickson, 2004). This evidence suggests that positive emotion facilitates the building strong social bonds, providing social resources that can be used in times of need.

Concerning psychological resources, Lazarus, Kanner, and Folkman (1980) hypothesized that during stressful life events where negative emotions are predominant, positive emotions can serve as an emotional break, support the individual's effort to cope, and provide personal resources that have been exhausted. Supporting this belief, research has revealed that positive emotions can act as a shield to defend against the effects of stressful situations (Folkman & Moskowitz, 2000). For example, a longitudinal study of caregiving partners of men with AIDS demonstrated that caregivers experienced positive psychological states in addition to negative psychological states throughout the caregiving and bereavement processes (Folkman, 1997). Furthermore, Fredrickson and Levenson (1998) found that positive emotions allayed the effects of negative emotions. They induced negative and then positive affect in their participants, and discovered that participants who were induced to feel contentment or amusement after having

recently experienced negative affect recovered more quickly than those participants who were induced to feel neutral emotions after experiencing negative affect (Fredrickson & Levenson, 1998). In addition, Tugade and Fredrickson (2004) demonstrated that people who found positive meaning in negative circumstances showed increased abilities to achieve efficient emotion regulation. These findings indicate that positive emotions can be beneficial to psychological health and can contribute to the coping process.

The undoing effect. Fredrickson and colleagues (2000) argue that if positive emotions broaden an individual's thought-action repertoire, they should also act as antidotes for the effects of negative emotions, which the authors argue narrow an individual's thought-action repertoire. In other words, positive emotions should be able to undo the effects of negative emotions; a phenomenon coined as the "undoing hypothesis" (Fredrickson & Levenson, 1998). Although not directly testing the undoing effect, research on self-regulation and coping has demonstrated that the experience of positive emotion during chronic stress and times of adversity can serve as resources for coping, and help manage reactions to threat and stress (Folkman, 1997; Folkman & Moskowitz, 2000; Reed & Aspinwall, 1998).

Fredrickson and colleagues (2000) provided evidence for the undoing hypothesis by conducting a study with university students examining whether positive emotions can "undo" or regulate the effects of negative emotions. Results revealed that feelings of contentment or amusement produced faster cardiovascular recovery from anxiety and stress than did neutral or sad feelings. Although these findings support the undoing hypothesis, further studies need to be conducted to speak to unanswered questions. For example, it would be beneficial to ascertain whether positive emotions, in addition to facilitating cardiovascular recovery from the effects of negative emotions, also undo the cognitive and behavioral narrowing effects of negative emotions (Fredrickson et al., 2000).

Measures of positive emotions and emotional expression. Because this dissertation examined the expression of positive emotion during discussion of interpersonal trauma, the

following section presents how positive emotion has been measured in previous studies. Positive emotion is frequently measured using self-report measures and occasionally using observer-coding systems. Most self-report measures that assess for positive emotion also assess for other emotions, including negative emotions (e.g., anxiety). One commonly used self-report measure is a modified version of the Positive and Negative Affectivity Schedule (PANAS) developed by Watson, Clark, and Tellegen (1988). On the PANAS, individuals are asked to rate the extent to which they feel a number of emotions *right now*. Ratings are made on a 5-point Likert scale ranging from 1 (very slightly or not at all) to 5 (extremely). The Positive Activation (PA) subscale, which specifically measures positive emotions, was originally comprised of 10 items (active, alert, attentive, determined, enthusiastic, excited, inspired, interested, proud, strong), and the modified version added 18 additional affective terms (amused, angry, anxious, blue, calm, content, curious, depressed, disappointed, discouraged, disgusted, happy, relaxed, relieved, sad, satisfied, surprised, tired).

Two other self-report measures are commonly used to assess for positive emotion: the Modified Differential Emotions Scale (mDES) created by Gross and Levenson (1995) and the Mental Health Inventory (MHI), developed by Veit and Ware (1983). The mDES asks participants to recall the past 24 hours and rate their strongest experience of each of 19 specific emotions on a 4-point scale (0 = not at all, 4 = extremely). These emotions include amusement, anger, awe, compassion, contempt, contentment, disgust, embarrassment, gratitude, hope, joy, interest, love, pride, guilt, sadness, shame, fear, and surprise. The MHI provides an assessment of several domains of mental health including anxiety, depression, behavioral control, positive affect, and general distress. The positive affect subscale consists of 11 items and asks individuals to indicate on a 4-point scale (1 = not at all true, 4 = completely true) the extent to which they experienced positive emotions on a daily basis.

Other less commonly used measures of positive emotion are the Emotion Report Form (Ekman, Friesen, & Ancoli, 1980), and the Comprehensive Personality and Affect Scales

(COPAS; Lubin & Whitlock, 2002). On the Emotion Report Form, individuals rate the greatest amount felt of nine emotions (amusement, anger, anxiety, contentment, disgust, fear, happiness, sadness, and serenity). The COPAS is a brief 53-item self-report measure that consists of 15 scales (five personality scales, five positive affect scales, and five negative affect scales), in which five positive emotions and their associated affective adjectives with connotative relevance were included (love, vitality/vigor, joy, excitement, and contentment).

There are two commonly used observer-rating scales of positive emotions. The Emotional Facial Action Coding System (EMFACS) developed by Friesen and Ekman (1984) is an objective measure that allows one to code emotional facial action through viewing video-tapes or live viewing of human interactions. The coding system uses a computerized emotion dictionary based on cross-cultural studies, laboratory studies, and experiments. In contrast, the Linguistic Inquiry and Word Count (LIWC) created by Pennebaker and Francis (Pennebaker et al., 2007), is a text-analysis computer program used to examine writing samples and written transcripts of verbal discussions. The program organizes the occurrence of words into different lexical, psychological, and content categories. The positive emotion category, a sub-section within the Affect Processes category, consists of 406 positive emotion words such as happy, pretty, and good. The LIWC program will be used in the present study.

Purpose of the Study and Research Questions

Recent theories of positive emotion propose that feelings such as happiness, joy, love, interest, and hope can broaden one's range of thoughts and actions, build long-lasting physical, intellectual, social, and psychological resources, and allay the effects of negative emotions (Cohen & Pressman, 2006; Cohen & Wills, 1985; Folkman & Moskowitz, 2000; Fredrickson, 1998, Fredrickson & Branigan, 2005, Fredrickson & Cohn, 2008; Fredrickson & Levenson, 1998). Additionally, positive emotion may facilitate resilience and adaptive coping processes during stressful life events (Billings et al., 2000; Folkman & Greer, 2000; Folkman & Moskowitz, 2000). Although Bonnano, Colak, and colleagues (2007) found that adult survivors

of childhood sexual abuse smiled and laughed when talking about the most distressing event of their lives with interviewers associated with the study, little research exists on how positive emotion is expressed in the context of discussing and sharing interpersonal trauma in psychotherapy.

The purpose of the current case study, therefore, was to extend current work in positive psychology by examining positive emotion during discussions of interpersonal trauma in individual psychotherapy. The following research questions were addressed: (a) Did the client use positive emotional words during discussion of interpersonal traumatic material in the context of individual therapy? (b) At what frequency were positive emotion words expressed in relation to overall affective words and negative emotion words during discussion of interpersonal trauma? (c) What were the themes that emerged during the expression of positive emotion over the course of the therapeutic process? (d) How did the survivor's expression of positive emotion during discussion of trauma relate to the broaden and build theory?

Chapter II. Method

The purpose of this chapter is to present a summary of the methods used in this study. First, the chapter outlines the study's design and then provides a description of the participants, instrumentation, sampling procedure, and data collection process. Next, there is a discussion of the data coding system, human subjects considerations, and the analysis procedures.

Research Design

A qualitative approach may be particularly useful in clinical and counseling psychology research because it is congruent with models and methods used in clinical practice (Morrow, 2007). Qualitative research is used when answering questions of how or what, instead of why (Morrow, 2007). Furthermore, qualitative research is appropriate when understanding the context or setting in which participants confront dilemmas or concerns, when investigating topics for which there is a dearth of research, and when trying to explain existing theories that do not adequately explain the question being explored (Creswell, 2007; Morrow, 2007). The present study examined positive emotion in the disclosure of trauma during psychotherapy, as theories of positive emotion and coping have not adequately described this phenomenon.

The research design of the present study is a descriptive, single case-study approach within a bounded system (Creswell, 2007; Yin, 2003). Within this kind of study, the "investigator explores a bounded system (a case)...over time, through detailed, in-depth data collection involving *multiple sources of information* (e.g., observations, interviews, audiovisual material, and documents and reports), and reports a case *description* and case-based themes" (Creswell, 2007, p. 73). It is appropriate to use a single-case study when studying a single case at two or more points in time (Yin, 2009). An embedded analysis or analysis of themes was used where a specific aspect of the case was studied. A single case was used to conduct this research in order to gain an in-depth understanding of the research topic and questions.

Participant

This study used a single-case study approach. Purposeful sampling was used to access one psychotherapy case from an archival database of video-recorded psychotherapy sessions at a southern California university's community counseling centers.

In order to be included in the study, the client-participant had to meet certain inclusion and exclusion criteria. The client-participant had to be at least 18 years of age at the time of intake, English-speaking, and must have given written consent for written records and videotaping to be included in the research database. The client-participant had to have completed at least 15 sessions of therapy so that the researcher could examine the expression of positive emotion over time, and gather a sufficient amount of information about the course and context of therapy, as some written measures are given after every 5 psychotherapy sessions. The study required there to be at least 15 video-recorded psychotherapy sessions, and the videotaped sessions and written measures must have included discussion of an interpersonal trauma that was directly experienced by the participant. There were no specifications for the participant, as related to gender, socioeconomic status, race/ethnicity or religiosity. Individuals seeking couples, family, or child/adolescent therapy were not included in the sample.

The selected client-participant was a 28 year-old (at the time of intake), unmarried, heterosexual, Christian, able-bodied, African American female who had moved from Kentucky to Los Angeles on her own just prior to seeking psychotherapy at a southern California university's community counseling center. Her intake paperwork indicated that she had no contact with her father and spoke with her mother over the phone every 2 weeks. The client-participant's intake paperwork also indicated that she considers her older brother and cousin to be part of her support system. Throughout her time in treatment she worked as an accountant at a travel agency. Yet she reported that despite her steady job she continued to struggle financially. Additionally, the client-participant indicated that was involved in a committed, long-distance relationship with a professional singer who lived in her hometown.

At intake, she endorsed a number of presenting problems on the Client Information Adult Form. The presenting problems she indicated as most significant were difficulty expressing emotions, feeling inferior to others, lacking self confidence, difficulty controlling her thoughts, and trouble communicating sometimes. Other difficulties she indicated experiencing were feeling angry much of the time, feeling down or unhappy, feeling lonely, experiencing guilty feelings, feeling down on herself, concerns about emotional stability, having difficulty being honest/open, being suspicious of others, and concerns about finances.

The client-participant also endorsed having experienced financial strain or instability, death and loss, drug use or abuse, addictions, and sexual abuse. According to the Intake Report, she was able to discuss the circumstances of her sexual abuse with the therapist-participant, and reported that her uncle had raped her when she and her brother were left in his care. She stated that after the initial sexual assault her uncle attempted to rape her again, at which point she informed him that she would tell her mother what he had done if he ever tried to touch her again. She indicated that this was the last time he tried to assault her and that she had neither disclosed the assault to anyone, nor received psychological treatment to process the experience. In the Intake Report, the therapist-participant noted that the client was curious as to whether the sexual assault was part of the reason for which she was having difficulties opening up to people. Specifically, at intake the client-participant reported experiencing difficulty opening up to her friends and expressed desire to explore this issue further in therapy. Additionally, she indicated that her hands often become cold when she attempts to talk about uncomfortable topics, including the rape. The client-participant was given an Axis I diagnosis of Partner-Relational Problem (V61.10) and a GAF of 75 upon intake by the therapist-participant.

Through review of videotaped psychotherapy sessions, it was discovered that the client-participant was experiencing WPH by her boss, who she reported frequently berated her and her co-workers. It was observed that she became visibly angry and upset when discussing her boss.

Additionally, the client-participant gave several indications that the WPH was causing her to consider quitting on a daily basis, despite her fragile financial situation.

Researchers

The current study used a team of four researchers to code and audit the data (Coder 1, Coder 2, Coder 3, and Auditor 4). Coder 1 (the primary researcher and author of this dissertation) was an able bodied, 28 year-old, progressive, heterosexual, Caucasian, Russian-American female who comes from a family with a middle to high socioeconomic status and is a doctoral student in clinical psychology. As a clinician, I generally conceptualize clients and conduct psychotherapy from both cognitive-behavioral and dialectical behavioral orientations. Through my experience and training in these orientations and through my own personal life experience, I have come to believe that the experience of positive emotion can aid in the recovery from problems rooted in negative emotions such as depression, suicidality, anxiety, and stress-related disorders, and can increase general well being and serve as a buffer against stressful life events. Thus, I expect that a client who has experienced trauma, and who is making an effort to process that trauma in a therapeutic context, will be likely to have experienced positive emotion when discussing traumatic material. Conversely, I expect that individuals who do not experience any positive emotion when processing their trauma may have a more difficult time in coping with their past traumatic events.

Coder 2 was an able bodied, 27 year-old, heterosexual female of European descent. She was raised Catholic in a family of middle socioeconomic status, and identifies as Italian-American and Irish-American. She is currently enrolled in a clinical psychology doctoral program. She tends to conceptualize clients from a cognitive-behavioral perspective and finds value in having structure and specific interventions when working with clients. Based on her experience working with clients she feels that applying some sort of structure or theoretical model to work with survivors/victims of trauma may be beneficial in helping the client through a difficult time. Furthermore, coder 2 believes that understanding what interventions or techniques

therapists can use with survivors of trauma in helping them progress through therapy may be beneficial. In terms of this study, Coder 2 expected to find predominantly negative emotions, such as sadness and anger. Additionally, she believed that there was a possibility for the client-participant to exhibit some flat affect when discussing the trauma. Coder 2 did not think that there would be very much positive emotion expressed by the client-participant, and if there was any, she expected that it would be masking some deeper feelings of sadness or anger.

Coder 3 was an able bodied, 31 year-old, heterosexual, married, first generation Russian-American female doctoral student in clinical psychology. She generally conceptualizes clients from a psychodynamic perspective and works from an integrated therapy approach, incorporating psychodynamic, cognitive-behavioral and mindfulness techniques. Her experiences as a clinician over the past 7 years have led her to believe that therapists can benefit from becoming familiar with strategies that can be used to repair ruptures and conflict with their clients, as conflict appears to be a part of every close human relationship, including therapeutic interactions. She also believes that conflict can be a healthy part of any relationship as it forces people to grow and challenge themselves in new ways. Coder 3 believes that if conflict is managed effectively, new opportunities can be created for both individuals and relationships to grow because it can bring about greater understanding and meaning. Her expectations concerning this study were for the client-participant to express a range of emotions, including sadness, anger, guilt, disgust, shame, and embarrassment when talking about the trauma. Additionally, Coder 3 expected the client to exhibit relief in talking about the trauma with the support of the therapist-participant.

Auditor 4 (the dissertation chairperson) is an able bodied, 43 year-old, European-American, progressive, Christian, heterosexual, married woman of middle to high socioeconomic status. As an associate professor of psychology with degrees in clinical psychology and law, she teaches, mentors and engages in independent and collaborative research with students, including coders 1-3, and colleagues. Auditor 4 believes in the integration of diverse fields of inquiry and of research and practice. Accordingly, she generally conceptualizes clients using multiple theoretical

perspectives (including behavioral, cognitive-behavioral, dialectical behavior therapy, family systems, stages of change and other strength-based and positive psychology approaches) and is supportive of evidence-based treatments. Regarding this study, she also expects that a client who has experienced trauma and discusses it in therapy will express both positive and negative emotions.

Instrumentation

This section reviews the instruments used in this study. The demographic information, written data, and psychotherapy sessions examined in this study were obtained from an archival research database at the community counseling clinics. This database includes the therapists' written material about their clients, measures completed by all clients at the clinics at the intake session and at 5 session intervals, and videotapes of sessions. These measures are used to determine the needs and strengths of clients, and to monitor their progress and satisfaction.

Determining experience of interpersonal trauma. In order to determine whether the client had experienced an interpersonal trauma in his/her life, multiple instruments were examined. In the Family Data Section of the Client Information Adult Form (Appendix A), the client must have indicated "yes this happened" in the Self column under the question "Which of the following have family members including yourself struggled with?" for at least one of the following: physical abuse, sexual abuse, emotional abuse, and/or rape/sexual assault. The client-participant selected for this study indicated, "yes this happened" in the Self column for sexual abuse. To further support this information, the Intake Evaluation Summary (Appendix B) was examined. The therapist must have indicated that the client discussed an interpersonal trauma in at least one of the following sections of the Intake Evaluation Summary: Presenting Problems (section 2), History of Presenting Problems, (section 3), and/or Psychosocial History (section 4). In the History of Presenting Problems (section 3), the therapist-participant indicated that the client-participant had reported one incidence of CSA that occurred when she was in the third grade. The therapist-participant also mentioned the client's experience of CSA in the Family

History section of the Intake Evaluation Summary. The client must have also discussed or disclosed the interpersonal trauma during two or more psychotherapy sessions that were videotaped. Through a review of all videotaped psychotherapy sessions, the researchers found discussions of CSA and WPH in 6 out of the 13 sessions.

Additional sources of information were also considered when determining if a possible participant had experienced an interpersonal trauma. On the Telephone Intake form (Appendix C), the participant may have indicated in the Reason for Referral section that his/her reason for calling to schedule a psychotherapy appointment was due to some sort of interpersonal trauma. However, the client-participant selected for this study did not indicate CSA or WPH as reason for which she was seeking treatment. Furthermore, on the newest version of the University of Rhode Island Change Assessment (URICA; DiClemente & Hughes, 1990; Appendix D), the client may have indicated some sort of interpersonal trauma as the problem on which he/she was working. After reviewing the three URICA's completed by the client-participant over the course of her therapy, it was discovered that she had not indicated an interpersonal trauma as a problem on which she was working.

Determining verbal expression of positive emotion and insight. The Linguistic Inquiry and Word Count (LIWC; Pennebaker et al., 2007) was used to determine the expression of positive emotion and the use of insight words. As previously described in the literature review, the LIWC is a text-analysis computer program used to examine writing samples and written transcripts of verbal discussions. This program was created specifically for use with written and verbal disclosures of traumatic experiences (Pennebaker et al., 2007). The disclosure paradigm analyzed with the LIWC program has been found to be equally valuable for senior professionals with advanced degrees, maximum-security prisoners with sixth grade educations, and individuals of different backgrounds, such as French-speaking Belgians, Spanish-speaking residents of Mexico City, and English-speaking New Zealanders (Pennebaker, 1997). While research has not focused on the validity of the LIWC with African American populations specifically, studies have

included African American participants in their samples (Burton & King, 2004; Burton & King, 2008; Shaw et al., 2007; Shaw, Hawking, McTavish, Pingree, & Gustafson, 2006), with African Americans making up to 46% of the sample in one study (Pasupathi, Henry, & Carstensen, 2002).

The LIWC 2007 dictionary, the integral mechanism on which this program functions, is composed of approximately 4,500 words and word stems that define one or more word categories (Pennebaker et al., 2007). The program organizes the occurrence of words into different lexical, psychological, and content categories. Specifically, when a word is entered into the program, the dictionary is searched for a match and if the entered word matches a word in the dictionary, the appropriate word category is identified (Pennebaker et al., 2007). There are four main categories: Linguistic Processes, Psychological Processes, Personal Concerns, and Spoken Categories (Pennebaker et al., 2007). Under the category of Psychological Processes are Affective Processes and Cognitive Processes (Pennebaker et al., 2007). For the purpose of the present study, positive emotion was determined using the positive emotion category (i.e., general expression of positive feelings or attributions), a sub-section within the Affective Processes category. Similarly, insight was determined using the insight category (i.e., self-reflection and the search for understanding about the nature of an experience or one's self), a sub-section within the Cognitive Processes category. The positive emotion category consists of 406 positive emotion words such as happy, pretty, and good, and the insight category consists of 195 words such as realize, see, and understand.

The internal reliability and external validity for the LIWC program was determined using the program output and independent judge ratings. The reliability for the positive emotion subcategory was .97 and the negative emotion subcategory was .97. Given the high reliability and validity of this system, it was an appropriate measure to use for the current study.

Therapeutic context and process of disclosure. Five measures were used to learn about the client-participant and her therapeutic context in the process of discussing a trauma. First, the Outcome Questionnaire-45.2 (OQ-45.2; Burlingame, Lambert, Reisinger, & Neff, 1995)

(Appendix E) is a self-report measure comprised of 45 items. Each item of the measure is answered on a 5-point Likert scale. The measure consists of three subscales: which assess for Symptom Distress, and distress in Interpersonal Relations, and in Social Roles over the past week. The OQ-45.2 has an internal consistency range of .70-.93 and a test-retest reliability range of .78-.84 (Burlingame et al., 1995). This measure provided valuable information on the client's symptom presentation over the course of her therapy.

Second, the University of Rhode Island Change Assessment (URICA) Scale (DiClemente & Hughes, 1990) was used to determine the client-participant's readiness to change within treatment (Appendix D). The URICA is a self-report measure comprised of 32 items, with responses placed on a 5-point Likert scale. Its four subscales (precontemplation, contemplation, action, and maintenance) each assess the individual's stage of change (i.e., the client's readiness to change during therapy). The URICA has internal consistency reliability ranging from .79-.89 (McConaughy, Prochaska, & Vlicer, 1983).

Third, the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Fetzer Institute & National Institute on Aging [NIA], 1999) was used to examine the role of religion and spirituality in the client-participant's life (Appendix F). The 54-item scale examines important dimensions of spirituality and religion and their connection to physical and mental health. While the BMMRS has a strong Judeo-Christian focus, other items are included that pertain to individuals who have different practices and religious and spiritual beliefs. Subscales of the BMMRS include daily spiritual experiences, meaning, values, beliefs, forgiveness, private religious practices, religious/spiritual coping, religious support, religious/spiritual history, commitment, organizational religiousness and religious preference (Fetzer Institute & NIA, 1999). Subscales within the BMMRS are moderately correlated, signifying that they are distinct constructs (Fetzer Institute & NIA, 1999; Idler, Hudson & Leventhal, 1999). Reliability coefficients for the subscales are: .91 for daily spiritual experiences, .64 for values/beliefs, .66 for forgiveness, .72 for private religious activities, .82 for public religious activities/organizational

religiousness, .64-.86 for religious support, .54-.81 for religious and spiritual coping, and .77 for religious intensity (Fetzer Institute & NIA, 1999; Idler et al., 1999).

Fourth, the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) was used to assess the client-participant's perception of the adequacy of social support she received from family, friends, and her significant other (Appendix G). This 12-item measure uses a 7-point Likert scale that ranges from very strongly disagree to very strongly agree. Subscales within the measure include family, friends, and significant other, which are each assessed with four items (Zimet et al., 1988). High ratings on a subscale indicate a high level of perceived social support within that area. Internal consistency for the MSPSS ranges from .85 to .91, indicating good consistency for the scale and its subscales (Zimet et al., 1988). Furthermore, test-retest reliability ranges from .72 to .85 which suggests that the measure possesses adequate stability over time (Zimet et al., 1988). Although the MSPSS was first used with a sample of undergraduate students, it has sound psychometric properties across diverse samples including adolescents living abroad, pediatric residents, pregnant women, psychiatric outpatients, adolescent psychiatric inpatients, urban youth, older adults, Turkish samples, and adolescents in China (Canty-Mitchell & Zimet, 2000; Cecil, Stanley, Carrion, & Swann, 1995; Chou, 2000; Eker, Arkar, & Yaldiz, 2001; Kazarian & McCable, 1991; Stanley, Beck, & Zebb, 1998; Zimet, Powell, Farley, Werkman & Berkoff, 1990).

Fifth, the Working Alliance Inventory – Client version (WAI-C; Tracey & Kokotovic, 1989) and Working Alliance Inventory – Therapist version (WAI-T; Tracey & Kokotovic, 1989) were used to gain an understanding of whether the client-participant and therapist-participant were working collaboratively and purposefully and connecting emotionally over the course of psychotherapy (Appendix H; Appendix I). The WAI-C and WAI-T are shortened versions of the original 36-item Working Alliance Inventory (Horvath & Greenberg, 1989). These self-report measures consist of 12-items that are scored on a 7-point Likert scale ranging from never (1) to always (7). Higher scores on the WAI-C and WAI-T indicate more positive ratings of the

working alliance. These measures consist of three subscales: (a) Goals, (b) Tasks, and (c) Bond (Tracey & Kokotovic, 1989). The WAI-C has an internal consistency ranging from .90 to .92 on each subscale and the WAI-T has an internal consistency ranging from .83 to .91 on each subscale (Tracey & Kokotovic, 1989). Finally, the Treatment Summary (Appendix J) provided further information as to the client's course of therapy in addition to the reason for termination or transfer to a new therapist.

Procedures

Sampling procedure. An archival database was used to obtain the research data. Each participant completed a written consent form to include his/her written and video materials in the research database (Appendix K). This study used purposive sampling in order to target the specific phenomenon being studied. First, a list of research record numbers was obtained. Second, English-speaking adults over the age of 18 who partook in individual therapy was purposefully selected. Third, the sample was narrowed to include only clients who had experienced interpersonal trauma (see previous section for operational definition). This included reviewing clinic measures for indications of trauma. Fourth, the sample was narrowed to clients who filled out intake measures and follow-up measures. Fifth, the sample was narrowed to those who have at least 15 sessions video-taped. Next, the researchers reviewed the videos of the remaining clients and narrowed down the sample to clients who disclosed trauma in two or more video-taped therapy sessions. The researchers were left with one client who met the requirements for inclusion and exclusion criteria, and this client was used for the case study.

Transcription. Five master's level psychology graduate students were hired to transcribe all videotaped therapy sessions. They were trained to transcribe therapy sessions verbatim and to record the occurrence and duration of each potential discussion of an interpersonal trauma after receiving training on this concept (Yin, 2003).

Coding. Three doctoral level psychology graduate students served as the coders for this study, and their research supervisor served as the auditor. The coders and auditor were trained to understand the essential concepts, terms, and issues that are relevant to the study (Yin, 2003), including how to accurately identify and code occurrences of trauma discussions. Before coding the videotapes of the participant's therapy, the coders and auditor practiced coding until they reach 75% agreement on practice cases. After training was completed, and after the research assistants transcribed all videotaped psychotherapy sessions, the coders and auditor reviewed the videotaped psychotherapy sessions in which there were potential trauma discussions.

Transcriptions of psychotherapy sessions containing trauma discussions were then coded for the expression of positive emotion words, negative emotion words, and affective words in general using the LIWC analysis program. These words were then analyzed over the length and course of the psychotherapy sessions to determine the frequency at which positive emotion words were expressed in relation to overall affective words and negative emotion words during discussion of interpersonal trauma

Additionally, videotaped sessions were examined by the coders/research team for smiles and laughter expressed by the client-participant. Operational definitions of smiles and laughter were developed from a review of the literature on expression of positive emotion (Bonano & Keltner, 1997) and from information taken from the EMFACS, a method for using the Facial Action Coding System (FACS, Ekman & Friesen, 1976) focusing only on the facial actions that might be relevant to detecting emotion. For the purpose of this study, smiles were defined as a facial action characterized by the raising of the lip corners towards the cheekbones and showing of teeth. Laughter was defined as a smile accompanied by audible laughter-related vocalization (i.e., "he he" and/or "ha ha" and an open mouth. First, each coder individually reviewed the videotaped psychotherapy sessions for these expressions of positive affect. The research team then came together and compared their notes on when the client-participant smiled and/or laughed, and discussed any discrepancies in observation until the team reached a consensus. The

researcher then went through each transcript and noted whether the client-participant's smiles and laughter were congruent or incongruent with the topic of discussion.

The coders/research team also coded psychotherapy sessions containing discussions of interpersonal trauma for themes within and across sessions. Since the team used a positive psychology lens, they found themes that were reflective of the client's strengths and virtues (e.g., assertiveness and self-respect/pride) as well as themes that reflected potentially maladaptive behaviors and/or coping strategies (e.g., mistrust of others and insecurity; Seligman & Csikszentmihalyi, 2000). However, themes and subthemes were not informed from a purely strengths-based approach, but rather were created by more openly observing videotapes and transcripts of the course of psychotherapy to determine what themes emerged. More specifically, to create themes and sub-themes the coders and auditor read through the transcripts individually, noting any recurring topics that stood out in client-participant's therapy process. It was important for each research team member to individually review the transcripts before meeting as a team, in order to provide different opinions and perspectives and circumvent individual biases (Hill, Thompson, & Nutt Williams, 1997). The three coders then met to discuss each transcript containing a trauma discussion, line by line, noting recurring topics that were recorded individually by each coder. When the research team came to a line that contained an individually noted theme, each person presented their ideas and discussed the potential theme until the team reached a consensus that an overall theme indeed existed in that line of the transcript. If it was agreed that a theme category label was warranted, the research team discussed how each coder had labeled the theme individually, until consensus was reached on the theme category label. For example, each coder often came up with different emotions expressed by the client. When an emotion was named as a theme, it was discussed to see if it appeared across the course of therapy or if it was only in that particular session. If the emotion appeared only in that particular session, it was not labeled as a theme, as the team wanted to see what emotions appeared consistently across the course of therapy for the client. However, if it was apparent across the course of

therapy it was labeled as a theme.

Next, the research team worked independently to determine larger general themes and sub-themes based on the themes that were created as a team. This process involved re-reading the transcripts and grouping together specific themes that appeared to be related or to serve a similar function for the client. Once all of the specific themes were grouped together, each team member created general, overarching themes that best categorized/described the more specific sub-themes.

The coders then met to discuss their groupings of sub-themes and creation of overall general themes to determine agreement on how each individual had organized the different theme categories. Based on the team's discussion, sub-themes were moved to different general themes categories, and themes categories were re-worded in order to best capture the complexity of the data. A themes key was created for reference.

The auditor for the study independently reviewed the transcripts and themes key, and made suggestions based off of her own ideas and observations. The research team met a final time to discuss the auditor's notes, and made changes based on consensus about theme categories that should be added, and sub-themes that would make more sense if moved to different theme categories. Research team members individually went through each session containing a trauma discussion, and found specific quotes that best exemplified each theme and sub-theme.

The researcher then qualitatively analyzed the transcripts to examine which sub-themes co-occurred with the expression of positive affect. Positive affect that was incongruent with co-occurring sub-themes was discussed in terms of its possible function. The researcher sought to consider the possible adaptive functions of the expression of positive affect (e.g., emotional breaks and emotion regulation) as well as possible maladaptive functions (e.g. avoidance, repressive coping, and "saving face" in front of an evaluative audience), which is consistent with the positive psychology framework of presenting a more balanced view of humans through a focus on both strengths and weaknesses.

Human Subjects/Ethical Considerations

All participants consented to have their records included in the research database prior to the intake interview at the community clinic (Appendix K). All therapists in the study consented to allow their therapy tapes and client records to be part of the research database (Appendix L). Limits of confidentiality were reviewed during the intake procedure. To preserve participant confidentiality, all identifying information was removed from the clients' written documents. A research number was given to each research participant in order to de-identify them.

In addition, each researcher/coder and transcriber completed an IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to increase understanding and adherence to ethical subject research. All researchers and transcribers signed a confidentiality statement indicating they will keep all sensitive information confidential (Appendix M; Appendix N).

Data Analysis

To analyze the data, research assistants examined the participant's videotaped psychotherapy sessions, and noted any potential discussions of trauma. The research assistants then transcribed all videotaped psychotherapy sessions, and noted the start and stop times of the discussions for the researchers. Discussions were then entered into the LIWC computer program to code for the expression of positive emotion during the trauma discussion (Pennebaker et. al., 2007).

All LIWC data were entered into a table that recorded the percent of positive emotion words expressed during a trauma discussion (see Appendix O). The categories in the table are session ID, word count, percentage of affective words, percentage of positive emotion words, percentage of negative emotion words, percentage of cognitive processing words, and percentage of insight words. Additionally, averages of these percentages across all discussions of CSA and

WPH, and across all trauma discussions as a whole were calculated and recorded in a table (Appendix P). The data were then examined to determine whether positive emotion was expressed during discussion of interpersonal trauma, the percentage of positive emotion words expressed, and ratio of positive emotion words used in relation to the number of affective words, negative emotion words, and insight words. Additionally, LIWC data were used to determine whether insight words were used during discussions of interpersonal trauma in which the client-participant expressed positive emotion. Finally, the researcher examined the average percentage of affective words, positive emotion words, negative emotion words, and insight words spoken by the client-participant across all discussions of sexual abuse and all discussions of workplace harassment within each recorded session.

Data were also analyzed by creating summaries of each psychotherapy session in which there was a discussion of interpersonal trauma. In each summary, the researcher noted topics of discussion, salient interactions between the client-participant and therapist-participant, general pacing and course of the session, and positive affect expressed by the client-participant. The researcher also highlighted whether the client-participant's positive affect was congruent or incongruent with the topic of discussion. Other salient contextual data (e.g., ethnic and cultural background, symptom distress, working alliance, treatment outcome) were also reported.

As this study took a single case study perspective, the researcher then analyzed the data and determined if they were consistent with, or an exception to, the broaden and build theory. This was done by exploring trauma discussions in which the client-participant expressed positive affect. The broaden and build theory and other theories of positive emotion state that positive emotion facilitates wider-ranging action/ response-tendencies toward more general goals such as affiliation and exploration (Fredrickson, 1998; Izard, 1977). To examine the client-participant's demonstration of exploration, the researcher specifically analyzed the trauma discussions for urges to contemplate new ideas, development of alternative solutions to problems,

reinterpretation of situations, reflection on behaviors, urges to investigate (i.e., asking the therapist-participant questions or attempts to better understand the topic of discussion) (Fredrickson, 1998). The broaden and build theory also proposed that these new ideas, solutions, and reflections build lasting physical intellectual, social and psychological resources (Fredrickson, 1998). Concerning psychological resources, Lazarus and colleagues (1980) hypothesized that during stressful life events where negative emotions are predominant, positive emotions can serve as an emotional “break,” support the individual’s effort to cope, and provide personal resources that have been exhausted. Supporting this belief, research has revealed that positive emotions can act as a shield to defend against the effects of stressful situations (Folkman & Moskowitz, 2000). To analyze trauma discussions for possible psychological resources the client-participant may have gained from expressing positive affect, the researcher specifically examined what occurred when negative emotion (i.e. expressions of anger) was followed by positive affect and if this allowed for a “break” (i.e. time off from a discussion of a stressful topic, or a shift in the topic of discussion).

Additionally, a themes key (Appendix Q) was created to operationally define themes and sub-themes, and a themes tracking table was created to track themes that surfaced within the client-participant’s speech. Within this table, themes were organized by those that occurred during the discussion of an interpersonal trauma and those that occurred outside of the trauma discussion, and specific quotations uttered by the client-participant that best exemplified each theme and sub-theme were recorded. A Themes Occurrences Table (Appendix R) was created to track the number of occurrences of themes and sub-themes within and outside of discussions of trauma over the course of the client-participant’s psychotherapy. The themes and sub-themes were examined across the psychotherapy sessions for any patterns (i.e. themes that seemed to re-occur at specific points in therapy), with particular attention paid to themes that coincided with the expression of positive affect (i.e., smiling and laughing). A Themes/ Positive Affect Co-occurrence Table (Appendix S) was created in order to track the number of times that positive

affect was expressed during occurrences of each sub-theme. For each session containing discussions of trauma, the researcher noted the number of times that positive affect co-occurred with each sub-theme, and the number of times it did not occur with each sub-theme within the session. Co-occurrences of sub-themes and positive affect were examined across psychotherapy sessions for any patterns (e.g., which sub-themes seemed to evoke more positive affect and which sub-themes seemed to evoke the least positive affect).

Chapter III. Results

This chapter presents the results of the single case study. After providing an overview of the course of therapy, results from the LIWC analysis are reviewed. The chapter concludes with a presentation of themes that emerged within each psychotherapy session that contained a trauma discussion and themes that emerged within each trauma discussion. All quoted materials in this section are based on written measures and video-recorded psychotherapy sessions from an archival database.

Course of Therapy

The client-participant was in therapy for a total of 21 sessions, six of which contained discussion of interpersonal trauma. When she first called into the community-counseling center for a phone intake, she reported that she needed help adjusting to living in a city. Additionally, she indicated that she tends to hold a lot in, and wanted to talk with someone about her problems. During the formal intake, the patient reported that she has difficulty expressing her feelings to her friends, and stated that she feels she is “shut down” and would like to explore feelings that she has pushed away. She also reported she would like advice about her boyfriend.

One of the intake measures (OQ 45.2), which determines symptom distress, suggested that the client-participant was experiencing distress in relation to her social role. The therapist-participant noted on the paperwork that she should pay particular attention to anger management in therapy, as the client-participant was angry at work and was afraid she might “do something she would regret.” Additionally, on an intake measure assessing perceived social support (MSPSS), the client-participant indicated that she has a weak social support system with boyfriend as her strongest source of support, and her family as her weakest source of support. Finally, the client-participant’s responses on an intake measure assessing readiness for change (URICA) suggested that she was in the action stage of change, which signified that she was actively working on her problems and making changes in her life.

At sessions seven and 14 the client-participant completed follow-up measures. At session seven, the client-participant was no longer experiencing distress in relation to her social role. Conversely, on the score summary sheet, the therapist-participant indicated that the client-participant, “[did feel her problems [were] out of control,” which indicates a discrepancy between what the client-participant reported on the measure and how she presented in psychotherapy. On the URICA, there was a discrepancy between what the therapist-participant noted as the problem on which the client was working and what the client-participant noted she was working on. The client-participant noted she was still working on “communication” while the therapist-participant noted she was working on “emotional expression lacking.” The client-participant’s responses on the URICA indicated that she was in the contemplation stage, suggesting that she was planning on making changes towards her new problem within the next 6 months. The client-participant indicated a strong working alliance with the therapist as evidenced by her answers on the WAI-Client.

At session 14, the client-participant did not indicate any significant symptom distress as evidenced by her responses on the OQ-45.2. In terms of the URICA, the client-participant indicated that she was working on “the voice inside of [her],” and her responses suggest that she was in the action stage of change. The client-participant’s responses on the WAI-Client indicate that she felt a strong working alliance with the therapist-participant.

The client-participant discussed two distinct interpersonal traumas over the course of her psychotherapy. These interpersonal traumas included her experience of childhood sexual abuse as a child by her uncle, and her experience of workplace harassment by her boss in her place of employment. The client-participant only indicated the childhood sexual abuse in her intake paperwork. Discussing of interpersonal trauma occurred in approximately 6 out of the 21 therapy sessions, however, it is possible that there were more trauma discussions since only 16 of the 21 sessions were videotaped. The following section provides a summary of the sessions in which there were discussions of interpersonal trauma (i.e., sessions 1, 6, 7, 9, 12, and 18).

Session one. The client participant's first session of psychotherapy contained 12 distinct discussions of interpersonal trauma. The topic of these discussions was the client-participant's history of childhood sexual abuse (CSA), as well as her more recent experience with workplace harassment by her boss. The session began with the therapist-participant thanking the client for sharing her trauma in the last session. The client-participant responded by laughing, smiling, and speaking rapidly and unintelligibly. The therapist then quickly changed the topic of discussion by asking about client's week. The client-participant began relaying the details of the previous night in which she drove home after drinking several alcoholic beverages. She laughed and smiled while retelling the events of the evening.

