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Pepperdine University
Graduate School of Education and Psychology

EXAMINING TRAINEE THERAPISTS' RESPONSES TO CLIENT DISCUSSIONS
TRAUMA IN PSYCHOTHERAPY: A QUALITATIVE ANALYSIS

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Christopher J. Howells

August, 2012

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

This clinical dissertation, written by

Christopher John Howells

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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DEDICATION

This dissertation is dedicated to my wife Gina and my daughter Ellie.

Gina, you have given me strength and support when I have needed it most. With each passing day, you continue to amaze me with your kindness, your selfless generosity, and your caring heart. You have been both my Buddy and my Person when I have needed them the most, and you made our first year of marriage wonderful in spite of everything we have faced. Without your love and confidence in me, I never would have been able to finish graduate school or this dissertation. I know that with you by my side, I can do anything. I love you with all my heart, and I am a better me because of you.

Ellie, you truly have been a blessing in our lives. Although you surprised us with your early arrival, Mommy and I have been forever changed because of you. For us, the best part of every day is getting to watch you grow up.

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I would like to thank everyone who has helped in the development, execution, and completion of this dissertation. First, I would like to thank my lab mates, Ani Khatchadourian and Renee Sloane-Alas. The countless phone calls and emails would have been unbearable if I did not have the two of you with whom I could laugh and commiserate. Your hard work, willingness to face challenges, and relentlessness inspired me not to give up hope.

I also would like to thank Dr. Susan Hall, my dissertation chairperson. I could not have completed this project without her. She never stopped encouraging me to set the bar higher, and I am a better person, clinician, and professional because of the process.

Additionally, I would like to thank Drs. Harrell and Tangeman, my other committee members. Your selflessness, dedication, and expertise added a level of strength and complexity to both this dissertation and my clinical work.

Furthermore, would like to thank Lt Col Ann Hryshko-Mullen, Maj Todd Tice, and the 13 other psychology residents at Lackland AFB. You all played a tremendous part in the completion of this body of work, and I have been able to make it through this residency because of you.

Lastly, I would like to thank all of the past and present service members of the United States military. I am both honored and humbled to stand among you. Although my journey has been difficult, many of you have done more with less. I know that this process has made me better equipped to serve you and my country, and I proudly do it without any hesitation.

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Advisors: Drs. Kathleen Eldridge, Ph.D. & Susan Hall, J.D., Ph.D.

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Cognitive Processing Therapy (CPT) for Post Traumatic Stress Disorder

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ABSTRACT

Current psychology literature offers several definitions for trauma as well as recommended psychotherapy approaches. As trauma presentation and impact can vary greatly across individuals, choosing a specific treatment approach can be quite challenging, especially for training therapists whose clinical judgment and experience to guide decision-making is limited. As such, little is understood about how novice clinicians reconcile definitional and treatment model conflicts when providing trauma treatment. This exploratory qualitative study analyzed the trauma treatment sessions of 5 training therapists. The process and content themes that emerged from the training therapists' responses were categorized as follows: (a) establishing a mutual understanding of the client's experience, (b) providing guidance and support, (c) encouraging alternative processing, (d) affecting session flow, (e) coping, and (f) client struggles/difficulty. These findings were discussed within the context of current trauma treatment recommendations. Patterns that emerged in the therapists' responses suggested that in their efforts to process trauma, the trainee therapists provided validation of the clients' experiences, offered guidance and support to examine the trauma in an alternative way, helped them identify coping skills and sources of support, and emphasized client resilience through strength-focused responses; however, in doing so, they inadvertently engaged in a variety of behaviors, such as relying too heavily on facts and thoughts about the trauma, shifting session focus away from the trauma, or using interfering verbalizations (e.g., multiple questions at once), all which appeared to undermine client emotional engagement with traumatic material in the coded sessions.

Thus, this study's results suggested that training therapists appear to need to be better educated academically and clinically to identify trauma and common treatment barriers that arise, so that they can better plan and implement effective trauma treatments with a clinical population. Specific supervision and training goals that are objective, skill-based, and potentially can be used to enhance training therapists' clinical treatment of trauma, are offered. Future research appears needed to identify what components of recommended trauma treatment training therapists are using, including how training therapists apply Cognitive-Behavioral treatments, and elucidate aspects of trauma treatment that may contribute to and prevent therapy drop out.

Chapter I. Literature Review

Treatment of psychological trauma has long focused on ameliorating the negative effects and dysfunction experienced by people after traumatic events (Tedeschi & Calhoun, 2004). With ever-increasing pressure, clinicians are encouraged to use empirically based interventions for addressing trauma that are tailored to specific diagnoses (Binder, 2004; Foa, Rothbaum, & Furr, 2003; Wells, Trad, & Alves, 2003). Unfortunately, though many evidence-based models for treating trauma focus on constellations of symptoms that fit into one established diagnostic template, such as Posttraumatic Stress Disorder (PTSD; the diagnosis often connected with trauma), only a small percentage of those who suffer from effects of trauma go on to meet full PTSD criteria (American Psychiatric Association [APA], 2000). Also, up to 80% of individuals with PTSD suffer from a comorbid psychological condition (Foa, Keane, & Friedman, 2000; van der Kolk, Roth, Pelcovitz, Sunday, & Spinnazola., 2005). Not often considered traumatic are negative life events, such as divorce or death of a spouse. Nevertheless, because these highly stressful events can have a significant impact on one's physical and mental health (Holmes & Rahe, 1967), they may contribute to more subjective responses after distressing and traumatic events. Accordingly, clinicians should consider that trauma is not a dichotomous concept, but one that exists on a continuum.

In addition, the field of positive psychology prompts therapists to shift their focus from symptom-based treatments to those which also incorporate strength-based interventions (Linely, Joseph, Harrington, & Wood, 2006). In the field of trauma, one such area involves posttraumatic growth, which can be defined as sustained long-term

resilience and positive change after a traumatic event (Joseph & Linley, 2006; Seligman & Csikszentmihalyi, 2000). Linley et al. (2006) suggested that practitioners work to integrate positive interventions with traditional modalities of trauma treatment to better address the clinical picture of someone who has experienced a distressing event because traditional models of treatment are pathology-biased and fail to address the full range of human experience after a traumatic event.

Despite these recommendations, research on how psychology graduate student trainees understand and work with psychological trauma is limited. One potential reason for this lack of clarity may be related to the existence of conflicting theories of trauma and models of treatment. Trainee therapists, who often have limited theoretical knowledge at the beginning of their careers, may have difficulty integrating competing research and training on how to treat trauma. Thus, this qualitative dissertation will explore how trainee therapists respond to client communications of trauma, including those related to events defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (*DSM-IV-TR*; APA, 2000) as meeting criteria for PTSD, as well as expressions that represent sub-threshold negative life events.

The literature review begins with an examination of narrow and broad definitions of trauma and the ways in which it can be understood and experienced. The section follows with an overview of positive psychology, the theoretical framework of this dissertation study, and it then examines interventions from this perspective. Next, this dissertation reviews posttraumatic growth and its applications in the therapeutic context. It continues with a review of how clinical psychology student trainees are taught to understand and manage trauma in psychotherapy. It reviews various models of trauma

treatment, discusses the process of client trauma disclosure, examines positive psychological interventions and integrated models for trauma treatment, evaluates transtheoretical factors in treating trauma, and explores recommendations for training clinicians to work with psychological trauma. This chapter concludes with a summary of the literature reviewed, a description of the purpose of the current study and the research question that was examined.

Trauma and Positive Psychology

Definitions of trauma. Within the psychological literature, trauma has been defined as both the negative events that cause psychological distress, as well as an individual's reactions to an event or the effects caused by the event, which include symptoms and other mental disorders (Briere & Scott, 2006; Hall & Sales, 2008). Conservatively, trauma may be equated with the types of events that often lead to a diagnosis of Posttraumatic Stress Disorder (PTSD) or the symptoms of PTSD. Other research suggests that exposure to a traumatic event is not a necessary criterion for the development of PTSD (Bodkin, Pope, Detke, & Hudson, 2007). As the body of literature on trauma expands, researchers and clinicians seem to have difficulty coming to a consensus to definitively capture what constitutes trauma, as their definitions wrestle with both objective and subjective components (Hall & Sales, 2008; Weathers & Keane, 2007).

Objective components of trauma (event-focused). When it was first recognized in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, (*DSM-III*; APA, 1980), the term *trauma* was defined as: “a recognizable stressor that would evoke significant symptoms of distress in almost everyone” (p. 238). It was required that the

event be “generally outside the range of usual human experience [such] as simple bereavement, chronic illness, business losses, or marital conflict” (p. 238). As such, the definition of trauma was based predominantly on the magnitude of the stressor. Secondary emphasis was placed on the rarity of occurrence of this type of event; however, as epidemiological research began to show that traumas of this nature and magnitude were more prevalent than originally believed, criticism over the wording of the original definition forced the authors of DSM to revise their diagnostic criteria (Weathers & Keane, 2007).

Over DSM revisions, the definition of PTSD has been modified in an effort to better account for the statistical frequency of traumatic events and the subjectivity of dimensional interpretations of extreme distress (Weathers & Keane, 2007). Specific wording around the event needing to be of a particularly high magnitude was dropped in DSM-IV, and the determination of trauma became more contingent on an individual’s perception of an event being as highly physically threatening, rather than based a more objective assessment (Weathers & Keane, 2007). The newest definition allows events, such as traffic accidents and invasive medical procedures, those which do not fall outside of usual human experience, potentially to be considered traumatic.

Still, the authors of the current diagnostic standards have worked to keep the diagnosis of PTSD close to the original intended meaning and application, with DSM-IV-TR defining trauma as the

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 (Criterion A1). The person’s response to the event

must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). (APA, 2004, p. 463)

From this perspective, traumas have been, and continue to be, identified as specific major events that fall outside of normal human experience and are psychologically overwhelming for individuals (Briere & Scott, 2006; Weathers & Keane, 2007).

Hall and Sales (2008) note that many within the field of psychology keep fidelity to the original definition, equating trauma with PTSD. As such, the diagnostic criteria of the disorder has become one typical means of identifying, labeling, and describing events of a particular magnitude and nature, which elicit a particular set of symptoms. The presence of a specific triggering event is a necessity for a PTSD diagnosis, as the occurrence of PTSD symptoms in the absence of a Criterion A1 traumatic event requires a diagnosing clinician to assign a diagnosis of an Adjustment Disorder (APA, 2004; Weathers & Keane, 2007). Typically, traumatic events can be subdivided into two categories: traumas which are interpersonally violent in nature and take place on either a small or large scale (e.g., rape, sexual abuse, torture, war, etc.), and those which are not interpersonal in nature and which include accidental injuries, catastrophic natural disasters, and chronic illness (Sparta, 2003). Regardless of their nature, however, the commonality among all traumas within this definition is that they must involve the direct or vicarious threat of harm or death. Interestingly, though, PTSD is one of the only mental health diagnoses, which contains embedded assumptions about its etiology (Bodkin et al., 2007). That is, inherent in assigning the diagnosis is an understanding that an event of a specific nature and magnitude was directly responsible for inducing the condition in an individual.

Despite efforts to establish more representative diagnostic criteria, there continues to be a struggle for accuracy as the authors work to clarify diagnostic language and the boundaries of the Criterion A1 such that they are neither too inclusive nor too restrictive (Van Hooff, McFarlane, Baur, Abraham, & Barnes, 2009; Weathers & Keane, 2007). Likely in response to the ambiguity around what events constitute trauma, the PTSD diagnostic threshold has become more open to interpretation (Weathers & Keane, 2007). Inherent in the language is a risk of what experts call *conceptual bracket creep* or over-identification of PTSD in instances where criteria are not strictly met (McNally, 2004; Spitzer, First, & Wakefield, 2007). This type of conceptualization can lead to an over-application of the diagnosis in real-world settings (Rosen & Taylor, 2007). Regardless, specific events implicated in PTSD continue to be the conservative reference point used by clinicians in real-world settings to identify trauma.

In addition, broader definitions of trauma exist outside of the DSM classification system, and therefore, may be considered or referred to as sub-threshold. First, many researchers and clinicians argue not only that threats to one's physical well-being can be considered traumatic, but also that stressors that are threats to one's psychological integrity can be overwhelming and can cause subjective traumatic suffering similar to those who have experienced event-based trauma (Briere & Scott, 2006). Events which have a cataclysmic impact on an individual's worldview and emotional functioning (Calhoun & Tedeschi, 1999), which challenge beliefs about one's sense of safety and control (Janoff-Bullman, 1992), or which cause a significant increase in levels of emotional distress (Joseph, Williams, & Yule, 1995), are all considered trauma within psychological literature.

While the PTSD criteria have long been the benchmark for defining what trauma is, research suggests that strict adherence to the A1 threshold for defining trauma may not be as critical as DSM suggests (Gold, Marx, Soler-Baillo, & Sloan, 2005). Only a small fraction of those exposed to a traumatic event actually develop PTSD (Breslau, Davis, Andreski, & Peterson, 1991). In a study of 454 college undergraduates who had experienced either a PTSD Criteria A1 level event (trauma congruent group) or a significant negative event such as the death (non-unexpected) or life-threatening illness of a spouse, a major medical illness themselves, or family conflict (trauma incongruent group), Gold et al. (2005) found that the levels of PTSD symptomatology and distress were significantly higher in the trauma incongruent group than in the trauma congruent group. Critiquing the findings of Gold et al. (2005), Boals and Schuettler (2009) studied 558 college undergraduates and found that DSM-defined trauma led to a higher prevalence and degree of PTSD symptomatology than non DSM-defined trauma in this population. Their findings also suggested that a variety of events that both meet and fall short of DSM-IV-TR diagnostic threshold can lead to the development of symptoms related to PTSD and trauma. These results further suggest that this phenomenon is highly moderated by the type of emotional response of the individual.

Second, PTSD based definitions of single trauma exposure may not appropriately account for the range of difficulties often seen in those who more chronically experience traumatic events. Trauma that occurs repeatedly and cumulatively, often over a period of time and within specific contexts and relationships, is referred to in psychology literature as *Complex Trauma* (Courtois, 2004; van der Kolk, 2005). This type of prolonged and severe (and often interpersonal) childhood trauma, which includes emotional abuse,

physical abuse, sexual abuse, neglect, witnessing domestic violence, exposure to family mental illness or substance abuse, and living in highly violent environments (e.g. conditions of war), can have complex and profound effects on an individual's core abilities for self-regulation and interpersonal relatedness (Cook et al., 2005; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). Although PTSD criteria tend to capture aberrantly traumatic experiences, upwards of 4 million children cases of potential child abuse are reported annually within the United States, with roughly 1 in 5 instances meeting criteria for obvious child harm (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2008). Worldwide, approximately 1 in 3 children are estimated to experience physical abuse (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2008), and prevalence estimates of childhood trauma histories in the general psychiatric population range from 40 to 70% (van der Kolk et al., 2005). This type of complex and chronic trauma exposure represents a highly common problem that is well within the "normal" experience of many individuals.

Briere and Scott (2006) warn that defining traumas as distinct events can give the erroneous impression that experiencing a traumatic event does not increase the likelihood of experiencing further trauma, and that traumas are independent of one another. Although this relationship may be much less true of non-interpersonal traumatic events, such as motor vehicle accidents or natural disasters, many studies strongly suggest that individuals who experience interpersonal trauma are at a statistically greater risk of experiencing further interpersonal trauma (Briere & Scott, 2006). Thus, it can be very

difficult to determine which events are specifically linked to a particular presentation of symptoms and distress (Briere & Jordan, 2009). Although these additional negative experiences may not necessarily meet diagnostic criteria for a diagnosis of PTSD, they have the potential to be subjectively traumatic to the individual because of the potential for repetition of the original trauma (Briere & Scott, 2006).

Third, while conventionally the label of “trauma” had been reserved to classify events of a severe magnitude that are very uncommon, more recent applications of the term may include events that are less acute in nature as well as more “ordinary” stressors and negative life events from a variety of contexts, which do not meet trauma criteria as designated by PTSD, though which can be substantially distressing nonetheless (Weathers & Keane, 2007). One such model for understanding this type of suffering is the Social Readjustment Rating Scale (SRRS) or Holmes-Rahe Stress Scale, a 100 point scale of Life Changing Units (LCUs) that measures individuals’ levels of stress after specific life events (Holmes & Rahe, 1967; Rahe, Meyer, Smith, Kjaer, & Holmes, 1964). This scale assigns life stressors, many of which are not of a PTSD-defined Criterion A magnitude, with a specific number out of 100. These scores, obtained from a sample that cut across differences in sex, age, social class, education, marital status, social class, ethnicity, and religion among residents of the United States, represent units of subjective distress experienced by an individual who has undergone the identified event.

The Holmes-Rahe Stress Scale suggests that negative events, of a range of magnitudes, can increase stress levels and can make one more susceptible to illness and mental health problems (Holmes & Rahe, 1967; Rahe et al., 1964). Additionally, it also

provides support for the notion that events that do not meet A1 magnitude criteria are still substantially overwhelming and subjectively traumatic. When matched up with events that meet criteria for DSM identified trauma, only 3 of the 10 most distressing events could meet criteria for a potential PTSD-eliciting event. In sum, it may not be a specific nature or magnitude of an event that determines if an event is experienced as trauma, but rather the individual's emotional response that determines if an event is traumatic.