At this point the therapist-participant again changed the topic of discussion, reminding the client that one of her goals for therapy was to be more emotionally open and to communicate her emotions. The therapist-participant began to ask the client-participant specific questions about the bodily sensations that occur when she experiences emotion. The client-participant smiled and laughed and noted that her hands become cold whenever she discusses her feelings. She also identified her heart beating fast and an urge to laugh "too much" when she becomes nervous. The therapist-participant continued to facilitate the discussion about how the client-participant experiences emotion, and the client-participant revealed that she does not share her emotions with her friends or family, and that only her boyfriend has seen her cry. She added that whenever she discusses the trauma it "comes out as anger" and never as sadness.

As the therapy session moved forward, the client-participant revealed other traumatic events that she had experienced throughout her life. In the second trauma discussion, the client-participant alluded to a trauma that occurred when she first moved to Los Angeles. She stated that she was able to cry in front of her boyfriend during this time. At this point in the session, the client-participant briskly sat up in her seat and smiled. Seemingly in response to the client-participant's shift in demeanor, the therapist-participant quickly changed the topic of discussion, and asked why the client had initially come into therapy.

The next 10 discussions of interpersonal trauma were centered upon the client-participant's experience of workplace harassment. The client-participant expressed intense anger toward her boss, often calling him insulting names. It was notable that she exhibited very little positive emotion (i.e., smiling and laughing) when expressing her anger toward and hatred of her boss. However, when the client-participant seemed to calm down after expressing her anger, she would begin to smile and laugh. For example, after emphatically telling the therapist-participant that her boss is a "fat bastard," she states, "Okay, I'm back" while laughing and smiling, as if to communicate that she felt she had gotten carried away. It was also notable that the client-participant reported that her hands became very cold when she discussed her boss.

Throughout the discussion of workplace harassment, the therapist-participant seemed to be more reserved during these expressions of anger, remaining quiet or nodding in agreement with the client-participant. Furthermore, when the therapist-participant did speak, it seemed she was focusing on the content of the discussion rather than on the emotion behind the discussion. For example, there were several times in which the therapist-participant asked questions about the client-participant's role at her job or tried to problem solve for her (e.g., "Why don't they tell you—I mean isn't there a simple solution of them telling you when it becomes 300 order?") rather than reflecting the emotion the client-participant was expressing. Within her discussion of workplace harassment, the client-participant also revealed several occasions in which she stood up to her boss, and described these incidents with both anger and pride, again, expressing very little positive emotion.

Additionally, the client-participant discussed her mistrust of friends, stating that she often "tests" them by expressing an opinion she "[knows] is dead wrong" but pretends she believes is "dead right." She indicated that her friends usually "take the bait," and that she consequently "weeds them out" based on whether or not they are able to "form their own opinion." The client-participant also exhibited mistrust for her own boyfriend, explaining that she often lets him think he is in control, but ultimately she makes the important decisions. While talking about her

mistrust of others, the client-participant occasionally expressed both smiles and laughter, especially when discussing her mistrust of friends. She expressed less positive emotion when discussing maintaining the control in her relationship. Again, during this discussion, the therapist-participant asks clarifying questions about content, rather than targeting emotion or the process of therapy.

Throughout the session, the therapist-participant made several interpretations, some of which were received well by the client-participant, as evidenced by verbal and/or non-verbal agreement (nodding and smiling), and some of which were not received well, as evidenced by verbal disagreement. One instance was particularly noteworthy, in that the therapist-participant made an interpretation that the reason the client-participant has difficulty trusting others is because she was taught by her family at a young age that she had to protect herself and be responsible for herself, and therefore grew up too quickly. The client-participant responded by openly disagreeing with therapist-participant, stating that she did not feel that she had to grow up too quickly. While the client-participant verbally disagreed with the therapist participant, she did not seem to have a negative emotional reaction in response to the interpretation, and the tone of the therapy session remained friendly.

Toward the end of the session, the therapist-participant asked the client-participant to think about the ways in which she still guards herself and is mistrustful of others due to her experiences in childhood. The client-participant then smiled and asked the therapist how to “fix” it if she still needs to be responsible, to which the therapist-participant replied that she does not need to give up responsibility to open up within relationships and give people a chance to know her. The session lasted approximately 65 minutes and ended with therapist-participant thanking the client-participant for opening up in the session.

Session six. The sixth session had two separate discussions of trauma, one concerning the client-participant’s history of CSA, and the second concerning her experience of workplace harassment. The session began with the therapist-participant asking how the client-participant is

doing. In response, the client-participant began to laugh, stating that she did not have anything to talk about. When asked why she was laughing, the client-participant seemed to become insecure as evidenced by her response: "I don't know. I'm stupid." She continued to laugh until the therapist participant asked her if she had spoken to her boyfriend after their argument over his ex-girlfriend and the child they had together.

The client-participant then immediately launched into an explanation about the "drama" occurring between her boyfriend and his ex. Specifically, the client-participant voiced concern that she was not getting the complete truth from her boyfriend, and that he was not handling the situation well. During this discussion the client-participant seemed to focus on the idea of respect and control, expressing frustration that she did not have control over the situation, and felt disrespected by the way her boyfriend was handling it. Furthermore, she talked for long periods of time with little interjection from the therapist-participant, and expressed very little positive emotion. As in the intake session, the client-participant stopped her monologue abruptly, stating, "So that's where I'm at with that," and began to smile and laugh.

At this point in the therapy session, the therapist-participant states that she wants to shift the focus of the discussion to the client-participant's difficulty expressing and identifying emotion, rather than on her boyfriend. The client-participant began to laugh, and agreed to switch topics. The therapist-participant then asked the client-participant if she has noticed any change in her emotions. This prompted the client-participant to discuss how she responded to memories of her CSA, explaining that normally she had immense difficulty feeling sadness, as it always turned to anger. However, she stated that when it comes to her CSA she makes a conscious effort to remind herself that she is sad, not angry, and indicated that she will always be mad if she does not, "get the sadness taken care of." Throughout this discussion about her emotions, the client began to smile and laugh with every word she spoke.

After briefly discussing her difficulty identifying and expressing emotions, the client-participant quickly shifts the topic from a deeper or process-centered discussion to a more surface

level or content-centered discussion about her decision of whether or not to act in a movie she feels would be degrading. During her discussion about potentially participating in a degrading movie, she expressed her fear that she will be asked to do things that make her a sexual object. She emphatically pointed out that she does not like “the sluts” or a “whole bunch of dudes right here and I’m up here just dancing around shaking my ass.” The client-participant was adamant about not falling into any stereotypes and not portraying herself as eye-candy, yet also expressed desire to work as an actress. She also expressed fear of judgment from others.

The client-participant next addressed her feelings toward her mother and her struggle with money. She began the discussion by describing her negative feelings toward her mother, stating that she remembers being mean to her mother on purpose. When she described a specific example in which she made her mother cry, she begins to laugh. Throughout this discussion, the client-participant frequently laughed at times that did not seem congruent with the topic of the discussion, such as times when she was describing something about which she was angry or sad. The therapist-participant made the interpretation that usually when children have anger toward their parents, they tend to have underlying feelings that they are not expressing. In response, the client-participant explained that throughout her childhood she did not have rules, and could do whatever she wanted.

The client-participant also explained that her mother was always “broke” and that she has anger toward her mother because she feels there has been pressure on her to send her family money now that she moved away. When asked by the therapist-participant how it makes her feel that she does not have money to send back to her family, she responded, “just annoyed” and laughed. Again, the client-participant’s expression of positive emotion is incongruent with her verbal statements. The client-participant also reported that she feels it is unfair to be counted on for money when she is not the parent, and describes a situation in which her mother won 10,000 dollars and said she was sending the client-participant money but never followed through. The client-participant became particularly angry due to the fact that her mother did not send her

money to help her with her transition to living in a new city, and then later complained to friends and family that the client-participant was successful in Los Angeles but not sending money home.

The client-participant ended the discussion suddenly by stating, “So it’s annoying, yes it is” and laughs. The therapist-participant observed that the client-participant seems to laugh when she is annoyed or upset, and made the interpretation that the client-participant is dissociating from painful feelings when she laughs. Instead of responding, the client-participant begins to talk about how selfless she is, constantly thinking of ways to help friends in need even when she is struggling financially. However, she expressed resentment and frustration toward her boyfriend because he does not demonstrate her work ethic or drive to find a way to support himself. She also explained that she is resistant to receiving help from others, because she does not want to owe anyone anything. She expressed very little positive emotion during her monologue, and the therapist-participant participated minimally. Throughout this discussion, the client-participant talked for long stretches of time with little interjection from the therapist-participant, who only nodded or uttered brief verbal agreement (e.g., Mm-hmm).

The session ends with the client-participant playing a voicemail from her boss, in which he blames and belittles the client-participant and her co-workers for mistakes they have allegedly made, and threatens that the responsible employee will “burn in hell.” The client participant smiles at two points during his rant, one right after he states, “whoever is responsible for this shit I’m sorry but we can no longer put up with that you know,” and another time when the voicemail comes to an end. She also laughs during the discussion after the message is played, after she exclaims, “I swear I’m gonna hit this fat man in his eye.” The session went over time (approximately 68 minutes in length), ending abruptly when the message was done playing with the client-participant and therapist-participant discussing the inappropriate nature of the phone message. While the phone message was being played, the therapist-participant interjected infrequently, asking clarifying questions, but did not address the client’s emotional state after listening to the message.

Session seven. The seventh session of psychotherapy contained two discussion of workplace harassment and three discussions of CSA. The client-participant partook in two out of three trauma discussion about CSA; however, she did not participate in one of these discussions as the therapist makes a statement about CSA but does not get a response from the participant. These discussions of trauma were discussed in the context of a therapy board game, which was facilitated by the therapist and played throughout the session. The session began with therapist introducing the game to the client-participant, and explaining the rules, which included picking cards and asking the other player questions about a range of personal topics. One of the rules was that the therapist-participant and client-participant could not comment on the others answers. The therapist-participant seemed to stick to this rule rigidly, while the client-participant frequently disregarded the rule, asking the therapist-participant multiple questions about her responses.

In the first trauma discussion, the therapist-participant asked the client-participant what she feels challenged by. The client-participant answered that she feels challenged by her co-workers, due to her hatred of work, and that anything they say puts her on edge. She did not express positive emotion while discussing this topic; however, she laughed directly after the therapist-participant changed the topic by moving forward in the game.

The next trauma discussion occurred when the client-participant is asked to share an experience she will never forget. She revealed that she will never forget the “molestation,” at which point she paused and laughed. She then explained that she feels as though it does not affect her, and feels “detached” from the event. She described situations in which people discuss molestation, and stated that she feels as though it never happened to her. The client-participant then shifted the discussion by asking where to put her card, as if she was ready to move on in the game. The therapist-participant stayed on the topic by asking the client-participant if she wanted to talk more about what happened to her. The client-participant laughed and agreed to discuss the trauma only if the therapist-participant asked her specific questions.

The therapist-participant then asked the client-participant what happened to her, and the client-participant provided a brief account of the CSA. While she was specific in identifying her uncle as the perpetrator and the general circumstances around which the CSA occurred, she never shared with the therapist what, specifically, her uncle did to her. However, she did share how the CSA came to a halt, stating that one day she began to say “no” to her uncle, at which point he stopped the abuse. The client-participant stated that she believes he stopped because he was afraid she would tell her mother. She then laughed before going on to add that she had no respect for him after what he did to her. Additionally, she stated that the only reason she did not tell her mother was because she was afraid her mother would kill him and end up in jail, and then the client-participant would have no one to take care of her. It is particularly notable that the client-participant laughed after this last utterance, as it was very incongruent with the topic of her discussion. At this point, the client-participant continued the discussion and laughed as she described her happiness when she discovered that her uncle died. She also described her anger and rebellious behavior toward him. She did not express any positive emotion when describing her anger toward him.

After being prompted by the therapist-participant, the client-participant described how her CSA experience has changed the way she views the world, noting that she is “rougher” with men and prefers to have the power in her relationships for fear that if she shows vulnerability she will be taken advantage of. She also indicated that she maintains her independence because she does not trust anyone. Specifically, she stated that she likes to do everything on her own and does not like to accept help because she never wants to owe anyone anything. There was minimal to no expression of positive emotion throughout her answer, but the client-participant seemed to abruptly finish the discussion and laughed.

The third trauma discussion occurred when the therapist-participant picked a card asking her to, “say something about child abuse.” To answer the question, she stated, “it’s never the victims fault, and it’s always the perpetrator’s fault.” She then elaborated on her statement, at

which point the client laughed. The therapist-participant then gave the dice to the client-participant in order to move forward with the game, rather than stay on the topic.

The fourth trauma discussion occurred later in the session, when the client-participant addresses the comment the therapist-participant had made about CSA in the previous trauma discussion. The client-participant openly disagreed with the therapist, stating that she believes the victim contributes somewhat to his/her own abuse. To explain herself further, she used the example of R. Kelly, who she believes is a “dirty old man” but insists that the girls he molested also have some responsibility because they probably wanted to sleep with him. The client-participant uses derogatory language when describing the girls who would want to sleep with R. Kelly, and adds that they were “asking for it.” The therapist-participant responded by explaining that children do not have power, and do not have the mental maturity that adults do. The client-participant responded to the therapist-participant’s explanation by agreeing with her and stating that her explanation makes sense. However, once the therapist-participant finished her explanation, the client-participant began to laugh, and joked that she would not buy R. Kelly’s CD.

Next, the therapist pursued the topic of discussion by asking the client-participant where she was coming from in asking about the therapist-participant’s statement about CSA. The client-participant then began to describe her views of women, stating that she believes women are deceitful and that they like to seduce men and get them into trouble. To provide proof for her statement, she cited the example of her boyfriend’s ex-girlfriend who she believes is manipulative. However, she also expressed frustration for her boyfriend’s inability to take control over the situation, calling him a doormat, and expressing fear that the problem will grow in magnitude because he not being assertive enough. When discussing the situation between her boyfriend and his ex, the client-participant expressed no positive emotion and used profanity frequently. She then seemed to calm down after expressing her anger and frustration, and began to laugh.

The final trauma discussion was very brief, and consisted of the client-participant describing how she behaves when she is angry. She cited a specific example in which she became angry at work and “went off” and said something “crazy.” She explained that when angered she has a tendency to say something “snappy,” and if that does not seem to get the desired result she “gets louder,” as she stops caring what the other people have to say. She added that she used to become violent when angered; however she is now able to walk away. The client-participant laughed both during and after this trauma discussion. The session ended with the therapist-participant giving the client-participant measures to complete. The therapist-participant left the room, and the client-participant stayed past the allotted hour for the session, as she stayed in the room to complete the measures.

Session nine. The ninth session of psychotherapy contained two discussion of trauma relating to the client-participant’s experiences of workplace harassment by her boss. The session began with the therapist-participant and client-participant continuing to play the therapy board game that they had played in the previous session. The client-participant began the session by discussing her relationship with her mother. She expressed anger toward her mother for rarely contacting her, and laughed frequently when expressing her anger. For example, she laughed while calling her mother a “bitch.” Throughout this discussion the therapist-participant asked few questions limited mostly to clarifying questions. When the client-participant seemed to have finished discussing her mother, the therapist quickly jumped in to move the game forward. The client-participant and therapist-participant then discussed a range of topics in response to the game’s questions, including their favorite movies and how the client-participant spends time with her boyfriend. These surface discussions lead to the first trauma discussion, as the client-participant stated that she watches movies at work due to boredom. She emphasized that she spends nine hours at a time sitting in a “box,” and laughed and smiled while describing how bored she becomes at work.

The client-participant then continued the conversation by discussing her desire to look for other jobs that would allow her to audition for acting and modeling jobs during the day. She discussed the strategies she is thinking of using in order to best set herself up to successfully obtain a job, emphasizing that her ideal job would be mindless. The client-participant then suddenly stopped talking and apologized for talking too much, smiling throughout her apology. The therapist-participant assured her that therapy is a place to discuss anything on her mind, and the client-participant continued to strategize about when to quit her job.

The therapist-participant then shifts the focus back to the game, and the client-participant picks a card asking her how she behaves when she is angry. She described how she behaves at different levels of anger, using an experience with her boss as an example. In this second discussion of trauma, the client-participant described her boss “getting in [her] face,” and her response of avoiding him. She indicated that he continues to speak to her to get a reaction out of her until she can “no longer take it,” at which point she warns him that she will do something “really rude” if he does not stop. She explained that she does not raise her voice during these altercations; however, she stated that if continued to push her she would “hit [him] in his face,” at which point she began to laugh and smile. As this discussion comes to the end, the client-participant continues to smile and the therapist-participant again shifts the focus back to playing the game.

As the game continued, several topics surfaced including the client-participant’s attitude toward life, which she describes as “positive but realistic.” She indicated that she is very logical and always thinks of the consequences of her actions, stating that even if her actions are “bad,” she will be able to anticipate a negative outcome. She expressed frustration with her boyfriend, as he does not seem to consider how his behavior will affect the outcome of a situation. Throughout this discussion the therapist-participant challenged the client-participant to consider that always planning ahead and assessing the consequences of one’s actions could be stressful and time consuming. The client-participant denied that this process is stressful to her; however, she

acknowledged one situation (the situation with her boyfriend, his ex, and his child) where constantly analyzing provokes anxiety in her.

Another topic that was discussed during the game was the client-participant's experience of religion. She recounted her experience in Catholic school and church, stating that she found it boring. She indicated, however, that she was interested in knowing what she was supposed to do with her life, which she thought she would be able to find through the church. Additionally, the client-participant expressed anger toward her mother for relying on religion to help their family instead of trying harder to provide for them. She also expressed anger that she was not allowed to question the Bible's inconsistencies, explaining that this made her more doubtful of Catholicism.

The session ended with the client-participant bringing up the topic of her boyfriend, his ex, and their baby. She explained that she feels as if she should not be upset about the situation because her boyfriend's ex does not live in Los Angeles; however, she states that she is constantly thinking about it. She expressed frustration at herself, exclaiming "who gives a fuck," while smiling. Additionally, she cautiously revealed that she fears her boyfriend's ex would find a way to control him by using their child, and that her boyfriend would not stand up to her. She appeared to be self-conscious about disclosing her fear as evidenced by asking the therapist-participant not to laugh at her. Additionally, she laughed, smiled, and twisted her hair when discussing her fear. The therapist-participant challenged the client-participant during this discussion by asking her how her boyfriend's ex acting emotional and manipulative would affect the client-participant's life. The client-participant responded, "because he's gonna have to go away from me." The therapist-participant reflected back to the patient that she fears he will spend less time with the client-participant because he will have to try and smooth things over with his ex. The client-participant agreed with this interpretation, adding that his lack of assertiveness will make it unlikely that he will take control of the situation. The discussion was interrupted when the client-participant's cell phone rang. The therapist-participant noted that the session had gone

over, but stated that they should continue the topic at the next session. The client-participant agreed and stated, “Oh, I’m gonna cry,” while laughing and smiling.

Session twelve. The twelfth session of psychotherapy contained two discussion of trauma, one relating to the client-participant’s experience of workplace harassment by her boss, and the second about her CSA. The session began with the client-participant returning the follow-up measure paperwork to the therapist-participant. The therapist-participant spent the first few minutes answering the client-participant’s questions about a measure (URICA). Specifically, the client-participant stated that she did not remember what she had indicated on the last measure as the problem on which she was working in therapy. The therapist-participant responded by stating, “It doesn’t matter what you put, it’s whatever you want, you’re feeling right now... You’re trying to see what the change is.” Although the therapist-participant did not further explain what the measure was examining, the client-participant seemed to understand and moved on.

Next, the client-participant initiated a discussion about finally talking to her boyfriend about her feelings related to the situation with his ex and the baby they have together. She indicated that she put off the discussion for a number of days because she felt there was a never a good time to bring up the topic. The client-participant also expressed concern that she did not address the topic as the therapist-participant had instructed her to, stating “it didn’t come out as good as I should have said it, like you told me to say it.” The client-participant explained that it was important for her to talk to her boyfriend about how she had been feeling because without communication she believes that their relationship would not last.

When the therapist-participant questioned how the client-participant’s boyfriend had reacted to the discussion, the client-participant revealed that she had guessed the password to her boyfriend’s ex’s email. The therapist-participant first seemed shocked, repeating what the client-participant had revealed so as to make sure she had heard correctly. The therapist-participant and the client-participant then both began to laugh, at which point the client-participant asked the therapist to stop laughing. The therapist-participant apologized, and the client-participant

continued the conversation by stating that her boyfriend had been upset when she told him what she had done. At this point, the therapist-participant reminded the client-participant that hacking into someone's email account was illegal. The client-participant stated that she did not care, and the therapist-participant questioned her by asking, "You don't care?" The therapist-participant quickly changed her tone and assured the client-participant that she could not report her to authorities. The client-participant stated that if the therapist-participant reported her, she would go to jail, at which point she began to laugh and smile. The client-participant continued to discuss how the discussion with her boyfriend had gone, stating that it is important for her to talk about things that are on her mind. She frequently added that her boyfriend could break up with her if he did not like her talking about the situation with his ex-girlfriend. The client-participant also expressed feelings of shame about hacking in to her boyfriend's ex-girlfriend's email, stating that it was hard to admit to her boyfriend what she had done. She both laughed and smiled when revealing her feelings of shame to the therapist. This topic led to the first trauma discussion, in which the client-participant talked about her boss sitting near her when she hacked into her boyfriend's ex-girlfriend's email account. This discussion lasted only a few seconds.

The client-participant continued to discuss her thoughts and feelings about her boyfriend's ex-girlfriend. Specifically, she expressed anger toward and mistrust of her boyfriend's ex-girlfriend. The client-participant seemed to spend the majority of the discussion explaining details of her boyfriend's past with his ex-girlfriend. The therapist-participant spoke very little during this discussion, only interjecting to ask clarifying questions. Throughout the discussion, the client-participant also expressed frustration toward her boyfriend for not taking responsibility for and control over the situation. She cited the specific example of him failing to get a paternity test. When describing how difficult it had been for her to tell her boyfriend about how she was feeling, she stated that she was, "freezing cold, crying and scared," while laughing and smiling.

The client-participant then shifted the focus of conversation to her “inner voice,” which she explains holds her back from doing what she wants to do in life and makes her lack confidence. Additionally, she stated that her inner voice makes her doubt others and to be afraid, even when coming to therapy. The client-participant also discussed how her inner-voice keeps her from pursuing a singing career, as she is constantly doubting and judging herself. The therapist-participant provided multiple reflections throughout the discussion, and asked the client-participant what role the “voice” plays in her life. With prompting by the therapist-participant, the client-participant was able to identify that the voice has played a protective role in her life, telling her to be wary of others and the world. The therapist-participant also challenged the client-participant to identify who her inner voice most sounds like. Instead of directly answering the therapist-participant’s question, the client-participant diverted back to the topic of her boyfriend. Specifically, she revealed that she feels financially responsible for her boyfriend, and added pressure from her mother to send money home. She expressed very little positive emotion throughout this discussion, and the therapist-participant seemed to take a less active role, only providing active listening techniques.

Toward the end of the session the discussion returned to the client’s critical inner voice. This lead into the third trauma discussion, in which the therapist made an interpretation that the client’s inner voice developed in childhood as a way to protect her from her uncle and to act as a “parent voice” since her mother was not actively involved in disciplining her. This seemed to upset the client, as evidenced by her putting her head in her hands and exclaiming, “if you think about it like that, it’s disgusting.” Her affect however, was incongruent with this exclamation in that she was smiling while speaking these words.

The last part of the session was spent helping the client to identify ways in which she could get over her fear of singing in public. The therapist-participant provided psychoeducation on phobias and panic attacks, and suggested ways that the client could control her critical inner voice. Throughout this discussion, the client-participant expressed positive emotion when

discussing being “mad as hell” at her inner voice and when guessing that she would cry if she had to practice singing in front of the therapist as exposure work. She also smiled and laughed when asking the therapist-participant whether her fear of singing is a phobia. It seemed as though she was embarrassed when asking this question as evidenced by putting her head in her hands. The session ended at approximately 60 minutes.

Session eighteen. The eighteenth session of psychotherapy contained two discussion of trauma relating to the client-participant’s experiences of workplace harassment by her boss. The session began with the client-participant reporting that she had difficulty following through with the therapist-participant’s suggestion to make positive self-statements throughout the week. While explaining to the therapist participant that she was unable to complete the assignment, the client frequently giggled and smiled.

She continued to smile and laugh as she explained that she fears singing or talking to herself aloud, as she worries that people will hear her and judge her. She continued to discuss her critical inner voice, and how it prevents her from pursuing a singing career. Additionally, she smiled and shared that she does not want people to hear the music she listens to or her talk in her apartment because she does not want anyone to “know her.” She explained that she did not even want a roommate because she did not want to be friends with the person she lived with, and would rather be alone. Throughout the conversation the therapist-participant asked questions to try and pinpoint what exactly the client-participant feared about others hearing her or knowing her. The client-participant laughed frequently when explaining she fears that others will judge her and think that she is crazy. Additionally, the therapist-participant tried to use different scenarios to help illustrate how one’s frame of mind can affect her self-confidence. She also made the observation that the client-participant is hard on herself, which seemed to surprise the client-participant as she explained she thought she was “cool.” She smiled and laughed when expressing her surprise.

The client-participant shifted the topic of discussion approximately half way through the session to focus on her frustration and anger toward her boyfriend for his selfishness. She cited a specific example in which he had an extra computer and did not give it to her even though he knew how much she needed one. She indicated that she was particularly upset about his demonstration of selfishness because she is always thinking of how she can help him financially. This topic of conversation led to the first trauma discussion, in which the client-participant explained that she would have to delay quitting her job so that she could earn enough money to afford a computer. The client-participant appeared to be distressed, exclaiming, "So I'm like I wanna leave now. Can't stand this damn place." This trauma discussion lasted only a few moments, after which the client-participant stated that she does not need her boyfriend's computer because she can and always has taken care of herself. The client-participant did not express positive emotion during this first trauma discussion or the conversation leading up to it.

The client continued to talk about her anger toward boyfriend, stating that he should have thought of giving her the computer immediately. She added while laughing that she should be "cool" to herself since other people will not be. The client-participant then shared that her boyfriend would no longer be visiting her because she cannot afford to pay for his plane ticket. This led to the second trauma discussion, in which she expressed hatred toward her job and explained that even though her boss has been "cooler" recently, she still feels as though she is living the life of 50 year old rather than a young adult. She cursed frequently when describing her hatred for her job, and smiled when using an expletive to curse at her boss (she was acting as if speaking to him). This discussion only lasted approximately a minute, and the client-participant changed the topic of discussion abruptly back to her problems with her boyfriend. The therapist-participant did not play an active role in this discussion and did not ask any follow up questions about the client-participant's feelings about her job.

The remainder of the session was spent discussing the client-participant's relationship problems. Specifically, she stated that her boyfriend becomes jealous when she networks in order

to find acting and modeling work. She expressed anger and frustration toward him, and shared that she feels as though he wants to get famous and then have her tag along by his side. The therapist-participant commended the client-participant for beginning to stand up for herself, and the client-participant thanked the therapist participant for noticing. She began to tell the therapist-participant other ways she is starting to take care of herself, and shared that she wishes her boyfriend would dump her because constantly needs to be reassured and is unable to take care of her.

The session lasted approximately 60 minutes and ended with the therapist giving the client-participant homework to sit down and imagine herself singing aloud, with specific instructions to let her nervousness go if her hands become cold while doing the visualization. The client-participant smiled and shared that her hands were cold already. As the therapist continued to give the client-participant instructions for her homework, the client participant laughed and stated again that she was already “freezing cold.” The last moments of the session were spent scheduling the client-participant’s next session.

LIWC Analysis

The Linguistic Inquiry and Word Count (LIWC) computer program (Pennebaker et al., 2007) was used to determine the client’s verbal expression of positive emotion during discussions of trauma within the six psychotherapy sessions summarized in the previous section. The following section provides a summary of the percentage of overall affect words, positive emotion words, negative emotion, cognitive processing words, and insight words spoken by the client-participant in each trauma discussion (see Appendix Q), as well as the average percentage of affective words, positive emotion words, negative emotion words, cognitive processing words, and insight words spoken by the client-participant across all trauma discussions for each session (see Appendix R). Averages were rounded off to two decimal places; thus the affective words category’s percentage may not equal the percentages of its subcategories, positive and negative emotion words). The information presented in this section is organized by trauma discussion.

Childhood sexual abuse. There were seven discussion of the client-participant's childhood sexual abuse throughout the course of therapy, which included details of the trauma, in addition to her thoughts and feelings about the trauma. Two of these discussions took place in the first session, one occurred in the sixth session, three occurred in the seventh session, and the final discussion took place in the twelfth session.

The first trauma discussion of the first session occurred approximately 3 minutes into the session and lasted for 21 seconds. The client-participant spoke a total of 22 words in this discussion, with 4.55 % of the words categorized as affective words, 4.55% of the words categorized as positive emotion words, and 0% categorized as negative emotion words by the LIWC computer program. Out of the 22 total words in the first discussion of trauma, 4.55% were categorized as cognitive processing words and zero words categorized as insight words. The second discussion of CSA occurred approximately 18 minutes into the therapy session and lasted 33 seconds. The client-participant verbalized a total of 124 words, with 12.2 % categorized as affective words, 10.57 % categorized as positive emotion words, and 1.63 percent categorized as negative emotion words. Out of the 124 total words in the second discussion of trauma, 13.01% were categorized as cognitive processing words and 2.44% were categorized as insight words by the LIWC computer program.

There was one discussion of CSA in the sixth session occurring approximately 5 minutes into session and lasting one minute and 11 seconds. Within this discussion, the client-participant spoke a total 293 words, with 13.99% categorized as affective words, 6.83% categorized as positive emotion words, and 6.83% categorized as negative emotion words by the LIWC computer program. Out of a total of 293 words spoken in this discussion, 17.41% were categorized as cognitive processing words and 5.46% were categorized as insight words.

In session seven, three discussion of CSA occurred at approximately 9, 23, and 32 minutes into the session. The first discussion of CSA lasted 9 minutes and 20 seconds. The discussion contained a total of 2202 words spoken by the client-participant, with 4.41%

categorized by the LIWC computer program as affective words, 3.68% categorized as positive emotion words, and 0.73% categorized as negative emotion words. Out of the 2202 words spoken in this discussion, 17.35% were categorized as cognitive processing words and 3% were categorized as insight words. The second discussion of CSA lasted for 24 seconds. The discussion contained a total of seven words spoken by the client-participant, with 0% categorized as affective words and 0% categorized as cognitive processing words by the LIWC computer program. The third discussion of CSA lasted 7 minutes and 13 seconds. This discussion contained 651 total words spoken by the client-participant, with 6.45% categorized as affective words, and 3.69% categorized as positive emotion words. Of the 651 words spoken in this discussion, 18.28% were categorized as cognitive processing words and 6.3% were categorized as insight words by the LIWC computer program.

There was one discussion of CSA in the twelfth session that occurred approximately 47 minutes into the session and lasted 27 seconds. Within this discussion, there were a total of 11 words spoken by the client-participant, with 0% categorized by the LIWC computer program as affective or cognitive processing words.

The average percentage of affective words, positive emotion words, and negative emotion words spoken by the client-participant was calculated across all discussions of CSA within each recorded session. In the first session, the average percentage of affective words was 8.4% and the average percentage of cognitive processing words was 8.78% during a total of 54 seconds. The average percentage of positive emotion words was 7.56, the average percent of negative emotion words was 0.82%, and the average percentage of insight words was 1.22%. A total of 16 minutes and 57 seconds of discussions of CSA in the seventh session contained an average of 3.62% affective words and 11.88% cognitive processing words. The average percentage of positive emotion words was 2.46%, the average percentage of negative emotion words was 1.16%, and the average percentage of insight words was 3.10%. Sessions six and 12 each contained only one discussion of CSA, at 1 minute and 11 seconds for session six and 27

seconds for session 12, while sessions 9 and 18 only contained discussions of workplace harassment.

Workplace psychological harassment. There were 18 total discussions of the client-participant's experience of workplace harassment that occurred over the course of therapy. The client-participant discussed details about how she was being harassed by her boss at work, as well as her thoughts and emotions about her experiences at work. Ten discussions of workplace harassment took place in the first session, one took place in the sixth session, two occurred in the seventh session, three occurred in the ninth session, one took place in the 12th session, and three discussions took place in the 18th session.

The first discussion of workplace harassment occurred approximately 21 minutes into the first session and lasted 12 seconds. There were a total of 64 words spoken by the client-participant throughout this discussion, with 11.11% categorized as affective words, 6.67% categorized as positive emotion words, and 4.4% categorized as negative emotion words. Out of the 64 words in the discussion, 8.89% were categorized as cognitive processing words and 0% were categorized as insight words. The second discussion of workplace harassment occurred approximately 23 minutes into the session and lasted 24 seconds. There were a total of 560 words spoken by the client-participant in this discussion, with 7.32% categorized as affective words, 2.5% categorized as positive emotion words, and 4.82% categorized as negative emotion words. Out of the 560 words in the discussion, 17.32% were categorized as cognitive processing words and 3.75% were categorized as insight words by the LIWC computer program. Approximately 25 minutes into the first session, the third discussion of workplace harassment occurred, lasting 25 seconds. There were a total of 134 words in the discussion, with 2.99 percent categorized as affective words, 0.75% categorized as positive emotion words, and 2.25 categorized as negative emotion words. Out of the 134 words in the discussion, 23.13% were categorized as cognitive processing words and 0% were categorized as insight words. The fourth discussion of workplace harassment took place approximately 26 minutes into the session and lasted 31 seconds. There

were a total of 106 words, with 9.43% categorized as affective words, 1.89% categorized as positive emotion words, and 7.55% categorized as negative emotion words. Out of the 106 words in the discussion, 11.32% were categorized as cognitive processing words and 0.94% were categorized as insight words by the LIWC computer program. At approximately 28 minutes into the first session the fifth discussion of workplace harassment occurred, lasting 1 minute and 48 seconds. The client-participant spoke a total of 352 words, with 7.1% categorized as affective words, 1.99% categorized as positive emotion words, and 5.11% categorized as negative emotion words. Out of the 352 words spoken, 19.03% were categorized as cognitive processing words and 2.27% were categorized as insight words.

The sixth discussion of workplace harassment in the first session occurred approximately 30 minutes into the first session and lasted 21 seconds. There were a total of 99 words spoken by the client-participant in this discussion, with 8.08% categorized as affective words, 6.06% categorized as positive emotion words, and 2.02% categorized as negative emotion words by the LIWC computer program. Of the 99 words in the discussion, 13.13% were categorized as cognitive processing words and 1.01% were categorized as insight words. At approximately 32 minutes into the first session, the seventh discussion of workplace harassment took place, lasting one minute and four seconds. There were a total of 287 words spoken by the client-participant throughout this discussion, with 5.57% of the words categorized as affective words, 3.14% categorized as positive emotion words, and 2.44% categorized as negative emotion words. Of the 287 words in the discussion, 20.91% were categorized as cognitive processing words and 2.79% were categorized as insight words by the LIWC computer program. The eighth discussion of workplace harassment took place at approximately 35 minutes into the first session and lasted 1 minute and 4 seconds. The client-participant spoke a total of 224 words in this discussion, with 7.14% categorized as affective words, 5.8% categorized as positive emotion words, and 1.34% categorized as negative emotion words. Of the 224 words in the discussion, 18.75% were categorized as cognitive processing words and 1.79% were categorized as insight words by the

LIWC computer program. At approximately 45 minutes into the first session, the ninth discussion of workplace harassment occurred, lasting three minutes and 25 seconds. There were a total of 714 words spoken by the client participant, with 7.98% categorized as affective words, 3.64% categorized as positive emotion words, and 4.34% categorized as negative emotion words by the LIWC computer program. Of the 714 words in the discussion, 17.93% were categorized as cognitive processing words and 1.54% were categorized as insight words. The last discussion of workplace harassment took place at approximately 49 minutes into the first session and lasted only 18 seconds. The client-participant spoke a total of 166 words throughout the discussion, with 4.82% categorized as affective words, 3.01% categorized as positive emotion words, and 1.81% categorized as negative emotion words by the LIWC computer program. Of the 166 word in the discussion, 21.69% were categorized as cognitive processing words and 2.41% were categorized as insight words.

The sixth session only contained one discussion of workplace harassment, which occurred approximately 1 hour into the first session and lasted 8 minutes and 28 seconds. The client-participant spoke a total of 281 words in the discussion, with 4.27% categorized as affective words, 1.78% categorized as positive emotion words, and 2.49% categorized as negative emotion words. Of the 281 words spoken, 16.81% were categorized as cognitive processing words and 2.37% were categorized as insight words by the LIWC computer program.

The seventh session contained two discussion of workplace harassment, the first occurring approximately 7 minutes into the session and lasting 29 seconds, and the second occurring approximately 52 minutes into the first session and lasting 21 seconds. The first discussion of workplace harassment had a total of 119 words spoken by the client participant, with 10.92% categorized as affective words, 9.24% categorized as positive emotion words, and 1.68 categorized as negative emotion words. Of the 119 words in the discussion, 20.17% were categorized as cognitive processing words and 0% were categorized as insight words by the LIWC computer program. The second discussion of workplace harassment contained a total of 56

words spoken by the client-participant, with 7.14% categorized as affective words, 3.57% categorized as positive emotion words, and 3.57% categorized as negative emotion words. Of the 56 words in the discussion, 14.29% were categorized as cognitive processing words and 1.79% were categorized as insight words by the LIWC computer program.

Both discussions of trauma in the ninth session were centered on workplace harassment. The first discussion took place at approximately 9 minutes into the ninth session and lasted 18 seconds. The client-participant spoke a total of 65 words throughout the discussion, with 4.62% categorized as affective words, 1.54% categorized as positive emotion words, and 3.08% categorized as negative emotion words. Of the 65 words in the discussion, 26.15% were categorized as cognitive processing words and 0% were categorized as insight words by the LIWC computer program. The second discussion of workplace harassment occurred approximately 18 minutes into the ninth session and lasted 1 minute and 27 seconds. Within this discussion, there were a total of 332 words spoken by the client-participant, with 8.43% categorized as affective words, 5.12% categorized as positive emotion words, and 3.31% categorized as negative emotion words. Of the 332 words in the discussion, 20.78% were categorized as cognitive processing words and 2.71% were categorized as insight words by the LIWC computer program.

In the 12th session, there was only one discussion of workplace harassment, which occurred approximately 12 minutes into the session and lasted only 3 seconds. There were a total of 22 words spoken by the client-participant, with 4.55% categorized as affective words, 0% were categorized as positive emotion words, and 4.55% categorized as negative emotion words. Of the 22 words in the discussion, 13.64% were categorized as cognitive processing words and 0% were categorized as insight words.

The final two discussions of workplace harassment took place in the 18th session. The first discussion occurred approximately 28 minutes into the session and lasted 17 seconds. The client-participant spoke a total of 79 words throughout this discussion, with 5.06% categorized as

affective words, 3.8% categorized as positive emotion words, and 1.27% categorized as negative emotion words. Of the 79 words in the discussion, 12.66% were categorized as cognitive processing words and 3.8% were categorized as insight words. The last discussion occurred approximately 32 minutes into the 18th session and lasted 30 seconds. There were a total of 205 words spoken by the client-participant in this discussion, with 10.24% categorized as affective words 4.39% categorized as positive emotion words, and 5.85% categorized as negative emotion words. Of the 205 words in the discussion, 14.63% were categorized as cognitive processing words and 4.39% were categorized as insight words by the LIWC computer program.