Congruent with the aforementioned model, Bryant-Davis and Ocampo (2005) suggest that racism, an unfortunately common phenomenon, can cause substantial psychological distress and may be subjectively experienced as traumatic in a manner similar to rape, domestic violence, or other physical traumas. Briere and Scott (2006) note that ethnic minorities and women may be more frequently exposed to events that can produce traumatic stress than other cultural groupings; this type of contact with violence may be one of the ways in which certain minority populations are uniquely traumatized. Bryant-Davis and Ocampo (2005) noted that individuals exposed to the psychological violence of racism may develop similar cognitive, emotional, and physiological symptoms, as well as impairments in relational functioning and trust to those who have experienced interpersonal physical violence. For example, fear of re-victimization, avoidance behavior, and hypervigilance to the threat of future violence can permeate their lives (Bryant-Davis & Ocampo, 2005). Another core similarity between these types of physical violence and psychological violence seems to be the wielding of power and control by the perpetrator over the victim (Bryant-Davis & Ocampo, 2005). Moreover, other forms of social maltreatment (e.g., social and economic deprivation, sexism and homophobia) may produce similar negative effects and potentially can increase the

likelihood that these individuals will be further victimized during their lives (Briere & Lanktree, 2008; Carter, 2007).

Individuals may be especially susceptible to experiences of trauma if they emigrate from their home country. Specific stressors associated with various stages of the immigration process can precipitate symptoms of PTSD (Foster, 2001). For instances, individuals leaving a country may do so to flee persecution (Foster, 2011). Their journey to the new host country may contain elements that are life threatening, and their living circumstances may elicit fear due to violence, overcrowding, or a lack of resources necessary to survive, such as food (Foster, 2001). These individuals become ethnic minorities in their new home country, and they are susceptible to having inadequate support systems and being exposed to minority persecution, both of which can further threaten their psychological integrity (Foster, 2001). Clinical work with these individuals often will focus on the potential trauma and/or grief related to the immigration; for some this process can last for years (Weiss & Berger, 2008).

Fourth, distressing phenomena does not have to be individually directed for it to lead to psychological dysfunction, and certain populations may be at a greater risk for exposure to systematically traumatizing forces than others. While possibly more salient incidents of racism occur to varying degrees on an individual interpersonal level (e.g., verbal statements, non-verbal behavior, etc.), global and historically rooted expressions of racism may impact minority group members on a macro level (Harrell, 2000). Jones (1972) suggests that racism (though arguably prejudice potentially faced by any member of a non-dominant sociocultural grouping) can manifest in a variety of different manners, which include disparities in social status/functioning/achievement (i.e., *institutional*

racism), the promulgation of negative attributes through various media formats (e.g., news, art, entertainment), and the propagation of racial attitudes in a sociopolitical contexts (e.g., public debates; political discussions); however, the total experience of racism by any individual is the combined and often simultaneous exposure to multiple forms of this phenomenon rather than the interaction with racism in only one domain (Harrell, 2000).

In conclusion, it appears that the experience of trauma is not fully contingent on an individual experiencing a singular event of an objectively particular nature and magnitude. Rather, it may be that an individual's subjectively influenced experience around an event perceived as distressing influences whether the event is defined as traumatic. The subjective components of trauma are discussed in more detail in the next subsection.

Subjective components of trauma (effects of and responses to trauma events).

Although trauma is often defined by the specific event that produces distress, it can also be understood in terms of the potential subjective effects of that experience, which include specific symptoms as well as other associated disorders (Briere & Scott, 2006; Hall & Sales, 2008). The effects that are most closely related to trauma are those seen in the specific symptoms of PTSD and Acute Stress Disorder (ASD; APA, 2004.) The three major symptom areas of traumatic events in the DSM-IV are re-experiencing of the traumatic event (e.g., through flashbacks or nightmares), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (i.e., avoiding cognitive and emotional cues to the trauma), and symptoms of increased arousal (e.g., hypervigilance, difficulty falling asleep, etc.; APA, 2004).

More recently, Friedman, Resick, Bryant, and Brewin (2011), in conjunction with the American Psychiatric Association task force on Trauma and Stress Related Disorders, have proposed that the PTSD criteria be modified in the upcoming *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*. Specifically, the authors, who are experts in the field of trauma, have recommended that the A1 criterion be more clearly specified to eliminate ambiguity and that the A2 criteria be eliminated, as it has no clinical utility. Further recommendations include the addition of a new category of symptoms for negative cognitions and mood associated with the traumatic event (which often is seen in clinical populations), a deconstructing and restructuring of the hypervigilance, avoidance, and arousal symptoms to include the new grouping, and the elimination of the acute/chronic specifier (Friedman et al., 2011).

Although the diagnostic criteria of PTSD can provide guidelines for the identification of trauma, many times that framework for understanding the impact is incomplete. Many people who experience significantly distressing events will not meet criteria for PTSD, but can meet diagnostic criteria for other anxiety, depressive, somatic, substance abuse, and psychotic disorders (Briere & Scott, 2006). Furthermore, some individuals exposed to events that result in death or major loss can experience Complicated or Traumatic Grief, diagnoses not codified in the DSM-IV, but which represent pathological subjective reactions that are impairing and not better accounted for by diagnoses of PTSD, Bereavement, or an anxiety or depressive disorder (Briere & Scott, 2006; Lichtenthal, Cruess, Prigerson, 2004). These reactions to loss are of a greater intensity, of a longer duration, and lead to a different presentation of symptoms

and impairment than what would be expected after the loss, even when accounting for the appropriateness of response within an individual's culture (Lichtenthal et al., 2004).

In addition, an individual's subjective appraisal of a negative event has a strong influence on how distressing an event is perceived to be. As noted above, "everyday" life stressors, if experienced as highly overwhelming, can potentially produce patterns of symptoms that are similar to people diagnosed with or who have met criteria for PTSD (Bodkin et al., 2007; Spitzer et al., 2007). While current diagnostic criteria posit a dichotomous model for understanding trauma, there is an increasing body of literature that supports alternative conceptualizations that capture the subjectively determined responses to events.

For example, Briere and Spinazzola (2009) propose that the effects of trauma be conceptualized on a complexity continuum, one end of which represents responses to adult-onset single-episode traumatic events such as a motor vehicle accident or a violent assault. At the other end of this spectrum, the authors propose, are responses to early, extended, multiple-instance, and sometimes highly invasive traumatic events, which may be less easily identifiable because of the nature of the precipitating events as well as the shame or stigma associated with them events (Briere & Spinazzola, 2009). Reactions to this type of trauma are often multifaceted, and individuals at this end of the spectrum frequently present with a more complicated array of mood, anxiety, affect regulation, and interpersonal symptoms (Briere & Spinazzola, 2009).

Unlike many who experience isolated instances of trauma, individuals whose trauma exposure is more chronic and interpersonal often display an interconnected array of psychological signs and symptoms. Trauma researchers have developed various

theoretical constructs, such as *complex PTSD* (Herman, 1992), *disorder of extreme stress, not otherwise specified* (DESNOS; Pelcovitz et al., 1997), *self-trauma disturbance* (Briere, 2002), or the proposed DSM diagnosis of *Developmental Trauma Disorder* (DTD; van der Kolk, 2005), which seem to capture the clinical presentation of many who have experienced multiple-event or chronic trauma that is often interpersonal in nature (Courtois & Ford, 2009).

Some recent conceptualizations of complex trauma suggest that it is a sub-type of PTSD, especially in light of how some individuals with that presentation respond to specific PTSD treatments (Freidman et al., 2011). Courtois and Ford (2009), however, have proposed that this trauma manifestation is qualitatively distinct from that found in PTSD:

Complex traumatic stress disorders therefore go well beyond what is defined as the classic clinically significant definitions (Criterion A) and beyond the triad of criteria (intrusive re-experiencing of traumatic memories, avoidance of reminders of traumatic memories and emotional numbing, and hyperarousal in Criteria B-D) that make up the diagnosis of posttraumatic stress disorder. (p. 2)

Regarding its etiology, complex psychological trauma involves exposure to traumatic stressors that (a) are repetitive and chronic; (b) involve harm, abandonment, and/or neglect by caregivers or other responsible adults; and (c) occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence, during which critical periods of brain development are occurring rapidly or being consolidated (Ford & Courtois, 2009). Diagnostically in DTD, van der Kolk (2005) requires exposure to one or multiple forms of "developmentally adverse interpersonal trauma" (e.g., physical or emotional abuse, abandonment, sexual assault, threats to bodily integrity) in place of the PTSD objective (A1) criteria (Ford & Courtois, 2009). Furthermore, the

author reworks criteria (A2), specifically identifying “rage, betrayal, fear, resignation, defeat, [and] shame” as the subjective criterion for childhood complex stress disorders (van der Kolk, 2005, p. 405). Regardless of the proposed label for this broad-reaching condition, consistent among all of the aforementioned constructs is that the posttraumatic sequelae associated with complex trauma can impact an individual’s mind, emotions, body, and relationships (Ford & Courtois, 2009).

As introduced above, many of the effects seen in these individuals are not captured in the symptom criteria of PTSD. In fact, only 1 in 4 chronically traumatized children meet criteria for a PTSD diagnosis; many suffer from a range of other psychological disorders, including anxiety, depression, disruptive behavioral disorders, eating disorders, disorders of separation and attachment, and sleep disorders (Cook et al., 2005). Typically, there may not even be an appropriate diagnosis that captures the range of symptoms often seen in a child with chronic trauma exposure (Cook et al., 2005; Kinniburgh et al., 2005). Nonetheless, the impact of this type of trauma may be especially significant because chronic trauma is typically early and interpersonal, and the effects of trauma can be especially severe and long lasting when the trauma is caused by another person (APA, 2004), and when it occurs early in life at the hands of a primary caregiver or attachment figure (Pearlman & Courtois, 2005). Furthermore, when compared to those who have experienced non-interpersonal event-based trauma, individuals who have experienced chronic interpersonal trauma, especially before the age of fourteen, demonstrate a substantially greater prevalence for a variety of biological and psychosocial impairments and symptoms (see van der Kolk et al., 2005 for a full review of comparison of prevalence rates of chronic trauma effects between early interpersonal

trauma, interpersonal trauma after age fourteen and non-interpersonal event-based trauma).

Greater psychological damage is seen in individuals who experience events that are deliberate and willful and/or due to negligence, human error, or disregard (Courtois & Gold, 2009). Furthermore, those who are hurt by other people often experience a sense of betrayal due to having been objectified in the process (Courtois & Gold, 2009). These individuals may have residual experiences of shame and blame (e.g., a child abuse survivor who is not believed or the rape survivor who is told she was at fault), adding layers of complexity to the trauma picture (Courtois & Gold, 2009).

As referenced earlier, trauma that occurs repeatedly and cumulatively can have severe and pervasive effects on an individual (Cook et al., 2005; Kinniburgh et al., 2005). Complex childhood trauma (Courtois, 2004), has been implicated in the emergence of significant and often severe impairments in interpersonal and psychological functioning (Cook et al., 2005; Kinniburgh et al., 2005). Furthermore, studies and theory strongly point to the fact that children who are exposed to early chronic trauma often experience lifelong problems, which place them at a higher risk for experiencing additional trauma as well as experiencing impairments in a variety of domains (e.g., psychological, legal, vocational, and relational) across their lifetime (Cook et al, 2005). Compared to individuals who have not experienced trauma, those who have been exposed to early childhood trauma evidence a high incidence of changes in the brain associated with impairments in multiple areas (van der Kolk et al., 2005). Both children and adults who have experienced chronic trauma frequently evidence difficulties in attachment, regulating and managing affect (e.g., difficulties identifying, expressing, and controlling

feelings), behavioral control (e.g., issues of impulsivity and management of destructive behavior that includes damage to property and self-harm), the development of self-concept (e.g., low self-esteem and pathological feelings of shame/guilt), moral and social development, biological functioning (e.g., somatization and analgesia), and in cognition and memory (e.g., disorganized process and problems with maintaining attention and concentration); additionally they are significantly at risk for experiencing dissociative episodes (Cook et al., 2005; Kinniburgh et al, 2005; Solomon & Heide, 2005).

As adults, children who have experienced chronic early trauma often suffer from a host of psychological problems and diagnoses as well. These conditions may include substance abuse, affective disorders, anxiety disorders, eating disorders, Antisocial and Borderline Personality Disorders, sexual problems, and severe dissociation (Kinniburgh et al., 2005). Most notably, though, the effects of complex trauma are relatively similar to the symptoms seen in Borderline Personality Disorder (BPD; APA, 2004), as individuals who suffer from BPD show significant problems in identity, affect regulation, and interpersonal relationships (Briere & Scott, 2006). These observed similarities led to some of the seminal studies, which demonstrated that the majority of individuals diagnosed with BPD experienced early and chronic abuse and maltreatment (Herman, Perry, & van der Kolk, 1989; Pearlman & Courtois, 2005).

All of the aforementioned symptoms and deficits can impede the formation and maintenance of healthy relationships with others (Cook et al., 2005; Ford & Courtois, 2009; Freidman et al., 2011). These traumatized individuals often establish relationships with others who have experienced similarly significant trauma (Briere & Scott, 2006; Cook et al., 2005; Pearlman & Courtois, 2005; Kinniburgh et al., 2005). There seems to

be a natural gravitation for these individuals to find others who have had comparable experiences. Perhaps this trend occurs because many traumatized individuals, especially those who have experienced chronic and early trauma, report feeling shame, a sense of being permanently damaged, and a belief that no one else can understand their life experience (van der Kolk et al., 2005). It is possible that by finding others like themselves who have had common experiences, these traumatized individuals can alleviate some of the suffering they feel.

Conversely, research strongly suggests that in conjunction with limited discrimination in their attachment-seeking behavior, chronically traumatized individuals are also more likely than those who have not experienced chronic trauma to perceive innocuous situations and interactions as potentially threatening. These individuals may engage in highly risky or addictive behaviors to assist with managing difficult affective states, and paradoxically, they may cling to unhealthy relationships in a frantic manner to avoid being left along (Pearlman & Courtois, 2005). Their relationships very often are oriented around themes of abandonment or fears of victimization; these individuals may use overly deferent behavior to avoid feeling uncomfortable emotions associated with rejection, thus increasing the likelihood that they may be victimized by others (van der Kolk, 2005). In addition, those who have experienced chronic abuse often evidence difficulties with perspective taking, appropriately understanding boundaries, and recognizing the motives of other people (Cook et al., 2005). As a result, the relationships of these individuals may be full of suspiciousness and distrust given their often frightening and chaotic early attachment-building experiences.

Other impairments in emotional-cognitive functioning may play a role in how chronically traumatized individuals perceive their social world. Children who have experienced ongoing abuse, as well as adults who have BPD, display a significantly greater tendency than non-abused children and individuals who do not have BPD to read neutral faces of others as hostile or threatening (Donegan et al., 2003; Pollak, Cicchetti, Hornung, & Reed, 2000). Because of the lack of perceived safety in their world, many children who experience chronic trauma are forced to manage overwhelming emotional and psychological experiences by relying on primitive and frequently inadequate coping skills, such as avoidance, aggression (towards oneself and towards others), and dissociation (Kinniburgh et al., 2005; van der Kolk, 2005). These individuals, who very often are in a state of chronic emotional arousal, continue to rely on these premature strategies for self-protection, which in turn can lead to further complex impairment. Chronic and early trauma can impact the formation of that individual's personality around the trauma such that traumatic themes may impact many areas of functioning (Pearlman & Courtois, 2005).

Although ongoing trauma typically may be understood within a dyadic relationship, exposure to chronic stress does not necessarily have to occur on the individual level for it to result in a traumatic reaction. Ongoing group exposure to violence on a community and country level also can play a role in the manifestation of PTSD and other psychological dysfunction (Fowler, Tompsett, Brackiszewski, Jacques-Tiura, & Baltes, 2009). The findings of the meta-analysis of Fowler et al. (2009) suggest that the effects of exposure to ongoing neighborhood violence are associated with the development of PTSD-like symptoms (e.g., chronic hyperarousal), especially among

children and adolescents. Moreover, children and adolescents from these environments seem to be at a much greater risk of developing the full disorder of PTSD (Fowler et al., 2009), and this effect has been found in non-Western South African children as well (Shields, Nadasen, & Pierce, 2008). Further research suggests that this effect also may be seen among young adults, independent of gender or ethnicity (Wilson, Rosenthal, & Battle, 2007), as well as adult females, the latter of whom may be twice as likely as women not exposed to this type of violence for developing anxiety and depressive symptoms (Clark et al., 2007). It appears that regardless of the means of exposure to it, chronic stress often precedes traumatic reactions.