The average percentage of affective words, positive emotion words, and negative emotion words spoken by the client-participant was calculated across all discussions of workplace harassment within each recorded session. The first session contained an average of 7.15% affective words, 17.21% cognitive processing words, 3.55% positive emotion words, and 3.61% negative emotion words, and 1.65% insight words from a total of 3 minutes and 33 seconds of trauma discussion. The seventh session contained an average of 9.03% affective words, 17.23% cognitive processing words, 6.41% positive emotion words, and 2.63% negative emotion words, and 0.9% insight words from a total of 50 seconds of trauma discussion. Discussions of workplace harassment in the ninth session contained an average of 6.53% affective words, 23.47% cognitive processing words, 3.33% positive emotion words, and 3.20% negative emotions words, and 1.36% insight words from a total of two minutes and 15 seconds of trauma discussion. The 18th session contained an average of 7.65% affective words, 13.65% cognitive processing words, 4.09% positive emotion words, 3.56% negative emotion words, and 4.10% insight words from a total of 47 seconds of trauma discussion. Session six and 12 each contained only one discussion of workplace harassment.

Themes Analysis

Through analysis of the reoccurring topics in the client-participant's speech over the course of psychotherapy, six general themes emerged along with 29 more specific sub-themes.

For each session containing a discussion of CSA or workplace harassment, themes and sub-themes were recorded in a table (Appendix L). Additionally, specific quotes uttered by the client-participant that best illustrated each sub-theme were also added to the table. The following section includes a description of the general themes and their more specific sub-themes, specific quotations that best exemplify each sub-theme, a review of how many times the themes and sub-themes occurred within each session and within each discussion of trauma, and observations of positive emotional expression that co-occurred with the themes and sub-themes.

Self-protection. The theme of self-protection refers to the variety of ways in which the client-participant avoided experiencing negative life events by maintaining her physical and psychological safety. This theme occurred 25 times in session one, 25 times in session two, 31 times in session seven, 10 times in session nine, 19 times in session 12, and 22 times in session 18. Each variation of her attempts to protect herself was recorded as a sub-theme, and included avoidance of talking about the trauma, avoidance of emotion, mistrust of others, sense of responsibility, financial security, distancing from others, and respect for others. Self-protection occurred both within discussions of trauma and outside of discussions of trauma; however, its sub-themes were not present in every session containing a trauma discussion.

Avoidance of trauma discussion was one way in which the client-participant attempted to protect herself. This sub-theme refers to the client-participant's reluctance to discuss her experience of CSA. In session one, the sub-theme of avoidance of trauma discussion occurred three times outside of discussions of trauma, once in the first discussion of sexual trauma, and once in the second discussion of sexual trauma. In session seven, it occurred four times in the second discussion of sexual trauma. Avoidance of trauma did not occur in sessions six, nine, 12, or 18. This sub-theme was noted specifically in response to discussing the topic of the client-participant's childhood sexual abuse and not in response to workplace harassment. It seemed that the client-participant actively avoided this topic completely, or discussed it very briefly in broad terms, without reporting any details of the incident. For example, in the first session, the

therapist-participant attempted to bring up the client-participant's sexual trauma by reminding her of a previous discussion. She stated, "So what we talked about last time, you know about your uncle and it was kind of, it was a little bit rough, you know?" Instead of acknowledging their previous discussion, the client-participant avoided the topic by stating, "About what?" Similarly, in session seven, the client-participant did not avoid the topic of her sexual trauma completely; however, it seemed as though she glossed over the topic by avoiding reporting any details of the trauma and rushing through the discussion. She stated,

I'm kind of by myself,[client gestures with left hand] playing with my toys, and he'll call me in the room, he was in my mom's room [client points to the wall with hand], and he'll be like, basically because I bought you Burger King, and you know like, and he's like don't tell your momma and I'm like ok, first time.

Additionally, the client-participant seemed to avoid talking about the trauma at the time it occurred, in that she did not tell her mother. She stated, "Like, I didn't tell my mom... But of course you don't tell your momma something like that because you need your parents to be here." In this quote, the client-participant described her fear that her mother would retaliate against the perpetrator if she found out about the sexual abuse, and she therefore avoided talking to anyone about what had happened to her.

The sub-theme of avoidance of trauma discussion co-occurred with the client-participant's expression of positive emotion (i.e., smiling and laughing) 4 out of 5 times in session one and two out of four times in session seven. The client-participant's expressions of positive emotion during discussions involving this sub-theme were not congruent with the topic of discussion.

The second sub-theme under the theme of self-protection was avoidance of emotion. This sub-theme refers to the client-participant's reluctance to discuss feelings other than anger during psychotherapy and with others in her life. In session one, this sub-theme occurred once outside of trauma discussions and six times in the second discussion of sexual trauma. In session six, it

occurred two times in the first discussion of sexual trauma. In session seven, avoidance of emotion occurred six times outside of trauma discussion and three times in the second discussion of sexual trauma. In session nine, the sub-theme occurred once outside of trauma discussions. In session 12 avoidance of emotion occurred four times outside of trauma discussions, and in session 18 it occurred two times outside of trauma discussion. Similarly to the sub-theme of avoidance of trauma discussion, avoidance of emotion occurred during discussions of sexual trauma but not during discussions of workplace harassment.

It became clear over the course of psychotherapy that the client-participant did not like to experience negative emotions other than anger, and often defaulted to anger when she was aware that she should be feeling sadness. In session one, the client stated, "Because people never see me sad...especially not my cousin because I grew up with her...I ain't never seen her cry, and she's never seen me cry...I'm laughing because that's how I am, and I don't want to talk." Similarly, within the second trauma discussion of the first session she stated, "Ok, so then I cried and it's like it's ok. As long as I don't do it every day. I'd get sick of it." Through these examples, the client-participant seems to be communicating feeling uncomfortable expressing sadness. In session six during the first trauma discussion, the client-participant stated, "It like, it just bothers my emotions. 'Cause everything else I'm like, 'ok whatever, ok I'm mad' but I'm not you know...it's ok to express sadness, don't automatically turn it into anger." This is a good illustration of the client-participant's tendency to express anger in the place of other more vulnerable negative emotions. Additionally, the client-participant seemed to demonstrate awareness of her emotional avoidance, stating,

...it's like I've been so detached from it, like I could listen to other people talk about them being molested and I don't even think that I have anything to do with that... it don't affect me, but kind of like what you said, I'm wondering if it does and I just don't know it.

The sub-theme avoidance of emotion co-occurred with the expression of positive emotion 7 out of 7 times in session one, 0 out of 2 times in session six, 2 out of 9 times in session seven, 0

out of 1 time in session nine, 0 out of 4 times in session 12, and 0 out of 2 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 9 out of 25 times. The client-participant's expressions of positive emotion during discussions in which this sub-theme emerged were not congruent with the sub-theme/topic of discussion.

Mistrust of others was another sub-theme that serves as an example of how the client-participant attempted to protect herself. This sub-theme refers to the client-participant's reluctance to confide in others with emotions and secrets, as well as her disbelief that others would offer help without expecting something in return. In session one, mistrust of others occurred five times outside of trauma discussions and once in the second discussion of sexual trauma. In session six, mistrust of others occurred once outside of trauma discussions. In session seven, the sub-theme occurred four times outside of trauma discussions and three times during second discussion of sexual trauma. In session nine, it occurred once outside of trauma discussions. In session 12, mistrust of others occurred nine times outside of trauma discussions, and in session 18 it occurred once outside of trauma discussion.

Throughout the course of psychotherapy, it seemed that the client-participant was suspicious of others' intentions. In session seven, the client-participant stated, "I was wondering what was 'gonna happen because it was just too, we was just getting along way too good." This quote is a perfect example of the client-participant's belief that others did not have good intentions. Furthermore, the client-participant seemed to be reluctant to ask others for help due to her mistrust. In the second trauma discussion of the seventh session the client-participant stated, "...it took a long time for me to accept help or to accept something." The client-participant's mistrust of others also seemed to bleed into her friendships in that she had difficulty opening up to those close to her. This was evident during session one when the client-participant stated, "...I may as well just tell the wall, because I'm going to get the same response" and in the 12th session when she stated, "No, no. I don't even give nobody a chance to say nothin."

The client-participant expressed positive emotion during the occurrence of this sub-theme 4 out of 6 times in session one, 0 out of 1 time in session six, 0 out of 7 times in session seven, and 0 out of 1 time in sessions nine, 12, and 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 4 out of 17 times. The client-participant's expressions of positive emotion during discussions involving this sub-theme were not congruent with the sub-theme or topic of discussion.

One sub-theme under the theme of self-protection that seemed to recur over the course of psychotherapy was the client-participant's sense of responsibility. This sub-theme refers to the client-participant's strong feelings of obligation to take care of herself and others involved in her life. Sense of responsibility occurred three times outside of trauma discussions in session one, eight times outside of trauma discussions in session six, one time outside of trauma discussions in session nine, four times outside of trauma discussions in session 12, and seven times outside of trauma discussions in session 18. This sub-theme did not occur during session seven, and only occurred outside of discussions of trauma throughout all sessions. It seemed that the client-participant had to take care of herself as a child due to her mother's low level of involvement in her daily life. She stated, "I mean I gotta get up and go to school, I got this to take care of you know, I don't know, she ain't never been like really strict on me. I could pretty much do whatever I wanted." The client-participant also demonstrated a sense of responsibility for her boyfriend. In session 12 she stated, "I feel like because, ok this is wrong, but I feel like he's a responsibility of mine right now. I feel like I have a kid."

In terms of the positive emotional expression, the client-participant smiled and laughed during the occurrence of the sub-theme sense of responsibility 2 out of 3 times in session one, 3 out of 8 times in session six, 0 out of 1 time in session nine, 0 out of 4 times in session 12, and 0 out of 7 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 5 out of 23 times. Positive emotion expressed by the

client-participant during discussions involving this sub-theme was not congruent with the sub-theme or topic of discussion.

The sub-theme of financial security occurred frequently throughout the client-participant's course of therapy and seemed to be another way in which she attempted to protect herself. This sub-theme refers to the client-participant's strong feelings and actions related to money and the importance of having enough money. Financial security occurred 14 times outside of trauma discussions in session six, eight times outside of trauma discussions in session seven, six times outside of trauma discussions in session nine, five times outside of trauma discussions in session 12, and three times outside of trauma discussions in session 18. This sub-theme did not occur in session one, and only occurred outside of discussions of CSA and workplace harassment over the course of therapy.

In addition to her current financial situation, this sub-theme included the client-participant's concern about her boyfriend's lack of income and her economic status growing up. For example, when discussing her experience as a child in session six, the client-participant stated, "I was wondering was it because we was broke, like we didn't get to have everything everybody else had so I always had an attitude." Her concern for finances seemed to extend to her boyfriend, which was demonstrated in session 18 when she stated, "you not, you have not made it yet, you cannot take care of me, therefore I take care of myself. What else you want me to do?" However, this sub-theme usually emerged when referencing her current financial problems. For example, in session seven the client-participant stated, "I don't like taking off work...I'm kind of in debt and I mean don't like that."

The client-participant seemed to express positive emotion during the occurrence of this sub-theme when she was discussing her financial situation in the past (i.e., childhood) or when she was discussing getting paid. This sub-theme co-occurred with the expression of positive emotion 2 out of 14 times in session six, 3 out of 8 times in session seven, 4 out of 6 times in session nine, 0 out of 5 times in session 12, and 2 out of 12 times in session 18. Across all

sessions, this sub-theme occurred in the presence of positive emotional expression a total of 10 out of 36 times. The client-participant's expressions of positive emotion during discussions involving her financial situation in the past or involving her lack of money in the present were not congruent with the topic of discussion. However, her expression of positive emotion when discussing getting paid was congruent with the topic of discussion.

Another way in which the client-participant seemed to attempt to protect herself was by distancing from others. Distancing from others, as a sub-theme, refers to the client-participant's tendency to avoid forming and maintaining close relationships with others in life to prevent herself from being emotionally hurt. This sub-theme occurred two times in the second discussion of sexual trauma in session seven, and nine times outside of trauma discussions in session 18. An example of how the client-participant distanced herself from others is when she expressed her opinion about allowing people to get to know her, stating, "I'm like, I don't want people to know what I'm listening to, like none of that. As far as I'm concerned, it's just like I don't even want you to think I'm here." Similarly, she said, "I knew I didn't want a roommate that was anything like me, cuz I didn't want to be friends." It is evident through these quotes that the client participant made considerable effort to stop others from getting to know her and vice versa.

The client-participant expressed positive emotion when discussing this sub-theme zero out of two times in session seven and two out of nine times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of ten out of 36 times.

The client-participant's expressions of positive emotion during discussions involving this sub-theme were not congruent with the sub-theme or topic of discussion.

The last sub-theme within the theme of self-protection is respect for others. This sub-theme refers to the client-participant's strong feelings of consideration and courtesy for others, especially elders and those who treated her with respect. In session one, this sub-theme occurred once outside of trauma discussions, twice in the fifth discussion of workplace harassment trauma, and once in the 11th discussion of workplace harassment trauma. It occurred twice in the second

discussion of sexual trauma in session seven, once outside of trauma discussion in session nine. This sub-theme did not occur in sessions six, 12, and 18, and occurred during discussions of both sexual and workplace harassment trauma. The client-participant's beliefs about respect are illustrated in session one during the fifth trauma discussion when she says, "The only reason why I'm there is because of this nice ass lady. She's very sweet, very nice, she'll do anything for you....the only reason why I'd be respectful really is because of Mickey." Similarly, when describing a situation in which she normally would have retaliated against her boss, she stated, "But I—She was right there and I don't want no fifty-something year old picking up no piece of paper like that. It's just not respectful." However, it was also evident that the client-participant did not feel that everyone deserved respect. For example, in the second trauma discussion of session seven she stated, "...where I grew up, dudes don't really deserve respect." Similarly she relayed that she was, "...kind of glad because that gave me a thing, don't respect all adults, cause they don't deserve it," when talking about her sexual abuse.

Respect for others co-occurred with the client-participant's expression of positive emotion 0 out of 4 times in session one, 0 out of 2 times in session seven, and 0 out of 1 time in session nine. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 0 out of 7 times.

Power and control. Power and control was a general theme that emerged across all sessions in which there was a discussion of trauma. The theme of power and control refers to the ways in which the client-participant attempted to feel competent and gain command over her environment and life experiences. This theme occurred a total of 12 times in session one, 27 times in session six, 35 times in session seven, 16 times in session nine, 13 times in session 12, and 30 times in session 18. Power and control occurred within discussion of both sexual and workplace harassment trauma, as well as outside of discussions of trauma. Sub-themes that were gleaned from the larger theme of power and control included assertiveness, aggression, desire/attempt to control self, desire/attempt to control environment/others, and independence. While many of

these sub-themes occurred frequently over the course of psychotherapy, they were not all present in every session containing a trauma discussion.

One sub-theme that emerged within the larger theme of power and control was assertiveness. This sub-theme refers to the client-participant's use/desired use of determination and decidedness during important life experiences. It occurred in the fourth and ninth discussions of trauma in session one, in the second discussion of trauma in session seven, and in session 12. In session one, assertiveness occurred once outside of trauma discussions, twice during the fifth discussion of workplace harassment trauma, and once during the 11th discussion of workplace harassment. Assertiveness also occurred three times in the second discussion of sexual trauma in the seventh session, and three times outside of trauma discussions in the 12th session. Assertiveness was observed occurring in discussions of both workplace harassment and in discussions of CSA, as well as outside of trauma discussions.

This sub-theme included the client-participant's discussion of situations in which she had acted assertively with others, or had wanted to act assertively. For example, when discussing workplace harassment from her boss, she stated, "I just started talking back. Because I don't care, like you're not going to talk to me like that." Additionally, the client-participant discusses developing an assertive style early on in childhood in response to the CSA she experienced. She explained, "...so I just developed an attitude. I was like no, I don't care, I'm not doing that." Furthermore, assertiveness emerges as a sub-theme in her relationship with her boyfriend. In session 12 the client-participant described her changed attitude toward discussing things with him about which she was upset and stated, "He'll try to wiggle his way out of it, but I'm not letting him do it no more. I tell him, you want to dump me, do it whenever you feel like it cause I'm gonna bring it up anytime I feel like it." These quotes demonstrate how the client-participant used assertiveness to maintain power and control over certain situations.

In terms of positive emotional expression, the client-participant laughed and/or smiled during discussions in which this sub-theme emerged 1 out of 4 times in session one and 0 out of 3

times in session seven and 12. While there was some expression of positive emotion that co-occurred with the sub-theme of assertiveness in session one, in all other sessions there was no co-occurrence. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 1 out of 9 times. The one occurrence of positive emotional expression in the presence of this sub-theme was incongruent with topic of discussion.

The second sub-theme within the overall theme of power and control is aggression. This sub-theme refers to hostile feelings and attitudes expressed by the client-participant during psychotherapy. Aggression occurred once in the seventh discussion of workplace harassment trauma in session one and once during the second discussion of workplace harassment trauma in session seven. In session nine, the sub-theme occurred once outside of discussions of trauma and twice in the second discussion of workplace harassment trauma. Aggression did not occur during sessions 12 and 18, and occurred in discussions of both sexual trauma and workplace harassment trauma, as well as outside of trauma discussions. Aggression included hostility (real or imagined) expressed toward another person. For example, in the first session during the seventh discussion of workplace harassment from her boss the client stated, "Because I yelled at him and he shut the fuck up even though he was still mad." Similarly, in the second discussion of workplace harassment in session six, the client-participant stated, "I'm glad he didn't say that in my face because I woulda had to talk to him, be like don't be talking about burning in hell, fuck you." Finally, in session nine, the client-participant described how she expresses anger and explained, "First step is, say something smart. Second step is say something even smarter. Third step is ignore before I go off. Fourth step is go--say something to let them know you're not playing... be like, 'Damn it stop. Okay bitch, stop. Okay I'm going to pull out this gun in my purse if you don't f***ing stop. Then people tend to stop.'" Although the client-participant did not act on these thoughts and feelings, these quotes serve as an example of how she used aggression to feel as though she had power and control in certain situations.

In terms of positive emotional expression, the client-participant smiled and/or laughed during discussion in which this sub-theme arose 0 out of 1 time in sessions one and six, 4 out of 10 times in session seven, and 2 out of 3 times in session nine. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 6 out of 15 times, all of which were incongruent with the topic of discussion.

Another sub-theme that occurred within the theme of power and control was desire/attempt to control self. This sub-theme refers to the client-participant's wishes and trials at gaining and maintaining mastery over her reactions to environment and life experiences. Desire/Attempt to control self occurred once outside of trauma discussions in session one, once outside of trauma discussions in session six, six times outside of trauma discussions in session seven, twice outside of trauma discussions in session nine, and four times outside of trauma discussions in session 18. This sub-theme did not occur during any discussions of trauma. Desire/attempt to control self emerged in session six when the client-participant said, "But I don't have to do if he wants me to do something I don't want to do, he ain't gonna push me, you know?" Additionally, she expressed a desire to control her inner experiences. For example, in session seven she stated, "I don't like getting in my head. I don't like playing around with it. I don't like it. I wish that I could just forget about it, period." It seemed that the client-participant tried very hard to control her reactions to life situations, and became distress when she had difficulty doing so.

In terms of positive emotional expression, the client-participant smiled and/or laughed 0 out of 1 time in sessions one and six, 1 out of 6 times in session seven, 2 out of 2 times in session nine, and 1 out of 4 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 4 out of 14 times. In sessions one, six, seven, and 18 the expression of positive emotion during discussions in which this sub-theme emerged was incongruent with the topic of discussion. In session nine, the first co-occurrence of positive

emotional expression with this sub-theme was congruent with the topic of discussion, while the second co-occurrence was incongruent with the topic of discussion.

A fourth sub-theme found within the theme of power and control is desire/attempt to control others/environment. This sub-theme refers to the client-participant's wishes and trials at gaining command of the reactions of others and the responses from the environment to life experiences. Desire/attempt to control others/environment occurred three times outside of trauma discussions in session one, 11 times outside of trauma discussions in session six, six times outside of trauma discussions and four times within the second discussion of sexual trauma in session seven, 11 times outside of trauma discussions in session nine, eight times outside of trauma discussions in session 12, and 11 times outside of trauma discussions in session 18. This sub-theme did not occur during discussions of workplace harassment trauma. It seemed that the client-participant often tried to control her environment by trying to foresee the results of her actions and adjusting accordingly. For example, in session six she stated "...don't give me shit cuz I don't want you asking for nothing. 'Cause I don't want you holdin' nothing over my head." The client-participant believed that by making sure she did not accept favors from others, they would not ask for something in return and she would not have to owe them anything. Additionally, she expressed frustration when others, especially her boyfriend, did not handle situations in the way she thought was best. For example, in the seventh session the client-participant exclaimed, "But then again, it's like shit, I can't just blame this lady. You was there, you should have said no. The problem is you don't know how to say no and all of that. That's how you live your life, more shit's gonna happen." These quotes illustrate how the client-participant either attempted or desired to control both her environment and the people in her life.

The client-participant expressed positive emotion during the occurrence of this sub-theme 0 out of 3 times in session one, 0 out of 11 times in session six, 1 out of 10 times in session seven, 1 out of 11 times in session nine, 0 out of 8 times in session 12, and 3 out of 11 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression

a total of 5 out of 54 times. None of these expressions of positive emotion were congruent with the topic of discussion.

The final sub-theme under the theme of power and control is Independence.

Independence refers to the client-participant's desired ability to reach and maintain autonomy from others. This sub-theme occurred three times outside of trauma discussions in session one, 11 times outside of trauma discussions in session six, six times outside of trauma discussions and four times within the second discussion of sexual trauma in session seven, 11 times outside of trauma discussions in session nine, eight times outside of trauma discussions in session 12, and 11 times outside of trauma discussions in session 18. Throughout the course of psychotherapy, the client-participant often expressed her belief that she is on her own that she can only depend on herself. For example, in session one she stated, "Well I had to think, 'Ok I have these skills, how can I make money?' ...I just try to use my brain. 'How can I get what I need?' Because if I don't, nobody is." Similarly, in session six she stated, "But nobody takes care of me in no kinda way, cause there ain't nobody I can tell nothing to that has a brain that can use it 'cept my cousin." Furthermore, she seemed to be reluctant to depend on others. This is illustrated in session six when she said, "...but sometimes I feel like I be asking for stuff and then when I get it and I be like I don't want it, you know what I mean? I don't know if it's insecurity." It appears that the client-participant does not feel comfortable receiving help from others.

In terms of positive emotional expression, the client-participant smiled and/or laughed 1 out of 5 times in session one, 2 out of 14 times in session six, 2 out of 6 times in session seven, 0 out of 2 times in session 12, and 0 out of 15 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 5 out of 42 times. These expressions of positive emotion were all incongruent with the topic of discussion except for one of the co-occurrences in session seven that was congruent.

Sense of self. Another general theme that emerged across the client-participant's course of therapy was sense of self. This theme refers the client-participant's feelings about self-efficacy

and place in the world. This theme occurred a total of 2 times in session one, 10 times in session six, 1 time in session seven, 4 times in session nine, 30 times in session 12, and 25 times in session 18. Sense of self did not occur in discussions of sexual trauma. Sub-themes that were found within sense of self included fear of judgment, insecurity, self-criticism, and respect for self/pride. While many of these sub-themes occurred frequently over the course of psychotherapy, only one sub-theme, fear of judgment, was present in every session containing a trauma discussion.

The first sub-theme under the theme of sense of self is fear of judgment. This sub-theme referred to the client-participant's distress at being thought of negatively by others, including strangers. In the first session, fear of judgment occurred one time outside of trauma discussions and one time in the third discussion of workplace harassment trauma. The sub-theme also occurred twice outside of trauma discussions in session six, once outside of trauma discussions in session seven, once outside of trauma discussions in session nine, four times outside of trauma discussions in session 12, and 12 times outside of trauma discussions in session 18. Fear of judgment did not occur during discussions of sexual trauma.

One relationship in which the client-participant demonstrated her distress at being thought of negatively by others was her relationship with the therapist-participant. For example, in session one during the third discussion of workplace harassment trauma, the client stated, "I don't want to start, you're going to get mad at me." When the therapist-participant asks the client-participant why she believes the therapist-participant will get angry with her, the client-participant responds, "Because I think I talk about it too much and I have to tell myself, 'Okay enough about the job.'" Here the client-participant expresses fear that by discussing her thoughts and feelings about work, she will receive a negative reaction from the therapist-participant.

The client-participant also discussed her fear of judgment from others in her social world, and the desire to be perceived in a certain light. For example in session 18 she stated, "I do know where it comes from for me going out of my way to let people know that I am cool you know?"

Through these quotes it seems that the client-participant worries about and attempts to control the way she is perceived by others.

In terms of positive emotion, the client-participant smiled and/or laughed during discussion of this sub-theme 2 out of 2 times in sessions one and six, 1 out of 1 time in sessions seven and nine, 3 out of 4 times in session 12, and 8 out of 12 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 17 out of 22 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

The second sub-theme that emerged under the theme of sense of self was insecurity. This sub-theme refers to the client-participants feelings of doubt and hesitancy in her abilities, knowledge and decisions. Over the course of the client-participants therapy, insecurity occurred five times outside of trauma discussions in session six, three times outside of trauma discussions in session nine, 25 times outside of trauma discussions in session 12, and seven times outside of trauma discussions in session 18. The sub-theme did not occur in sessions one and seven, and did not occur during discussions of sexual or workplace harassment trauma. One area in which the client-participant demonstrated insecurity was her intellect. For example, in session six she stated, "So, I was just wondering cause I tend to do that. Like, am that I retarded?" The client-participant also seemed feel insecure in her abilities to do certain things (e.g., singing). For example, in session 12 she shared, "this voice is telling me I ain't good enough. It ain't perf—it ain't as good as so and so..." Similarly, in the same session she stated, "Like, it just makes me have a lack of confidence. Like stuff that I know I can do, when I say ok I'm gonna do it, it tells me not to and I listen." These quotes suggest that the client-participant's insecurity about her abilities negatively affects her engagement in certain experiences.

The client-participant expressed positive emotion during the occurrence of the sub-theme insecurity 3 out of 5 times in session six, 3 out of 3 times in session nine, 5 out of 25 times in session 12, and 5 out of 7 times in session 18. Across all sessions, this sub-theme occurred in the

presence of positive emotional expression a total of 16 out of 40 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

A third sub-theme that was differentiated within the theme of sense of self was self-criticism. Self-criticism refers to the client-participant's disparaging and belittling beliefs about the ways in which she navigated life experiences. This sub-theme occurred twice outside of trauma discussions in session eighteen. It did not occur in sessions one, six, seven, nine, or 12, and did not occur during discussions of sexual or workplace harassment trauma. The sub-theme of self-criticism was differentiated from insecurity in that instead of simply doubting her abilities or intellect, the client-participant was observed to make harsh judgments about herself. For example, in session 18 she stated, "I guess it's because to me, my mistakes are so horrible." Similarly, in the same session she discussed her fear of singing and said, "So it's like, so you were doing this because you was, you were too stupid and scared to do that." These quotes illustrate the way in which she belittled herself through judging herself harshly.

Positive emotional expression co-occurred with the sub-theme of self-criticism 1 out of 2 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 1 out of two times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

A fourth sub-theme within power sense of self is respect for self/pride. Respect for self/Pride refers to the client-participant's positive self-esteem and feelings of dignity towards herself for how she handles positive and negative life experiences. This sub-theme occurred three times outside of trauma discussions in session six, one time outside of trauma discussions in session 12, and four times outside of trauma discussions in session 18. Respect for self/ Pride did not occur in sessions one, seven, or nine, and did not occur during discussions of either sexual or workplace harassment trauma.

The sub-theme often emerged in the client-participant's therapy when she was discussing making decisions about her career. Specifically, the client-participant communicated that she had

too much self-respect to take on jobs in the entertainment business in which she had to showcase her body. For example, in session six she stated, "...like advertising a big butt and bending over showing your breasts you know, I don't want to do that." Similarly, in session 18 she stated, "I didn't want to come out here based all on looks. I just didn't, you know what I'm sayin'? If I get somethin' because of it great. I want to have a skill, somethin' I can bank on." These quotes demonstrate the client-participant's respect for herself through the decisions she makes in terms of her career. Additionally, the client-participant exuded a sense of dignity when explaining that if she were single she would act the same way she acts as a woman in a relationship. For example, in session 18 she stated, "I still wouldn't be having sex with them for stuff. I don't smile in people's face, I don't use my girlyness to get what I want." Through this quote it seems that the client-participant has pride in the fact that she maintains her self-respect throughout her interactions with others, and in particular with men.

The sub-theme of respect for self/ pride co-occurred with the client-participant's expression of positive emotion 0 out of 3 times in session six, 0 out of 1 time in session 12, and 0 out of 4 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 0 out of 8 times.

Gender role struggles. Gender role struggles was another general theme that was found within the client-participant's course of therapy. This theme refers to the client-participant's ideas about the jobs and capacities of men and women in society. This theme occurred a total of two times in session one, four times in session six, six times in session seven, and three times in session 18. Sense of self did not occur in discussions of workplace harassment trauma. Sub-themes that were found within gender role struggles included stereotypes of men, stereotypes of women, and role reversals. While many of these sub-themes occurred frequently over the course of psychotherapy, they were not present in every session containing a trauma discussion.

One sub-theme found within the theme of gender role struggles was stereotypes of men. Stereotypes of men refers to the client-participant's beliefs about conventional roles of males in

society. This sub-theme occurred one time in the second discussion of sexual trauma in session one, one time outside of trauma discussions in session seven, and one time outside of trauma discussions in session 18. The sub-theme of stereotypes of men did not occur in sessions six, nine, and 12, and occurred both within discussions of sexual trauma and outside of discussions of trauma. Through her discussions in therapy, the client-participant often demonstrated very stereotypical views of men. For example, she seemed to endorse the belief that men should not cry through her statement: "...he's not gonna cry because he's a man, especially not in front of me." Similarly, it seemed that she believed that men do not like to be controlled. For example, in session seven she stated, "I wont just run over him cause no man wants to be run over." Furthermore, in session 18, the client-participant indicated that by acting independently and refusing help from her boyfriend, she would be able to "just make him feel less of a man."

The sub-theme of stereotypes of men co-occurred with the client-participant's expression of positive emotion 0 out of 1 time in sessions one, seven, and 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 0 out of 3 times.

A second sub-theme found under the theme of gender role struggles was stereotypes of women. The sub-theme of stereotypes of women refers to the client-participant's ideas about the standard roles of females in society. In session six, the sub-theme of stereotypes of women occurred three times outside of discussions of trauma. In session seven, the sub-theme occurred two times outside of discussions of trauma, once in the second discussion of sexual trauma, and twice in the fourth discussion of sexual trauma. Stereotypes of women occurred three times outside of trauma discussions in session nine, eight times outside of trauma discussion in session 12, and twice outside of trauma discussions in session 18. It occurred during discussions of sexual trauma as well as outside of trauma discussions. It seemed that some of the occurrences of this sub-theme occurred in discussions of the type of woman the client-participant did not want to become. For example, in session six she stated, "I don't mind getting paid for how I look, it's just I don't like the sluts I don't like—like a whole bunch of dudes right here and I'm up here just

dancing around shaking my ass like heck no...” Similarly, she seemed to be concerned with specific stereotypes of black women, and did not want to be perceived as falling into the category of those stereotypes. This was illustrated in session seven when she said, “...you know a black, a [client makes air quotations] beggin’ black woman. [client rests cheek on hand] You know what I’m saying? It’s like I don’t want to be one of those.” The client-participant also expressed believing stereotypes of women as promiscuous when discussing whether women are at fault for being sexually assaulted. For example, in the fourth discussion of sexual trauma in the seventh session, the client-participant stated, “I know my little cousins would definitely have sex with him [R. Kelly]. You know what I’m saying? Like I know these sluts would...” Not only does the client-participant seem to buy into stereotypes of women, but she also uses derogatory and stereotypical language to describe promiscuous women.

The client-participant’s expression of positive emotion co-occurred with the theme of stereotypes of women 0 out of 3 times in session six, 2 out of 5 times in session seven, 0 out of 3 times in session nine, 1 out of 8 times in session 12, and 0 out of 2 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 3 out of 21 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussions.

The final sub-theme under the theme of gender role struggles is role reversals. Role reversals refers to the client-participant’s struggles with deviation from societal standards of male and female duties and reactions, specifically reversal of duties and reactions. Role reversals occurred once outside of trauma discussions in sessions one and six. It did not occur during discussions of sexual trauma. The client-participant frequently expressed frustration with her boyfriend over the course of therapy. However, at times she expressed frustration and discomfort specifically in response to the fact that she was taking on more of the stereotypical male duties and reactions, while her boyfriend took on more of the stereotypical female duties and reactions. For example, in session one the client-participant stated, “Because I have a tendency to be the

male and it's like, ok, I let him take care of it though I know we're gonna fail. Just let him be a man. I have to tell myself to let him be a man." Similarly, she struggled with her role as the person in the relationship who made more money. In session six she stated, "...if it wasn't for me he wouldn't have been eating for two weeks." While it seemed that she felt comfortable in a more dominant and typically more male role, she also seemed struggle with this aspect of her relationship.

In terms of positive emotional expression, the client-participant smiled and/or laughed during the occurrence of this sub-theme 0 out of 1 time in the first and sixth sessions. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 0 out of 2 times.

Emotional difficulties. Another general theme that emerged within the course of the client-participant's therapy was emotional difficulties. This theme refers to complications the client-participant experienced when expressing and sharing feelings about life experiences with others. This theme occurred a total of six times in session one, 22 times in session six, six times in session seven, 11 times in session nine, four times in session 12, and four times in session 18. Emotional difficulties occurred during discussions of both sexual and workplace harassment trauma, as well as outside of trauma discussions. Sub-themes that were found within emotional difficulties included anger toward boss, anger toward mother, difficulty identifying and expressing emotion, frustration with boyfriend's lack of responsibility, and jealousy. While many of these sub-themes occurred frequently over the course of psychotherapy, they were all not present in every session containing a trauma discussion.

The first sub-theme under the general theme of emotional difficulties is anger toward boss. Anger toward boss refers to the client-participant's feelings of animosity, annoyance and hatred when discussing or working with her boss. In session one, this sub-theme occurred twice in the fourth discussion of workplace harassment trauma, once in the sixth discussion of workplace harassment trauma, once during the seventh discussion of workplace harassment

trauma, and twice during the 11th discussion of workplace harassment trauma. The sub-theme also occurred in the second discussion of workplace harassment in session six, and in the second discussion of workplace harassment in session nine. Anger toward boss did not occur during discussions of sexual trauma. This sub-theme mainly occurred in the form of the client-participant calling her boss names or using expletives when she imagined talking to him in therapy. For example, in the fourth discussion of workplace harassment in session one the client-participant stated, “But my boss is an absolute jackass. I cannot stand him and I can’t wait to say ‘you know what, fuck you I quit’.” In addition to speaking of him using derogatory language, the client-participant also expressed anger at him for the way he treated her. For example, in the 11th discussion of workplace harassment trauma in session one she stated, “I can't do what I want to do, and then to be verbally abused. Fuck that!” This sub-theme was also used to describe the client-participant’s reported acts of aggression toward her boss. For example, in the second discussion of workplace harassment trauma in session nine she stated,

Then I’ll just ignore him. Then he—because he ain’t getting no reaction he want to keep saying stuff, then I’m like, ‘Alright whatever’ I’m not even listening. Then finally when he’s made me too mad I’m like, ‘If you don’t stop I’m going to do something really fucking rude.

It seems that in addition to expressing her anger toward her boss in sessions with the therapist-participant, she had difficulty restraining herself from reacting to her anger in the presence of her boss as well.

The client-participant smiled and/or laughed during the occurrence of this sub-theme 2 out of 6 times in session one, 1 out of 2 times in session six, and 0 out of 2 times in session nine. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 3 out of 10 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

A second sub-theme that emerged under emotional difficulties was anger toward mother. Anger toward mother referred to the client-participant's feelings of agitation and impatience when discussing her current and past relationship with her mother. This sub-theme occurred 11 times outside of trauma discussions in session six and four times outside of trauma discussions in nine. Anger toward mother did not occur during discussion of either sexual trauma or workplace harassment trauma. Throughout therapy the client-participant expressed anger toward her mother that stemmed from childhood. She discussed the long-standing feeling she has had toward her mother in the sixth session when she stated, "I've always had a snotty attitude towards her. I used to make her cry when I was little, I didn't even know it 'til I got older." Additionally, she expressed agitation and impatience with her mother through the use of sarcasm when discussing the fact that her mother never calls her. In session nine she stated "Same thing she always says first, 'Why didn't you call me.' Like you know, her phone doesn't work. She doesn't have fingers...bitch." It seemed that when the client-participant spoke about her mother over the course of psychotherapy, it was always with anger.

The client-participant expressed positive emotion during discussions in which this sub-theme occurred 2 out of 11 times in session seven, and 2 out of 4 times in session nine. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 4 out of 15 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

A third sub-theme found within emotional difficulties was difficulty identifying/expressing emotions. Difficulty identifying/expressing emotions refers to the client-participant's problems labeling and discussing feelings other than anger about life experiences during psychotherapy and to others in her life. This sub-theme occurred once outside of trauma discussions in session six and twice during the first discussion of sexual trauma in session six. In session 12, it occurred once outside of trauma discussions. Difficulty identifying/expressing emotion did not occur during discussions of workplace harassment trauma. Over the course of

psychotherapy, the client-participant expressed some awareness that she has trouble labeling and letting out more vulnerable negative emotions such as sadness. For example, in session one when discussing how she deals with sadness she stated, "...I think mine, like it comes out as anger. Because I can express anger because where—like you said, it makes sense to me as a defense mechanism because I'm so nice." Similarly, in the first discussion of sexual trauma in the sixth session she said, "...first instinct is sad but it turns to anger. I'm so used to being not sad, but angry." The client-participant also seemed to become overwhelmed and fearful when feeling multiple emotions at once, and had trouble identifying exactly what she was experiencing. This is illustrated in session 12 when she stated, "Well I was freezing cold, crying and scared. Because I felt like a lot of stuff at once. I felt like a psychopath. I felt like, you know what I mean, I'm sitting there, not that I got the stuff out, I printed that shit out." This sub-theme surfaced as an issue the client-participant was aware of and actively wanted to work on.

In terms of positive emotional expression, the client-participant smiled and/or laughed during discussions in which this sub-theme emerged 2 out of 3 times in session six, and 1 out of 1 time in session 12. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 3 out of 4 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

A fourth sub-theme identified within emotional difficulties was frustration with boyfriend's lack of responsibility, which refers to the client-participant's feelings of disappointment, annoyance and irritation with her boyfriend's behaviors and his participation in their relationship. This sub-theme occurred five times outside of trauma discussions in session six, twice outside of trauma discussions in session seven, four times outside of trauma discussions in session nine, three times outside of trauma discussions in session 12, and four times outside of trauma discussions in session 18. It did not occur during discussions of either workplace harassment trauma or sexual trauma. When expressing frustration with her boyfriend's lack of responsibility, the client-participant usually referred to how he was handling a situation involving

his ex-girlfriend and the child he had with her. For example, in session six she stated, "...I feel like you're not handling your business, you ain't gonna interfere and you and that child, and that baby mama, whatever y'all ain't interfering with me..." The client-participant seems particularly frustrated that her boyfriend is not taking charge of his problems. Similarly, in session seven she stated, "He's a fucking welcome mat and just lets her in as long as she ain't doing nothing outrageous. It's just annoying." It also seemed that the client-participant felt compelled to take on the responsibility she felt her boyfriend was avoiding. For example, in session 12 the client-participant stated, "He's like I mean I'm gonna do it, I just don't want to feel like I'm dictated to. And I'm like, well you are getting dictated to, I'm dictating to you somethin' that's vital, that's somethin' that you need, somethin' that's urgent...It's important to me. It should be important to you." Through these quotes it is apparent that the client-participant harbors feelings of disappointment and irritation toward her boyfriend that are negatively affecting her relationship.