Positive effects seen after trauma. Outcomes of traumatic events are not always negative. Across culture and demographic differences, positive change after physically and psychologically traumatic experiences has been examined within a variety of contexts and populations. Growth following trauma has been reported by individuals exposed to a multitude of different difficult, tragic, catastrophic, or horrible experiences (Calhoun & Tedeschi, 1999). Growth after trauma has been measured in individuals who have had experiences which include child and adult sexual abuse, rape, combat exposure, transportation and mechanical accidents, bereavement, recovery from substance addiction, adults and children coping with chronic medical conditions such as arthritis, cancer, and HIV/AIDS, natural disasters, shootings, and being held as a hostage (Affleck & Tennen, 1996; Calhoun & Tedeschi, 2006; Hart, Vella, & Mohr, 2008; Helgeson, Reynolds, & Tomich, 2006; Joseph & Linley, 2006; Linley & Joseph, 2004; Littlewood, Venable, Carey, & Blair, 2008; Sheikh, 2004). Some stressors may be more acute, such as accidental death, while others like exposure to ongoing violence or war are more

chronic in nature (Park & Lechner, 2006). Many studies of growth recognize the impact of spirituality and religion on positive outcome (Pals & McAdams, 2004; Prati & Pietrantonio, 2009), as well as more western social pressures to learn and make positive changes after a negative experience (Linley & Joseph, 2004). This type of research is difficult to conduct, though, as individuals, groups, and societies can vary dramatically in both their potential for exposure to various types of traumas and the subjective ways in which they experience them (Park & Lechner, 2006). Even the perception of what constitutes a traumatic experience can be quite varied from one culture to another.

Because of the high degree of subjectivity around trauma and how it is experienced, models of growth following trauma and adversity attempt to address the underlying change process while accounting for differences and gender, age, ethnicity, and type of trauma (Park & Lechner, 2006). Linley and Joseph (2004) found that while demographic variables could not consistently be linked to whether growth occurred or not, across cultures and dimensions of trauma, the common factor in all positive change after negative stressful events is growth that occurs through the struggle with adversity. This type of change, posttraumatic growth, has been observed in males and females, people of all ages, and throughout differing cultures (e.g., Latina, German, American, British, Israeli) around the world (Sheikh, 2008). Such research in the area of positive psychology and posttraumatic growth suggests that many individuals can experience positive changes in self-perception, their relationships with others, and in their life philosophy (Calhoun & Tedeschi, 2006). Given their importance, positive psychology and posttraumatic growth will be further described.

Positive psychology. *History of positive psychology.* Within the field of psychology, trauma research has focused predominantly on the numerous physiological and psychological effects of trauma (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996). This seems historically congruent, as much of the foundation of the field of clinical psychology is rooted in a medical model of disease and pathology (Seligman & Csikszentmihalyi, 2000). In the years leading up to and following World War II, researchers and practitioners in the field of clinical psychology have strived to uphold its three missions as laid out by the American Psychological Association (APA): “curing mental illness, making the lives of people more productive and fulfilling, and identifying and nurturing high talent” (Seligman & Csikszentmihalyi, 2000, p. 6). To their credit, the product of research efforts spanning more than a half century has led to tremendous strides in the classification, understanding, and treatment of nearly a dozen distinct mental disorders and alleviated the suffering of millions (Gillham & Seligman, 1999; Seligman & Csikszentmihalyi, 2000). However, with the establishment of the Veterans Administration in 1946 and the National Institute of Mental Health, in 1947, positive psychologists argue that the focus of the field of clinical psychology moved away from its original tenets (Seligman & Csikszentmihalyi, 2000). There was a tradeoff among the APA missions, and alleviating mental illness, to a large degree, came at the expense of helping individuals nurture their strengths and live more productive and fulfilling lives (Joseph & Linley, 2006; Seligman & Csikszentmihalyi, 2000).

Weakness and strength traditionally have been treated as distinctly different from a western perspective. While advocates from client-focused branches of psychology have contended that the field of psychology largely was ignoring positive experiences of

emotional states, such as subjective well-being, happiness, and growth (e.g., the writings of Humanistic psychology's Abraham Maslow and Carl Rogers and the birth of Counseling Psychology), their concerns went relatively unrecognized by clinical psychology until the early 1990s (Gillham & Seligman, 1999; Lopez et al., 2006). As a means to reconnect it with its historic roots, Seligman and Csikszentmihalyi (2000) recommended that the focus of clinical psychology shift away from a psychopathology and disease only model, and increase efforts towards helping individuals live more positive and fulfilling lives. The movement of positive psychology has attempted to bring to the forefront the importance of increasing positive experiences in the lives of even those who are suffering.

Critiques of positive psychology. A common criticism of the field of positive psychology is that treatment from this perspective solely addresses client strengths and fails to examine problems in psychological functioning directly; however, this belief represents a common misconception of positive psychology, as proponents of this subfield do not often emphasize positive interventions at the complete expense of more traditional ones (Linley et al., 2006). Like many dichotomously understood constructs, there seems to be an innate trade-off between focusing on flourishing and focusing on deficit (Joseph & Linley, 2006). Weakness and strength are typically treated as distinctly different and polarized concepts, regardless of whether they are defined in a categorical or continuum model. This delineation may be a natural barrier that impedes practical integration of the traditional and positive psychological models (Joseph & Linley, 2006).

Furthermore, from a practical perspective, the importance of human survival may play a role in psychology's emphasis on negative events over positive ones (Gillham &

Seligman, 1999). A negative focus may be reflective of differences in urgency attributed to positive and negative emotions. Negative emotions often signal that there are immediate problems and objective dangers, and that vigilance to make changes in these areas of distress can play an evolutionary role of adapting behavior to avoid a threat (Gillham & Seligman, 1999). In the United States, especially, this concern with reducing and avoiding potentially damaging threats is reflected in many areas of the media (e.g., the news, television programs) and much of the information disseminated from the social science fields (Gillham & Seligman, 1999). Unfortunately, this focus on identifying threats and avoiding emotional experiences not only may contribute to a culture heavily focused on victimization, but also may limit peoples' ability to recognize the value that positive emotions have in producing creativity, happiness, and a much wider range of psychological survival and fulfillment (Gillham & Seligman, 1999).

The field of positive psychology attempts to bring to the forefront positive experiences and strengths, which have traditionally be undervalued or ignored. Researchers in this area posit that a strength-based concentration should be in better balance with more traditional foci (Linley et al., 2006), as a stand-alone DSM-based model (one whose emphasis is on alleviating distress) places substantial importance on ascribing pathology in a manner such that individuals often must be diagnosed with a problem or deficit before receiving treatment. Instead, clinicians should focus on the entire range of human experience, which involves addressing health, fulfillment, and well-being, as well as suffering, loss, and distress (Seligman & Csikszentmihalyi, 2000).

Another major critique of the field of positive psychology is that it has lacked culturally-informed agreed upon constructs for research, diagnosis, and intervention

(Dahlsgard, Peterson, & Seligman, 2005). These constructs traditionally have been rooted in terms developed within the DSM and International Statistical Classification of Diseases and Related Health Problems (ICD); however, as both are based on pathology, these models lack the terminology to capture the societal and cultural factors that play an important role in the development of identity, a system of values, and needs for well-being and happiness. Nothing like the DSM or ICD exists for human strengths (Dahlsgaard et al., 2005).

In response to the criticism, researchers and clinicians are beginning to organize positive psychology within in a multicultural context to examine related constructs across cultures (Lopez et al., 2006). For example, in an historic and cross-cultural literature search for virtues that are critical for human thriving, Dahlsgaard et al., (2005) examined scholarly writings of Confucianism, Taoism, Hinduism, Buddhism, Athenian Philosophy, Judaism, Christianity, and Islam, which the authors identified as ancient traditions that have had a prominent and enduring impact on humanity. The authors' findings suggest that courage (i.e., emotional strength in the face of opposition, such as honesty and forgiveness), justice (i.e., civic strength, which underlies a healthy community life), humanity (i.e., interpersonal strengths such as love and kindness), temperance (strengths that protect against excesses, such as forgiveness), wisdom (i.e., cognitive strengths, such as wisdom and creativity), and transcendence (i.e., strengths that provide meaning, such as gratitude and hope) represent common positive virtues that cut across culture and ethnic grouping (Dahlsgaard et at., 2005). The results of the study further suggest that across civilizations, positive experiences play a fundamental role in establishing core values.

It appears that outside of the history of clinical psychology and across cultural contexts, individuals are interested in leading fulfilling lives of value and purpose. It is perhaps for these reasons that researchers in the field of positive psychology have labored to introduce specific psychological interventions to assist clients who present to therapy.

Positive psychology interventions. The benefits of reducing the negative aspects of psychological distress are impossible to ignore; however, until the last two decades, the medical model focus on symptom reduction may have inhibited the progress of researchers and practitioners in the field of clinical psychology in fostering individual strength and talent (Gable & Haidt, 2005; Seligman & Csikszentmihalyi, 2000). As a result, psychological theories have been heavily biased towards identifying damage, and researchers and clinicians, whose work is informed by these theories, may have a somewhat limited understanding about facilitating strength and meaning in individuals (Gillham & Seligman, 1999). Nonetheless, it has become increasingly apparent that positive interventions play an important role in psychological treatment, especially given the fact that even people who suffer care about more than just their distress (Duckworth, Steen, & Seligman, 2005). Individuals in distress also want to increase strength in their lives by engaging in experiences that provide pleasure and assist them in making meaning out of their struggles (Duckworth et al., 2005).

At the level of treatment, providing therapy from a strength-based perspective requires clinicians to have a set of non-traditional techniques from which they can draw. Duckworth et al. (2005) suggest that positive psychological interventions should focus on increasing subjective well-being and improving strengths and talents. It is through this process that a client can learn to live a life that is meaningful and personally engaging,

and he/she can pull from these abilities to overcome life's challenges (Duckworth et al., 2005). Seligman et al. (2005) suggest interventions that include: writing a gratitude letter to someone who has been kind though never been thanked by the client, writing down three positive experiences each day for a week, and recalling a time when one has been personally successful and identifying and reflecting on personal strengths that were displayed during that time. Other interventions that have seem to have significant positive benefits (versus a randomly assigned control group) include spending 20 minutes for three consecutive days writing about intensely positive experiences (Burton & King, 2004) and writing down three things that went well on this day and reflecting on why (Seligman, Rashid, & Parks, 2006).

Research testing positive frameworks and interventions seems to demonstrate that at least in some situations, positive interventions can be highly effective with the alleviation of symptoms. In a random assignment, self-selection, internet-administered study, which consisted of mostly college educated individuals who had visited the lead author's book website, Seligman et al. (2005) examined the effects of exercises designed solely to increase happiness. The authors found that 3 of the 5 self-administered interventions increased happiness to levels that were significantly greater than the control group, with results remaining stable at least 6 months beyond termination of the study. The authors suggested that supplementing traditional interventions with positive ones can increase the benefits of treatment being provided.

Seligman et al. (2006) found that manualized 6-week positive group psychotherapy, whose focus was on using interventions aimed at building strength and gratitude, was more effective than a control group at reducing mild to moderate

depression among 40 undergraduate college students. Participants were included for the study based on their self-reported levels of depressive symptoms, which were determined to be in the mild to moderate range as measured by the Beck Depression Inventory, 2nd Edition (BDI-II). The benefits of the positive interventions, as measured longitudinally by the BDI-II, were maintained for at least 12 months after the group ended. In a follow up study, Seligman et al. (2006) compared both treatment as usual (integrated psychotherapy provided by 5 licensed psychologists, two Licensed Clinical Social Workers, and two supervised psychology interns) and treatment as usual with medication against 14-week manualized positive individual psychotherapy, for the treatment of Major Depressive Disorder. The authors found that the positive intervention group, consisting of 46 outpatient clinic clients who met diagnostic criteria and did not meet exclusion criteria (e.g., receiving current individual treatment, meeting criteria for a bipolar or psychotic disorder, having a co-morbid substance abuse diagnosis within the past year) demonstrated significantly fewer symptoms (as measured by the Zung Self-Rating Scale and the Hamilton Rating Scale for Depression), a significantly higher level of overall functioning, and significantly greater level of happiness and subjective well-being (as measured by the Positive Psychotherapy Inventory – a validated measure of happiness). All measures were also co-validated by the subjective reports of the clinicians.

In their meta-analysis of 49 well-being studies and 26 depression studies, Sin and Lyubomirsky (2009) found that positive psychology interventions were significantly more effective than comparison groups at reducing depression and boosting overall well-being. The findings suggested that clients will benefit greatly not only from coping with

negatives, but also by attending to and attaining positives in their lives. In addition, clients from non-individualistic cultures benefitted more from interventions that were more pro-social in nature (e.g., writing another person a gratitude letter versus assessing one's own individual strengths). In all clients, the implementation of multiple positive psychology interventions had a greater effect than the implementation of single positive interventions. Although research regarding their efficacy seems to substantiate the idea that positive psychological interventions can be effective in the alleviation of psychological distress, effects of this strength-based approach may not be limited to reducing distress.

Posttraumatic growth. Humanistic and existential psychologists, philosophers, and religious scholars have long written on the subject of change via adversity (e.g., Viktor Frankel, 1963, Irvin Yalom, 1980, writings in Christianity, Hinduism, Judaism, and Islam; Joseph & Linley, 2005). These foundational principles have been interwoven in culture and tradition throughout the world for thousands of years; however, similar to the movement to incorporate positive psychology into practice, clinical psychology has only recently begun to incorporate these ideas in treatment in a formal manner to more wholly help clients manage stressful and traumatic experiences.

Congruent with the focal shift in clinical psychology to incorporate positive interventions with traditional ones, there is an increasing body of research exploring the idea growth can occur as the result of adverse experiences (Ford 2012; Prati & Pietrantonio, 2009; Schuettler & Boals, 2011; Tedeschi & Calhoun, 1995). While trauma can be overwhelming and devastating, data suggest that 30 to 90% of individuals who have experienced traumas report they have been positively changed by their experience

(Joseph & Linley, 2005; Tedeschi & Calhoun, 1995). Growth following trauma has been associated with less depression and an increase in positive well-being (Helgeson et al., 2006).

A variety of constructs describing growth after an adverse negative or traumatic experience exist in theoretical and empirical psychology literature. These include, *adversarial growth* (Linley & Joseph, 2004), *stress-related growth* (Park, Cohen, & Murch, 1996), *heightened existential awareness* (Yalom & Lieberman, 1991), *thriving* (Abraido-Lanza, Guier, & Colon, 1998; O'Leary & Ickovics, 1995), *perceived benefits* (McMillen & Fisher, 1998), *benefit-finding* (Affleck & Tennen, 1996), *positive illusions* (Taylor & Brown, 1988), *positive by-products* (McMillen & Cook, 2003), and *posttraumatic growth* (PTG; Joseph & Linley, 2005). These terms have been used interchangeably throughout psychological literature (Joseph & Linley, 2005). However, while many models have described the process of positive change after a stressful or traumatic experience, few have attempted to account for how the process occurs (Joseph & Linley, 2005).

In an attempt to account for the process of PTG, Joseph and Linley (2005) theorized how growth may occur after a trauma. Their organismic valuing theory of growth through adversity holds that individuals are motivated intrinsically to rebuild their shattered worldview following a trauma (Joseph & Linley, 2005). Central to original model, Tedeschi and Calhoun (1995; 1996; 2004; Calhoun & Tedeschi, 1999, 2006) offer that the trauma itself is not responsible for posttraumatic growth, but rather what happens in the aftermath determines if growth occurs.

Furthermore, in their definition of trauma, Tedeschi and Calhoun (2004) interchangeably used the term trauma with crisis and highly stressful events, suggesting that to various degrees, those experiences each represent significant challenges to one's worldview. The authors specifically noted that their conceptualization of trauma was much broader than the DSM-IV definition. As such, PTG theory holds that individuals experience positive transformation as a result of their struggle with trauma or highly challenging life event.

Training Therapists to Work Effectively With Clients Who Have Experienced Trauma

A strong ability to integrate concepts and training appears critical for clinical work. Nevertheless, recommendations for how trainees should go about this process when working with clients with multiple interrelated presenting traumas seem limited. While a fair amount of research has been conducted on the orientations and treatment approaches of veteran therapists (e.g., Norcross & Goldfried, 2005; Orlinsky & Rønnestad, 2005), there is limited knowledge about how, in general, training therapists integrate theory in practice when working with clients presenting to treatment with a variety of different problems (Boswell, Castonguay, & Pincus, 2009). What is understood about the training of mental health providers, though, is that while seasoned clinicians use experience as a means to merge research and training, novice trainees, who often are exposed to many different orientations and protocols, may not possess the skills to integrate treatment models and tailor them adequately to a particular clinical situation (Boswell et al., 2009). This abstract critical skill seems to be found at the more advanced

phases of a trainee's development rather than the initial stages (Boswell & Castonguay, 2007).

In addition, within the field of clinical psychology there seems to be an ever-increasing push for clinicians to adhere to evidence-based practice (EBP) models of treatment (Binder, 2004), which are often single diagnosis or problem specific. Trainees in psychology graduate programs are impacted directly by this pressure, as the American Psychological Association (through the accreditation process) challenges faculty to adapt training to incorporate EBP training into the curriculum (Kratochwill, 2007). The belief is that students should receive education in models that have been empirically validated through randomized controlled trials (RCTs).