This sub-theme co-occurred with the client-participant's expression of positive emotional expression 1 out of 5 times in session six, 0 out of 2 times in session seven, 0 out of 4 times in session nine, 0 out of 3 times in session 12, and 2 out of 4 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 3 out of 18 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

The final sub-theme under the theme of emotional difficulties is jealousy. Jealousy refers to the client-participant's feelings of resentment and spite towards other women involved in her boyfriend's life. This sub-theme was present one time outside of trauma discussions in session six, twice outside of trauma discussion in session seven, and once outside of trauma discussions in session nine. Jealousy did not occur in sessions one, 12, or 18, did not occur within discussions of sexual trauma or workplace harassment trauma.

One area in which the sub-theme of jealousy arose multiple times was in how the client-participant felt about her boyfriend's child with his ex-girlfriend. For example, in session seven,

in response to the therapist-participant's question about how the client-participant was feeling about her boyfriend's ex-girlfriend and his child she stated, "...disgust, jealousy. Jealousy with a five year old." Similarly, in the same session she stated, "How can you tell that to your friends? My cousin, she would just be like 'are you stupid?' Like what do you think that's gonna do? Competing with a five year old. Did I tell you, he like well that's crazy. He's like 'I don't even know if she's mine.'"

Another person toward whom the client-participant expressed jealousy was her boyfriend's ex-girlfriend. For example, in session nine she stated, "I don't want her jealousy to get in my way. And it's goin' to. Because he's already done babied her. I'm talkin' about the mom." This quote illustrates the client-participant's jealousy of the way in which her boyfriend treated his ex, and the client-participant's interpretation of his lack of assertiveness with his ex as him "babying" her. The client-participant did not express positive emotion during any of the four occurrences of this sub-theme across all sessions.

Job dissatisfaction. The final general theme that emerged within the course of the client-participant's therapy was job dissatisfaction. Job dissatisfaction refers to the client-participant's discontent and unhappiness with her place of employment. This theme occurred a total of 15 times in session one, one time in session seven, twice in session nine, and four times in session 18. Job dissatisfaction occurred during discussions of workplace harassment trauma, as well as outside of trauma discussions. It did not occur during discussions of sexual trauma. Sub-themes that were found within the theme of job dissatisfaction included disengagement from job, hatred toward job, frustration with job responsibilities, and feeling trapped in job. While many of these sub-themes occurred frequently over the course of psychotherapy, they were all not present in every session containing a trauma discussion.

The first sub-theme that emerged under the theme of job dissatisfaction was disengagement from job. Disengagement from job refers to the client-participant's feelings of detachment, disconnection and indifference to her work and job duties. This sub-theme occurred

once during the 11th discussion of workplace harassment in the first session, once outside of trauma discussions in session nine, and once within the first discussion of workplace harassment trauma in session nine. It did not occur during sessions six, seven, 12, or 18. One way in which the client-participant demonstrated dissatisfaction with her job was through indifference. For example, in session one during the 11th discussion of workplace harassment trauma the client-participant stated, “I crawled out of this bed five minutes before I'm supposed to go and I might be late because of traffic, and I don't care and I hope I get fired.” Not only does she display a lack of care about getting to work on-time, but she even expresses hope that she will be fired and forced to leave a job that she had difficulty quitting. The client-participant also expressed being bored and feeling detached within her job. This is illustrated in the first discussion of workplace harassment of session nine when she stated, “And this is what I'm doing all day for nine hours [Client gestures downwards but movement is not visible]. So it's hella boring. They're cool, but it's just boring.” It seems that the client-participant no longer feels stimulated by her job, and therefore has become detached from caring about the work that she does.

In terms of positive emotional expression, the client-participant smiled and/or laughed during one out of one occurrence in session one, and one out of two occurrences in session nine. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of two out of three times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

The second sub-theme that was found within the theme of job dissatisfaction was hatred toward job. Hatred toward job refers to the client-participant's expressed feelings of anger, disgust and contempt with her work and the need to go to work. In session one, this sub-theme occurred three times outside of trauma discussions, once in the third discussion of workplace harassment trauma, once in the fifth discussion of workplace harassment trauma, once in the sixth discussion of workplace harassment trauma, and once during the 10th discussion of workplace harassment trauma. In session seven, the sub-theme occurred once during the first discussion of

workplace harassment trauma, and in session 18 it occurred once outside of trauma discussions and once in the second discussion of workplace harassment trauma. The client frequently and out rightly expressed her anger and disgust for her job over the course of therapy. For example, in session one she stated, “ I cannot stand it. I can’t. If I— [Client rubs forehead/eyes under her hat] I’m like a second away from walking out.” Similarly, during the seventh discussion of workplace harassment trauma in the first session she stated, “I hate it—I hate waking up in the morning. I hate going. I cannot stand it. I cannot stand it—.” The client-participant also had difficulty not reacting to her feelings of hatred toward her job when at work. For example, during the first discussion of workplace harassment trauma in session seven she stated, "I'm very challenged by people at work. Because I don't want to be there with them. So it's like a challenge for me to...hold my tongue." It is evident from these quotes that the client-participant seemed comfortable expressing her anger and disgust for her job in psychotherapy.

The client-participant expressed positive emotion during the occurrence of this sub theme 4 out of 6 times in session one, 0 out of 1 time in session seven, and 1 out of 2 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 5 out of 9 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

The third sub-theme found within the theme of job dissatisfaction was frustration with job responsibilities. Frustration with job responsibilities refers to the client-participant’s expressed feelings of dissatisfaction, annoyance and irritation with required duties at work, specifically those not related to her job description. This sub-theme occurred three times outside of trauma discussions in session one, and did not occur within discussion of workplace harassment trauma or discussions of sexual trauma. Within session one, the client-participant expressed irritation at the responsibilities she had to take on at work. For example she stated, “The simple—I told him, I said—and I told him, but ‘It’s my responsibility. Get up’--Do you want to know how big—inventory is a job in itself. Accounting and bookkeeping is a job in

itself.” Similarly, it seemed that she was frustrated that she had to take on responsibilities that were not a part of her job description. This was illustrated when she stated, “And not only do I do that, I have to, um—I mean everyone now and then they ask me questions because it’s not their responsibility to know when checks come in.” These quotes illustrate her struggle with the duties she had to perform at work, in addition to her unhappiness in the workplace environment. In terms of positive emotional expression, this sub-theme co-occurred with the client-participant’s smiles and/or laughter a total of one out of three times. The one expression of positive emotion during the occurrence of this sub-theme was not congruent with the sub-theme/topic of discussion.

The final sub-theme under the theme of job dissatisfaction was feeling trapped in job. Feeling trapped in job refers to the client-participant’s expressed emotions of being stuck and obligated at work despite a strong desire to leave. In session one, this sub-theme occurred twice outside of trauma discussions, once during the fourth discussion of workplace harassment trauma, and once during the eighth discussion of workplace harassment trauma. In session nine the sub-theme occurred once outside of trauma discussions, and in session 18, this sub-theme occurred twice during the second discussion of workplace harassment trauma. Feeling trapped in job did not occur during sessions six, seven, and 12, and occurred during discussions of workplace harassment trauma, as well as outside of trauma discussions. Part of the client-participant’s struggle with her job was the hours she had to work. Since she wanted to pursue a career in acting, a job in which she had to work from 9 to 5 O’clock made it difficult for her to audition. However, she also needed to support herself, which made it difficult for her to quit. For example, during the eighth discussion of workplace harassment trauma in session one she stated, “I feel trapped because I can’t do what I want. I didn’t come here to work a 9 to 5.” She also seemed to feel trapped physically in her job based on the physical arrangement of her workspace. This is evident in session nine when she stated, “Yeah, because I sit in a box at work.” Finally, the client-participant seemed to have concern that staying in her job would rob her of her youth. In session

18 she stated, “I feel like I’m their age. I feel like I may as well be 50.” These quotes illustrate the client-participant’s struggle with wanting to leave her job, but needing the security of the income.

The client-participant expressed positive emotion during the occurrence of this sub-theme one out of four times in session one, one out of one time in session nine, and 0 out of 2 times in session 18. Across all sessions, this sub-theme occurred in the presence of positive emotional expression a total of 2 out of 5 times. None of these expressions of positive emotion were congruent with the sub-theme/topic of discussion.

Chapter IV. Discussion

The current study examined the expression of positive emotion during discussions of interpersonal trauma over an individual's course of psychotherapy. Although researchers have looked at the expression of positive emotion during discussion of difficult life events in the context of a study (Bonanno, Colak, et. al. 2007), no one has examined how positive emotion is expressed in the context of discussing interpersonal trauma over the course of psychotherapy. Consistent with a balanced positive psychology perspective, this study sought to advance the current literature on trauma and positive emotion by qualitatively examining a client's language and non-verbal behavior in psychotherapy sessions as related to the Broaden and Build theory (Fredrickson, 1998). The qualitative design of the case study allowed for a thorough examination of what occurred within the context of psychotherapy, the type of trauma discussions and how these trauma discussions were processed within psychotherapy, the themes that arose over the course of psychotherapy, and the way in which positive emotion was expressed by the client-participant within and outside of trauma discussions both verbally and non-verbally.

In summary, it was found that positive emotion was expressed more than negative emotion across all trauma discussions, that positive emotion occurred more than negative emotion during discussions of CSA, and that positive emotion and negative emotion were expressed more equally in discussions of WPH. Additionally, it was found that the client-participant's expressions of positive emotion were frequently incongruent with the sub-themes with which they co-occurred, which might have indicated avoidance of traumatic material and/or trauma-related thoughts and feelings. For a visual summary of these results, please see (Appendix U).

After a brief summary of the case, the client's experiences of trauma, and the patterns that were observed within discussions of trauma over the course of psychotherapy, this chapter provides a discussion of the Linguistic Inquiry and Word Count (LIWC; Pennebaker et al., 2007) codes and qualitative themes that emerged in the case study across the client-participant's psychotherapy sessions to address the research questions. First, there is a discussion of the LIWC

results for positive emotion, negative emotion, and insight words, with a focus on how these results relate back to the broaden and build theory. Second, the sub-themes, co-occurring non-verbal expressions of positive emotion and incongruent positive affect that were observed across the course of psychotherapy are summarized and discussed, and related to the broaden and build theory. More specifically, incongruent positive affect is discussed in terms of its possible function, with special attention paid to considering the possible adaptive functions of the expression of positive affect (e.g., broadening of thought-action repertoire, emotional breaks, and emotion regulation) as well as possible maladaptive functions (e.g. avoidance, repressive coping, and “saving face” in front of an evaluative audience). This approach is consistent with the positive psychology framework of the study in that it presents a balanced view of the client-participant by considering both her strengths and weaknesses. Lastly, methodological limitations are discussed and implications and future directions of research are explored.

Case Summary

This case involved a 28 year-old, Christian, African American female who moved to Los Angeles from Kentucky just prior to beginning psychotherapy at a Southern California university community counseling center. Over the course of therapy the client-participant worked for a travel agency company, and was in a long-distance relationship with a man from her hometown. The client-participant presented to therapy primarily with concerns about the difficulty she was having expressing emotion, as well as problems adjusting to living in a new city with little social support. However, over the course of therapy other difficulties emerged including financial stress, problems at work, her desire to have a different career, and difficulties within her relationship. Her course of therapy lasted 21 sessions, 18 of which were videotaped. Over the course of therapy, the client-participant disclosed two distinct traumatic experiences, including the experience of being sexually abused by her uncle in childhood, and the experience of being psychologically harassed by her boss at work. Discussions of these traumas occurred in videotaped sessions one, six, seven, nine, and 12. A review of the treatment summary indicated

that therapy ended after 21 sessions as the therapist-participant stopped working at the clinic. Additionally, the client-participant did not want to transfer to another therapist and chose to discontinue treatment.

Trauma experiences. A review of the initial paperwork completed by the client-participant and the Intake Report completed by the therapist-participant revealed that the client-participant had experienced CSA. She was able to discuss the circumstances of her CSA with the therapist-participant in her initial psychotherapy session (as well as in sessions one, six, seven, and 12), and reported that her uncle had sexually abused her when she and her brother were left in his care. She did not report how old she was when this occurred. The client-participant stated that after the initial incident, her uncle attempted to sexually abuse her again, at which point she informed him that she would tell her mother what he had done if he ever tried to touch her again. She shared with the therapist that this was the last time he tried to assault her and that she had neither disclosed the abuse to anyone, nor received psychological treatment to process the experience. She also explained that she did not discuss these incidents with her mother because she feared her mother would take illegal actions against her uncle and end up in jail. She stated that the fear of losing her mother was enough to stop her from opening up about her CSA.

The client-participant's age at the time of her sexual assault is consistent with research findings demonstrating that sexual victimization is higher among adolescents than adults (Fisher, Cullen, & Turner, 2000). This may be particularly true for African American adolescent females who have been shown to report experiencing rape at a higher rate than their Caucasian, Puerto Rican, and Asian peers. Also, 23.4% of African American women were likely to experience some type of sexual assault over the course of their lives (Zinzow et al., 2010).

Research also suggests that being of low socioeconomic status may be a risk factor for sexual assault, with findings indicating that women whose income is at or below the poverty line are at increased risk for sexual victimization (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010). Given that approximately 25.6% of African American women are living in poverty, the

client-participant may have been particularly at risk (Bryant-Davis et al., 2010). The client-participant made her socioeconomic status evident over the course of therapy through frequent discussions of her financial struggles both during her time in treatment and throughout her childhood. When referring to her childhood, the client-participant discussed her mother's inability to provide for her family, and described feeling insecure as child that people would not like her because she was "poor." When referring to her current financial struggles, she explained that she was barely able to pay her bills every month, and occasionally went without food when she ran out of money. This topic was identified as the sub-theme financial security under the theme of self-protection. Financial security occurred frequently (Total= 36 times across sessions six, seven, nine, 12, and 18) and positive emotion was expressed 10 out of the 36 times when discussing this topic; yet all positive emotion during discussions involving this sub-theme were not congruent with the topic of discussion. This finding suggests that financial security was a salient yet difficult topic for the client-participant.

Another finding of the current study was that the client-participant's relationship with her mother and with women in general seemed to be significantly affected by her experience of CSA. The sub-themes anger toward mother (under the theme of emotional difficulties) and stereotypes of women (under the theme of gender role struggles) occurred frequently over the course of psychotherapy. Specifically, the client-participant frequently expressed anger and hostility toward her mother for her lack of involvement in her childhood, and for her inability to properly provide for her family. Additionally, the client-participant expressed hostility toward other women, calling them derogatory names such as "gold-digger," and generally viewed them suspiciously. These findings are consistent with literature on interpersonal functioning of women with a history of childhood sexual abuse (Herman, 1981). Herman (1981) found that survivors of sexual assault expressed more anger and hostility toward other women than toward the actual perpetrator. A more recent study supports these findings in that women who reported sexual abuse in childhood were more likely than women who did not experience childhood sexual abuse to endorse negative

beliefs about women (Kraus & Roth, 2010). Furthermore, the study found that survivors of sexual assault expressed anger, hostility, bitterness, and even contempt for their mothers, which was hypothesized as having to do with a strong sense of betrayal and resentment for their mother's lack of protection (Herman, 1981). The client-participant's expression of positive affect co-occurred with the sub-theme anger toward mother a total of four out of 15 times, while her expression of positive affect co-occurred with the sub-theme stereotypes of women 3 out of 21 times. All expressions of positive affect during discussions in which these sub-themes emerged were incongruent. Given the client-participant's reported comfort with expressing anger, it seems that her expression of positive affect during these sub-themes was not authentic, and likely reflected anger or contempt.

Throughout the course of psychotherapy the client-participant displayed several negative responses to her experience of CSA, including avoidance of emotions, anger, and difficulties trusting others (Briere & Scott, 2006; Hall & Sales, 2008; Joseph et al., 1997). Avoidance of emotion was a sub-theme under the theme of self-protection that occurred frequently in psychotherapy sessions. Specifically, the client-participant expressed reluctance to discuss feelings other than anger during psychotherapy and with others in her life, and stated that when she felt sadness or anxiety she pushed these feelings away and expressed anger, as she felt comfortable expressing this emotion. Research findings indicate that denial and emotional suppression are the most common forms of coping in women who were sexually abused in childhood (Leitenberg et al., 1992). However, these coping methods were found to be associated with significantly greater maladjustment in adulthood (Leitenberg, Greenwald, & Cado, 1992). Furthermore, African American women who experienced severe CSA have been found to exhibit avoidance and numbing symptoms, along with other general symptoms of posttraumatic stress disorder (Glover et al., 2010). The client-participant expressed positive affect a total of 9 out of 25 times that this sub-theme was discussed, and her expressions of positive emotion were not

congruent with this sub-theme. This finding suggests that positive affect may have served as an avoidance strategy for the client-participant.

While the client-participant avoided negative emotions such as sadness and anxiety, she frequently expressed anger toward her boss and her mother. Although trauma survivors are typically portrayed as fearful and helpless rather than angry and hostile, a growing body of research indicates that anger and hostility are significantly associated with PTSD in trauma-exposed adults (Orth & Wieland, 2006). Although the therapist did not give the client-participant a PTSD diagnosis, the client-participant exhibited some symptoms of PTSD. Specifically, she exhibited persistent avoidance of thoughts, feelings, and conversations associated with her experience of CSA, as well as numbing of general responsiveness when she was asked directly about the CSA. For example, she stated that she felt very removed from her experience of CSA, almost as if it never happened to her. This is consistent with the finding that African American adult survivors of childhood violence were found to use desensitization as a coping mechanism, describing emotional numbness in response to traumatic life events (Bryant-Davis, 2005). Additionally, she reported and exhibited persistent hyperarousal symptoms that included hypervigilance (i.e., interpreting people as having bad intentions and mistrustful of others), irritability and outbursts of anger (observed in session when discussing topics such as work, her boyfriend, and her experience of CSA), and difficulty concentrating and completing tasks (as evidenced by her responses on the Outcome Questionnaire). However, she did not report any symptoms of re-experiencing such as nightmares, flashbacks, or intrusive memories or thoughts.

The client-participant's expressions of anger may have served a function for her, as effective expression of anger has been found to result in assertion of interpersonal independence and defining of interpersonal boundaries (Kennedy-Moore & Watson, 1999). However, anger may also be used as a method of dissociation for avoiding trauma related emotions (Feeny, Zoellner, & Foa, 2000; Marx & Sloan, 2002). Both of these findings seem to be relevant to the client-participant, as she reported that she often expressed anger when feeling sadness (i.e.,

subtheme of avoidance of trauma related emotions), as well as when she stood up for herself (i.e., subtheme of assertion of interpersonal boundaries). The researcher also observed that the client-participant expressed positive affect a total of 3 out of 10 times when expressing anger toward her boss, and 4 out of 15 times when expressing anger toward her mother. None of these expressions of positive emotion were congruent with the above sub-themes. Implications of this finding will be discussed in the next section.

The client-participant also seemed to struggle with trusting others as a result of her CSA. Mistrust of others was identified as a sub-theme under the theme of self-protection, and it occurred frequently over the course of psychotherapy. Specifically, the client-participant expressed a reluctance to confide in others with her emotions, and believed that others would not offer her help without expecting something in return. This finding makes sense given that CSA occurs in an interpersonal context, and can, “disrupt the normal developmental processes of learning to trust and form stable and secure relationships with others” (Luterek, Harb, Heimberg, & Marx, 2004, p. 91; Briere, 1992). This finding (as well as other sub-themes such as desire/attempt to control others, insecurity, self-criticism, and distancing from others) is also consistent with literature on the effects of trauma on cognitive schemas, suggesting that survivors of CSA may show particular disruption in the areas of trust, safety, power, esteem, and intimacy (Goodman & Dutton, 1996; Wright, Collinsworth, Fitzgerald, 2000). The client-participant expressed positive affect a total of 4 out of 17 times with the sub-theme mistrust, and none of these expressions of positive affect were congruent with the sub-theme or topic of discussion. Given that mistrust was a sub-theme that was related to her trauma experiences, it was likely to evoke negative emotion in the client-participant. Therefore, it is likely that her expression of positive affect served as a way to avoid uncomfortable negative emotion.

While the client-participant displayed negative symptomatology that seemed to be related to her experience of CSA, she also reported some positive outcomes from her experience. Specifically, she cited learning to stand up for herself and considering other’s intentions before

going along with what they say as a positive outcome of her CSA. Additionally, she stated that she learned how to say no to others who she felt did not have good intentions. The client-participant revealed a sense of pride when discussing her ability to stand up for herself reflecting a sense of empowerment. Respect for self/ pride was noted as a sub-theme under the theme of sense of self that emerged over the course of psychotherapy. Specifically, the client-participant expressed feelings of dignity toward herself for the way she was able to handle difficult life experiences. The sub-theme usually occurred when she discussed how she stood up to her uncle who sexually abused her, when she discussed talking back to her boss, and when discussing the way in which she confronted her boyfriend about difficult topics. This finding is consistent with the literature on posttraumatic growth, which states that individuals who have experienced traumatic events develop the sense that they have the capacity to survive and prevail in the face of adversity (Tedeschi & Calhoun, 2004). This may be particularly true for individuals who have experienced intra-familial sexual abuse, as research has shown that survivors who were sexually abused by a family member versus a stranger demonstrated higher levels of posttraumatic growth (Lev-Wiesel, Amir, & Besser, 2005). The client-participant did not appear to experience any of the other domains of posttraumatic growth.

Regarding WPH, a review of videotaped psychotherapy sessions revealed that the client-participant was experiencing psychological abuse by her boss, who she reported berated her and her co-workers. Specifically, she indicated that her boss screamed at her and her co-workers, insulted her intelligence, called her derogatory names, and used profanity directed toward her when angry. During one session she played a message left by her boss, in which he shamed and berated the client-participant and her co-workers for making a mistake at work. Throughout the course of psychotherapy, the sub-theme anger toward boss (under the theme of emotional difficulties) frequently emerged. Specifically, her anger often took the form of calling her boss derogatory names and expressing what she would like to say to him if she did not have to worry about any repercussions. This anger was reflected in the client-participant's responses on the

Outcome Questionnaire, such as, “I [frequently] feel irritated,” and, “I [frequently] feel angry enough at work to do something I might regret.” Additionally, the client-participant gave several indications that the psychological abuse from her boss was causing her to consider quitting on a daily basis, despite her fragile financial situation. The client-participant did not indicate that the WPH she suffered from her boss included any sexual harassment or racial discrimination; however, she clearly reported experiencing abuse. Her description seems to be consistent with literature on WPH and bullying. Bullying has been described as a “persistent pattern of negative acts” (Lee & Brotheridge, 2006, p. 353), and WPH involves repeated or persistent hostility over an extended period of time, which undermines the person’s sense of competence as an employee and a person (Keashly & Harvey, 2005).

The client-participant’s experience of WPH was also consistent with research examining African American women’s experiences in the workplace, as African American women have a long history of harassment in the workplace (West, 2002). The client-participant may have been particularly at risk for WPH given that young African American women in low status jobs report the greatest frequency of harassment (Mansfield, Koch, Henderson, & Vicary, 1991).

Also, the client-participant’s expression of negative mood in response to abuse from her boss (as evidenced by the sub-themes anger toward boss, hatred of job, and feeling trapped in job) is consistent with the literature on the effects of psychologically abusive behaviors on employees in the workplace (Keashly & Harvey, 2005). Her hatred toward her job and feeling trapped in her job were both identified as sub-themes under the theme of job dissatisfaction. Specifically, she expressed feelings of anger, contempt, and disgust with her work and the need to go to work. When discussing her hatred of her job, the client-participant expressed positive affect a total of five out of nine times. Furthermore, she communicated that she felt stuck and obligated to stay in her job despite a strong desire to leave. When expressing feeling trapped in her job, she expressed positive affect a total of 2 out of 7 times. None of her expressions of positive affect were congruent with these sub-themes, suggesting that her smiles and laughter were not authentic and

may have served as a way to avoid negative emotions associated with her workplace trauma. Similarly, a review of the client-participant's OQ-45 revealed that she was experiencing distress in her social role. However, when individual items on this measure were examined, it was evident that elevation on this scale was due to distress in her role at work. For example, she endorsed items such as: "I feel stressed at work," "I never find my work satisfying," "I am not working as well as I used to," and, "I feel that I am not doing well at work." Her endorsement of these items is also consistent with the sub-themes disengagement from job, and frustration with job responsibility.

These findings are consistent with research that has linked WPH to work withdrawal behaviors, greater intention to leave, and decreased productivity (Keashly & Harvey, 2005). In terms of withdrawal behaviors, the client-participant reported in one session of psychotherapy that she woke up 5 minutes before having to be at work every morning, not caring if she was going to be late, and went long periods of time without engaging with her co-workers. Furthermore, the client-participant exhibited intention to leave her job frequently over the course of therapy, and problem solved about how to quit and still maintain some form of financial stability. In terms of decreased productivity, the client-participant stated that much of her time at work was spent looking for other jobs, working on her resume, or going on social networking websites. The client-participant acknowledged that each of these behaviors was a result of the WPH she suffered regularly from her boss.

The client-participant's experiences of multiple traumas (i.e., CSA and WPH) reflect a trend in the trauma literature. Specifically, research findings have demonstrated that individuals who have experienced interpersonal trauma in their lives are at increased risk of experiencing additional forms of interpersonal trauma later in life (Briere & Scott, 2006). Furthermore, findings indicate that sexual abuse in childhood is associated with other forms of traumatic exposure besides sexual re-victimization in adulthood (Banyard, Williams, & Siegel, 2001). CSA may be a risk factor for exposure to a variety of other traumatic stressors as well as the negative mental

health effects that go along with those stressors (Banyard et al., 2001). Studies on the effects of multiple traumas have found that individuals exposed to multiple traumatic events experience more symptoms of PTSD and depression than individuals exposed to a single traumatic event (Suliman et al., 2009). Given these findings, it is likely that the client-participant's history of CSA puts her at increased risk to experience higher levels of distress in response to the WPH she experienced from her boss. Her exacerbated distress in response to her experience of WPH seemed to contribute to her overall hatred of her job and desire to quit.

Processing of trauma. The client-participant discussed her experiences of CSA and WPH in 6 out of the 21 sessions of videotaped psychotherapy sessions. She also disclosed her history of CSA on the intake paperwork that she filled out at her initial session at the university community counseling center. After reviewing the written measures and videotaped sessions, the researchers were unable to ascertain whether the client-participant had previously discussed her traumatic experiences with formal or informal support networks. Therefore, it is unknown as to whether the client-participant's discussion of her traumatic experiences in therapy was her first time talking about these matters.

The client-participant's discussion of her CSA was consistent with the literature documenting patterns of disclosure of CSA. Specifically, research has demonstrated that women tend to delay disclosure of sexual abuse well into adulthood (Alaggia, 2005). Furthermore, disclosures of CSA later in life are often to a mental health professional (Pino & Meier, 1999). Ethnic minority women in particular have been found to discuss their traumatic experiences with formal support sources such as a primary care provider or mental health professional (Ullman & Filipas, 2001).

The client-participant reported that when she was a child/adolescent she did not tell anyone about the CSA she experienced by her uncle because she was concerned about the repercussions (i.e., that her mother would act out violently toward her uncle and be put in jail). The client-participant's concern about the potential negative consequences within her family that could

result from disclosing her experience of childhood sexual abuse is consistent with findings that individuals are less likely to initially disclose childhood sexual abuse when the perpetrator is a family member due to guilt over changes in the family structure, guilt for possible change in familial socioeconomic status, and fear of being removed from the home (Nagel, Putnam, Noll, & Trickett, 1997). The client-participant may have used introspection (i.e., thinking about the experience and analyzing its meaning and effect) as a coping mechanism up until her first disclosure in adulthood, as this has been found to be common among African American survivors of childhood violence (Bryant-Davis, 2005).

Additionally, findings demonstrate that those who did try to disclose in childhood did so in an indirect, behavioral manor (Alaggia, 2005). Specifically, adolescents have been found to display angry outbursts, withdrawal, avoiding being at home, and/or running away to alert adults to problems (Alaggia, 2004). These findings are consistent with the client-participant's behavior in that she reported having an "attitude" with her mother throughout her childhood, and on one occasion acted out to the point of making her mother cry. She did not, however, report withdrawing, avoiding being at home, or running away from home during her childhood, although, she did demonstrate a persistent pattern of avoidance (i.e., sub-themes avoidance of emotion and avoidance of trauma topic) throughout the course of psychotherapy.

Moreover, the way in which the client-participant discussed her CSA over the course of psychotherapy was consistent with research findings that disclosures are often tentative, involve some telling and then retracting, can be partial or full, and occur over time (Alaggia, 2005). It seemed that the client-participant had briefly discussed her experience of CA in the intake session (there was no videotaped recording of this session, but it was mentioned in the recording of the first session); however, when she was asked about it in the first session, she barely acknowledged it and was resistant to continue talking about it, as evidenced by her one word, yes or no answers. She was asked to discuss the CSA again in the seventh session. While she was able to process her anger toward her uncle and her gained sense of strength from the experience, she still described

the abuse vaguely and did not provide details of what actually happened to her in the videotaped sessions.

Alaggia (2005) identified barriers that may impede the disclosure of sexual abuse. One identified barrier to disclosure was an individual's feelings of responsibility for the event. Although the client-participant did not explicitly state that she felt she bore the responsibility for her experience of CSA, she did seem to have difficulty with the therapist's statement that sexual abuse is never the "victim's" fault. The client-participant explained that she believed that "victims" play a role in their sexual abuse and "ask for it" by dressing or acting in certain ways. The client-participant's belief that women are responsible for being sexually abused could likely have deterred her from disclosing earlier in her life, as she may have felt the abuse was her fault. Other barriers to disclosure that seemed inconsistent with the client-participant's experience or that were simply not mentioned over the course of psychotherapy were fears of becoming an abuser with one's own children (the client-participant did not have children), fears of being viewed as a victim, and anticipation of being blamed or not believed.

Furthermore, the finding that the client-participant believed women were responsible for their experiences of sexual abuse reflects the literature on the effects of CSA on survivor's self-evaluations, in that experiences of childhood sexual abuse were found to be associated with cognitive polarization of the sexes, including a tendency to see women as inherently manipulative and vulnerable (Kraus & Roth, 2010). This was evident through the sub-theme of stereotypes of women, which occurred frequently over the course of psychotherapy. Further evidence of this could be observed in the client-participant's tendency to identify with more masculine characteristics. This was noted as the sub-theme role reversal under the theme of gender role struggles. Specifically, the client-participant reported that she took on the male role in her relationship, explaining that she provided for her boyfriend financially and made most of the important decisions. It seems that identifying with what she deemed more masculine characteristics allowed her to separate herself from her negative, derogatory views of women.

Over the course of psychotherapy the client-participant discussed her experiences of WPH more frequently and readily than her childhood sexual abuse. Additionally, she became visibly angry when discussing her negative experiences at work, as evidenced by pressured speech with few pauses, raised voice, and use of profanity directed toward her boss. Her anger was observed through the sub-themes of anger toward boss, which occurred frequently over the course of psychotherapy, as previously discussed. She also frequently described the ways in which she stood up to her boss, which was observed through the sub-theme assertiveness. This sub-theme is consistent with literature on African American women survivors of childhood violence, as confrontation (i.e., talking to the perpetrator about the abuse to increase emotional well-being and self-concept) has been found to be a common coping mechanism within this population (Bryant-Davis, 2005).

Although there seems to be a dearth of research about the process of disclosing WPH specifically, research about the benefits of discussing traumatic material seems consistent with the client-participant's discussion of WPH (Janoff-Bulman, 1992; McAdams, 1996; Pennebaker & Keough, 1999; Pennebaker et al., 1997). McAdams (1996) and Janoff-Bulman (1992) assert that people create self-narratives to understand who they are and their place in the world as they change over time. Discussion of trauma allows people to explain and organize distressing life events, and could lead to repairs in a damaged sense of self and to a more resilient self-concept (Pennebaker & Keough, 1999; Pennebaker et al., 1997). The client-participant's damaged sense of self was primarily seen in the sub-themes of insecurity, fear of judgment, and self-critical. She expressed feelings of doubt in her abilities, knowledge, and decisions. Additionally, she felt that she was being thought of negatively by others and held disparaging beliefs herself. The client-participant expressed positive affect during discussion in which these sub-themes emerged. Specifically, she expressed positive affect a total of 17 out of 22 times when discussing her fear of judgment, a total of 16 out of 40 times when discussing her insecurity, and a total of 1 out of 2 times when being critical of herself. None of these expressions of positive affect were congruent

with the above sub-themes, suggesting that positive affect was not authentic and may have served the function of avoiding the anxiety, vulnerability, and/or sadness that likely accompanied these topics of discussion.

During discussions of WPH over the course of psychotherapy, the client-participant expressed frustration because she felt she was having to tolerate WPH for a job that she did not even like. However, she felt that she could not quit her job because she desperately needed the money. In these discussions reflecting the theme of feeling trapped in her job, the client-participant seemed to be expressing the inward-focused negative emotion of helplessness, which is common for targets of WPH (Brotheridge & Lee, 2010).

Yet, there was a notable change in her emotional state when she described specific incidents of WPH by her boss. In addition to the specifics of the WPH incident, she also described how she handled the situation, often making it seem as though she was in control and that her boss feared her on some level. This was observed through the sub-themes of assertiveness, desire/attempt to control others/environment, and Respect for self/Pride. In terms of assertiveness, the client-participant described situations in which she confronted her boss about his inappropriate behavior toward her and her co-workers. She also described “talking back” to her boss, although she did not explain what this entailed. Additionally, the client-participant frequently expressed that she wanted the ability to control others’ behaviors, or described situations in which she attempted to control others’ actions. In relation to her boss, this took the form of believing that by asserting herself, her boss would stop his hostile and aggressive behavior toward her and her co-workers. This sub-theme reflects research on African American survivors of childhood violence, which found that safety precautions (i.e., increasing one’s sense of control over situations through altering behavior to minimize chances of the event occurring again) was used as a coping mechanism (Bryant-Davis, 2005). Furthermore, her self-respect and pride were observed when she described instances in which her boss was bullying other co-

workers, stating that her boss would “never speak to [her] that way,” which seemed to insinuate that he had a different level of respect for her than for her co-workers.

Since the client-participant seemed to be experiencing feelings of helplessness and insecurity in response to the bullying she received from her boss, both the assertive actions she took toward her boss and the way in which she discussed her experiences of WPH in psychotherapy could have served the function of repairing her damaged sense of self. By re-telling her story in a way that made her feel more in control and powerful, and by attempting to control her boss through assertive behavior, she may have been able to obtain an increased sense of mastery, personal growth, and self-acceptance (Hemenover, 2003). The client participant’s expression of positive affect co-occurred a total of 1 out of 9 times with the sub-theme assertiveness, a total of 5 out of 54 times with the sub-theme desire/attempt to control others/environment, and did not co-occur with the sub-theme respect for self/pride. None of these expressions of positive affect were congruent with the topic of discussion. Given that assertiveness and attempt to control others/environment were discussed in the context of her WPH and other distressing topics (e.g., her boyfriend), it seems that her expressions of positive affect were likely used to avoid other uncomfortable feelings such as fear or anxiety.

Codes and Themes Related to the Broaden and Build Theory

Positive emotion words. Through a LIWC analysis of the client-participant’s verbal expressions, the researcher sought to address two research questions: (a) did the client-participant use positive emotional words during discussion of interpersonal traumatic material in the context of individual therapy? and (b) at what frequency were positive emotion words expressed in relation to overall affective words and negative emotion words during discussion of interpersonal trauma? In response to the first research question, the present study found that verbal expressions of positive emotion were present during discussions of both sexual and workplace harassment trauma over the course of the client-participant’s psychotherapy. This result is consistent with research findings that individuals coping with painful life circumstances experience positive

psychological states in addition to negative psychological states (Folkman, 1997; Folkman & Moskowitz, 2000). In fact, there were only three discussions of trauma in which positive emotion words did not occur (see Appendix T). Similarly, positive affect occurred during all sub-themes except for respect for others, respect for self/pride, role-reversal, and jealousy. Given that the sub-themes discussed over the course of psychotherapy were likely distressing for the client-participant, her expression of positive emotion may have served as an emotional break, supporting her efforts to cope (Lazarus et al., 1980). Research supports this assertion, as African American survivors of childhood violence have been found to use humor as coping strategy (Bryant-Davis, 2005).

More specifically, observations of incongruent positive emotion words and positive affect during these sub-themes and trauma discussions are consistent with research findings on repressive coping (Newton, Haviland, & Contrada, 1996). According to Newton and colleagues (1996), repressive coping is a class of emotion-focused coping that involves an avoidant stance toward negative affect, and unpleasant thoughts and memories. In their study, repressive coping was operationalized as low scores on a self-report measure of anxiety, and high scores on a social desirability scale (i.e., unlikely to admit to socially undesirable, but common, behaviors such as gossiping and having aggressive impulses). Negative emotion was induced by asking participants to prepare and give a speech about their most undesirable personality characteristic, and participants were told that they would be evaluated either by a clinical psychologist and two graduate students (high salience condition) or by one graduate student occasionally (low salience condition). Positive affect was measured using the Discriminative Facial Movement Coding System (MAX), a reliable and valid coding system that identifies emotion-related changes in the brow, the eyes and cheeks, and the mouth. Social smiles were identified by the turning upward of the mouth corners without simultaneous gathering of the skin around the eyes to create the appearance of a narrowed eye. Findings demonstrated that repressive copers tended to use social smiles when experiencing negative emotion and when public self-awareness was heightened.

One way these individuals seem to cope with and avoid the uncomfortable emotions that occur with exposure to negative affective material is by accessing pleasant thoughts (Boden & Baumeister, 1997). This finding seems consistent with the client-participant's presentation, as during discussions of both CSA and WPH she focused on her power and control over the perpetrator and her boss (the abusers), as evidenced by the sub-themes assertiveness and desire/attempt to control others/environment, which likely made her feel more safe. Furthermore, individuals using repressive coping have been found to reduce their cognitive effort when asked to recall negative memories. This is also consistent with the findings of this study, as the client-participant gave a vague and short description of her experience of CSA. Similarly, while she was able to discuss her experience of WPH more freely, she did not provide detailed descriptions or specific instances of her boss's psychological abuse.

Research findings on repressive coping also suggest that the incongruent emotional response patterns (i.e., expression of positive affect when experiencing negative emotion) associated with repressive coping is observed when the individual perceives that she is in the presence of an evaluative audience (Newton, 1992). While it seems that there was a strong therapeutic alliance, at times the client-participant expressed concern of being judged by the therapist-participant (as evidenced by the sub-theme fear of judgment), suggesting that the client-participant likely saw the therapist-participant as an evaluative audience. Thus, these findings are also consistent with one aspect of the broaden and build theory of positive emotions, which asserts that positive emotions appear to have the unique ability to psychologically down-regulate negative emotions helping individuals achieve efficient emotion regulation (Fredrickson et al., 2000; Tugade & Fredrickson, 2004).

Addressing the second research question, the researcher found that across all trauma discussions and all psychotherapy sessions, in which trauma discussions occurred, more than half of the affective words expressed by the client-participant were categorized as positive emotion words (Affective words=6.58%; Positive Emotion words=3.72%; Negative Emotion

words=2.84%). The finding that the client-participant expressed more positive emotion words overall than negative emotion words during discussions of both CSA and WPH was unexpected, as studies using the LIWC computer program to analyze writing samples of trauma accounts have found that survivors of trauma tend to use more negative than positive emotion words when describing traumatic events (Hemenover, 2003; King & Miner, 2000; Pennebaker et al., 1997).