In the field of trauma treatment, this practice of model matching with empirically validated protocols may be a difficult one, as the etiology of trauma is often multivariate, with a combination of events (rather than a single one) adversely impacting a client's clinical presentation (Briere & Jordon, 2009). Clients who have experienced trauma can present with such a wide variety of cognitive, somatic, psychological, and interpersonal difficulties (Briere & Jordon, 2009) that it may be difficult for trainees to know where to begin treatment. Thus, an examination of the various types of models from which training clinicians are pulling techniques may improve understanding of how novice clinicians may be incorporating therapeutic interventions when working with clients who have experienced trauma. This section begins with a review of the standard empirically supported treatment models for the treatment of single event traumas, examines the role and process of client disclosure of trauma during psychotherapy, explores positive psychology community-based interventions for the treatment of trauma, looks at

movement in the field towards the integration of models of trauma treatment, and examines literature on the education and training of psychology trainees with regard to trauma.

Treatment models for specific event traumas. At present, the majority of empirically supported treatments for children, adolescents, and adults who have experienced single event traumas are cognitive-behavioral in nature (Friedman, 2008; Hajcak & Starr, 2010; Hamblen; Schnurr, Rosenberg, & Eftekhari, 2009; Silverman et al., 2008). The goal of these types of treatments is the reduction of clinically significant PTSD-based symptoms. While there exist some conflicting analyses regarding effect sizes, the majority of trauma research suggests that treatments which directly focus on the traumatic event and an individual's affects and memories around the event are the most effective therapeutic methods for directly reducing PTSD-like trauma symptomatology in adults, when compared with other psychological interventions (e.g., supportive psychotherapy) not specifically designed to do so (Benish, Emel, & Wampold, 2008; Ehlers et al., 2010; Friedman, 2008; Hamblen et al., 2009). Furthermore, the most widely researched treatments for single episode trauma in children and adolescents are also cognitive-behavioral in nature (Silverman et al., 2008). In their meta-analytic review of RCTs for the treatment of PTSD trauma symptoms in this children and adolescents, Silverman et al. (2008) found that cognitive-behavioral treatments were significantly more effective at reducing PTSD symptoms, depression, anxiety, and externalizing behavior problems than treatments that were not cognitive-behavioral in nature.

One of the primary cognitive-behavioral treatments for single event trauma is Prolonged Exposure (PE), a model whose goal is to have clients gradually confront both

their traumatic memories as well as real-world situations that evoke anxiety so that they can learn to experience them without using maladaptive coping strategies like behavioral avoidance (Foa & Meadows, 1997). This treatment is believed to modify faulty cognitive processes by allowing clients to reactivate traumatic memories, emotionally processing them, and experiencing them in a manner such that these memories are neither fully overwhelming nor representative of the client's entire existence (Foa, Rothbaum, & Furr, 2003). In a meta-review of multiple studies testing the efficacy of cognitive and exposure therapies, Foa et al. (2003) determined that for adults with PTSD, PE-based interventions led to a significantly greater symptom reduction than did "standard care" treatment methods.

The other principal cognitive-behavioral model for PTSD symptomatology, which is empirically supported for adults, is Cognitive Processing Therapy (CPT), a treatment whose design is to challenge and change self-blame and distorted beliefs, which inhibit the natural trauma recovery process, through Socratic questioning (Resick & Schnicke, 1992). Although there is an exposure component to CPT, the main focus during the therapy is to adjust dysfunctional beliefs about the meaning of the traumatic event (Resick & Schnicke, 1992). Therapists challenge dysfunctional beliefs, mitigating their impact on the natural recovery process (i.e., dysfunctional beliefs prevent engagement with natural feelings associated with the trauma), helping clients experience emotions related to the trauma and associate new meaning to their experiences (Resick, Monson, & Chard, 2010). Resick, Nishith, Weaver, Astin, and Feuer (2002) found that among female adult rape victims, the majority of whom were Caucasian and African American, CPT was effective as prolonged exposures for the treatment of chronic PTSD, and CPT

appeared more effective at reducing guilt symptoms. Furthermore, Schulz, Huber, and Resick (2006) found that among refugees from war-torn Bosnia and who were residing in the United States and receiving psychological treatment for PTSD, CPT was significantly more effective at reducing trauma symptoms than no treatment, even when the treatment was delivered through an interpreter.

While Eye Movement Desensitization and Reprocessing (EMDR) treatment, another adult PTSD treatment that seems to have evidence to support its efficacy, it currently remains unclear how much of this treatment's efficacy is due to the exposure component (Friedman, 2008; Hamblen et al., 2009). In fact, Foa et al., (2003) argue that while other cognitive-behavioral interventions may be shown to be effective, underlying those treatments is the presence of some exposure-based interventions. However, to some degree the authors may be overstating the results of the research they reviewed, as studies of other evidence-supported cognitive-behavioral therapies often classify as exposure-based any treatment that has at least some exposure components (Friedman, 2008; Hamblen et al., 2009). In sum, it appears that both PE and CPT both have strong empirical support for use among adults with PTSD.

Among children and adolescents, Trauma-Focused Cognitive-behavioral Therapy (TF-CBT) was the only treatment that met standards of being "well established" as a valid and reliably tested intervention for the treatment of single event trauma (e.g., natural disaster; traumatic grief/loss) in youths (Silverman et al., 2008). TF-CBT is a conjoint parent and child treatment for children and adolescents who are experiencing significant behavioral and emotional distress related to life events that are traumatic (Medical University of South Carolina, 2005). Through a components-based model,

children and parents obtain psychoeducation, and learn skills to improve communication as well as process, talk about, and manage emotions related to a traumatic event (Medical University of South Carolina, 2005). Children are encouraged to share their traumatic experiences verbally, in written narrative form, or in another more developmentally appropriate manner (e.g., through drawing; Medical University of South Carolina, 2005). Clinicians who provide TF-CBT are encouraged to tailor the treatments to the specific cultural group and family from which a child comes so that (National Child Traumatic Stress Network, 2008). Specifically, Cohen, Mannario, and Deblinger (2006) make recommendations for the treating clinician to inquire about the culture of the child's family to understand how it may impact the child's experience of trauma (e.g., attitudes about self-blame, shame, issues around the disclosure process, etc.), as well as how the parents' culture also may impact the traumatic presentation (National Child Traumatic Stress Network, 2008).

The research of Silverman et al. (2008) suggests also that school-based group CBT is "possibly efficacious" for the treatment of the aforementioned post-trauma symptoms (Silverman et al, 2008). Many treatments in their study were determined to have insufficient empirical evidence, though of the ones that had limited RCT support, many were cognitive-behavioral in nature (Silverman et al., 2008).

Alternative interventions for single episode trauma may be indicated when an event is experienced by multiple individuals and when traditional trauma-focused interventions are contraindicated. The use of treatments that are not traditionally psychological appears to be much more common outside of Western-influenced environments, as Western treatments of psychological trauma often involves the

individual verbal recitation of narratives in spite of the fact that this practice can be both psychologically and culturally dystonic (Harris, 2009). In fact, neuropsychological evidence appears to suggest that the way the human brain stores and processes traumatic information undermines the one's ability to verbalize highly affective information (Harris, 2009). Compared to those without PTSD, individuals who have PTSD evidence greater deactivation in Broca's area, the region of the brain associated with language production, in response to trauma-related stimuli (Pitman, Shin, & Rauch, 2001). It appears that this process in fact may interfere, to some degree, with the development of coherent narratives that serve to help an individual process trauma (Cozolino, 2006).

In a multiple case study of four traumatized youth combatants from a war-affected area of Sierra Leone, Harris (2009) found that the interplay of symbolization and ceremony, in both a verbal and non-verbal manner, facilitated trauma symptom recovery in the boys (Harris, 2009). This research further suggests that interventions aimed at cultural coping, such as practicing cultural rites (e.g., art and dance), may also be important as well as effective in the recovery from trauma (Harris, 2009).

Concordantly, Yule (2000) suggests that it may be appropriate to offer group-focused treatments that are not directly trauma-oriented to refugees who jointly have experienced violence and trauma in their country of origin and who have been relocated to the United States. Additionally, psychosocial interventions aimed at strengthening the individual and the community well-being (e.g., facilitating engagement in religious activities and in traditional cultural practices; strengthening immediate and extended family bonds; providing educational opportunities) are recommended for refugees who are experiencing PTSD symptoms (De Jong, Scholte, Koeter, & Hart, 2000; Porter &

Haslam, 2001). Although specific deficit-focused treatments have been demonstrated to be effective in reducing PTSD symptoms, these interventions may be less appropriate for individuals from non-Western cultures and ethnic groups.