To further explore these results, the researcher examined verbal expression of positive emotion by trauma type. Results showed that the client-participant expressed more positive emotion words during discussions of CSA than during discussions of WPH. More specifically, during discussions of CSA, most of the affective words expressed by the client-participant were positive emotion words, while less than a third were categorized as negative emotion words (CSA discussion: Affective words=5.94; Positive Emotion words=4.19; Negative Emotion words=1.71). During discussions of WPH, however, the client-participant's use of positive and negative emotion words was more balanced. Slightly over half of all affective words used were categorized as positive emotion words, while slightly less than half were categorized as negative emotion words (WPH: Affective words=6.80; Positive Emotion words=3.56; Average Negative Emotion words=3.23). Furthermore, when comparing the ratio of positive to negative emotion words used in discussions of CSA versus the ratio of positive to negative emotion words used in discussions of WPH, the client-participant used approximately two and a half times more positive emotion words than negative emotion in discussions of CSA, whereas the ratio of positive to negative emotion words used during discussions of WPH were almost equal.

Although no research was found comparing emotional expression during discussion of CSA versus WPH, this finding that the client-participant expressed more positive emotion during discussions of CSA resonated with one study of CSA survivors. Bonanno and colleagues (2002) found that CSA survivors who did not discuss an abuse experience when provided an opportunity to do so were more likely to display polite smiles. Even though the client-participant did discuss her CSA, her vague, short description suggested that she might have been withholding details of

her experiences. However, it is possible that she provided details of her CSA in her non-videotaped intake session.

Still, the researcher did not expect the finding that positive emotion occurred more in discussions of CSA versus WPH. She thought that the client-participant's experience of CSA was a more severe trauma than WPH, and therefore believed that the client-participant would have expressed more negative emotion words than positive emotion words during these discussions. However, findings of incongruent positive emotional expression made sense given the client participant's reported dislike for and avoidance of experiencing negative emotions other than anger, which was also reflected in the sub-themes avoidance of emotion and avoidance of trauma topic.

Finally, the client-participant's use of insight words was also examined over the course of psychotherapy as emotional and cognitive involvement may play complimentary roles in the processing of and adjustment to traumatic life events (Ullrich & Lutgendorf, 2002). Across all trauma discussions, 15.42% of words were categorized as cognitive processing words, while 1.93% were categorized as insight words. Studies using LIWC analysis to examine the use of insight words during discussions of traumatic events have not reported the percentage of cognitive processing words, making it difficult to ascertain whether the ratio of insight words to cognitive processing words found in this study was normative. The client-participant expressed a lower percentage of insight words when compared to studies examining the use of insight words during discussions of trauma, which reported percentages between 2.50% and 3.22% (King & Miner, 2000; Pennebaker et al., 1997).

When examining the use of insight words by type of trauma discussion, discussions of CSA contained 10.09% cognitive processing words and 2.46% insight words. Discussions of WPH revealed that the client-participant used less insight words than in discussions of CSA, with 17.29% of words in the discussions categorized as cognitive processing words and 1.75% categorized as insight words. Research indicates that the use of insight words in describing past

events is associated with the active process of reappraisal, therefore, the client-participant's use of insight words during discussions of CSA and WPH could suggest she was reconstructing her thoughts and interpretations of these experiences (Tausczik & Pennebaker, 2010). The sub-theme desire/attempt to control others/environment that emerged during both discussions of CSA and WPH is one possible way that the client-participant reconstructed her interpretations of these traumas.

Furthermore, studies examining the benefit of writing about traumatic events found that individuals who benefited from expressive writing related to their trauma used more positive than negative emotion words, and also demonstrated an increase in their use of insight words (King & Miner, 2000; Pennebaker & Francis, 1996; Pennebaker et al., 1997). While the client-participant in the current study expressed more positive than negative emotion words during trauma discussions, she did not use more insight words when expressing positive emotion than when expressing negative emotion. In fact, the client-participant's use of insight words seemed to vary over the course of psychotherapy, and did not seem to be related to her expressions of either positive or negative emotion words. This finding is inconsistent with an aspect of the broaden and build theory of positive emotion, as experiences of positive emotions are proposed to create the urge to reinterpret situations and reflect on behaviors (i.e., insight; Fredrickson, 1998). However, there may have been other ways in which the client-participant demonstrated broadening of her thought-action repertoire after expressions of positive emotion that were not detected by the LIWC. This possibility will be explored further in the next section of this dissertation.

Positive emotion and exploration/interest. One way that positive emotion may have broadened individuals' thought-action repertoire is through exploration and interest (Fredrickson, 1998; Izard, 1977). According to Fredrickson (1998), exploration and interest involve the urge to contemplate new ideas, develop alternative solutions to problems, reinterpret situations, reflect on behaviors, and to investigate. A qualitative analysis of the transcripts of the current study's

psychotherapy revealed that all five of these theoretical components of exploration and interest occurred after the expression of positive affect during trauma discussions.

First, over the course of psychotherapy the client-participant reflected on her behaviors after expressing positive affect seven times during discussions of CSA and twice during discussions of WPH. For example, at the beginning of the second discussion of CSA the client-participant smiled and then commented on her tendency to joke/laugh about her trauma when really she is sad about it. She stated, "I'm laughing just because that's how I am, and I don't want to talk. You know...It comes out as mad or not happy about it, but never sad." By analyzing and reflecting on the way in which she avoids negative emotions other than anger (i.e., sub-theme of avoidance of emotion), the client-participant is able to gain insight into her own behavior. She further demonstrated insight and reflection on her behavior later in the trauma discussion when she stated, "Its just, I think mine, like, it comes out as anger. Because I can express anger because where—like you said, it makes sense to me as a defense mechanism because I'm so nice." Not only is the client-participant able to identify how she behaves emotionally, but she is able to recognize her anger as a defense mechanism, demonstrating objectivity and insight. Although research has not directly examined the effect of positive affect on interest or reflecting on behaviors, research on the broadening effect of positive emotion has shown that individuals who express more positive emotion tend to demonstrate more broad minded coping, including seeing situations more objectively. Furthermore, the client-participant demonstrated reflection on her behavior more often in discussion of CSA than in discussions of WPH, which is consistent with the broaden and build theory, as there was more overall positive emotional expression in discussions of CSA.

Other aspects of exploration and interest that emerged in the context of expression of positive affect over the course of psychotherapy were the urges to contemplate new ideas and reinterpret situations. The client-participant demonstrated the urges to contemplate new ideas and reinterpret situations within the same discussion four times during discussions of CSA and once

during discussions of WPH. For example, in the second discussion of CSA in the first session, the client-participant laughed throughout the therapist's interpretation about the reason for which the client-participant may not feel comfortable expressing sadness. The client-participant then stated, "I never thought of it like that" in reference to the therapist-participant's interpretation. Similarly, after another interpretation by the therapist-participant hypothesizing the reason for which the client-participant may be self-critical, the client-participant smiled and then stated, "Oh yeah. If you think about it like that, it's disgusting. Yeah that's the only thing I can say because nobody was like that." Since both of these examples occurred in response to prompting by the therapist-participant, and did not originate from the client-participant, it could be argued that the client-participant was not demonstrating an urge. However, it seems that she was at the least displaying willingness to consider new ideas and reinterpret situations.

These findings are consistent with the proposed broadening function of positive emotion, as the client-participant demonstrated her ability to integrate ideas that she had not yet considered, allowing her to gain a new perspective on her past as well as on her current functioning. Research on the broadening effect of positive emotion has demonstrated similar results. For example, studies have shown that individuals engaged in a reasoning task demonstrated more efficient integration of new information than those experiencing a neutral or negative emotion (Estrada, Isen, & Young, 1997). Furthermore, positive affect has been found to promote more variety seeking among consumer food products (Kahn & Isen, 1993), which may suggest that people experiencing positive emotion are more likely to consider new ideas of products that could be useful to them. The finding that the client-participant demonstrated urges to contemplate new ideas and reinterpret situations more in discussions of CSA than in discussions of WPH seemed to be consistent with the broaden and build theory since she also expressed more positive emotion throughout discussions of CSA.

The client-participant also exhibited the urge to investigate or curiosity after expressing positive affect, which was defined here as including asking questions or demonstrating that she

wanted to try to figure out the topic of discussion. The urge to investigate occurred a total of four times during discussions of CSA and did not occur during discussions of WPH, a finding that is consistent with broaden and build theory given that more positive emotion occurred during discussions of CSA. More specifically, in the second discussion of CSA in the first session, the client-participant laughed and then delved deeper into the idea that she has difficulty expressing sadness due to the need to be responsible and strong that was developed during her childhood. For example, she stated, “No you’re right, I understand that, I get it. But I don’t know if I grew up too quick, because I felt like a kid...” Here the client-participant seems to want to further investigate the therapist-participant’s interpretation of her emotional behavior, by comparing it to how she experienced her childhood. Moreover, in the first discussion of CSA in session six, the client-participant smiles as she explains that her past experience of CSA still bothers her. She then goes on to ask the therapist-participant how to, “get out of anger and into sadness,” demonstrating her desire to understand and learn more about how to process emotion. While few studies have directly examined the relationship between urge to investigate/curiosity and positive emotion, a study by Kashdan, Rose, and Finsham (2004) found that curiosity was associated with positive subjective experiences; a finding that is consistent with the broaden and build theory.

Finally, the client-participant exhibited the development of alternative solutions four times during discussions of WPH. She did not seem to develop alternative solutions to problems during discussions of CSA; however, this could be explained by the fact that her experience of CSA occurred in the past and was not a problem for which she was trying to find a solution. More specifically, in her discussion of WPH in the ninth session, the client-participant began laughing after angrily discussing her boss and then began to discuss how she could leave her job when none of her co-workers are trained to take on her job responsibilities. For example, she stated, “But he ain’t gonna say nothing because I’ll just be like, ‘Well you know what? I don’t think I should be responsible for that because’ — And he’ll be like, ‘Okay.’” Another example of the client-participant developing alternative solutions to her problems took place when she was

trying to develop ways to manage her negative emotional reaction to going to work. She stated, “So I just have to tell myself, ‘Nope, [Client shakes head “no”] not today. Be calm. Don’t let him make you nervous. Just sit there and be okay. In two weeks we get paid.” This quote reflects the client-participant’s generation of an alternative solution to her normal reaction of becoming anxious and angry when in her boss’ presence. These findings are consistent with research demonstrating that positive affect, induced by showing participants a comedy or by giving them a bag of candy, leads to the kinds of thinking that enable people to solve problems requiring ingenuity and innovation (Isen et al., 1987). Furthermore, in addition to research linking positive emotion with repressive coping, positive emotion has also been linked with a broad style of coping associated with a broad perspective on problems, seeing beyond the immediate stressor, and generating multiple courses of action (Fredrickson & Joiner, 2002; Fredrickson, Tugade, Waugh, & Larkin, 2003).

Positive emotion and psychological resources. Not only does the broaden and build theory propose that positive emotions broaden the scope of attention and thought-action repertoires, but it goes further to propose that this broadening builds lasting physical, intellectual, social and psychological resources (Fredrickson, 1998). While it was outside the scope of and data available in this study to determine whether the client-participant’s expression of positive emotion led to the full range of personal resources, the researcher was able to examine the transcripts for a psychological resource: possible emotional “breaks” provided by the client’s expression of positive affect, that may have supported her effort to cope (Lazarus et al., 1980).

Over the course of psychotherapy, the client-participant frequently seemed to gain an emotional break from the topic of discussion by expressing positive affect as this process was observed eight times during discussions of WPH and three times during discussions of CSA. This finding seemed contrary to the broaden and build theory, as the researcher expected to see more emotional breaks in discussions of CSA when the client-participant expressed more positive emotion. However, as previously discussed, it is possible that the client-participant avoided

negative emotion and used repressive coping more during discussions of CSA, and therefore did not need as much of an emotional break in these discussions. Another possibility for this finding is that the client-participant was more distressed and needed more emotional breaks during discussions of WPH, as this was an interpersonal trauma with which she was currently dealing and struggling with. Anger, resentment, anxiety, and depression have been associated with WPH in the literature (Keashley & Harvey, 2005).

One example of positive affect potentially providing an emotional break for the client-participant was in the first discussion of WPH in the first session. The client-participant expressed hatred toward her job, and when asked by the therapist participant to talk about her boss the client smiled and stated, "I don't want you to get mad at me...because I think I talk about it too much," reflecting the theme of fear of judgment. Then instead of talking about her boss as the therapist-participant had requested, the client-participant went on to discuss her job more generally. There were also times in which the client-participant's expression of positive affect led the therapist-participant to initiate a break from the topic of discussion. For example, in the fourth discussion of WPH in the first session, the client-participant described an incident in which her boss verbally abused her and her co-workers. She then laughed and smiled as she continued to describe her hatred for her job. At this point the therapist participant switched the topic of discussion by asking the client-participant how she found her current job and if she was looking for new jobs. It seems as though the client-participant's expression of positive affect may have cued the therapist-participant to shift the focus of the discussion away from the client-participant's experience of WPH. This observation is similar to research on "collusive resistance," suggesting that due to possible countertransference, compassion fatigue, burnout, and/or vicarious traumatization, therapists may collude with clients to avoid confronting difficult and painful material (Fox & Carey, 1999). However, this may also have been the therapist-participant's attempt to empower the client-participant through problem solving.

The client-participant's expression of positive affect also seemed to serve as a way for her to emotionally regulate after expressing negative emotion. Research has revealed that the experience of positive emotions can act as a shield to defend against the effects of stressful situations, allowing one to recover more quickly than when experiencing neutral emotions after negative affect (Folkman & Moskowitz, 2000; Fredrickson & Levenson, 1998). This finding is consistent with the client-participant's expression of positive affect during discussions of WPH and CSA in that she displayed positive affect after discussions in which she had expressed negative emotion (usually anger). For example, in the second discussion of CSA in the seventh session, after the client-participant finished discussing the circumstances of her CSA, she laughed and smiled every time she talked for three talk turns in a row. Furthermore, in a discussion of WPH in the sixth session the client-participant discussed an event in which her boss verbally abused she and her co-workers and laughed once she finished describing the circumstances of the incident. She then smiled while stating, "I hate it. Hate it, hate it, hate it. I cannot stand his ass." This pattern of positive emotional expression is consistent with research on the benefits of positive emotion, which has found that inducing positive emotion can counteract the effect of ego depletion (i.e. the depletion of energy and/or strength) related to the effects of negative emotional experiences (Tice, Baumeister, Shmueli, & Muraven, 2007). Additionally, research findings suggest that the experience of positive emotion has been found to improve self-regulation as compared to the experience of a neutral emotion, and speeds recovery from the cardiovascular aftereffects of stressors inducing fear, sadness, or anxiety (Fredrickson & Levenson, 1998; Fredrickson et al., 2000; Tice et al., 2007).

Methodological Limitations

The researcher noted multiple limitations regarding case study research more generally, in addition to limitations concerning this study specifically. One concern about case study research was the lack of meticulousness with which case studies have been conducted in the past,

including negligence in following systematic procedures and allowing biases to sway the direction of the results and conclusions of a study (Yin, 2009). In terms of negligence, Yin proposes that the lack of careful practices associated with case studies is most likely due to the fact that there are very few methodological texts containing specific procedures to follow when conducting a case study. The researcher attempted to minimize carelessness by taking a systematic approach to all phases of the study. More specifically, the researcher conducted the current case study according to the procedures proposed by Stake (1995) as outlined by Yin (2003). These procedures included (a) determining that a case study approach was indeed appropriate for the research problem (the researcher sought to gain an in-depth understanding of the expression of positive emotion within the context of a trauma case); (b) using purposeful sampling to select a case that showed different perspectives on the problem (the researcher was looking at a trauma case through a positive psychology lens with the hopes of gaining a different perspective on the struggle with traumatic experiences); (c) drawing on multiple sources of information for data collection, such as observations, interviews, documents, and audiovisual materials (the researcher used observation, audio-visual material, documents, and clinic measures in data collection); (d) analyzing data using an embedded analysis of a specific aspect of the case, including a detailed description of the history of the case, and the chronology of therapy sessions (the researcher provided a detailed description of each psychotherapy session, describing the chronology of how the session unfolded, as well as behavioral observations within sessions); (e) analyzing themes to understand the complexity of the case (the research team created themes and sub-themes that emerged over the course of the client-participant's psychotherapy); and (f) reporting the meaning of the case (the researcher interpreted the meaning of her observations and findings and compared them to the broaden and build theory as well as other relevant theories of emotional expression). Additionally, a training and coding manual (Appendix U) was created in order to document the steps taken throughout the study, including the procedures for training research assistants to transcribe videotaped sessions and code for discussions of trauma, the

procedures for training research team members to code for positive affect, and the process by which the research team coded themes and sub-themes. Tables were also created to track LIWC findings, the occurrences of positive affect, and the themes and sub-themes that emerged over the course of psychotherapy.

In terms of biases, the nature of this type of research is inherently subjective (Mertens, 2009) and it is possible that the researcher's unique beliefs and perspectives could have affected the way in which she categorized themes and sub-themes, as well as the way she interpreted the findings. Related to categorizing themes and sub-themes, each research team member individually reviewed the transcripts before meeting as a team, in order to "provide a variety of opinions and perspectives, [helping] to circumvent the biases of any one person" (Hill et al., 1997, p. 523). During the individual review of transcripts, research team members took notes regarding their rationale for identifying and categorizing themes. The research team then met and discussed their ideas and thought processes. An example of one disagreement that emerged among the research team was how the sub-themes sense of responsibility and respect for others should be categorized. While some team members felt sense of responsibility should be its own category, with respect for other as a sub-theme, other team members believed they both were ways in which the client-participant protected herself, and thus should be subsumed under self-protection. This disagreement was resolved by reviewing the context in which these sub-themes occurred and discussing the function that these sub-themes likely played in the client's life, which all team members ultimately agreed was a protective function. Decision-making steps taken by the research team were recorded in order to ensure credibility (i.e., congruency of findings with reality), dependability (i.e., detailed reporting of the process within the study) and confirmability (i.e., the extent to which beliefs, decisions, and adopted methods are acknowledged within the research report; Kazdin, 2003). These decision-making steps were then shared with the auditor.

In terms of biases influencing interpretation of the findings, the researcher made sure to state her expectations of what she thought she would find at the outset of the study. In particular, the researcher believes that the experience of positive emotion can aid in the recovery from problems rooted in negative emotions such as depression, suicidality, anxiety, and stress-related disorders, and can increase general well being and serve as a buffer against stressful life events. The researcher believes that this bias was probably most salient when attempting to connect the findings of the study to the broaden and build theory, as she was specifically looking for ways in which the expression of positive emotion may have benefited the client-participant (i.e., through exploration/interest, emotional breaks, and emotion regulation), and therefore may not have been aware of times in which positive emotion was unhelpful or had a neutral effect on the client-participant. The researcher attempted to address this bias by presenting other possible functions (such as avoidance/repressive coping) that positive emotion could have served for the client-participant.

Additionally, the ethnicity of the coders may have also introduced bias into the study, as each coder was of a different race, ethnicity, and socioeconomic status than the client-participant, and was not an expert in the client-participant's culture. The researcher attempted to address this bias by presenting her race, ethnic background, and socioeconomic status, and by comparing the findings of the study to research on African American women within the specific areas of the current study. Yet, still the researcher could have missed the meaning of culture-specific verbalizations (e.g., use of ebonics) when qualitatively analyzing the transcripts, leading to misunderstanding of what the client-participant was trying to communicate. For example, the client-participant used derogatory words when referring to women, which was coded as the sub-theme stereotypes of women. However, it is possible that some of these derogatory words were used casually or as slang, and therefore the client-participant may not have been communicating her actual beliefs about women. Future research should include at least one coder and/or auditor

with expertise in the culture of the client-participant in order to recognize culture-specific verbalizations and behaviors and appropriately communicate those results.

An additional concern was that case studies do not allow for scientific generalization (Yin, 2009). However, Yin asserts that this concern can also be applied to a single quantitative experiment. He points out that scientific facts are never grounded in single experiments, but rather in multiple replications of experiments under different conditions (Yin, 2009). Unlike quantitative research that seeks to generalize from a sample to a population, the goal of case studies is to generalize and further develop existing theories (analytic generalization; Yin, 2009). A single case study can be used to “determine whether a theory’s propositions are correct or whether some alternative set of explanations might be more relevant” (Yin, 2009, p. 47). The current case study sought to examine whether the findings on the expression of positive emotion during discussion of trauma was consistent with or an exception to the broaden and build theory of positive emotion. While the researcher was able to compare the findings of the study to certain aspects of the broaden and build theory (i.e., how positive affect may have facilitated exploration/interest and emotional breaks from the effects of negative emotion), she was unable to compare the findings to other aspect of the theory (such as whether the client-participant demonstrated broadening of her momentary mindset to include a broader range of thoughts and actions after expressing positive emotion) due to the inadequate definition of the term broadening and its multitude of wide-ranging descriptors and ideas (Fredrickson, 1998; Lyubomirsky, 2000). Furthermore, client-participant demographic factors were considered as to their possible contribution to the expression of positive emotion based on the relevant literature. However, due to the complex effects of demographic and socialization factors on individual and therapy dyad behavior, the researcher could only make hypotheses as to their effects on expression of positive emotion. Additionally, generalizability is not as much of a concern as it is in traditional quantitative studies, as each participant’s perspective is considered to be unique (Merriam, 2002).

Rather, the researchers improved the transferability of the findings by providing sufficient description of observations and processes so that others could ascertain if and how the findings can be applied to their research-related or clinical situations.

A third concern about case studies was that they take a long time to complete, and that the materials they yield are lengthy and unreadable due to their narrative nature (Yin, 2009). However, while this may have been true of case studies in the past, there are ways a case study can be written wherein narrative can be avoided (Yin, 2009). For the present study, narrative was only used to provide support for interpretations of findings or as illustrations for identified themes/sub-themes so that the reader would be able to understand the researcher's process of arriving at certain conclusions. Furthermore, since case studies do not depend exclusively on ethnographic or participant-observer methods of data collection, which emphasize detailed observational evidence and often take long periods of time to complete, they can be carried out in shorter amounts of time (Yin, 2009). This was the case with the current study, as the researcher was able to use an archival database including video-taped sessions and clinic measures to obtain information (such as symptom distress over the course of therapy, therapeutic alliance information, and stages of change information) that otherwise would have taken a longer time to gather through participant interviews.

A fourth common concern about case studies is that they are not "true experiments" and cannot determine causal relationships (Yin, 2009). However, rather than determining what causes the phenomenon of interest, qualitative methods examine how complex processes work (Kazdin, 2003; Morrow, 2007). Furthermore, while "true experiments" can establish causation, they often do not explain how or why a phenomenon has occurred (Yin, 2009). Case studies can add valuable information that is not obtained from "true experiments", and can compliment experiments by offering a more complete picture of what is being studied (Morrow, 2007). The single case study approach that was used in the current investigation allowed the researcher to

gain an in-depth understanding of how positive emotion was expressed when coping with interpersonal trauma in the context of a full course of psychotherapy. While the researcher was able to observe how the client-participant expressed positive emotion over the course of psychotherapy through LIWC findings (i.e., the percentage of positive emotion words expressed within and outside of therapy sessions) and through coding of positive affect (i.e., smiles and laughter) across therapy sessions, the study still did not paint a complete picture of the phenomenon being studied due to limitations of these methods of coding. Furthermore, the researcher had limited data given the fact that the study used an archival database that only contained certain videotaped sessions and clinic measures.

Regarding limitations of the LIWC computer program, it may not have accounted for all of the potential positive emotions that the client-participant expressed verbally. The LIWC examines word usage only, and does not provide information about the context in which the words are embedded (Hirsh & Peterson, 2009). Since discourse operates at multiple levels simultaneously including word, sentence, paragraph, and page, the meaning of writing samples can be lost during a simple word count (Hirsh & Peterson, 2009). Furthermore, examining the meaning and context of verbal positive emotional expression was made more difficult by the fact that the LIWC did not specifically indicate which words in the transcripts it categorized as affective, positive emotion, negative emotion, cognitive, and insight words. Another limitation of the LIWC is that its categories are statistically related to each other, but the words within the categories may include a variety of different meanings (Hirsh & Peterson, 2009). A study by O'Carroll Bantum and Owen (2009) with a sample of 49 women with stage one or two breast cancer (race, culture or ethnicity not specified) found that while LIWC was effective at identifying whether a given word was indicative of a positive or negative emotion, it did not reliably identify the specific type of emotion that the word represented. Additionally, O'Carroll Bantum and Owen (2009) found that self-reported positive and negative emotion were not highly

correlated with LIWC codes of positive and negative emotional expression; they therefore suggested that behavioral linguistic measures should be considered as a supplement to self-report data (O'Carroll Bantum & Owen, 2009). To address these limitations, the researcher also observed the client-participant's expression of positive affect across psychotherapy sessions and examined supplemental self-report data in the clinic measures. Furthermore, the researcher attempted to understand the context in which positive affect was expressed by noting the themes and sub-themes that co-occurred with smiles and/or laughter. A final limitation of the LIWC is that while studies using the LIWC program have included a variety of populations including African American participants (Pennebaker, 1997), studies have not focused on the validity of the LIWC with African American women. Therefore, the specific cultural language and slang used by the client-participant may have been analyzed without consideration of the client-participant's ethnic and cultural context, which may have led to inaccurate findings. There was also a cultural limitation of the current study in that the ethnicity of the therapist-participant was unknown. Therefore, the researcher was not able to examine findings in the context of possible cultural dynamics that were occurring between the therapist-participant and client-participant. Future studies examining phenomena within the context of individual psychotherapy should attempt to identify the ethnic and racial background of both participants in order to identify culture specific verbalizations and behaviors that may have influenced findings.

In terms of limitations related to identifying the expression of positive affect, the poor quality of the video-recorded psychotherapy sessions made it difficult to see details of the client-participant's facial expressions, which ruled out the possibility of using the EMFACS coding system to identify positive emotions that may have been expressed through facial expressions or body language (Ekman, Friesen, & Ancoli, 1980; Gelder, 2006). For this reason, the study focused on smiles and laughter defined more generally, without distinguishing between *duchenne* and non-*duchenne* smiles/laughter (i.e., "felt" smiles and laughter vs. smiles/laughter expressed during experience of neutral or negative emotions), making it difficult to interpret whether the

feeling behind the smile/laughter was communicating “felt enjoyment,” or a lack of positive feeling all together (Ekman & Friesen, 1982). However, the researcher noted when the client-participant’s expression of positive affect was congruent or incongruent with the co-occurring themes and sub-themes, with the intention of identifying felt versus un-felt smiles, as well as the potential function of the positive affect. Finally, the researcher was able to look for theoretical components of the broaden theory that occurred after the expression of positive affect, but she was not able to determine whether the expression of positive affect was the impetus for the occurrence of these components. Therefore, it is possible that broadening was related to some other process that was outside the scope of this study. Given these limitations, it is hoped that the researcher’s conclusions and discussions of the findings are helpful in beginning the discussion of the possible function of positive emotion during discussion of trauma; however, further research is needed to examine these issues.

Future Directions

In order to understand the function of positive emotional expression during trauma discussion, the researcher suggests continuing to critically examine the broaden and build theory in the context of psychotherapy. One suggestion for future research is to operationally define broadening, as its descriptors encompass too many wide-ranging ideas to make it an effective theoretical tool (Lyubomirsky, 2000). For example, Izard (1977) asserts that positive emotions lead to wider-ranging action- or response-tendencies toward more general goals. Broadening, therefore, could be operationally defined as the action-tendencies that have been associated with positive emotions. However, the action tendencies associated with positive emotion (e.g., affiliation and exploration) in the literature would also have to be operationalized given their current vague descriptions.

Once operationalized, research could focus on observing the occurrence of broadening in psychotherapy, as well as the expressed emotions that seem to facilitate or thwart the broadening

process. Expressed emotion could be assessed using multiple methods including the EMFACS (Ekman et al., 1980), emotion themes (e.g., themes of sadness or joy), and self-report measures. Furthermore, research should examine whether negative emotions could lead to broadened thinking and positive emotions to narrowed thinking, and should search for other potential factors that might facilitate the broadening process, as this would provide a balanced approach to examining the theory (Lyubomirsky, 2000; Seligman & Csikszentmihalyi, 2000).

Another possible direction for future research is to examine the role of positive emotion and cognitive processing in adapting to traumatic events, as emotional and cognitive involvement may play complimentary roles in the processing of and adjustment to traumatic life events (Ullrich & Lutgendorf, 2002). Furthermore, research suggests that finding positive meaning in negative circumstances leads to increased abilities to achieve efficient emotion regulation (Tugade & Fredrickson, 2004). While the present study examined the client-participant's use of insight words through the use of the LIWC, it was difficult to examine the emotional context in which insight words were expressed as the LIWC did not indicate which words were categorized as insight words in the transcripts. Furthermore, given that the meaning of writing samples can be lost during a simple word count (Hirsh & Peterson, 2009), the LIWC may not have adequately identified the client-participant's use of insight even if it had indicated which words were categorized as insight words in the transcripts. Future studies in this area could use the EMFACS (Ekman et al., 1980) to code for positive emotion, and themes analysis to code for themes of meaning making and cognitive processing (including insight) within the context of the discussion in which positive emotion occurred.

Yet another suggestion for future research is to examine the undoing effect of positive emotion in the context of psychotherapy, as previous research has only tested this theory in the context of a research study (Fredrickson et al., 2000). The researcher observed patterns of positive affect and negative emotional expression and interpreted the possible role that positive

emotion played given the context in which it occurred in psychotherapy sessions; however, future research should look at the causal relationship between negative emotion and positive emotion. While a previous study examining the undoing effect found that feelings of contentment or amusement produced faster cardiovascular recovery from anxiety and stress than did neutral or sad feelings (Fredrickson et al., 2000), it would be beneficial to examine the effect of spontaneous (rather than induced) positive emotion on the effects of negative emotion within the context of psychotherapy. Future research could replicate this previous study in the context of psychotherapy by examining client-participants who are in psychotherapy to process trauma. These studies could assess the expression of emotion using the EMFACS while the six cardiovascular measures used in Fredrickson and colleagues' study (2000) could assess cardiovascular activation and recovery.

Furthermore, future research should examine the effect of positive emotion on the therapeutic relationships, as it has been suggested that positive emotions can increase and sustain social relationships (Fredrickson, 1998). Studies have indicated that positive emotions lead people to include others in their self-concept, increase trust in others, lead people to initiate conversations with others, and predict greater enjoyment of social activities (Cohn & Fredrickson, 2006; Dunn & Schweitzer, 2005; Isen, 1970). Future research could use observations of videotaped psychotherapy sessions and code for verbal and non-verbal gestures of affiliation, bond, and reciprocation, paying particular attention to how these positive emotions may facilitate, or not facilitate these processes.

Finally, the researcher found that referring to research and literature on cultural factors such as race, ethnicity, and gender of the client-participant was helpful in identifying patterns of trauma discussion and expression of positive emotion that were particular to the client-participant's specific life experiences. However, future researchers with expertise in particular ethnic populations should explicitly focus on identifying how positive emotion is expressed in the

context of trauma by people from those ethnic populations using culturally appropriate assessment tools, as research suggests that emotional expression and rules about emotional display vary by ethnicity (Matsumoto, 1993). Furthermore, examining the influence of societal and cultural factors on positive emotional expression would provide a more balanced approach to examining the broaden and build theory and its implications for psychotherapy (Seligman & Csikszentmihalyi, 2000).

Potential Contributions

Current theories and research on positive emotion propose that positive feelings such as happiness, joy, and hope have the ability to expand thought and action repertoires, build resources, undo the effects of negative emotions, and lead to resilience and adaptive coping. However, little research exists on how positive emotion is expressed in the context of discussing and sharing interpersonal trauma in psychotherapy. This study sought to explore the use of positive emotion during disclosure and discussion of interpersonal trauma in psychotherapy, with the aim of gaining insight into how and to what extent a client used positive emotion to cope or adapt in the face of CSA and WPH.

The findings of the current case study supported previous literature in that the expression of positive emotion occurs during discussion of trauma (Folkman, 1997). Furthermore, findings from this study suggest that use of positive emotion words such as love, nice, sweet, and hope (in the LIWC), as well as non-verbal expressions of positive emotion such as smiles and laughter, may serve multiple functions including the avoidance of negative emotions and unpleasant thoughts/memories, “saving face” in the presence of an audience perceived as evaluative (e.g., a therapist), a break from the discussion of unpleasant topics and their associated thoughts and emotions, and a way to emotionally regulate after expressions of negative emotion (Folkman & Moskowitz, 2000; Fredrickson & Levenson, 1998; Lazarus et al., 1980; Newton et al., 1996).

More specifically, the finding that positive emotion occurred more than negative emotion words in discussions of CSA suggests that positive emotion may play an important role in coping with painful emotions, memories, and the processing of distressing life events. These findings may be particularly pertinent to African American women as research suggests that African American survivors of childhood violence tend to use humor in order to improve their mood and to hide their pain with laughter and smiling (Bryant-Davis, 2005).

Furthermore, the finding that the client-participant demonstrated contemplation of new ideas, developed alternative solutions to problems, reinterpreted situations, reflected on her behaviors, and investigated topics further after expressing positive emotion suggests that positive emotion may lead to cognitive and behavioral changes that could be useful in the psychotherapeutic process. However, it is also possible that the co-occurrence of positive affect with these theoretical components of broadening were circumstantial, and that some other process not examined by this study was responsible for facilitating broadening of thought-action repertoires.

Given these findings, therapists working with individuals who have experienced interpersonal trauma could consider that the expression of positive emotion during discussion of trauma may occur more often than not, and could be normative. It could be related to avoidance/repressive coping and/or even a sign of strength or resilience, which could help to promote quality of life and possibly flourishing (Keyes & Lopez, 2005). The expression of positive emotion during discussion of trauma may be especially pertinent for therapists working with African American women survivors of childhood abuse (Bryant-Davis, 2005). In these cases, therapists could provide a more effective therapeutic environment by acknowledging and supporting the use of positive emotions throughout the disclosure process. Furthermore, it may benefit the therapist to foster positive emotional expression, as it may play an important role in facilitating cognitive, emotional, and behavioral change. For example, interest may produce

reframing or insight, pride could foster one's sense of purpose leading to important behavioral changes, hope could increase motivation to attain one's goals, and joy may support one's desire to engage in experiential work (Fitzpatrick & Stalikas, 2008; Snyder et al., 1991). Therefore, a therapist working with the client-participant in the current study could acknowledge her ability to access positive emotion when coping with negative emotion as a strength that has given her the resilience to bounce back from difficult life events.

At the same time, therapists could also consider the possible role of positive emotions as a therapy-interfering avoidance strategy, and would accordingly need to explore whether avoidance was an adaptive coping mechanism and/or a behavior that is maintaining and/or exacerbating symptomatology. For example, in the current study the client-participant gave a very vague description of her CSA and occasionally it seemed that positive emotion served as a way to avoid the conversation altogether. A therapist working with this client could again recognize the client's use of positive emotion as a strength, but could point out that if the trauma is continuously avoided, the related symptoms will likely persist. If the client were to then go on to discuss her CSA in detail while laughing occasionally, this could be again framed as a strength.

Findings of the current study also have implications for future research examining broaden and build constructs. Through this study, the researcher struggled with the vague and overinclusive definitions of the terms broaden and build, and with how to identify the occurrence of these processes. In order to compare the findings of the study to the broaden and build theory, the researcher looked to literature on the action tendencies associated with positive emotion, and selected the action-tendencies that would be most observable when examining the transcripts. Therefore, it will be particularly important for researchers examining these constructs to expand upon the work started in this dissertation by creating operational definitions and concrete examples that will make both broadening and building observable and causally identifiable

phenomena. It will also be important for researchers to examine whether factors, other than positive emotion, may contribute to the broadening process.

These recommendations are consistent with a positive psychological framework, as the goal of positive psychology is to seek a more balanced view of humans by focusing on strengths and virtues rather than solely on pathology, weakness, and damage (Seligman & Csikszentmihalyi, 2000). Furthermore, the role of the positive clinical psychologist is to promote psychological health through recognizing human strengths during therapy and instilling hope (Maddux et al., 2004; Pedrotti et al., 2009). This dissertation proposes that therapists should recognize their clients' strengths in addition to their weaknesses, and acknowledge and support inherent coping processes that may include the use of positive emotion, as these processes could be signs of avoidance, resilience and even thriving.

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APPENDIX A

Client Information Adult Form

CLIENT INFORMATION **ADULT FORM

ID# _____

THIS FORM IS INTENDED TO SAVE YOU AND YOUR INTAKE INTERVIEWER TIME AND IS IN THE INTEREST OF PROVIDING YOU WITH THE BEST SERVICE POSSIBLE. ALL INFORMATION ON THIS FORM IS CONSIDERED CONFIDENTIAL. IF YOU DO NOT WISH TO ANSWER A QUESTION, PLEASE WRITE "DO NOT CARE TO ANSWER" AFTER THE QUESTION.

TODAY'S DATE _____

FULL NAME _____

HOW WOULD YOU PREFER TO BE ADDRESSED? _____

REFERRED BY: _____

MAY WE CONTACT THIS REFERRAL SOURCE TO THANK THEM FOR THE REFERRAL? YES NO

IF YES, PLEASE PROVIDE CONTACT INFORMATION FOR THIS PERSON/AGENCY

Personal Data

ADDRESS: _____

TELEPHONE (HOME): _____ BEST TIME TO CALL: _____ CAN WE LEAVE A MESSAGE? Y N
(WORK): _____ BEST TIME TO CALL: _____ CAN WE LEAVE A MESSAGE? Y N

AGE: _____ DATE OF BIRTH: _____
MARRIAGE STATUS: MARRIED SINGLE DIVORCED COHABITATING SEPARATED WIDOWED
HOW LONG? _____ PREVIOUS MARRIAGES? _____
HOW LONG SINCE DIVORCE? _____

LIST BELOW THE PEOPLE LIVING WITH YOU:

NAME	RELATIONSHIP	AGE	OCCUPATION

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

ID# _____

CLIENT INFORMATION **ADULT FORM

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

MEDICATIONS BEING TAKEN: _____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

OTHER SERIOUS ILLNESSES

DATE

sample

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHODIAGNOSIS, PSYCHIATRY, MARITAL COUNSELING, GROUP THERAPY, ETC.)

DATE

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

- ELEMENTARY/MIDDLE SCHOOL: LIST GRADE _____
- HIGH SCHOOL: LIST GRADE _____
- CRED
- HS DIPLOMA
- VOCATIONAL TRAINING: LIST TRADE _____
- COLLEGE: LIST YEARS _____
- GRADUATE EDUCATION: LIST YEARS OR DEGREE EARNED _____

CURRENTLY IN SCHOOL? SCHOOL/LOCATION: _____

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATE/DURATION
_____	_____	_____
_____	_____	_____

ID# _____

CLIENT INFORMATION **ADULT FORM

HOUSEHOLD INCOME:

- UNDER \$10,000
- \$11,000-30,000
- \$31,000-50,000
- \$51,000-75,000
- OVER \$75,000

OCCUPATION: _____

Family Data

IS FATHER LIVING?

Yes IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

IF NOT LIVING, HIS AGE AT DEATH: _____ YOUR AGE AT HIS DEATH: _____

CAUSE OF DEATH: _____

IS MOTHER LIVING?

Yes IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

IF NOT LIVING, HER AGE AT DEATH: _____ YOUR AGE AT HER DEATH: _____

CAUSE OF DEATH: _____

BROTHERS AND SISTERS

NAME	AGE	OCCUPATION	RESIDENCE	CONTACT HOW OFTEN?
------	-----	------------	-----------	--------------------

LIST ANY OTHER PEOPLE YOU LIVED WITH FOR A SIGNIFICANT PERIOD DURING CHILDHOOD.

NAME	RELATIONSHIP TO YOU	STILL IN CONTACT?
------	---------------------	-------------------

THE FOLLOWING SECTION WILL HELP US UNDERSTAND YOUR NEEDS AND FACTORS THAT MAY IMPACT YOUR LIFE OR TREATMENT. BELOW IS A LIST OF EXPERIENCES WHICH MAY OCCUR IN FAMILIES. PLEASE READ EACH EXPERIENCE CAREFULLY. PLEASE INDICATE WHETHER ANY OF THESE EXPERIENCES HAVE HAPPENED TO YOU OR YOUR FAMILY. SOME OF THESE MAY HAVE BEEN TRUE AT ONE POINT FOR YOU OR IN YOUR FAMILY BUT NOT TRUE AT ANOTHER POINT. IF THE EXPERIENCE NEVER HAPPENED TO YOU OR SOMEONE IN YOUR FAMILY,

ID# _____

CLIENT INFORMATION **ADULT FORM

Current Difficulties

PLEASE CHECK THE BOXES TO INDICATE WHICH OF THE FOLLOWING AREAS ARE CURRENT PROBLEMS FOR YOU AND REASONS FOR COUNSELING.

PLACE TWO CHECK MARKS TO INDICATE THE MOST IMPORTANT REASON(S).

- | | |
|---|--|
| <input type="checkbox"/> FEELING NERVOUS OR ANXIOUS | <input type="checkbox"/> DIFFICULTY WITH SCHOOL OR WORK |
| <input type="checkbox"/> UNDER PRESSURE & FEELING STRESSED | <input type="checkbox"/> CONCERNS ABOUT FINANCES |
| <input type="checkbox"/> NEEDING TO LEARN TO RELAX | <input type="checkbox"/> TROUBLE COMMUNICATING SOMETIMES |
| <input type="checkbox"/> AFRAID OF BEING ON YOUR OWN | <input type="checkbox"/> CONCERNS WITH WEIGHT OR BODY IMAGE |
| <input type="checkbox"/> FEELING ANGRY MUCH OF THE TIME | <input type="checkbox"/> FEELING PRESSURED BY OTHERS |
| <input type="checkbox"/> DIFFICULTY EXPRESSING EMOTIONS | <input type="checkbox"/> FEELING CONTROLLED/MANIPULATED |
| <input type="checkbox"/> FEELING INFERIOR TO OTHERS | <input type="checkbox"/> PRE-MARITAL COUNSELING |
| <input type="checkbox"/> LACKING SELF CONFIDENCE | <input type="checkbox"/> MARITAL PROBLEMS |
| <input type="checkbox"/> FEELING DOWN OR UNSHAPPY | <input type="checkbox"/> FAMILY DIFFICULTIES |
| <input type="checkbox"/> FEELING LONELY | <input type="checkbox"/> DIFFICULTIES WITH CHILDREN |
| <input type="checkbox"/> EXPERIENCING GUILTY FEELINGS | <input type="checkbox"/> DIFFICULTY MAKING OR KEEPING FRIENDS |
| <input type="checkbox"/> FEELING DOWN ON YOURSELF | <input type="checkbox"/> BREAK-UP OF RELATIONSHIP |
| <input type="checkbox"/> THOUGHTS OF TAKING OWN LIFE | <input type="checkbox"/> DIFFICULTIES IN SEXUAL RELATIONSHIPS |
| <input type="checkbox"/> CONCERNS ABOUT EMOTIONAL STABILITY | <input type="checkbox"/> FEELING GUILTY ABOUT SEXUAL ACTIVITY |
| <input type="checkbox"/> FEELING CUT-OFF FROM YOUR EMOTIONS | <input type="checkbox"/> FEELING GRIEVED ABOUT ATTRACTION TO MEMBERS OF SAME SEX |
| <input type="checkbox"/> WONDERING "WHO AM I?" | <input type="checkbox"/> FEELINGS RELATED TO HAVING BEEN ABUSED OR ASSAULTED |
| <input type="checkbox"/> HAVING DIFFICULTY BEING DOWN | <input type="checkbox"/> CONCERNS ABOUT PHYSICAL HEALTH |
| <input type="checkbox"/> DIFFICULTY MAKING DECISIONS | <input type="checkbox"/> DIFFICULTIES WITH WEIGHT CONTROL |
| <input type="checkbox"/> FEELING CONFUSED MUCH OF THE TIME | <input type="checkbox"/> USE/ABUSE OF ALCOHOL OR DRUGS |
| <input type="checkbox"/> DIFFICULTY CONTROLLING YOUR THOUGHTS | <input type="checkbox"/> PROBLEMS ASSOCIATED WITH SEXUAL ORIENTATION |
| <input type="checkbox"/> BEING SUSPICIOUS OF OTHERS | <input type="checkbox"/> CONCERNS ABOUT HEARING VOICES OR SEEING THINGS |
| <input type="checkbox"/> GETTING INTO TROUBLE | |

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

Social/Cultural (Optional)

1. RELIGION/SPIRITUALITY: _____
2. ETHNICITY OR RACE: _____
3. DISABILITY STATUS? _____

APPENDIX B

Intake Evaluation Summary

Pepperdine Community Counseling Center
Intake Evaluation Summary

Client:
Intake Date(s):

Intake Therapist:
Date of Report:

I. Identifying Information

(Name, age/D.O.B., gender, marital status, # children, occupation/employment status, education, ethnicity, and current living arrangements)

II. Presenting Problem/Current Condition

(Description of client's current difficulties, and why s/he is seeking help at this time; describe symptoms and impact on current functioning, including onset, frequency and duration)

Sample

III. History of the Presenting Problem & History of Other Psychological Issues

(Trace development of present problem, including previous psychological treatment, hospitalizations, medication; discuss other significant psychological difficulties and prior treatment
Address history of substance abuse, suicidal ideation/attempts, & aggressive/violent behavior)

IV. Psychosocial History

- A:** Family History (Family constellation, family of origin and current family, family dynamics, domestic violence/abuse; Include family psychiatric, medical and substance abuse history)
- B:** Developmental History (Note progression of development milestones, as well as particular strengths or areas of difficulty)
- C:** Educational/Vocational History (Highest grade completed, strengths/weaknesses, learning issues/interventions; Work history, including any work related difficulties)
- D:** Social Support/Relationships (Current social support network; Intimate relationships and their history, especially as related to presenting problem)
- E:** Medical History (When was client last seen by a doctor? Describe current/past medical conditions, injuries, medications, procedures/surgeries)
- F:** Cultural Factors and Role of Religion in the Client's Life
(Cultural group identification /identity, acculturation issues relevant to presenting problems/therapy)
(Religious affiliations, strength of commitment to/involvement in religion, view of spirituality and its role in emotional problems/suffering and intervention)

G: Legal History (Arrests, incarcerations, parole/probation, current lawsuits, child custody. Is the client court ordered into therapy?)

V. Mental Status Evaluation

Hygiene & grooming:

Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

Motor Activity (calm, restless, agitated, retarded):

Mood (euthymic, dysphoric, elevated, irritable, anxious):

Affect (appropriate/inappropriate to mood, labile, expansive, blunted, flat):

Thought Process (associations may be logical, tight & coherent, or loose & tangential):

Thought Content (appropriate; delusions, odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

Judgment & Insight (intact, good, fair or poor/impaired):

VI. Client Strengths (Intelligence, personality, internal resources, coping skills, support system, talents and abilities, motivation, educational/vocational skills, health)

VII. Summary and Conceptualization

(Summarize your understanding of the client's central issues/symptoms, how these developed, and factors that maintain them. Present differential diagnosis, with justification for diagnoses given):

VIII. DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: Current GAF:
 Highest GAF during the past year:

IX. Client Goals

X. Treatment Recommendations

Be as specific as possible. Note: suggested therapy modalities and frequency of contact, issues to be addressed, adjunctive services such as psychological testing or medication evaluation. Recommendations should be connected to presenting problems and diagnoses)

Therapist Date

Supervisor Date

APPENDIX C

Telephone Intake Form

A copy of this form should be included in the client's chart

ID# _____

Pepperdine Community Counseling Center
Telephone Intake Interview

Caller Information

INTERVIEWER: _____ DATE OF TELEPHONE INTAKE: _____ TIME: _____

WHAT IS YOUR NAME?: _____

WHO IS THIS APPOINTMENT FOR? _____ M F DOB: _____ AGE: _____

_____ M F DOB: _____ AGE: _____

IF THE POTENTIAL CLIENT IS NOT THE CALLER, ASK, "WHAT IS YOUR RELATIONSHIP TO (CLIENT'S NAME)?" _____

WHAT IS (CLIENT'S) ADDRESS?: _____

WHAT IS (CLIENT'S) PHONE NUMBER(S): _____ (H) _____ (W) _____ (CELL OR PAGER)

IS IT OK THAT WE LEAVE A MESSAGE AT ANY OR ALL OF THE NUMBERS, IDENTIFYING OURSELVES AS BEING FROM THIS COUNSELING CENTER? Y N

HOW DID YOU HEAR ABOUT US? (LIST NAME AND NUMBER): _____

MAY WE CONTACT THEM TO THANK THEM FOR REFERRING YOU? Y N

WHO DOES (CLIENT) LIVE WITH? SELF OTHERS -

LIST: _____

DOES (CLIENT) HAVE CHILDREN?: _____

WHO IS INCLUDED IN (CLIENT'S) SUPPORT SYSTEM? _____

sample

ADDRESS CONFIDENTIALITY AND LIMITS TO CONFIDENTIALITY BEFORE PROCEEDING WITH THE PHONE INTAKE:

"I'd like to find out about your situation and for what reason you're seeking help. This will help me figure out how our counseling center might be of assistance/service. But before we begin I need to explain about confidentiality and its limits. Here at the Pepperdine Counseling Center we pride ourselves on guarding our clients' privacy, and on creating an environment where people can feel comfortable about discussing very personal matters. With that said, we want you to know that everything you describe to me is confidential, however, if I begin to understand that your's or someone else's life is in danger, or when there are significant concerns about a child or elder person's safety, I may need to break that confidentiality and take steps to assure that everyone is safe. Do you have any questions about this?...if not, let's proceed"

Type of Service

What type of appointment is being requested? Check all that apply

- Therapy
- Assessment
- Don't know or unsure
- Child
- Adolescent
- Adult
- Don't know or unsure
- Individual
- Couple (Ask if there has been any domestic violence)
- Family
- Group
- Don't know or unsure

ID# _____

Is there a preference for a particular type of therapist (i.e. gender, sexual orientation)?

Why? _____

Reason for Referral

PLEASE TELL ME A BIT ABOUT YOUR REASON FOR CALLING TODAY?:

sample

ARE THERE ANY PAST OR CURRENT LEGAL PROBLEMS?: Y N

IS THERE A COURT ORDER THAT REQUIRES TREATMENT? Y N

FOR WHAT REASON? _____

CLIENT TOLD LIMITS REGARDING COURT ORDERS? Y N

ARE THERE ANY PAST OR CURRENT DRUG AND/OR ALCOHOL PROBLEMS?: Y N

ANY CURRENT THOUGHTS OF HURTING YOURSELF?: Y N

ANY PREVIOUS THOUGHTS OR ATTEMPTS AT HURTING YOURSELF?: Y N

IF SO, WHEN WAS THE LAST TIME YOU *THOUGHT* ABOUT HURTING YOURSELF?: _____

WHEN WAS THE LAST TIME YOU *ATTEMPTED* TO HURT YOURSELF?: _____

DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOU HAVE A "BAD TEMPER" OR THAT YOU GET MAD EASILY?: Y N

IF SO, PLEASE PROVIDE EXAMPLES: _____

ANY PAST VIOLENCE TOWARDS OTHERS?: Y N

ID# _____

ARE YOU CURRENTLY OR HAVE YOU EVER SEEN A PSYCHIATRIST, PSYCHOLOGIST, OR COUNSELOR?:

IF SO, ASSESS WHEN, WHERE, HOW LONG, TYPE (INPATIENT/HOSPITALIZATION OR OUTPATIENT)

ARE YOU CURRENTLY OR HAVE YOU EVER TAKEN PSYCHIATRIC MEDICATION?:

IF SO, LIST: _____

DO YOU HAVE ANY SCHEDULE CONSTRAINTS OR TIME/DAY REQUESTS? _____

If Treatment is for a Minor (Under 18 Years Old)

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

IF CALLER/PARENT INDICATES EITHER JOINT OR SOLE CUSTODY OF CHILD, ASK:

IS THERE DOCUMENTATION AVAILABLE (IN CUSTODY PAPERS ABOUT WHO IS RESPONSIBLE FOR HEALTH CARE) THAT YOU CAN BRING TO THE INTAKE SESSION? Y N

IS THERE AGREEMENT AMONG CAREGIVERS REGARDING SEEKING TREATMENT FOR THE CHILD? Y N

WHO WILL BE BRINGING THE CHILD TO THE CLINIC?: _____

DOES YOUR CHILD KNOW THAT HE/SHE WILL BE COMING FOR THERAPY/ASSESSMENT SERVICES? Y N

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY? Y N

Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL? Y N

WOULD YOU LIKE TO KNOW WHAT YOUR FEE RANGE WILL BE? Y N

IF YES, ASK: WHO WILL BE PAYING FOR THE SERVICES RECEIVED HERE?: _____

WHAT IS (CLIENT'S) OCCUPATION?: _____

WHAT IS (CLIENT'S) APPROXIMATE GROSS FAMILY INCOME? _____ FEE RANGE QUOTED: _____

Intake Interviewer Checklist

I INFORMED THE POTENTIAL CLIENT OF LIMITS OF CONFIDENTIALITY FOR THE PHONE INTERVIEW

I INFORMED THE POTENTIAL CLIENT OF THE NONREFUNDABLE \$25.00 INTAKE SESSION FEE.

I INFORMED THE POTENTIAL CLIENT THAT CLINIC THERAPISTS ARE UNLICENSED GRADUATE STUDENTS WHO ARE SUPERVISED BY LICENSED PROFESSIONALS (CLINICAL PSYCHOLOGISTS AND/OR MARRIAGE FAMILY THERAPISTS)

ID# _____

- I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT ~~SOME TIMES AUDIO TAPE SAMPLES OF THEIR SESSIONS DURING SUPERVISION~~ ~~VIDEOS AND~~
- (PER CLINIC POLICY)** I ASKED THE POTENTIAL CLIENT FOR PERMISSION TO HAVE THE INTAKE THERAPIST GIVE THEM A CALL PRIOR TO THE INTAKE SESSION
- I INFORMED THE POTENTIAL CLIENT THAT THE INTAKE SESSION IS 2.5 HOURS IN LENGTH AND THAT THIS SESSION HELPS THE THERAPIST AND HIS/HER SUPERVISOR GAIN A BETTER UNDERSTANDING OF THE POTENTIAL CLIENT'S PRESENTING PROBLEMS. GATHERING THE INFORMATION DURING THIS FIRST SESSION IS CRUCIAL FOR TREATMENT PLANNING. I ALSO INFORMED THE POTENTIAL CLIENT OF THE IMPORTANCE OF ARRIVING PROMPTLY FOR THE SESSION.
- I INFORMED THE POTENTIAL CLIENT THAT FOLLOWING THE INTAKE SESSION, THE THERAPIST WILL PROVIDE HIM/HER WITH FEEDBACK AND MAKE TREATMENT RECOMMENDATIONS WHICH MAY BE FOR CONTINUED TREATMENT IN OUR CLINIC OR MAY BE A REFERRAL TO ANOTHER CLINIC.
- I INFORMED THE CLIENT THAT THEIR PLACEMENT WITH A THERAPIST IS SOMEWHAT DEPENDENT ON THE POTENTIAL CLIENT'S TIME FLEXIBILITY.
- (PER CLINIC POLICY)** I CREATED A CLIENT FILE AND PLACED THE TELEPHONE INTAKE INTERVIEW IN IT.
- (PER CLINIC POLICY)** I PROVIDED THE CLINIC DIRECTOR WITH THE TELEPHONE INTAKE INTERVIEW.
- (PER CLINIC POLICY)** I ASSIGNED THE POTENTIAL CLIENT TO A THERAPIST.
THERAPIST: _____
- ~~I INFORMED THE POTENTIAL CLIENT ABOUT THE CLINIC LOCATION AND TAKING ARRANGEMENTS~~
- I CONTACTED THE REFERRAL SOURCE AND THANKED THEM.
- (PER CLINIC POLICY)** I SCHEDULED THE INTAKE SESSION.
DATE: _____
TIME: _____
THERAPIST: _____

sample

APPENDIX D

University of Rhode Island Change Assessment (URICA) Scale

ID # _____

Name _____ Date _____ Session # INTAKE

SCS

Each statement below describes how people might feel when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all statements that refer to your "problem", answer in terms of the primary problem or issue that brought you to therapy.

Please write that problem or issue here: _____

In the following questions, the words "here" and "this place" refer to the clinic.

There are five possible responses to each of the items in the questionnaire:

- 1 = strongly disagree
- 2 = disagree
- 3 = undecided
- 4 = agree
- 5 = strongly agree

Circle the number that best describes how much you agree or disagree with each statement.

1. As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2. I think I might be ready for some self-improvement.	1	2	3	4	5
3. I am doing something about the problems that had been bothering me.	1	2	3	4	5
4. It might be worthwhile to work on my problem.	1	2	3	4	5
5. I'm not the problem one. It doesn't make much sense for me to be here.	1	2	3	4	5
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.	1	2	3	4	5
7. I am finally doing some work on my problems.	1	2	3	4	5
8. I've been thinking that I might want to change something about myself.	1	2	3	4	5
9. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10. At times my problem is difficult, but I'm working on it.	1	2	3	4	5
11. Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
12. I'm hoping this place will help me to better understand myself.	1	2	3	4	5
13. I guess I have faults, but there's nothing (but I really need to change).	1	2	3	4	5
14. I am really working hard to change.	1	2	3	4	5
15. I have a problem and I really think I should work on it.	1	2	3	4	5
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent relapse of the problem.	1	2	3	4	5

Date: _____ Session #: INTAKE ID # _____

- 1 = strongly disagree
- 2 = disagree
- 3 = undecided
- 4 = agree
- 5 = strongly agree

17. Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19. I wish I had more ideas on how to solve the problem.	1	2	3	4	5
20. I have started working on my problems but I would like help.	1	2	3	4	5
21. Maybe this place will be able to help me.	1	2	3	4	5
22. I may need a boost right now to help me maintain the changes I've already made.	1	2	3	4	5
23. I may be part of the problem, but I don't really think I am.	1	2	3	4	5
24. I hope that someone here will have some good advice for me.	1	2	3	4	5
25. Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
26. All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
27. I'm here to prevent myself from having a relapse of my problem.	1	2	3	4	5
28. It is frustrating, but I feel I might be having occurrences of a problem I thought I had resolved.	1	2	3	4	5
29. I have worries but so does the next person. Why spend time thinking about them?	1	2	3	4	5
30. I am actively working on my problem.	1	2	3	4	5
31. I would rather cope with my faults than try to change them.	1	2	3	4	5
32. After all I had done to try and change my problem, every now and then it comes back to haunt me.	1	2	3	4	5

APPENDIX F

Brief Multidimensional Measure of Religiousness/Spirituality

Cover Sheet-Brief Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research ID # _____

A note to our clients

This next measure asks about your experiences, if any, with spirituality and religion and how they relate or don't relate to your overall well-being. Our goal in using this measure is to assess and begin a conversation with you to better understand the role of religiosity and spirituality in your life, whatever that may be.

We understand that religion and spirituality is a sensitive topic. So, we would like your feedback on this questionnaire.

We recognize that the words used in the questionnaire may or may not be consistent with your own beliefs, and do not cover all beliefs. *Therefore, if you choose to fill it out, you can substitute "God," "church" and/or "congregation" (for example) with words that make more sense to you.* Also, although many items on the questionnaire provide responses for people who do not believe in a higher power and/or who do not participate in religious or spiritual activities, please feel free to write n/a in the measure next to questions/responses that do not apply to you.

Please take a minute to review this measure^{1st} before deciding whether to fill it out or not.

If you chose not to fill out all or part of this measure, we hope you will tell us why in the space below:

If you choose to fill out the measure, you will have an opportunity to share your thoughts about it with us at the end.

Thank you!

Brief Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research

10. I have forgiven those who hurt me.

- 1-Always or almost always
- 2-Often
- 3-Seldom
- 4-Never

11. I know that God forgives me.

- 1-Always or almost always
- 2-Often
- 3-Seldom
- 4-Never

Private Religious Practices

12. How often do you pray privately in places other than at church or synagogue?

- 1-More than once a day
- 2-Once a day
- 3-A few times a week
- 4-Once a week
- 5-A few times a month
- 6-Once a month
- 7-Less than once a month
- 8-Never

13. Within your religious and spiritual tradition, how often do you meditate?

- 1-More than once a day
- 2-Once a day
- 3-A few times a week
- 4-Once a week
- 5-A few times a month
- 6-Once a month
- 7-Less than once a month
- 8-Never

14. How often do you watch or listen to religious programs on TV or radio?

- 1-More than once a day
- 2-Once a day
- 3-A few times a week
- 4-Once a week
- 5-A few times a month
- 6-Once a month
- 7-Less than once a month
- 8-Never

15. How often to you read the Bible or other religious literature?

- 1-More than once a day
- 2-Once a day
- 3-A few times a week
- 4-Once a week
- 5-A few times a month
- 6-Once a month
- 7-Less than once a month
- 8-Never

16. How often are prayers or grace said before or after meals in your home?

- 1-At all meals
- 2-Once a day
- 3-At least once a week
- 4-Only on special occasions
- 5-Never

Religious and Spiritual Coping

Think about how you try to understand and deal with major problems in your life. To what extent is each of the following involved in the way you cope?

17. I think about how my life is part of a spiritual force.

- 1-A great deal
- 2-Quite a bit
- 3-Somewhat
- 4-Not at all

18. I work together with God as partners.

- 1-A great deal
- 2-Quite a bit
- 3-Somewhat
- 4-Not at all

19. I look to God for strength, support, and guidance

- 1-A great deal
- 2-Quite a bit
- 3-Somewhat
- 4-Not at all

20. I feel God is punishing me for my sins or lack of spirituality.

- 1-A great deal
- 2-Quite a bit
- 3-Somewhat
- 4-Not at all

0# _____

Brief Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research

21. I wonder whether God has abandoned me.
 1-A great deal
 2-Quite a bit
 3-Somewhat
 4-Not at all

22. I try to make sense of the situation and decide what to do without relying on God.
 1-A great deal
 2-Quite a bit
 3-Somewhat
 4-Not at all

23. To what extent is your religion involved in understanding or dealing with stressful situations in any way?
 1-Very involved
 2-Somewhat involved
 3-Not very involved
 4-Not involved at all

Religious Support

These questions are designed to find out how much help the people in your congregation would provide if you need it in the future.

24. If you were ill, how much would the people in your congregation help you out?
 1-A great deal
 2-Some
 3-A little
 4-None
25. If you had a problem or were faced with a difficult situation, how much comfort would the people in your congregation be willing to give you?
 1-A great deal
 2-Some
 3-A little
 4-None

Sometimes the contact we have with others is not always pleasant

26. How often do the people in your congregation make too many demands on you?
 1-Very often
 2-Fairly often
 3-Once in a while
 4-Never

27. How often are the people in your congregation critical of you and the things you do?
 1-Very often
 2-Fairly often
 3-Once in a while
 4-Never

Religious/Spiritual History

28. Did you ever have a religious or spiritual experience that changed your life?
 No
 Yes

IF YES: How old were you when this experience occurred?

29. Have you ever had a significant gain in your faith?
 No
 Yes

IF YES: How old were you when this occurred?

30. Have you ever had a significant loss in your faith?
 No
 Yes

IF YES: How old were you when this occurred?

Commitment

31. I try hard to carry my religious beliefs over into all my other dealings in life.
 1-Strongly agree
 2-Agree
 3-Disagree
 4-Strongly disagree

32. During the last year about how much was the average monthly contribution of your household to your congregation or to religious causes?

\$ _____ OR \$ _____
 Contribution Contribution
 per year per month

33. In an average week, how many hours do you spend in activities on behalf of your church or activities that you do for religious or spiritual reasons?

Brief Multidimensional Measurement of Religiousness/Spirituality for Use in Health Research

Organizational Religiousness

34. How often do you go to religious services?

- 1-More than once a week
- 2-Every week or more often
- 3-Once or twice a month
- 4-Every month or so
- 5-Once or twice a year
- 6-Never

35. Besides religious services, how often do you take part in other activities at a place of worship?

- 1-More than once a week
- 2-Every week or more often
- 3-Once or twice a month
- 4-Every month or so
- 5-Once or twice a year
- 6-Never

Religious Preference

36. What is your religious preference?

IF PROTESTANT
Which specific denomination is that?

Overall Self-Ranking

37. To what extent do you consider yourself a religious person?

- 1-Very religious
- 2-Moderately religious
- 3-Slightly religious
- 4-Not religious at all

38. To what extent do you consider yourself a spiritual person?

- 1-Very spiritual
- 2-Moderately spiritual
- 3-Slightly spiritual
- 4-Not spiritual at all

Thank you for completing this questionnaire. Please share your comments about filling out this questionnaire in the space below:

APPENDIX G

Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

- Circle the “1” if you **Very Strongly Disagree**
- Circle the “2” if you **Strongly Disagree**
- Circle the “3” if you **Mildly Disagree**
- Circle the “4” if you are **Neutral**
- Circle the “5” if you **Mildly Agree**
- Circle the “6” if you **Strongly Agree**
- Circle the “7” if you **Very Strongly Agree**

	Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

APPENDIX H

Working Alliance Inventory – Client

Name: _____ Date: _____ ID #: _____
 Session #: _____

WORKING ALLIANCE INVENTORY SHORT FORM - CLIENT

Below is a list of statements about your relationship with your therapist. Using the following scale, rate the degree to which you agree with each statement, and circle the corresponding number.

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

3. I believe my therapist likes me.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

4. My therapist does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

5. I am confident in my therapist's ability to help me.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

6. My therapist and I are working toward mutually agreed upon goals.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

7. I feel that my therapist appreciates me.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

Name: _____ Date: _____ ID #: _____
 Session #: _____

9. My therapist and I trust one another.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

10. My therapist and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

CLIENT EXPERIENCES SCALE

Please help us improve our program by answering some questions about the services you have received. Please circle one answer for each question below.

1. To what extent are our services meeting your needs?

1	2	3	4
None of my needs are being met	Only a few of my needs are being met	Most of my needs are being met	Almost all of my needs are being met

2. In an overall, general sense, how satisfied are you with the services you are receiving?

1	2	3	4
Very dissatisfied	Somewhat dissatisfied	Somewhat satisfied	Very satisfied

3. Are the services you are receiving helping you to deal more effectively with your problems?

1	2	3	4
No, they seem to make things worse	No, they really aren't helping	Yes, they are helping somewhat	Yes, they are helping a great deal

4. If you were to seek help again, would you come back to our clinic?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Please provide us with suggestions or recommendations for the improvement of our services:

APPENDIX I

Working Alliance Inventory – Therapist

Client Name: _____ Therapist Name: _____

Client ID #: _____ Date: _____ Session #: _____



WORKING ALLIANCE INVENTORY SHORT FORM - THERAPIST

Below is a list of statements about your relationship with your client. Using the following scale, rate the degree to which you agree with each statement, and circle the corresponding number.

1. My client and I agree about the things s/he will need to do in therapy to help improve his/her situation.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

2. What my client is doing in therapy gives him/her new ways of looking at his/her problem.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

3. I believe my client likes me.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

4. My client does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

5. I am confident in my client's ability to help him/herself.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

6. My client and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

7. I feel that my client appreciates me.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

Client Name: _____ Therapist Name: _____

Client ID #: _____ Date: _____ Session #: _____

8. We agree on what is important for my client to work on.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

9. My client and I trust one another.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

10. My client and I have different ideas on what his/her problems are.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

11. We have established a good understanding of the kind of changes that would be good for him/her.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

12. I believe the way we are working with my client's problem is correct.

1	2	3	4	5	6	7
Not at all True	A Little True	Slightly True	Somewhat True	Moderately True	Considerably True	Very True

Diagnosis at Termination:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Disposition (state whether the case has been transferred or terminated, and give reasons why):

sample

Recommendations for Follow Up (If the case is being transferred, list specific treatment recommendations for the next therapist, including what worked and did not work with the client(s).):

Student Therapist

Supervisor

Date

Date

APPENDIX K

Client Consent Form

Pepperdine University
Counseling and Educational Clinics
Consent for Services

Welcome to Pepperdine University's Counseling and Educational clinics. Please read this document carefully because it will help you make an informed decision about whether to seek services here. This form explains the kinds of services our clinic provides and the terms and conditions under which services are offered. Because our clinic complies with the Health Insurance Portability and Accountability Act (HIPAA), be sure to review the Privacy Rights pamphlet that was also given to you today. It is important that you understand the information presented in this form. If you have any questions, our staff will be happy to discuss them with you.

Who We Are: Because the clinic is a teaching facility, graduate students in either the Clinical Psychology Doctorate Program or the Masters in Marriage and Family Therapy Program provide the majority of services. Our graduate student therapists are placed in the clinic for a time-limited training position, which typically lasts 8-12 months. In all cases, all therapists are supervised by a licensed clinical psychologist or a team that includes a licensed mental health professional. The clinic is housed in Pepperdine University and follows the University calendar. As a general rule, the clinic will be closed when the University is not in session. No psychological services will be provided at those times.

- I understand and agree that my services will be provided by an unlicensed graduate student therapist who will be working under the direct supervision of a licensed mental health professional.
- I understand and agree that, as required by law, my therapist may disclose any medical, psychological or personal information concerning me to his/her supervisor(s).
- I confirm that I have been provided with information on how to contact my therapist's supervisor(s) should I wish to discuss any aspects of my treatment.

I understand and agree with the above three statements.

Services: Based on the information you provided in your initial telephone interview, you have been referred to the professional service in our clinic appropriate to your concern. The clinic provides the following professional psychological services:

Psychotherapy: The first few sessions of therapy involve an evaluation of your needs. At the end of the evaluation phase, a determination will be made regarding whether our services appropriately match your mental health needs. A determination will also be made regarding whether to continue with services at our clinic, or to provide you with a referral to another treatment facility more appropriate to your needs. As part of your services, you will be asked to complete questionnaires during your intake session, at periodic intervals (e.g., every fifth session), and after you have completed treatment. Psychotherapy has both benefits and risks. Risks sometimes include being asked to discuss unpleasant aspects of your life and experiencing uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Sometimes decisions are made in therapy that are positive for one family member and can be viewed negatively by another family member. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience. In order for therapy to be effective, a commitment to regular attendance is necessary. Frequent cancellations or missed therapy appointments may result in termination of services or a referral to an alternative treatment setting. Unless otherwise arranged, therapy sessions are scheduled once a week for 50 minutes. Educational Therapy is also offered in some of our clinics. This is an intervention that focuses on learning difficulties by addressing how circumstances in a person's life contribute to these difficulties. Educational therapy combines tutoring as well as attention to socio-emotional issues that affect learning.

Psychological Assessment: The clinic provides psychological and psychoeducational assessments. These assessments may be initiated by you, your therapist or a third party. Assessment sessions are longer than therapy sessions and can take several hours to complete. The number of sessions required for conducting the assessment will be determined based on the nature and number of tests administered. You have the right to request a copy of your assessment report and test data. You also have the right to receive feedback regarding your assessment results. However, there are some situations in which we may not be able to release test results, including test data, to you: a) When such a disclosure may cause substantial harm or misuse of the test results and test data, and/or b) When you were notified and agreed in advance and in writing that the assessment was ordered and/or paid for by a third party and that we would release your results only to that third party. The benefits of psychological assessment include a clearer understanding of your cognitive and emotional functioning. Although the risks of participating in a psychological assessment are generally no greater than the risks of counseling, test results may reveal information that may be painful and/or difficult to accept. If that is the case, we recommend that you review with the examiner options for addressing your concerns.

Consent to Video/audiotaping and Observations: It is standard procedure at our clinic for sessions to be audiotaped and videotaped for training/teaching and/or

research purposes. **It should be noted that videotaping for teaching/training purposes is a prerequisite for receiving services at our clinic.** In addition, sessions may be observed by other therapists and/or supervisors at the clinic through the use of a one-way mirror or direct in-session observation.

- For Teaching/Training purposes, check all that apply:

I understand and agree to

_____ Video/audiotaping

_____ Direct Observation

Psychological Research: As a university based clinic, we engage in research activities in order to determine the effectiveness of our services, including client satisfaction, as well as to better understand assessment and therapy practices. Participation in research is totally voluntary and means that the forms you complete as a part of your treatment will be placed in a secure research database. Clinic staff will remove any of your identifying information (e.g., name, address, date of birth) from the written materials before they are placed in the database. You may also consent to have your taped sessions included in the research database, and if so these tapes will be used and stored in a confidential manner. Only those professors and graduate students who have received approval from the Clinic Research Committee, and who have signed confidentiality agreements, will be granted access to the database in order to conduct scholarly research. If any information from the database is involved in a published study, results will be discussed in reference to participant groups only, with no personally identifying information released. Your services do not depend on your willingness to have your written and/or taped materials included in our research database. You may also change your mind about participation in the research database at any time. While there is no direct benefit to you to have your materials placed in the database, your participation may provide valuable information to the field of psychology and psychotherapy.

Please choose from the following options (confirm your choice by initialing in the margin).

- I understand and agree that information from my services will be included in the Research Database (check all that apply).

_____ Written Data

_____ Videotaped Data

_____ Audiotaped Data

OR

- I do not wish to have my information included in the Research Database.

-
- I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs.

OR

- I do not wish to be contacted in the future

about the opportunity to participate in other specific research programs.

Fees: The fee for the initial intake is nonrefundable.

Payment for services is due at the time the services are rendered. You're on going fee will be based on your income (for minors: the income of your parents) or upon your ability to pay. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hour notice of cancellation prior to the appointment time. Please notify us of your cancellation via phone. Please do not use E-mail since we cannot guarantee a secure and confidential correspondence. Failure to pay for services may result in the termination of treatment and/or the use of an outside collection agency to collect fees. In most collection situations, the only information released is your name, the nature of services provided and amount due.

Payment for psychological assessment services: The intake fee is due at the time of the first appointment. Following this appointment, the full cost of the psychological testing will be determined. Payment in full for the psychological testing is required prior to the completion of the testing. Feedback from the testing as well as a test report will be provided after payment has been made in full. Fees for psychological testing cover: initial interview, test administration, scoring and interpretation, oral feedback of test results, and a written test report. Any additional services requested will be billed separately.

After Hours and Emergency Contact: Should you need to reach your therapist during or after business hours you may leave a message on the clinic's voice-mail. The therapist will most likely return your call by the next day. Should you need to contact your therapist for an urgent matter, you may use the clinic's pager number, provided to you, to get in touch with the on-call therapist. Please be aware that the clinic is not equipped to provide emergency psychiatric services. Should you need such services, during and/or after business hours, you will be referred to more comprehensive care centers in the community.

Confidentiality & Records: All communications between you and your therapist are strictly confidential and may not be disclosed to anyone outside the clinic staff without your written authorization. However, there are some situations in which disclosure is permitted or required by law, without your consent or authorization:

- Your therapist may consult with other mental health professionals regarding your case. The consultants are usually affiliated with Pepperdine University. Your therapist may also discuss your case in other teaching activities at Pepperdine,

such as class discussions, presentations and exams. Every effort is made to avoid revealing your identity during such teaching activities.

- If the situation involves a serious threat of physical violence against an identifiable victim, your therapist must take protective action, including notifying the potential victim and contacting the police.
- If your therapist suspects the situation presents a substantial risk of physical harm to yourself, others, or property he/she may be obligated to seek hospitalization for you or to contact family members or others who can help.
- If your therapist suspects that a child under the age of 18, an elder, or a dependent adult has been a victim of abuse or neglect, the law requires that he/she file a report with the appropriate protective and/or law enforcement agency.
- If you are involved in a court proceeding and a request is made for information about the services provided to you, the clinic cannot provide any information, including release of your clinical records, without your written authorization, a court order, or a subpoena.
- If you file a complaint or lawsuit against your therapist and/or the clinic, disclosure of relevant information may be necessary as part of a defense strategy.
- If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action. Disclosure will be limited to what is necessary for each situation.

Your Records: The clinic keeps your Protected Health Information in your clinical records. You may examine and/or receive a copy of your records, if you request it in writing, except when: (1) the disclosure would physically or psychologically endanger you and/or others who may or may not be referenced in the records, and/or (2) the disclosure includes confidential information supplied to the clinic by others.

HIPAA provides you with the following rights with regard to your clinical records:

- You can request to amend your records.
- You can request to restrict from your clinical records the information that we can disclose to others.
- You can request an accounting of authorized and unauthorized disclosures we have made of your clinical records.
- You can request that any complaints you make about our policies and procedures be recorded in your records.
- You have the right to a paper copy of this form, the HIPAA notice form, and the clinic's privacy policies and procedures statement.

The clinic staff is happy to discuss your rights with you.

Treatment & Evaluation of Minors:

As an unemancipated minor (under the age of 18) you can consent to services subject to the involvement of your parents or guardians.

- Over the age of 12, you can consent to services if you are mature enough to participate in services and you present a serious danger to yourself and/or others or you are the alleged victim of child physical and/or sexual abuse. In some circumstances, you may consent to alcohol and drug treatment.
- Your parents or guardians may, by law, have access to your records, unless it is determined by the child’s therapist that such access would have a detrimental effect on the therapist’s professional relationship with the minor or if it jeopardizes the minor’s physical and/or psychological well-being.
- Parents or guardians will be provided with general information about treatment progress (e.g., attendance) and they will be notified if there is any concern that the minor is dangerous to himself and/or others. For minors over the age of 12, other communication will require the minor’s authorization.
- All disclosures to parents or guardians will be discussed with minors, and efforts will be made to discuss such information in advance.

My signature or, if applicable, my parent(s) or guardian’s signature below certifies that I have read, understood, accepted, and received a copy of this document for my records. This contract covers the length of time the below named is a client of the clinic.

Signature of client, 18 or older
(Or name of client, if a minor)

and/or

Signature of parent or guardian

Relationship to client

Signature of parent or guardian

Relationship to client

_____ please check here if client is a minor. The minor’s parent or guardian must sign unless the minor can legally consent on his/her own behalf.

Clinic/Counseling Center
Representative/Witness

Translator

Date of signing

APPENDIX L

Therapist Consent Form

**INFORMED CONSENT FOR THERAPIST PARTICIPATION
IN PEPPERDINE CLINICS RESEARCH DATABASE PROJECT**

1. I, _____, agree to participate in the research database project being conducted under the direction of Drs. Eldridge, Ellis, and Hall, in collaboration with the clinic directors. I understand that while the study will be under the supervision of these Pepperdine GSEP faculty members, other personnel who work with them may be designated to assist or act in their behalf. I understand that my participation in this research database is strictly voluntary.

2. One purpose of research at the Pepperdine University GSEP Clinics and Counseling Centers is to examine the effectiveness of new clinic policies and procedures that are being implemented. This is being done through standard internal clinic practices (headed by the clinic directors and the Clinic Advancement and Research Committee) as well as through the construction of a separate research database (headed by Drs. Eldridge, Ellis, and Hall). Another purpose of this research project is to create a secure database from which to conduct research projects by the faculty members and their students on other topics relevant to clinical practice.

3. I have been asked to participate in the research database project because I am a student therapist or intern at a GSEP Clinic or Counseling Center. Because I will be implementing the new clinic policies and procedures with my clients, my input (or participation) will provide valuable data for the research database.

My participation in the research database project can involve two different options at this point. I can choose to participate in any or neither of these options by initialing my consent below each description of the options.

First, my participation in the research database project will involve being asked, from time to time, to fill out questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures. In addition, my participation involves allowing questionnaires that I complete about my clients (e.g., treatment alliance) and/or tapes from my sessions with clients to be placed into the database.

Please choose from the following options by placing your initials on the lines.

- I understand and agree that the following information will be included in the Research Database (check all that apply).
 - _____ Written questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures
 - _____ Written Data about My Clients (e.g., Therapist Working Alliance Form)
 - _____ Video Data of sessions with my clients (i.e., DVD of sessions)
 - _____ Audio Data of sessions with my clients (i.e., CD or cassette tapes of sessions)

OR

- I do not wish to have any/all of the above information included in the Research Database.

Please choose from the following options by placing your initials on the lines.

- I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

OR

- I do not wish to be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

4. My participation in the study will last until I leave my position at the GSEP Clinic or Counseling Center.
5. I understand that there is no direct benefit from participation in this project, however, the benefits to the profession of psychology and marriage and family therapy may include improving knowledge about effective ways of training therapists and implementing policies and procedures as well as informing the field about how therapy and assessments are conducted in university training clinics.
6. I understand that there are certain risks and discomforts that might be associated with this research. These risks include potential embarrassment or discomfort at having faculty review materials about my clinic practices, which may be similar to feelings about supervisors reviewing my work ; however this risk is unlikely to occur since the written materials will be coded to protect your identity. Sensitive video data will be also coded to protect confidentiality, tightly secured (as explained below), and reviewed only by those researchers who sign strict confidentiality agreements.
7. I understand that I may choose not to participate in the research database project.
8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also understand that there might be times that the investigators may find it necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).
9. I understand that the investigators will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project.
10. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including

suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. I understand there is a possibility that information I have provided regarding provision of clinical services to my clients, including identifying information, may be inspected and/or photocopied by officials of the Food and Drug Administration or other federal or state government agencies during the ordinary course of carrying out their functions. If I participate in a sponsored research project, a representative of the sponsor may inspect my research records.

11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access. In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.
12. I understand I will receive no compensation, financial or otherwise, for participating in study.
13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at (310) 506-8559, Dr. Meshia Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.
14. I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness to continue in the study.
15. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

Participant's signature

Date

Participant's name (printed)

I have explained and defined in detail the research procedure in which the participant has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

Researcher/Assistant signature

Date

Researcher/Assistant name (printed)

APPENDIX M

Researcher Confidentiality Statement – Coder

As a research coder appointed by Susan Hall, J.D., Ph.D., I understand that I am expected to abide by specific principles and responsibilities to ensure effective and proper participation in the research.

I understand that coders must be sensitive to working with highly confidential material and act with appropriate discretion. Although participant numbers are used as the only method of subject identification, coders may hear names or other identifying information during the course of observing videotapes. I understand that I am prohibited from discussing any information seen or heard in the videotapes or audiotapes except with other coders and researchers involved with the study. In addition, I will only speak to research staff about information on the videotapes in a confidential environment and never in a public location. I will limit such disclosures to the minimum information that is necessary and sufficient for the purposes of communication. I also understand that coders may not discuss participant-related or other confidential material even after their involvement with the research is complete. I will also not remove any material related to the study from the office(s) of Dr. Hall or the Pepperdine Applied Research Center. In the highly unlikely event that I recognize one or more people on a videotape, I will stop the videotape immediately and inform Dr. Hall.

I will commit to _____ hours per week (to be specified by Dr. Hall) and attend all relevant coding meetings. First, I will learn a coding system so that I can use it reliably. Then, I will observe tapes and code them for research purposes. Due to the intensity of training, I agree to remain a coder on the research project for _____ months (to be specified by Dr. Hall).

I have been appointed by Susan Hall, J.D., Ph.D., to code videotaped and/or audiotaped material related to research at Pepperdine University, Graduate School of Education and psychology. The expectations of this position have been explained to me by Dr. Hall or a research assistant working with her. I understand the expectations outlined above, and agree to abide by them.

Coder Signature: _____

Date: _____

Witness Signature: _____

Date: _____

APPENDIX N

Research Assistant Confidentiality Agreement – Transcriber

As a research assistant (RA) appointed by Susan Hall, J.D., Ph.D. and co-supervised by her dissertation students, Karina G. Campos, M.A., Lauren DesJardins, M.A., and Whitney Dicterow, M.A., I understand that I am expected to abide by specific principles and responsibilities to ensure effective and proper participation in the research program designed to investigate trauma disclosure in psychotherapy.

I understand that RAs must be sensitive to human subjects issues involved with working with highly confidential material and act with appropriate discretion. Although participant numbers are used as the only method of subject identification, RAs may hear names or other identifying information during the course of observing videotapes. I understand that I am strictly prohibited from discussing any information seen or heard in the videotapes, audiotapes or transcripts except with others involved with the study. In addition, I will only speak to research staff about information on the videotapes in a confidential environment and never in a public location. I will limit such disclosures to the minimum information that is necessary and sufficient for the purposes of communication. I also understand that RAs may not discuss participant-related or other confidential material even after their involvement with the research is complete. I will also not remove any material related to the study from the office(s) of Dr. Hall or the Pepperdine Applied Research Center or clinic. In the highly unlikely event that I recognize one or more people on a videotape, I will stop the videotape immediately and inform Dr. Hall.

I will commit to _____ hours per week and attend all relevant coding meetings. First, I will complete human subjects and HIPAA training required by Pepperdine University's Graduate and Professional Schools Institutional Review Board, and submit my certificates of completion to Dr. Hall. Subsequently, I will learn a transcription procedure and/or coding system so that I can use it reliably. Then, I will observe and transcribe tapes and/or code them for research purposes. Due to the intensity of training, I agree to remain a RA on the research project for _____ months.

By signing this Confidentiality Agreement, you are stating your commitment to upholding research participants' privacy and confidentiality and your RA responsibilities, which involves a commitment to maintaining professional demeanor and adhering to the highest ethical standards. The expectations of my position as a RA with the Pepperdine Applied Research Center at Pepperdine University, Graduate School of Education and Psychology has been explained to me by Dr. Hall, her dissertation student(s), or another research assistant working with her. Should I have any questions whatsoever regarding my position and its expectations; I agree to discuss these with Dr. Hall. I understand the expectations outlined above, and agree to abide by them.

Printed Transcriber Name: _____

Transcriber Signature: _____

Date: _____

Witness Signature: _____

Date: _____

APPENDIX O

Data Tracking Sheet

x.x = Session #.Trauma Discussion # **Th-C** = Therapist and Client Speech for Whole Session

TD-C = Client Speech during Trauma Discussion

Session ID #	Time of disclosure (in minutes)	Word Count	% Affective Words	% Positive Emotion Words	% Negative Emotion Words	% Cog Process Words	% Insight Words	Type of Trauma
1 Th-C		14014	5.97	4.0	1.94	18.35	3.14	CSA/WPH
1.1 TD-C	3:07-3:28	22	4.55	4.55	0	4.55	0	CSA
1.2 TD-C	18:21-18:54	123	12.2	10.57	1.63	13.01	2.44	CSA
1.3 TD-C	20:56-21:08	64	11.11	6.67	4.44	8.89	0	WPH
1.4 TD-C	22:43-25:07	560	7.32	2.5	4.82	17.32	3.75	WPH
1.5 TD-C	25:36-26:01	134	2.99	0.75	2.24	23.13	0	WPH
1.6 TD-C	26:09-26:40	106	9.43	1.89	7.55	11.32	0.94	WPH
1.7 TD-C	27:47-29:35	352	7.1	1.99	5.11	19.03	2.27	WPH
1.8 TD-C	29:40-30:01	99	8.08	6.06	2.02	13.13	1.01	WPH
1.9 TD-C	32:17-33:21	287	5.57	3.14	2.44	20.91	2.79	WPH
1.10 TD-C	34:49-35:53	224	7.14	5.8	1.34	18.75	1.79	WPH
1.11 TD-C	44:52-48:17	714	7.98	3.64	4.34	17.93	1.54	WPH
1.12 TD-C	49:08-49:26	166	4.82	3.01	1.81	21.69	2.41	WPH
5	No Trauma							
6 Th-C		16318	5.43	3.68	1.72	17.81	3.25	CSA/WPH
6.1 TD-C	5:13-6:24	293	13.99	6.83	6.83	17.41	5.46	CSA
6.2 TD-C	59:55-68:23	281	4.27	1.78	2.49	16.81	2.37	WPH
7 Th-C		13560	5.5	4.06	1.44	16.78	3.29	CSA/WPH
7.1 TD-C	7:18-7:47	119	10.92	9.24	1.68	20.17	0	WPH

7.2 TD-C	8:58-18:18	2202	4.41	3.68	0.73	17.35	3.00	CSA
7.3 TD-C	23:08-23:32	7	0	0	0	0	0	CSA
7.4 TD-C	31:42-37:55	651	6.45	3.69	2.76	18.28	6.30	CSA
7.5 TD-C	52:08-52:29	56	7.14	3.57	3.57	14.29	1.79	WPH
9 Th-C		14022	4.68	3.29	1.36	16.45	3.38	WPH

9.1 TD-C	9:29-9:47	65	4.62	1.54	3.08	26.15	0	WPH
9.2 TD-C	18:30-19:57	332	8.43	5.12	3.31	20.78	2.71	WPH
10	No Trauma							
11	No Trauma							
12 Th-C		13385	4.94	3.41	1.5	17.33	3.36	CSA/ WPH
12.1 TD-C	12:24-12:27	22	4.55	0	4.55	22	13.64	WPH
12.2 TD-C	47:12-47:39	11	0	0	0	11	0	CSA
13	No Trauma							
14	No Trauma							
16	No Trauma							
18 Th-C		12213	4.52	3.17	1.33	16.99	3.72	WPH
18.1 TD-C	27:59-28:16	79	5.06	3.8	1.27	12.66	3.80	WPH
18.2 TD-C	32:30-33:00	205	10.24	4.39	5.85	14.63	4.39	WPH
19	No Trauma							
Unknown Session 1	No Trauma							

Unknown Session 2	No Trauma							

APPENDIX P

LIWC Averages
Sexual Trauma Averages of Client Speech

Session #	# of Discussions	Average Word Count	Average Affective Words	Average Positive Emotion Words	Average Negative Emotion Words	Average % Cognitive Process Words	Average % Insight Words
1	2	72.5	8.4	7.56	0.82	8.78	1.22
6	1	293	13.99	6.83	6.83	17.41	5.46
7	3	953.33	3.62	2.46	1.16	11.88	3.10
12	1	11	0	0	0	0	0
All Sessions	7	472.71	5.94	4.19	1.71	10.09	2.46

Workplace Harassment Averages of Client Speech

Session #	# of Discussions	Average Word Count	Average Affective Words	Average Positive Emotion Words	Average Negative Emotion Words	Average % Cognitive Process Words	Average % Insight Words
1	10	270.6	7.15	3.55	3.61	17.21	1.65
6	1	1267	4.27	1.78	2.49	16.81	2.37
7	2	87.5	9.03	6.41	2.63	17.23	0.90
9	3	198.5	6.53	3.33	3.20	23.47	1.36
12	1	22	4.55	0	4.55	13.64	0
18	3	142	7.65	4.09	3.56	13.65	4.10
All Sessions	20	269.5	6.80	3.56	3.23	17.29	1.75

Combined Sexual Trauma and Workplace Harassment Averages of Client Speech Across All Sessions

Average Affective Words	# of Discussions	Average Positive Emotion Words	Average Negative Emotion Words	Average % Cognitive Process Words	Average % Insight Words
6.58	27	3.72	2.84	15.42	1.93

APPENDIX Q

Themes Key

- I. **Self-protection – Avoidance of experiencing negative life events and maintenance of physical and psychological safety**
 - a. Avoidance of trauma discussion
 - i. Reluctance to discuss experience of CSA and related emotions
 - b. Avoidance of emotion
 - i. Reluctance to discuss feelings other than anger and sadness during psychotherapy and to others in her life; Use of humor to mask deeper feelings
 - c. Mistrust of others
 - i. Reluctance to confide in others with emotions and secrets; Disbelief that others would offer help without expecting something in return
 - d. Sense of responsibility
 - i. Strong feelings of obligation to take care of self and others involved in her life
 - e. Financial Security
 - i. Strong feelings and actions related to money and the importance of having enough money
 - f. Distancing from others
 - i. Avoid forming and maintaining close relationships with others in life to avoid being emotionally hurt
 - g. Respect for others
 - i. Strong feelings of consideration and courtesy for others, especially those who have treated her with respect

- II. **Power and Control – Ways to feel competent and gain command over environment and life experiences**
 - a. Assertiveness
 - i. Use/desired use of determination and decidedness during important life experiences
 - b. Aggression
 - i. Hostile feelings and attitudes expressed during psychotherapy
 - c. Desire/Attempt to control self
 - i. Wishes and trials at gaining and maintaining mastery over reactions to environment and life experiences
 - d. Desire/Attempt to control environment/others
 - i. Wishes and trials at gaining command of the reactions of others and the responses from the environment to life experiences
 - e. Independence
 - i. Desired ability to reach and maintain autonomy from others

- III. **Sense of Self – Feelings about self-efficacy and place in the world**
 - a. Fear of Judgment
 - i. Distress at being thought of negatively by others, including strangers
 - b. Insecurity
 - i. Feelings of doubt and hesitancy in abilities, knowledge and decisions
 - c. Self-critical
 - i. Disparaging and belittling beliefs about ways of navigating life experiences
 - d. Respect for Self/Pride
 - i. Positive self-esteem and feelings of dignity towards self for how handling positive and negative life experiences

- IV. **Gender Role Struggles – Ideas about the jobs and capacities of men and women in society**
 - a. Stereotypes of men
 - i. Beliefs about conventional roles of males in society
 - b. Stereotypes of women
 - i. Ideas about standard roles of females in society
 - c. Role reversals
 - i. Struggles with deviation from societal standards of male and female duties and reactions, specifically reversal of duties and reactions

- V. **Emotional Difficulties – Complications experiencing, expressing and sharing feelings about life experiences with others**
 - a. Anger toward boss
 - i. Feelings of animosity, annoyance and hatred experienced when discussing or working with her boss
 - b. Anger toward mother
 - i. Feelings of agitation and impatience expressed when discussing her current and past relationship with her mother
 - c. Difficulty identifying and expressing emotion
 - i. Problems labeling and discussing feelings other than anger about life experiences during psychotherapy and to others
 - d. Frustration with boyfriend's lack of responsibility
 - i. Expressed feelings of disappointment, annoyance and irritation with her boyfriend's behaviors and his participation in their relationship
 - e. Jealousy
 - i. Feelings of resentment and spite expressed towards other women involved in her boyfriend's life

- VI. **Job Dissatisfaction – Discontent and unhappiness with place of employment**
 - a. Disengagement from job
 - i. Feelings of detachment, disconnection and indifference with her work and job duties
 - b. Hatred toward job
 - i. Expressed feelings of anger, disgust and contempt with her work and the need to go to work
 - c. Frustration with job responsibility
 - i. Expressed feelings of dissatisfaction, annoyance and irritation with required duties at work, specifically those not related to her job description
 - d. Feeling trapped in job
 - i. Expressed emotions of being stuck and obligated at work despite a strong desire to leave

APPENDIX R

Themes Tracking Sheet

x.x = Session #.Trauma Discussion #
(x)= # of occurrences
s = Discussion of Sexual Trauma
w = Discussion of Workplace Harassment Trauma
o= Discussion in which a theme occurred outside of a trauma discussion

	Occurrences Per Session							Co-occur w/ PE	
	Session 1	Session 6	Session 7	Session 9	Session 12	Session 18	Total [by theme/sub-theme across sessions]	Y	N
Self-Protection	25	25	32	10	22	22	135	39	89
Avoidance of trauma discussion	1(3)o 1.1(1)s 1.2(1)s	None	7.2(4)s	None	None	None	3 o 6 s 9 Total	6	3
Avoidance of Emotion	1(1)o 1.2(6)s	6.1(2)s	7(6)o 7.2(3)s	9(1)o	12(4)o	18(2)o	14 o 11s 25 Total	9	16
Mistrust of others	1(5)o 1.2(1)s	6(1)o	7(4)o 7.2(3)s	9(1)o	12(9)o	18(1)o	21 o 4 s 25 Total	4	13
Sense of responsibility	1(3)o	6(8)o	None	9(1)o	12(4)o	18(7)o	23 Total	5	18
Financial security	None	6(14)o	7(8)o	9(6)o	12(5)o	18(3)o	36 Total	10	26
Distancing from others	None	None	7.2(2)s	None	None	18(9)o	9 o 2 s 10 Total	2	9
Respect for others	1(1)o 1.5(2)w 1.11(1)w	None	7.2(2)s	9(1)o	None	None	2 o 3 w 2 s 7 Total	3	4
Power and Control	12	27	35	16	13	30	133	28	106
Assertiveness	1.4(1)w 1.9(1)w 1.11(1)w	None	7.2(3)s	None	12(3)o	None	3 o 3 w 3 s 9 Total	8	1
Aggression	1.7(1)w	6.2(1)w	7(5)o 7.2(3)s 7.5(2)w	9(1)o 9.2(2)w	None	None	6 o 6 w 3 s 15 Total	6	9
Desire/Attempt to	1(1)o	6(1)o	7(6)o	9(2)o	None	18(4)o	14 Total	4	10

control self									
Desire/Attempt to control others/environment	1(3)o	6(11)o	7(6)o 7.2(4)s	9(11)o	12(8)o	18(11)o	50 o 4 s 54 Total	5	49
Independence	1(4)o	6(14)o	7(2)o 7.2(4)s	None	12(2)o	18(15)o	37 o 4 s 41 Total	5	37
Sense of Self	2	10	1	4	30	25	71	3 4	38
Fear of judgment	1(1)o 1.3(1)w	6(2)o	7(1)o	9(1)o	12(4)o	18(12)o	21 Total	1 7	5
Insecurity	None	6(5)o	None	9(3)o	12(25)o	18(7)o	40 Total	1 6	24
Self-criticism	None	None	None	None	None	18(2)o	2 Total	1	1
Respect for self/Pride	None	6(3)o	None	None	12(1)o	18(4)o	8 Total	0	8
Gender Role Struggles	2	4	6	3	8	3	26	3	23
Stereotypes of men	1.2(1)s	None	7(1)o	None	None	18(1)o	2 o 1 s 3 Total	0	3
Stereotypes of women	None	6(3)o	7(2)o 7.2(1)s 7.4(2)s	9(3)o	12(8)o	18(2)o	18 o 3 s 21 Total	3	18
Role reversals	1(1)o	6(1)o	None	None	None	None	2 Total	0	2
Emotional Difficulties	6	22	6	11	4	4	53	1 5	38
Anger toward boss	1.4(2)w 1.6(1)w 1.7(1)w 1.11(2)w	6.2(2)w	None	9.2(2)w	None	None	10 Total	3	7
Anger toward mother	None	6(11)o	None	9(4)o	None	None	15 Total	4	11
Anger toward perpetrator	None	None	7.2(2)s	None	None	None	2 Total	2	0
Difficulty identifying/expressing emotions	None	6(1)o 6.1(2)s	None	None	12(1)o	None	2 o 2 s 4 Total	3	1
Frustration with boyfriend's lack of responsibility	None	6(5)o	7(2)o	9(4)o	12(3)o	18(4)o	14 o 4 w 18 Total	3	15
Jealousy	None	6(1)o	7(2)o	9(1)o	None	None	4 Total	0	4
Job	15	0	1	2	0	4	22	9	12

Dissatisfacti on									
Disengagem ent from job	1.11(1) w	None	None	9(1)o 9.1(1)w	None	None	1 o 2 w 3 Total	2	1
Hatred toward job	1(3)o 1.3(1)w 1.5(1)w 1.6(1)w 1.10(1) w	None	7.1(1)w	None	None	18(1)o 18.2(1) w	4 o 6 w 10 Total	5	4
Frustration with job responsibilit ies	1(3)o	None	None	None	None	None	3 Total	1	2
Feeling trapped in job	1(2)o 1.4(1)w 1.8(1)w	None	None	None	9(1)o	18.2(2) w	2 o 4 w 6 Total	1	5
TOTAL (all sub- themes per session)	31 o 21 w 10 s 62 Total	81 o 3 w 4 s 88 Total	45 o 3 w 33 s 81 Total	37 o 9 w 46 Total	77 Total	85o 3w 88 Total	356 o 39 w 47 s 365 Total by sub theme	1 2 8	30 6

Appendix S

Co-occurrence of Themes and Positive Emotion Table

	Session 1		Session 6		Session 7		Session 9		Session 12		Session 18		Total [by sub-theme]	
	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Self-Protection														
Avoidance of trauma discussion	4	1	0	0	2	2	0	0	0	0	0	0	6	3
Avoidance of Emotion	7	0	0	2	2	7	0	1	0	4	0	2	9	16
Mistrust of others	4	2	0	1	0	7	0	1	0	1	0	1	4	13
Sense of responsibility	2	1	3	5	0	0	0	1	0	4	0	7	5	18
Financial security	0	0	2	12	3	5	4	2	0	5	1	2	10	26
Distancing from others	0	0	0	0	0	2	0	0	0	0	2	7	2	9
Respect for others	0	4	0	0	0	2	0	1	0	0	0	0	0	7
Power and Control														
Assertiveness	1	2	0	0	0	3	0	0	0	3	0	0	1	8
Aggression	0	1	0	1	4	6	2	1	0	0	0	0	6	9
Desire/Attempt to control self	0	1	0	1	1	5	2	0	0	0	1	3	4	10
Desire/Attempt to control others	0	3	0	11	1	9	1	10	0	8	3	8	5	49
Independence	1	4	2	12	2	4	0	0	0	2	0	15	5	37
Sense of Self														
Fear of judgment	2	0	2	0	1	0	1	0	3	1	8	4	17	5
Insecurity	0	0	3	2	0	0	3	0	5	20	5	2	16	24
Self-criticism	0	0	0	0	0	0	0	0	0	0	1	1	1	1
Respect for self/Pride	0	0	0	3	0	0	0	0	0	1	0	4	0	8
Gender Role Struggles														
Stereotypes of men	0	1	0	0	0	1	0	0	0	0	0	1	0	3
Stereotypes of women	0	0	0	3	2	3	0	3	1	7	0	2	3	18
Role reversals	0	1	0	1	0	0	0	0	0	0	0	0	0	2
Emotional Difficulties														
Anger toward boss	2	4	1	1	0	0	0	2	0	0	0	0	3	7
Anger toward mother	0	0	2	9	0	0	2	2	0	0	0	0	4	11
Anger toward perpetrator	0	0	0	0	2	0	0	0	0	0	0	0	2	0
Difficulty identifying/expressing emotions	0	0	2	1	0	0	0	0	1	0	0	0	3	1
Frustration with boyfriend's lack of responsibility	0	0	1	4	0	2	0	4	0	3	2	2	3	15
Jealousy	0	0	0	1	0	2	0	1	0	0	0	0	0	4
Job Dissatisfaction														
Disengagement from job	1	0	0	0	0	0	1	1	0	0	0	0	2	1
Hatred toward job	4	2	0	0	0	1	0	0	0	0	1	1	5	4
Frustration with job responsibilities	1	2	0	0	0	0	0	0	0	0	0	0	1	2
Feeling trapped in job	1	3	0	0	0	0	1	0	0	0	0	2	2	5
TOTAL (per session)	33	29	18	70	19	59	16	30	10	59	24	64	121	316

OVERALL TOTAL 432
(across sessions)

APPENDIX T

Training and Coding Manual

**DISCUSSION OF INTERPERSONAL TRAUMA IN PSYCHOTHERAPY TRAINING
AND CODING MANUAL**

This training and coding manual is intended to help orient you to the methods of transcription and coding that will be utilized for this research project. The specific therapy tapes will be clients and therapists at the Pepperdine University clinics that have been selected by the researcher based on inclusion/exclusion criteria (e.g., individual adult clients representing diverse ethnicities, gender, religions, and presenting issues). Karina G. Campos, M.A., Lauren DesJardins, M.A., and Whitney Dicterow, M.A., will be utilizing this criteria for their respective dissertations to gain a more in-depth understanding of how clients disclose and process trauma in relation to ruptures and repair of the therapeutic alliance, the stages of change theory, and the expression of positive emotion, within the context of individual psychotherapy (across the course of treatment). Your role as research assistants will be to transcribe the sessions in great detail and help with the preliminary coding phase for each discussion of an interpersonal trauma (see below).

I. TRANSCRIPTION INSTRUCTIONS

(Adapted from Baylor University's Institute for Oral History -
http://www3.baylor.edu/Oral_History/Styleguiderev.htm)

The first step will be to transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of client statements to then be coded using the Verbal Response Mode (VRM) codes for form and intent of disclosures of interpersonal trauma. Attached at the end of this section is a template that you will use for your transcriptions. After reading this manual and discussing questions during training, you will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the practice, we will review with you a completed transcript to check your work and address any questions.

A good transcription should reflect as closely as possible the actual words, speech patterns, and thought patterns of the speakers. The speakers' word choice, including his/her grammar, nonverbal gesture, including sighs, yawning, body movement (e.g., adjusting positions, posture etc), and speech patterns should be accurately represented. The transcriber's most important task is to render as close a replica to the actual event as possible. Accuracy, not speed, is the transcriber's goal.

When identifying who is speaking, us a "T" to indicate the therapist is speaking and a "C" to indicate the client is speaking. In addition, please use numbers to indicate how many times each person is speaking. For example, the first time the therapist speaks represent it as T1: and the second time as T2, T3, etc., and vice versa for the client (C1, C2, C3, etc.)

In addition to capturing the actual words, speech patterns and thought patterns of the speakers, we would like to try and capture some of the more important non-verbal behaviors/communication taking place between the therapist and client. In order to do so, please use parentheses with numbers inside of them to indicate pauses in a speaker's response. For example, use (3) to represent a three second pause or (10) for a ten second pause. Use this whenever there are significant pauses or moments of silence between the speakers.

When attempting to capture non-verbal behaviors/movements that are significant to the therapeutic interaction taking place, use brackets [] to indicate these movements and clearly state which person—the therapist or client—is performing the movement and what specifically he/she does. For example, [Client turned away from the therapist and looked down at the ground] or [Client laughs] or [Therapist sighed deeply and looked away briefly]. Only note hand gestures that have meaning. For example, the therapist gestures toward her heart when asking about how the client feels, or gestures hands toward self when asking client to say more. Do not note hand gestures that do not carry meaning, such as simply moving hands in the air while talking. Also use brackets to indicate the inability to hear/understand a word or sentence: [Unintelligible] or [Inaudible]. Please make every effort to hear and understand what is said. Sometimes you can figure out a word by the context of what the speaker is saying. If you can make an educated guess, type the closest possible approximation of what you hear, underline the questionable portion, and add two question marks in parentheses.

Example: I went to school in Maryville (??) or Maryfield (??).

If you and those you consult (i.e., other RA's) cannot make a guess as to what is said, leave a blank line and two question marks in parentheses.

Example: We'd take our cotton to Mr. _____(??)'s gin in Cameron.

If a speaker lowers his/her voice, turns away from the microphone, or speaks over another person, it may be necessary to declare that portion of tape unintelligible.

Example: When he'd say that, we'd— [unintelligible].

While there is some merit in having an absolutely verbatim tape, which includes all the feedbacks (such as Um-hm and Yeah), too many interruptions in the flow of the therapist's remarks make for tedious transcribing now and exhaustive reading later. Knowing when to include feedback sounds and when to omit them calls for very careful judgment. Usually the therapist's noises are intended to encourage the client to keep talking. Look at your transcript. If every other line or so is a therapist's feedback, go back and carefully evaluate the merit of each feedback. Do not include every feedback, especially if it interrupts the client's comments in midstream. Only if the feedback is a definite response to a point being made by the client should you include it. When in doubt, please ask the research team.

Type no more than two crutch words per occurrence. Crutch words are words, syllables, or phrases of interjection designating hesitation and characteristically used instead of pauses to allow thinking time from the speaker. They also may be used to elicit supportive feedback or simple response from the listener, such as: you know? see?, or understand?

Use of *Uh*: The most common word used as a crutch word is *uh*. When *uh* is used by the narrator as a stalling device or a significant pause, then type *uh*. But sometimes a person will repeatedly enunciate words ending with the hard consonants with an added "uh," as in and-uh, at-uh, did-uh, that-uh, in-uh. Other examples are to-uh, of-uh, they-uh. In these instances, do **not** type *uh*.

Guggles are words or syllables used to interrupt, foreshorten, or end responses, and also as sounds of encouragement. Guggles are short sounds, often staccato, uttered by the therapist to signal

his/her desire to communicate. They may be initial syllables of words or merely *oh*, *uh*, *ah*, or *er*. Spelling of specific guggles: Agreement or affirmation: uh-huh, um-hm; Disagreement: unh-uh.

For consistency, use **only** the following for exclamations:

- Uh
- Um
- Uh-huh
- Mm-hmm
- Unh-uh

Do **not** use ah, oh, er, and so forth. Pick from the list above and use what seems closest to what is being uttered.

Incomplete sentences are familiar occurrences in oral history because of its conversational nature. They are best ended with an em dash (—). Use one dash (-) for an incomplete word that is then continued (e.g., mo- mother). Interruptions should be indicated using an ellipsis (...).

Similarly, an ellipsis should be used when the person who was interrupted continues their sentence after the interruption.

Example: Interruption

T1: Do you feel like he was ignoring you or...

C2: No, I just felt like he wasn't understanding what I was saying.

Interruption and continuation

T1: He was coming toward me and I felt, I felt...

C2: Scared?

T2: ...scared and confused.

Quotation Marks:

1. When a direct expression is spoken by one person (I, he, she), set apart the expression with commas, use opening and closing quotation marks, and capitalize the first letter of the first word quoted.

Example: She said, "I am going to graduate in May."

2. When a direct expression is spoken by more than one person (we, they), do not use quotation marks, but do set apart the expression with commas and do capitalize the first letter of the first word quoted.

Example: They said, what are you doing here?

3. When a thought is quoted, do not use quotation marks, but do set the thought apart by commas and capitalize the first letter of the first word quoted.

Example: I thought, where am I?

When you have completed the transcription, please go through the session one time to make sure you have captured all the spoken data, and an additional time to ensure you have noted all the significant non-verbal behaviors.

TRANSCRIPTION TEMPLATE

CONFIDENTIAL VERBATIM TRANSCRIPT

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Session Number:
Client #:

Coder:
Date of Session:

C = Client
T = Therapist

Verbatim Transcript of Session	Initial Coding Impressions
T1:	
C1:	
T2 :	
C2:	
T3:	
C3:	
T4:	
C4:	
T5:	
C5:	

<p>I don't mean just beers, we'd drink hard liquor.</p>	
<p>T3: Yeah, you get thrown along with the lifestyle</p>	
<p>C3: Exactly, and that was also a problem because I have an addictive personality and it's, I believe it's hereditary and it's part of other problems that I have. C3.1: It just manifested itself very quickly. I did in perhaps one year, what some people would do 3, 4, 5 years. I just crammed it all together. I got started with the speed, and then I switched to cocaine. Now, people call it crack or rock, whatever you want to call it. Free, the freebasing. You buy the, buy it in the rock form or in the powdered form, and I spent, I spend \$7000 in 3 months on that.</p>	
<p>T4: So you're very efficient about the drug use, packing it into a short period of time.</p>	
<p>C4: Well I packed it in, unfortunately, I don't know if it's good or it's bad, I went from buying it from people I didn't really, trying to get what I could from wherever, to climbing up the ladder to finding the main source, so to speak. C4.1: And I was one of those people, who I'm always proud to say, I never did any sex or anything for drugs or anything like that. Now, I didn't do any, anything... prostitution, or there was a lot of girls that would, a lot of women that would do that.</p>	
<p>T5: [Head nodding] So it was very common.</p>	
<p>C5: And, I was the kind of person, I got my nose broken because I wouldn't sleep with somebody's; this one fella wanted me to sleep with him when his girlfriend was at work and I wouldn't do it so he busted my nose. That's the kind of person I am. I don't believe in, that the two have to meet. My love was drugs. I didn't need a man, I didn't need relationships. If I had the money, if I didn't have the money, I had a way to get, you know, get it through people. I had, I didn't just party you know. I partied with uh--</p>	
<p>T6: Contacts.</p>	

<p>C6: Yeah, people who used to be in the show business industry, so to speak. You know, or who were related, A girl that was related to a guitarist in a famous rock star's band, and I'm not gonna name names, and she unfortunately—she died of AIDS but she had the money and she had, always, there was always partying going on with her. We'd go to the hotel and party, party, party.</p>	
<p>T7: And you got caught up in that very quickly.</p>	
<p>C7: Oh, very quickly, and it's easy to I guess, if you have the personality for it, you know. And I didn't have any, and I was at a point in my life where I didn't really care about anything. And I wasn't young either. I was 32.</p>	
<p>T8: So it sort of felt natural to you.</p>	
<p>C8: It felt fun, it felt, actually, it felt good, you know. I was trying to, as they say, chase that next high. It got fun, but when I started running out of the money and I don't know how I had the stamina for it because I actually still worked, paid rent, kept a job, I did everything, well, which a lot of people can do, but for the amount of drugs and drinking I did-</p>	
<p>T9: Pretty remarkable--</p>	
<p>C9: Some people would probably not even be able to get out of bed. I'm not bragging about it. C9.1: Now, ten years later, I feel like I'm physically, I'm just kind of burnt out, you know, C9.2: I stopped doing cocaine in '95, and then I admitted myself into rehab in California that same year, and I've done it still on occasion, but I'm on medication which, thank goodness, doesn't make it where the drug has addictive properties.</p>	
<p>T10: Really?</p>	
<p>C10: Ya, I found it very interesting. I could do cocaine and put it down and not go back to it.</p>	
<p>T11: Which was new?</p>	
<p>C11: Which is something new to me, I mean, this is as recent as moving back to Chicago. [Therapist's head nodding] You know, I haven't been able, I've struggled in and out of sobriety, you know, I feel like Robert Downey, Jr. sometimes. [Therapist laughs] C11.1: It's like okay, but I've not, I've never</p>	

<p>gotten arrested for drugs, or for selling, you know, one of those people who was too smart to keep it in the house and you know, I even though I never had money I had the common sense of well, you don't keep it in the house, don't drive around with it, you don't drink and drive, you don't drink and use. You know, why ask yourself for trouble?</p> <p>C11.2: One time I had drank and drove, and that was because I was at my boyfriend's, we were out, I had an argument, and we both went our separate ways. So, I ended up having to go home inebriated. And, um, fortunately nothing happened so I was pretty lucky.</p> <p>C11.3: And um, I've been in and out of recovery with AA and NA and, although I love the program and I espouse to do it, they say anonymity in AA, but I think that the condition in a situation like this, it's...well, it's part of talking about recovery and addiction. And, I've worked in and out of the program, I was clean, and sober for 3 years until I moved back to Chicago. Because I had gotten myself surrounded by people in recovery. Yet, when I moved back here, I was not surrounded by people in recovery and I discovered that I was staying clean and sober for the wrong reasons. I was doing it for other people, not for myself. I was doing it to help my mother, because my mother was dying of cancer, so I tried to, I wanted to...</p>	
<p>T12: So the change again of, of moving--</p>	
<p>C12: Right, they say geographics; you are running away from yourself. But I left California for many reasons. And uh.</p>	
<p>T13: And coming back here in a way set off--</p>	
<p>C13: It set off, right. It set off everything because I felt like I had the freedom. There was nobody there, I had no sponsor, no clean and sober neighbor, nobody checking up on me so to speak to make sure I was still, I was still smoking pot. I hadn't quit marijuana and, but the alcohol was the one that really got to me. I had been, I had quit marijuana for about a 7-8 months after I got out of recovery, but ended up getting back into that situation when I moved in, uh, out of sober living and I ended up eventually moving in keeping a roommate who was a friend of mine from my drinking and using days who was dying of AIDS. But</p>	

<p>he needed someone to take care of him. And I was going back to school at night plus working, so basically, my drug use was limited to marijuana and alcohol, sometimes doing coke or whatever. I never liked speed really because I saw people, the more they did that their teeth would rot out and, you know, it's Drain-o or rat poison, it comes in so many different colors. I've noticed it's not that big here in Illinois, in Chicago.</p>	
<p>T14: So when you say your in and out of recovery now, its alcohol and marijuana your talking about—and every now and then cocaine.</p>	
<p>C14: Right, ya, well the cocaine, basically I've stopped, ah, pretty much avoided that because the individual who introduced me to that again, I avoid seeing him at all costs...which I do for my own well being. I don't want to ride the dragon again. I don't want to go there, even though I know that if I do, I'm not going to be going there again every day. I won't be getting loaded every day because of the medication I take. But, and, he was paying for it, but I realized it was just something that I wasn't even enjoying.</p>	
<p>T15: So why do it?</p>	
<p>C15: Right, you know, to me, everybody, I believe has an addiction. We all have addictions be it food, sex, drugs, alcohol, gambling, family life, work. You know, whatever it may be, I think everybody has one, one thing at least that they crave and that in the back of their mind that they focus on and they really desire.</p>	
<p>T16: And you said you think you have an addictive personality--someone who easily gets drawn into things</p>	
<p>C16: Yeah, well right, I have been. I'm an artist, freelance artist as well, and my addiction used to just be drawing. As a child, I would just come home and draw, you know.</p>	
<p>T17: So whatever you do like that you do it intensely</p>	
<p>C17: Yeah, I wish I could do it to make money and do it, you know. [Therapist laughs] Get a money making idea and do like that, I'd probably be rich, it's just um, but not able to find a proper substitute, you know. At this time, I'm trying to get back into drawing and</p>	

<p>being more creative, and my personal life, though I feel so mentally, emotionally, and physically exhausted after all I've been through in my life, that all I want to do is almost not do anything. I'm trying not to focus on any addictions. I'm at the point where I'm getting tired. You almost get tired of it physically. Like, if I drink I feel, I don't get the hangovers cuz I won't even allow myself to drink enough, but physically the next day, I feel, I ache, you know I feel the hangover with the headache would manifest itself with my body aches, and I don't want to, want to get up on the...you feel as vital and I've just done so much that I'm burning out.</p>	
<p>T18: And you've used up your chances, huh?</p>	
<p>C18: Yeah, pretty much. And being single all my, which, since 1990 and not having...being blessed without having children, which I never wanted, thank God, I'm not a kid lover. I chose not to have kids also because of my husband and that was one of the reasons we also parted ways. I was happy. I'm lucky enough to where I've had my own life and I've not had to drag anybody, drag anybody down with me, you know. It did affect family members. Anytime you're, you have an addiction, people who care about you, it will, but eventually they turn you away too.</p>	
<p>T19: Now what is recovery for you besides not using alcohol or marijuana?</p>	
<p>C19: To me recovery would be going to meetings, having a sponsor, working a twelve step program, um, I still try to incorporate 12 step beliefs and behaviors in my life as far as, "Let go, Let God," the use the steps, resentment, a lot of people say if you're drinking and using you cannot work the steps, but I think you can use them in a behavior, method of behavior modification if you're, instead of turning to getting loaded or anger or what have you, when you have a problem in life, try to do something positive, call somebody, read if you have an AA Big Book or an NA Big Book, pick something up in there and try to read it. Try to keep yourself as close to the, that behavior as you can because it helps you to get...the closer I try to stay to meetings, even if I'm drinking, if I go to meetings it helps me from not wandering too</p>	

far off track to where I'll say drink more, or just stop totally leaving in that whole lifestyle or that whole belief process.	
T20: There's a piece here which were missing before we go, which is what are you wanting to move toward? What do you--	
C20: What I want to move toward is to just be able to totally not have to drink or use. And at this point--	
T21: Which is doing nothing.	
C21: Right. Well, at this point I still enjoy my pot. I'll be the old person sitting out there smoking a joint on the steps with all my cats around me, you know, and that's okay with me, but I don't want to drink. That's what I'm trying to avoid, and I'll be, I'll go a couple weeks without drinking and then maybe I'll drink again. But it's getting to where I want it less and less again.	

II. CODING TIMING OF INTERPERSONAL TRAUMA DISCUSSION INSTRUCTIONS

The second step involves noting when interpersonal trauma discussions take place during the therapy session. This involves understanding our definitions of trauma as well as discussions about it

Definition of Interpersonal Trauma:

Interpersonal trauma includes the following events or experiences: combat, war, mass interpersonal violence not in the context of war, physical or sexual abuse, witnessing or experiencing domestic or family violence, emotional abuse, invalidation, neglect, hate crimes, school shootings, community violence, being kidnapped, torture, and traumatic losses (sudden or violent death of a loved one). These event-based definitions of trauma describe the nature of an event in a way that differentiates it from ordinary daily stressors.

Definition of Trauma Discussion:

The term discussion will be used to signify any disclosure of a traumatic experience including the initial disclosure or reporting of an interpersonal traumatic experience(s) to the therapist as well as any subsequent discussions about the experience(s). Additionally, the term discussion will be used to encompass any further conversations, social-sharing (i.e., re-evocation of an emotional experience in a socially shared language with some addressee present at the symbolic level), or behavioral (e.g., showing a picture or writing sample, bringing in a journal, or gesture referring to the event) and indirect verbal attempts (e.g., discussion about subsequent life results from the traumatic experience) to discuss feelings, thoughts, and beliefs about the interpersonal trauma.

When you observe an interpersonal trauma discussion, you should note the time in which the disclosure/discussion/sharing began and ended. As you are transcribing, please pause the video and make a note of the start time by writing the word Start and then the time in bold, highlighted (in green) brackets. When the discussion changes to a topic other than an interpersonal trauma

disclosure/discussion/sharing, again pause the video and write the word Stop and then the time in bold, highlighted (in red) brackets. If you have a question about what constitutes the beginning or end of an interpersonal trauma discussion, please ask the research team.

Example: I have had a difficult marriage **Start [1:14]**. Most of the time my husband hits me. Sometimes he even throws things at me... **Stop [1:45]**

<p>um, doesn't want to because she is, um, she gets really angry, and I sense that I really can't be myself around her, um, that she, for some reason, I don't know, it might be the past that she's angry and I have no idea because I don't know [client clearing throat] and I have a sense that she doesn't know either why she's angry with me. But, um [client looking down and taking a deep sigh], she was, um, we never really got along when we were growing up. Start [1:42] We fought a lot [client looking away and down]. I spent a lot of time with her. I grew up in a family of seven. And, um, she was very, she was always fighting with with all of us. She was very angry.</p>	
<p>T2: [therapist nodding] Fighting physically or verbally or both?</p>	
<p>C2: sometimes it was physical with my brothers, and, but it was verbal with me because I wouldn't I wouldn't get into fights with her because I was afraid of her because I watched how angry she would get with my brothers and my brothers were (2) they were pretty, violent too, and, um, one of my brothers, one of my younger bothers was in a gang, was a gang member, and she would fight with him. [therapist nodding] She, I saw her one time, um, put an iron right to his chest and when I saw these things happening, I just I grew really afraid of her. And so when we would argue I knew what she was capable of so, I I would stay clear of any like physical, anything physical with her. I would try to talk my talk my way out of it.</p>	
<p>T3: [therapist nodding] Mm-hmm. Were there ever times where she was physically violent with you?</p>	
<p>C3: Well, there was one time when we got into it and my mom was there and my father was there. Um [client sighs deeply], my mother immediately got between us [therapist nodding] and she just got us both together and said she was going to hit both of us. Um [client pressed lips], that was the only time that we were rolling on the floor and really nothing happened.</p>	
<p>T4: Mm-hmm [therapist nodding]</p>	
<p>C4: She just was, we were pulling each other's hair, and actually I was mo—I was mostly like trying to get her away from me, trying to get</p>	

her off of me.	
T5: Mm-hmm [therapist nodding]	
C5: Um, but that was the only time that we got into it. I never, after that, wanted to get into any physical. I don't, I don't know why I just-she really scared me.	
T6: Yeah I kind of get a sense, and tell me if I'm reading this accurately, that it's like you saw her as having no fear...	
C6: Right [client slowly nods]	
T7: ...as having no limits [slowly nodding] to what she would be willing to do.	
C7: Right [Client nods]. And that scared me.	
T8: Mm-hmm [therapist nodding]	
C8: And the verbal things that she would say to me were really scary. Like, "I'm gonna stab you, I'm gonna—" she would tell me all these things that she was gonna do to me.	
T9: Mm-hmm [therapist nodding]	
C9: And they were very detailed.	
T10: Mm-hmm [therapist nodding]	
C10: And that scared me. And the things that I saw I mean I saw her doing [client takes a deep breath in and out] being a, not being afraid of my brothers who were violent themselves. Um who were gang members who fought with weapons and that didn't scare her [client swallows]. They didn't scare her. So to me I thought she would, she would, there would be no limits to what she would do. That she...	
T11: So it sounds like [therapist scrunches up her face and squints] she feels dangerous to you [therapist nodding].	
C11: Yeah [client nods]. To this day she feels dangerous to me. And [licks lips] I had— I would go back and forth with having relationship with her. My sister has a really sweet personality. And then on the other hand, when you say something, and she interprets it as being, like she has to get on the defense...	
T12: Mm-hmm [therapist nodding]	
C12: ...she, she can get really violent. And it happened more with me [client scrunches up face inquisitively] I sensed, than with more-- I, I she was real sensitive with me. Um, well that's what my nieces say that it was something historically with us.	
T13: Mm-hmm [therapist nodding]	
C13: [Client looks down] Um, but she recently	

<p>had an altercation with my [client points to the side] my niece. And my niece confirmed to me that [client looks up at therapist] it wasn't me that it was my sister. And my sister has had a past with [client scratches chin] violence, like she has had a past with her husband with, with um, hitting her husband [client nods]. And I've seen her doing it.</p>	
<p>T14: So you know she's capable of being physically violent.</p>	
<p>C14: Mm-hmm</p>	
<p>T15: You know she has these really violent fantasies about what [client nods] she might do to you. She's had them over the years...</p>	
<p>C15: Mm-hmm [client nodding]</p>	
<p>T16: ...and you experience her as not having any internal limits [therapist's hands gesture toward middle of her body], no sense of [therapist nodding] something that will stop her even when she might actually be in danger.</p>	
<p>C16: Mm-hmm [client nods] that's right, that's correct.</p>	
<p>T17: So it does sound like she's a pretty scary person.</p>	
<p>C17: [client nodding] Yeah, although, um, for a lot, [client looks up at ceiling] for a long time and still [client looks down at floor], other family members, um, that were close to her [client looks back up at therapist] didn't want to believe that about her. And so I always thought that it was me. I always felt that it was me because I, we were really close [client looks down at ground], um,</p>	
<p>T18: Thought that it was you like [therapist scrunches up face, squints, and puts hand up in the air] you were overreacting or—</p>	
<p>C18: Yeah that I was overreacting or that my sister just didn't like me for whatever reason...</p>	
<p>T19: Mm-hmm [therapist nodding]</p>	
<p>C19: ...and it was— but I also sensed that they kind of protected her too. Um, (3) the, she can be really sweet she has a nice she has a really good disposition. Um, but once you get to know her she gets pretty scary and (3) [client gazes up in the air] we don't— she doesn't have a relationship really with any of my brothers [client gazes towards the floor] and my sister- my older sister who passed away they didn't get along either (3) so—</p>	
<p>T20: So it's not as if she really relates to</p>	

anybody in the family [therapist gestures at middle of body with both hands as speaks]	
C20: [client nodding] Right, right now she does, she's not— [client gestures with both hands as speaks] she's kind of isolated, um, each family member throughout the years and for me it happened very early because I grew up with her and I had experience with her.	
T21: So, it seems like what you're saying is [therapist gestures with both hands as speaks] so here you are now today an adult and this person is still being really scary for you. [therapist nodding]	
C21: [client nods head in agreement] Yeah, she is and that bothers me. [both therapist and client nod heads in agreement]	
T22: It bothers you because—	
C22: It bothers me because [client gazes down toward the floor away from the therapist] uh, she can't hurt me. [client looks directly at therapist] I mean, she can't do anything to me now. I mean, if she laid a hand on me, [client looks around the room] I know that I'd be able to call the co- call the police or— [therapist nodding] um, there'd be somebody there to defend me or I could defend myself. Stop [7:52]	

MASTER RUPTURE AND REPAIR TRANSCRIPTION

Safran & Muran Therapy Vignette 1 from Resolving Therapeutic Impasses
Disk 1 - Metacommunication

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Therapist: Dr. Jeremy Safran
Client: X

Session Number: 1
Date of Session: xx/xx/xxxx

C = Client; T = Therapist

Verbatim Transcript of Session	Initial Coding Impressions
T1: Ok, so why don't you tell me a little bit about what brings you here today?	Segment #1
C1: Well I was hoping that that you [client gestures with both hands towards therapist]	

<p>might be able to help me with, um, some, some [therapist nodding] behaviors that I have that seem to be causing me some problems. [therapist nodding] Uh, it's, it's mostly with, with relationships and I've, I've noticed that, uh, a lot of times I [client gestures with both hands while speaking] I seem to keep people at, at a arm's length [client extends one arm forward with palm open indicating an arm's distance] in, in a relationships. I seem to have what's, um, what's called a problem with intimacy, [client gestures with both hands facing one another towards the therapist] [therapist nods] uh, and I don't know if there's, um, if there's a, a better psychological [client motions with hands in a circle in front of middle of body] description of, of what the cause is, of, of that problem might be, [therapist nods head] um, whether I have some kind of a fear [client motions towards self with hand] of intimacy [therapist nods] uh, or if I had— if I had, uh, some sort of traumatic experience [client shakes head side to side] um either with my parents [client gestures to side with one hand and then the other side with the other hand] or with with any of my siblings or or perhaps even in an early [client gestures with both hands facing one another toward therapist] relationship and that, uh, that that baggage [client motions with one hand in front of chest toward therapist] from that has has now developed to the point where, um, how I interact with people [client gestures with both hands at sides towards therapist] is is really in in some way affected by this, um, by this this [client gestures towards self with both hands] fear of intimacy. [therapist nods] Um,</p>	
<p>T2: Can can, you, um, I mean you're getting a good [therapist gestures with both hands towards client and leans forward in chair] general description of the problem. I'm wondering if you can give me any, any examples [therapist sits back in chair] and you know in some ways the fresher the better.</p>	
<p>C2: [client gestures with both hands as speaks] The main way that that I've been trying to deal with this in, in the relationship with, with</p>	

my girlfriend is that she's very affectionate [therapist nodding] and she has this— she has this desire to be more physically affectionate with me [therapist nods] and, and that's something that I, I don't really seem able to [client shakes head and gestures with hands] respond to, and I think it probably, [client gestures with one hand toward client and scrunches face] I think it has to do with, um, problems I had with intimacy early on even as even as a little boy [client gestures with both hands towards client] in, in trying to um, uh return the affection uh of my parents. I mean I don't [client purses finger tips together on each hand together in front of middle of body] I really don't remember any kind of traumatic experience that, uh, I had growing up that would have that would have affected me this way but [client swallows and continues talking with hands] if I think about, uh, the, the, uh, the whole uh, uh, feelings that I have uh toward my parents and how that might be now affecting [client gestures with hands as if to indicated over a period of time] this problem with intimacy that I have today it, it seems— it really does seem to me that there, there are some unresolved things, uh, with my parents that are that are preventing me from from really expressing [client gestures with one hand in a circular motion towards self in front of body] the kind of physical affection, uh that um, that my that my girlfriend is looking for and I'm not, um, I'm not sure exactly how [client nods head and gestures with hands towards therapist] how a psychologist [client motions with one hand towards therapist in repetitive motion] would describe that but [client motions towards self with one hand] the way that I've been thinking about it though is that, um, I I I often try to seek my parents approval [client gestures towards therapist with both hands] and I really never— I don't feel that I ever really got the kind of approval that I needed from my parents. You know the kind [client gestures with both hands in front of body and palms facing out as if to block self] recognition that I needed from them and maybe, um, maybe in some way [client nods head] that that fear of rejection that I that I experienced early on

<p>with my parents is now creating, uh, this wall [client gestures with both hands in front of body as if to simulate a wall] between, uh, between me and relationships that I, uh, that I'm trying to have with other people and uh, you know that that I think is probably [client nods] uh, yeah I think that's I think that's a pretty good way to describe it is that there's this there's this fundamental [client gestures towards self with both hands] fear of rejection that probably stems from the way I was brought up and now that's really, um, having this uh [client shakes head from side to side] this this affect on relationships for me now [client nods head].</p>	
<p>T3: [therapist nods head] Ok. Um, I mean [therapist leans forward in chair, re-positions self, sits back, and gestures with one hand in a circular motion towards client] as as I'm listening to you talk, I'm sort of sitting here struggling [therapist gestures with one hand towards client] um, to come up with [therapist nods head] something to say and for some reason, you know I'm I'm having difficulty thinking of [therapist places elbow on arm of chair and leans head on hand] a meaningful response. And I'm trying to figure out why that is, and and I think part of it is that it it— (3) You know on one hand [therapist gestures in a downward motion with both hands] you're sort of laying out what the problem is in in you know in a really sort of good clear terms, but there's also way in which it sort of feels almost as if [therapist motions with one wrist in circular motion in front of body] you already know the the answer. It's it's like you're sort of— [therapist nodding]</p>	
<p>C3: Well, well I've thought a lot about this uh, [client looks directly at therapist and gestures with both hands] and I, you know I I certainly before before it ever occurred to me that I [client gestures with hands when speaking] that I should seek any you know kind of professional help, um uh, and I know I tend to think about things a lot [client leans forward in chair, nods head towards therapist and gestures with open hands towards therapist] I mean I do I do this a lot, you know, try to</p>	

<p>figure out what's you know what my problems are [client gestures with arms in a circular motion towards self] and see if I can come up with um, with uh, with some kind of solution, some some way of dealing with um, but um, I mean I don't know maybe I'm just not giving you [client gestures with both hands towards therapist] enough information that you can, you know uh, see this as clearly as I now can just from thinking about it from my from my life experiences.</p>	
<p>T4: Well no it doesn't feel like you're not giving me enough information, um, but I I'm wondering do you have any memory of how it felt [therapist gestures with one hand towards client] when I when I said that to you a minute ago that it feels like you've already got the answers? Do you have any memory of what that — if you don't that's [therapist puts hand out in front of body as if to stop something and shakes head from side to side one time] that's fine, but do you have any memory of what that what that felt like?</p>	
<p>C4: Um, well I feel like I feel like [client gestures with both hands towards therapist] you're you're trying to help help draw out my [client gestures in circular motion with one hand in front of body and nods head] thought process in all of this. That that, you know, I might I might have come to some conclusions about what the problem is and and you're trying to help me do that, but at the same time [client gestures towards self with both hands] I mean I have to tell you what I think the answers are. I mean I have to give you some sense of of where my head is in all of this [client continues to speak with hands] and then you know maybe, you know, I don't know, your, maybe you can help me, maybe you can't.</p>	
<p>T5: Mm-hmm [therapist nodding]. Right, so so it's important for you [therapist gestures with one hand in circular motion towards the client] you have thought about it a lot and it's important for you to, you know, at least start by letting me know your, what your understanding of it is or what your analysis of the situation is...</p>	

C5: Right, well I mean I have I have to start [client gestures with both hands palms up towards the therapist] somewhere...	
T6: Right	
C6: ...you know and I, you know I have certainly I have read a few books in psychology and I've [client gestures with hands as speaks] thought about, you know, how how, um, my young situation, you know, might might be described based on different theories in psychology and stuff like that. But I mean, don't don't get me wrong [client gestures with both hands palms facing toward therapist] I mean I'm I'm really hoping that that you will be able to help me, uh, you know and gi- and give me a different, I guess a different perspective in all of this, but, um, uh, but I want I want to participate in all that. [client gestures with both hands as speaks] I want I want you to value my insights about where things are, [therapist nods head] where my head is in all this. [client nods head]	
T7: Ok, so tha- that's important right [therapist leans forward in chair] that you, you know, that you have thought about it, [therapist adjusts self in chair] that you have some understanding [therapist gestures with one hand as speaks] of what's going on...	
C7: Right [client nods head]	
T8: ...and it's important for me to to recognize [therapist gestures with hands as speaks] that and and value it. [client and therapist nodding in agreement]	Segment #2 begins
C8: Right, and the same thing happens, you know in the relationship. I'm mean, if my girlfriend wants me to behave in a certain way and that's just not how I feel [client using hands to gesture], I mean, I want to be able to tell her, what my real feelings are, and, and, if you have thoughts about what's going on with me, I would want to be able to express my, my feelings to you [client gesturing with open hands towards therapist]. You know, know, the same way. I mean I'm the one here who's looking for help	
T9: I mean, I'm wondering, uh, are you feeling, um, so far that I am hearing and valuing, the, the sorts of things you're saying [therapist gesturing with hands], sort of	

<p>valuing your understanding?</p>	
<p>C9: yeah, yeah, for the most part, and I mean, you know, I want to be able to share, um, my, my feelings and thoughts about this as much as I can. And of course, have you take all of that into consideration. But, if I, I come to the conclusion that, because of my whole life experience, here's where I am, here's my interpretation of this, this is what I think is the problem. I mean, that's something that you [therapist changes position in chair as client is gesturing hand towards therapist in a pointing fashion] are going to have to figure out how, how we deal with it. I mean, uh, how, how, how, we can deal with it together.</p>	
<p>T: 10: Mm-hmm, allright, so that it's important that it's kind of a mutual process is what you're saying.</p>	
<p>C:10: Well, I hoping we get to that point [client is nodding head up and down]</p>	
<p>T11: Uh-huh [therapist is shaking head up and down], okay, okay [therapist shakes head up and down] (2), um, you're hoping we get to that point. So I mean, how would you describe, you know, the point we're at right now?</p>	
<p>C11: Well, well, I think right now you're probably trying to figure out what's going on with, with me and, and, I'm doing the best I can to describe that, you know, whether I just talk about how a certain situation makes me feel or whether I talk about a specific examples, and you know, what my interpretations are of those examples, I'm trying to be as straight forward as I can with you [client gestures hand towards therapist] about how I think about those examples and I'm hoping that maybe, um, you have a special perspective that you can use to, to improve my understanding, and, and then I get to a point, we, we together [client gesturing hands signifying a "we" collaborative motion] get to a point where, um, I'm able to somehow, get over those problems.</p>	
<p>T12: Mm-hmm, mm-hmm [therapist shaking head up and down]. I mean, there's a couple of things going on in my mind [therapist changes position in chair]. One is that, I mean, you're saying that you hope I have a special perspective...</p>	

<p>out], if I'm supposed to come, if I'm going to therapy if I'm going here and I'm doing this, I- I want an answer. I can't just talk and talk and talk and have you just say things that lead me in an abstract way. How is this going to work? I need to know from you [shifts gaze back to floor] how is this thing going to work [makes eye contact with therapist]? I need a concrete answer. How do I get from where I am now [indicates point A with hand] to somewhere else [indicates point B with other hand]? I need a [positions hands to signify path] way to go I [grazes one hand by the other signify a path] don't know how to go and I've been in therapy for two years and nothing seems to be helping. And [throws hands up in dismay and they fall in her lap] you're not helping either so, what do I do [let's hands fall loudly back on chair and continues to gaze at floor, then looks up]?</p>	
<p>T2 : Oh Okay, so you know I I'm hearing that you're not [leans forward in chair and then sits back again] very happy about our last session and you're feeling frustrated and also if I understand correctly that you'd like to hear more from me as as as to what as to how the therapy works or</p>	
<p>C2: [gazing at floor] How do you work? How do you do what you do? How does this, how is this supposed to help me [looks at therapist]? How do I fix what's going on?</p>	<p>DT2</p>
<p>T3: Okay I'll- I'll try to answer that I I mean even before I say anything I I want to say that I'm I have some concern about whether or not whatever I'm gonna say is gonna give you what you're really wanting but I'll- I'll do my best, okay? [client moves head back and grimaces] You have a funny look on your face...</p>	<p>ITM</p>
<p>C3: [looking at floor] I'm not sure why you're concerned about that, isn't that you're job [looks up at therapist]? To tell me how things [looks down at floor] are supposed to go? I'm confused then [looks up at therapist].</p>	<p>DT2</p>

<p>T4: Yeah I mean is my job to do my best to help you and to try to answer your questions [client nodding], yeah, there's just something about the, um, it's a bit [therapist grins] difficult for me to put it into words but something about the sort of intensity [pumps fists forward] with which your asking for things [client nodding] that makes me, um, sort of a little bit [therapist grins], um, sort of question my ability to give you the- the answer you're wanting but I'll- I'll try [therapist nods].</p>	<p>1TM</p>
<p>C4: Okay [client nods].</p>	
<p>T5: As I see it the way in which therapy works, is that, uh, the two of us [therapist grins], we'll we'll work together to, um explore things that you may be doing in relationships with other people that may be self defeating [client starts to speak then stops], that you may not be completely aware of, um, ways that you may see things that are self-defeating or ways in which you're dealing with your own feelings that are self-defeating, or ways in which you're- [client shaking head] you're shaking your...</p>	
<p>C5: [Client shaking head and looking at floor] I'm not defeating myself. I don't defeat myself. I don't understand how coming in here and working on it together [client pushes hands together] is gonna help. Aren't I— isn't - isn't it supposed to be that I say what's going on and then you tell me an answer [client looks up at therapist]? Give me an answer? Isn't that the way it usually works? You ask a question, you get an answer? I'm— [client looks down at floor] I don't understand what [client gestures in a circular motion pointing to herself and therapist], trying to do that would help. I, I don't think I'm defeating myself [client frowns]. I don't think I'm defeating myself at all [client frowning]. I think I come in here for answers and you're not giving them to me [client looks up at therapist].</p>	<p>CR (2); DT2</p>
<p>T6: [Therapist nods and leans chin on hand] Mm-hmm. [Therapist exhales]. I mean I'll certainly give you answers, um, to the extent</p>	<p>2TM</p>

<p>that I have them. Um, but also some of it will have to come out of the two of us really exploring things together.</p>	
<p>C6: [Client looks down at floor] See that's too abstract for me [client shaking head]. I, I need [client laughs] something in the concrete. [Client grinning] I need to know how to get from point A [indicates point A with left hand] to point B [indicates point B with right hand].</p>	<p>DT2</p>
<p>T7: Mm-hmm.</p>	<p>4T</p>
<p>C7: And if I'm just gonna sit here and get this abstract then I'm— it's kind of wasting my time, isn't it [client grins and looks up at therapist]? It's kind of, a waste of my time. That's what the two years [client laughs] have been with other people. It's just a waste of my time if I just, sit and get things in the abstract [client scrunches face, looks down at floor, and then looks up at therapist].</p>	<p>2CD</p>
<p>T8: Uh-huh. Yeah, um [therapist grinning], I— you know I'm trying to think if there's any way I can be more concrete [therapist stops grinning] than I am right now, um, [client nodding] I mean let me- let me give you an example, okay?</p>	<p>1TM</p>
<p>C8: Okay. That's concrete.</p>	
<p>T9: Even right now let's try to take a look at what's going on between the two of us. You obviously—you- you want something, okay? [Client nodding] You- you know, you want an answer, right? And I understand that you want an answer [client nods]. And, [therapist grins] I want to be able to give you what you need, okay?</p>	<p>2TM</p>
<p>C9: [Client nods] Okay.</p>	
<p>T10: But I think there's something about—you know, just to try to give you a sense of what's going on for me, there's something about the sort of the intensity [therapist motioning quickly with hand and grins slightly] with which your asking [client furrows brow], the—this sort of pressure that I need to produce something, that makes it difficult for me to...</p>	<p>1TM</p>
<p>C10: But isn't that your job? [Therapist nods] To produce something? To give me an answer? Isn't that your job?</p>	<p>DT2</p>
<p>T11: [Therapist shifts forward in seat] Well my job is to help you [client continues to</p>	<p>2TM</p>

<p>furrow brow]. But there’s something about, um, [exhales] what’s going on between the two of us right now, [client nods] which is making it difficult for me to really, give you what you want and you’re needing.</p>	
<p>C11: So aren’t you asking me to perform too? Aren’t you asking me to, give you stuff too?</p>	<p>2CD</p>
<p>T12: What— tell me more about that. Does it feel like I’m ...</p>	<p>2TM</p>
<p>C12: [Client looks down at floor] Aren’t you asking me to give you, give you what’s going on with me and articulate what’s going on with me? So I’m being asked to perform too. Aren’t I? [Client looks up at therapist, then throws hands up in air and lets them fall in her lap. She then looks down at her hands].</p>	<p>2CD</p>
<p>T13: I’m wondering if you felt criticized [client looks up at therapist] by what I said just now.</p>	<p>2TR</p>
<p>C13: [Client looks down at floor] Well of course I did. I—it felt like you were blaming me. Like I came in here and I was trying to say how I felt and trying to just be who I am and say what I wanted from you and needed from you and it’s like you, put right back on me [client shakes head].</p>	<p>2CC</p>
<p>T14: [Therapist nods] Okay. Um, I need to think about that a little bit. I mean I don’t think it was my intention to blame you. But maybe there was a way in which I was responding [client nods] out of feeling pressured and, you know maybe feeling-feeling a little bit blamed for, you know not giving you what you want [client nods], so that in- in turn I was kind of, um, you know sort of blaming you [client nods], where you know it’s kind of like [client nodding] passing a hot potato back and forth you know, like you’re saying I’m not doing my job, I’m saying you’re not doing your job. [Client nods]. Does that make any sense to you?</p>	<p>2TR; 2TM</p>
<p>C14: [Client nodding and looking at floor] Yeah. Yeah a little. Yeah. Yeah. [Client looks up at therapist].</p>	<p>2CC</p>
<p>T15: Okay so, um, you know if that is what’s going on between the two of us [client nods], then [therapist grins], you know what- what we’re going to do, you know, I- I’m not sure exactly how we’re going to get past this, [client nods] but I think, you know the two of</p>	<p>2TM</p>

us being able to, to agree that maybe some of what’s going on is [client nods]- is a start, right? And I’m willing to work with you [client nods] in order to help the two of us find a way of getting past this point [client nods], right? And and my sense is that that would be an important first step for us. [Client nods] Okay?	
C15: [Client nodding] Okay. Yeah, okay.	2CC

Coding System for Ruptures and Repair:

Definition of Ruptures: deteriorations in the relationship between therapist and client or a mismatch between clients’ and therapists’ treatment goals, tasks and personal bond. Accordingly, these deteriorations may result in negative affect and/or behaviors and appear during a therapy session in two alternative ways: *confrontational ruptures* and *withdrawal ruptures*. Ruptures can be a combination of both confrontation and withdrawal.

*Underlined codes = Inventory of Countertransference Behavior (ICB) items

Identifying a Rupture(s)

Rupture Codes	Examples	Comments
Confrontational Rupture (CR) <i>Def:</i> client explicitly reveals his/her dissatisfaction with the therapist or with some aspect of the therapy	<ul style="list-style-type: none"> - “I am so mad at you right now.” - “You don’t know what you are talking about.” - “I don’t think you understand me at all.” - Client’s fists clench up - Client moves head back and grimaces 	For CR and WR, you will be looking at the client’s verbal and non-verbal behavior to determine a rupture(s).
Withdrawal Rupture (WR) <i>Def:</i> client emotionally or cognitively withdraws from the therapeutic relationship	<ul style="list-style-type: none"> - Changes topic - Avoids eye contact - Looks withdrawn - Affect change (e.g., client becomes sad, happy, laughs, etc) - Posture changes - Deep sigh(s) 	
Disagreement on goals (DG)	Client: <ul style="list-style-type: none"> - “What are our goals?” - “I’m confused about what I am supposed to be working on___.” - “This is not what I expected therapy to be.” - “I thought I came in to talk about X and now, we’re talking about Y.” 	For these subsequent codes, you will be looking at the therapist and client to determine whether a rupture has occurred.

	<p>Therapist: - “I understand that you are really coming to talk about X, but it seems that Y is the real issue.”</p>	
<p>Disagreement on tasks (DT)</p> <p>DT1: <u>Therapist Provided too much structure</u></p> <p>DT2: Therapist Provided too little structure</p> <p>DT3: Therapist changed the topic at any point</p> <p>DT4: <u>Client indicated that Therapist talked too much in the session</u></p>	<p>Anything other than DT1-DT5</p> <p>- Sticking to an agenda too rigidly - little flexibility in addressing other issues that arise in therapy - Therapist pushes client to disclose/discuss too much without picking up on client’s cues - Therapist does not follow up with appropriate questions regarding client’s disclosure/discussion</p> <p>- Not setting any limits - Allowing time to pass by without discussing things related to treatment goals - “You’re not telling me what to do.” - “You really didn’t say much of anything.”</p> <p>- Changing the topic and/or Client responds negatively</p> <p>- “You never let me say anything.” - “I feel you never let me get in a word.” “ - I feel like I never get a chance to speak.” - Therapist interrupts client</p>	

<p>DT5: Therapist Engaged in unhelpful self-disclosure</p>	<ul style="list-style-type: none"> - Discussing personal material that is not related to the client or treatment 	
<p>Misalignment in bond (MB)</p> <p>MB1: <u>Therapist Critical of the client</u></p> <p>MB2: <u>Therapist Behaved as if he or she were “somewhere else”</u></p> <p>MB3: Therapist does not provide validation</p>	<p>MB – any misalignment in bond not falling into MB1-MB3</p> <ul style="list-style-type: none"> - Asking “why questions?” - Using “should” statements with judgmental quality - Blaming statements implying client is at fault - Not present - Looking at clock or watch - Yawning a lot - Not making eye contact - Leaves the room - Leaving too much silence and not responding, - Looking away - Not mirroring client’s mood, affect, and tone, - Laughing - Making an in appropriate joke 	

Repairing Ruptures

Repair Codes	Examples	Comments
<p>Stage 1 – attending to the rupture</p> <p>1TM: Therapist focuses client on immediate experience using metacommunication (M) and self-disclosure through the use of I statements</p>	<p>“I am feeling confused about our communication right now”</p> <p>“I noticed that you changed position when I said X.”</p> <p>“I have a sense that I am potentially being critical, rather than allowing you to really explore and express your concerns more fully.”</p>	<p>For the repair process, you will be coding both the client’s and therapist’s verbal and nonverbal behavior.</p>
<p>Stage 2 – Exploration of Rupture Experience</p>		

<p>2C: Client expresses negative feelings mixed with rupture</p> <p>2CC: Constructive</p> <p>2CD: Destructive</p> <p>2T: Therapist facilitates self-assertion in 3 different ways: 2TR: Therapist takes responsibility for interaction</p> <p>2TM: By refocusing on the “here and now” of the rupture occurring in the therapeutic relationship</p> <p>2TE: Use of an awareness experiment</p>	<p><i>*2C not a code – only 2CC & 2CD</i></p> <p>2CC: “I am feeling angry about what you just said.” 2CD: Client expresses feelings (verbally or nonverbally) in a blaming or belittling way.</p> <p><i>*2T: Not a code, just a category</i></p> <p>“I apologize for saying X.”</p> <p>“I have a feeling that you may be upset with me.”</p> <p>“Can you experiment with telling me directly how you are feeling right now.”</p>	
<p>Stage 3 – Exploration of Avoidance (<i>this stage is necessary only if client is displaying avoidance</i>)</p> <p>3Ca: Client displays block</p> <p>3T: Therapist probes block</p> <p>3TS: Therapist probes block on surface level</p> <p>3TD: Deeper level of connecting to client’s interpersonal relationship style</p> <p>3Cb: Client explores block</p>	<p>Changing the topic Speaking in a flat voice tone Speaking in general terms rather than the here-and-now specifics “Everything is fine.”</p> <p><i>*3T is not a code, only a category</i> <i>*Need a 3Ca to occur for a 3TS to happen</i></p> <p>“It feels to me like you attack and then soften the blow. Do you have any awareness of doing this?” “I noticed that you changed the subject.”</p> <p>“I wonder if this relates to your style of relating in other relationships?” “Do you notice yourself reacting in this way in other relationships?” “Has managing conflict</p>	

	<p>always been difficult for you?"</p> <p>"I guess I do feel kinda of hurt and confused right now."</p>	
<p>Stage 4 – Self-Assertion 4C: Client self-asserts (expressing a wish or need) spontaneously without therapist’s help</p> <p>4T: Therapist validates assertion directly in response to Client’s assertion (4C)</p>	<p>"I am noticing that I tend to get angry and lash out when I don’t know how to express that anger." "I think I need (X)." "I really want X in my relationships." "I need X but I feel I am not getting it."</p> <p>"I see." or "I hear you." "I’m so glad you have shared your feelings with me." guggles, reflecting back what client has just said, head nodding, eye contact, leaning forward</p>	

III. CODING OVERVIEW

The third step of the process involves the coding of timing and depth of disclosure, ruptures and repairs, use of positive emotion, and general themes during the context of a trauma discussion.

- A. Linguistic Inquiry and Word Count: The Linguistic Inquiry and Word Count (LIWC) will be used to code for depth of discussion of trauma and the use of positive emotion. The LIWC is a text analysis program which looks at the various emotional, cognitive, and structural components present in written and speech samples from individuals. This system has five main categories with numerous subcategories.
- B. Coding System for Ruptures and Repair: Codes and definitions of ruptures and repair were developed by one of the researchers (Karina Campos) with input from the research team and based on her review of the literature and existing coding systems (see above). It was used to code for ruptures and repairs during psychotherapy sessions in which a trauma discussion occurred.
- C. Positive Affect Coding System: Codes and definitions of positive affect were developed by one of the researchers (Whitney Dicterow) from her review of the literature (Keltner & Bonano, 1997) and from information taken from the EMFACS, a method for using the Facial Action Coding System (FACS, Ekman & Friesen, 1976, 1978) focusing only on the facial actions that might be relevant to detecting emotion. Specifically, the literature and information from the EMFACS were used to operationally define smiles and laughter (see below) to code for positive affect during psychotherapy sessions in which a trauma discussion occurred.

Positive Affect Codes	Definition
Smile (S)	- A facial action characterized by the raising of the lip corners

	towards the cheekbones and showing of teeth.
Laughter (L)	-A smile accompanied by audible laughter-related vocalization (i.e. “he he” and/or “ha ha” and an open mouth.

D. General Themes: Each of the psychotherapy sessions containing a discussion of interpersonal trauma were coded for themes both within and across the sessions. The research team worked independently to determine larger general themes and sub-themes based on the themes that were created as a team. This process involved re-reading the transcripts and grouping together specific themes that appeared to be related or to serve a similar function for the client (Ryan & Bernard, 2003). Once all of the specific themes were grouped together, each team member then created general, overarching theme labels that best categorized/described the more specific sub-themes.

Coding Steps

1. Read this manual to learn and understand the definition of interpersonal trauma and discussion of trauma. Familiarize selves with coding steps for each topic (rupture and repair definitions, depth of discussion change talk, positive emotion non-verbals).
2. Watch the video tape of a session and read the transcript all of the way through, take notes in the right hand column of the transcript to get a general gist of when a discussion of interpersonal trauma occurs, impressions of the therapeutic relationship and working alliance (non-verbals, language, tone, affect) and general themes present. Begin the preliminary coding process.
 - 2a. To code for general themes we will read through each transcript again individually and look for repetitions (i.e., topics that occur and reoccur) and transitions in content (i.e., naturally occurring shifts in content or pauses, changes in voice tone, presence of particular phrase that may indicate transitions e.g. so, anyway). Examine the content of each repetition and transition and extract themes. Then, categorize dialogue into themes and subthemes.
 - 2b. Run the full verbatim transcript through the LIWC computer program for results on depth of discussion of trauma and positive emotion. Run the verbatim transcript of the client’s speech during the trauma discussion through the LIWC computer program and collect results. Run the verbatim transcript of the therapist’s speech during the trauma discussion through the LIWC computer program and collect results. Run each individual line of verbatim transcription through the LIWC computer program as needed. Record data on LIWC tracking sheet.

For the purposes of this study the following main categories and subcategories of the LIWC will be analyzed:

1. Linguistic Processes Category
 - a. Total Word Count
2. Psychological Processes Category
 - a. Cognitive Processes
 - i. Insight
 - ii. Causation
 - b. Affective Processes
 - i. Positive Emotion

3. Individually, read the transcript again in detail by looking at each statement (C1, C2, etc.) and write your rupture and repair coding impressions on the code sheet including possible themes.
4. Review your code sheet and give your final ratings
5. Individually watch each recorded psychotherapy session while following along with the transcript, and note in the transcript when the client-participant smiles or laughs. Meet with research team to compare notes on when the client-participant smiled and/or laughed throughout the recorded psychotherapy sessions. Come to a consensus on noted smiles and laughs, returning to the recorded sessions if there is any discrepancy in observations between coders.

When coding, you want to try to balance attention to details with an ability to think abstractly and see the bigger picture. It is also important to maintain focus by pacing yourself carefully. It is difficult to code accurately when you are rushed or code in binges. In the discussion meetings, it helps to present your questions and confusions and to agree with others only when the consensus makes sense. Coding requires an openness and flexibility but not acquiescence.

Record each instance in the transcript that you believe a code is present on the code sheet (record "C1," "C2" etc. and the phrase you believe matches the code). Then, tally the frequency count on the code sheet. This will help to verify your overall score and will be used during group meetings to discuss and compare scores for the sessions. Refer to training materials when guidance is needed.

APPENDIX U

Summary Diagram

Interpersonal Discussions of Trauma

Childhood Sexual Abuse (CSA)
 Workplace Psychological Harassment (WPH)
 Themes/sub-themes that emerged during trauma discussions:
 Self-protection (Avoidance of talking about trauma, avoidance of emotion, mistrust of others, sense of responsibility, financial security, distancing from others, respect others)
 Power and Control (Assertiveness, aggression, desire to control self, desire to control others, independence)
 Sense of Self (Fear of judgment, insecurity, self-criticism, respect for self/pride)
 Gender Role Struggles (Stereotypes of men, stereotypes of women, role reversals)
 Emotional Difficulties (Anger toward boss, anger toward mother, difficulty identifying/expression emotion, frustration with boyfriend's lack of responsibility, jealousy)
 Job Dissatisfaction (Disengagement from job, hatred toward job, frustration with job responsibilities, feeling trapped in job)



Positive Emotional Expression

- Verbal expression of positive emotion determined by LIWC
- Non-verbal expression of positive emotion
 - Smiles
 - Laughter
- Research findings suggest that people experience positive emotion and negative emotion during distressing life events.
- Research using LIWC found that negative emotion occurs more than positive emotion during discussions of trauma.
- Researcher expected to find similar results.



CSA and WPH Findings

- Overall, more verbal expression of positive emotion occurred during discussions of CSA than did verbal expression of negative emotion.
- Overall only slightly more verbal expression of positive emotion occurred during discussions of WPH than did verbal expression of negative emotion.
- Positive affect occurred during 24 out of 28 subthemes.
- Positive affect did not occur during the sub-themes respect for others, respect for self/pride, role-reversal and jealousy



Broaden and Build Theory

- Positive emotions broaden the scopes of attention and cognition, leading to a wider variety of thoughts and action impulses in the mind building physical, social, intellectual, and psychological resources.

- **Possible Function of Positive Emotion During Client-Participant Trauma Discussions**
 - Exploration/Interest (Broaden)
 - Reflect on behaviors (CSA: 7x; WPH: 2x)
 - Urge to contemplate new ideas (CSA: 4x; WPH: 1x)
 - Urge to investigate (CSA: 4x; WPH: 0x)
 - Develop alternative solutions (CSA: 0x; WPH: 4x)
 - Psychological Resources (Build)
 - Emotion Regulation
 - Avoidance of trauma-related material and/or thoughts and emotions related to trauma.