Disclosure and discussion process of trauma in psychotherapy. The terms disclosure, discussions and expressions of trauma are used to signify verbalizations that consist of (a) descriptions of the traumatic event; (b) evaluative content such as thoughts, beliefs, and attitudes about the traumatic event; and (c) affective content such as one's feelings and emotions about the traumatic event (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rimé, 2001). Many empirically supported treatments of trauma are based around the idea that discussing traumatic experiences with others is both helpful and necessary for the treatment of trauma. Research seems to support these ideas, as up to 85% of individuals who experience trauma feel the need to share these experiences with others (Purves & Erwin, 2004). Furthermore, the disclosure of stressful and traumatic events has been linked to improvements in a variety of areas of functioning and psychological adjustment.

For example, in a study of 76 college undergraduate psychology students, Lutgendorf and Antoni (1999) found that when compared to a control group, individuals who were instructed to disclose thoughts and feelings around a stressful experience evidenced decreases in stress levels, decreases in intrusive and disturbing thoughts, and improvements in mood. Furthermore, the authors found that greater depth of involvement in the disclosure process predicted greater improvements in mood at the end of the study (Lutgendorf & Antoni, 1999). Detailed trauma disclosure, which focuses on re-processing thoughts and feelings associated with the stressful event, also appears to be

effective in enhancing self-regulation and feelings of control (Hemenover, 2003), as well as in helping individuals gain insight and meaning in their lives, and establish a more resilient self-esteem and identity (Pennebaker, 1997). This process also has been linked to improvements in physical health and improvements in work and school performance (Pennebaker, Kiecolt-Glaser, & Glaser, 1988).

Although active and detailed discussion around a traumatic event appears to be an effective way to help some individuals reduce trauma symptoms and improve functioning, clinicians should note that individuals can differ greatly in their disclosure processes. First, it can be important for individuals to feel safe and supported when disclosing personal and often painful experiences (Higgins Kessler & Nelson Goff, 2006). An individual's past supported experiences with self-disclosure may significantly impact his/her desire to self-disclose again, as that process seems to be positively correlated with a client's ability to perceive a therapist as warm and empathic (Halpern, 1977). The perception of having a good support network appears to be related to a client's level of self-disclosure and a lower level of distressing symptoms at intake (Kahn, Achter, & Shambaugh, 2001). It may be that an individual has to believe support is available before he/she is ready and willing to talk about his/her distress (Kahn et al., 2001). McNulty and Wardle (1994) have suggested that that disclosure of trauma can initially worsen a client's psychological state, as this process of connecting with traumatic emotional material can be both distressing and jolting for clients. It may be quite distressing for a client to have a therapist encourage self-disclosure around traumatic material, before he/she feels supported in the therapy.

Second, individuals differ in how they disclose trauma in a psychotherapy session,

and cultural and demographic factors may play a role in these differences. Self-disclosure around a traumatic event, such as child abuse, may occur various stages and cycles rather than in a linear fashion (Alaggia, 2005; Lindbald, 2007). Individuals may be ambivalent about discussing trauma, and may vacillate between disclosing and recanting traumatic experiences (Alaggia, 2005; Lindbald, 2007). Children may be more likely to discuss or express child abuse behaviorally rather than verbally (Alaggia, 2005), and older adolescents may be more likely to disclose trauma to peers rather than adults (Alaggia, 2005; London, Bruck, Ceci, & Shuman, 2007). Moreover, compared to women, men appear to be less willing to engage in the self-disclosure process due to feelings of anxiety, fear, and depression (Purves & Erwin, 2004). In addition, individuals may be less likely to disclose having been a victim/survivor of an interpersonal trauma if the perpetrator is a family member rather than a stranger (London et al., 2007), as there may be psychological (e.g., guilt, shame) and social consequences (e.g., problems within the family structure) of doing so.

There does not appear to be a pattern with regard to ethnicity or severity of abuse on the abuse disclosure process (London et al., 2007); nonetheless these factors can play a role in trauma disclosure. For example, attitudes around family preservation, sexual issues, and disclosure of trauma to a mental health professional can vary greatly among cultures (Alaggia, 2004). Individuals who have experienced marginalization around their race, ethnicity, religion, or socioeconomic statuses may feel too disempowered to disclose trauma, and may choose not to do so (Alaggia, 2004).

It appears there are a variety of elements that can impact when and how an individual chooses to disclose trauma to or discuss it with a mental health professional.

As this process can take time to naturally occur and can do so in different ways, models of trauma treatment that encourage immediate and direct work around traumatic material and symptoms may be inappropriate for some individuals who have experienced trauma. Therapists appear to play an important role in the disclosure process with their clients. Higgins-Kessler, Nelson, Jurich, and White (2004) recommend that these clinicians be aware of issues such as pacing, timing, and a client's appropriateness and readiness for this type of trauma work before they initiate it.

Positive psychological interventions for trauma. Positive psychological interventions have also been studied in the treatment of trauma. These models do not place an overall and direct focus on symptom reduction, but rather aim to supplement more traditional trauma treatment models by helping clients grow through positive changes in how they value their relationships, in their perceptions of self, and in their life philosophy (Joseph & Linley, 2005). While there exist various theoretical frameworks for how growth can occur after trauma (e.g., Janoff-Bulman's *Existential Reevaluation* and Tedeschi, Calhoun's *PTG*; Janoff-Bulman, 1992), many treatment models of facilitating growth after trauma provide guidelines rather than specific intervention strategies (Lechner & Antoni, 2004).

There exist some treatment recommendations and specific models that are rooted in underlying principles of eliciting positive changes after a traumatic event (e.g., hope, meaning making, increased positive functioning). Cognitive-Behavioral Stress Management (Antoni et al., 2001), a series of group-based cognitive interventions provided to recent breast cancer patients, was found to increase levels of measured optimism among those who received the treatment. Models of solution-focused therapy

for trauma treatment provide recommendations for clinicians to identify a clear end of treatment, think about a time when the client did not have the problem, highlight resilience in instances where the client was not impacted by the trauma when he/she expected he/she would be, and identify what would be different in the preferred future (Bannick, 2008; O'Hanlon, 1999). Although the aforementioned theories have treatment objectives that are loosely based on the notion of positive change through adversity, these models were not designed specifically to facilitate growth after trauma.

Tedeschi and Calhoun's model of PTG is, however, a treatment model designed to facilitate growth after a trauma (Tedeschi & Calhoun, 1996). This model builds on research suggesting that after adverse conditions, positive changes can be seen in areas including: emerging new possibilities and opportunities, establishing more meaningful relationships and greater compassion for others, feeling strengthened to face future challenges, reordering of priorities and a greater appreciation for life, and a deepening of spirituality (Calhoun & Tedeschi, 1999, 2006). In this model, which can be applied in individual, group, family, or couples modalities, the authors provide specific recommendations clinicians can use to facilitate growth (Calhoun & Tedeschi, 1999). The authors recommend 5 strategies clinicians can use with clients to encourage growth (Calhoun & Tedeschi, 1999). These recommendations include focusing on listening without attempting to solve the problem, recognizing growth as the client moves toward it, labeling growth when the client makes a reference to it, exploring the idea of PTG when a client expresses beliefs that growth after an event is not possible, and choosing effective words to reflect the client's growth (Calhoun & Tedeschi, 1999).

Although their model provides guidelines for how clinicians can begin to facilitate the growth process after a trauma, the authors caution that their strategies do not provide specific interventions, but rather should serve as general guidelines for encouraging PTG (Calhoun & Tedeschi, 1999). Furthermore, the authors recognize that theirs is a one-size-fits-all model, which does not address potential modifications that may be necessary when working with clients of differing cultural backgrounds whose values may run in conflict with the model (Calhoun & Tedeschi, 1999). Cultural differences exist in the expression and experience of growth after a trauma, as specific value systems can influence the types of post-trauma changes that are held to be important (Ho, Chan, & Ho, 2004). For instance, western cultures may emphasize greater independent growth and looking on the positive side of things, while non-Western cultures (e.g., Chinese, South African) may value change that is more interdependent or collective and place less stress on that type of optimism (Ho et al., 2004; Shakespeare-Finch & Copping, 2006). Although there may exist some universal dimensions of PTG (Ho et al., 2004), it can be important for clinicians to note how differences in cultural values can impact both the direction of treatment and how its success is measured.

It appears that treatments using strength-based interventions to facilitate growth after a trauma seem effective at eliciting significant positive changes, as measured by both an individual's subjective appraisal as well as the evaluations of others (Shakespeare-Finch & Enders, 2008; Weinrib et al., 2006). Still, Calhoun and Tedeschi's specific model of focusing treatment on PTG may represent more of a starting concept than a structured protocol. While they are often paired together, PTG and trauma symptomatology may not be directly related; reductions in trauma symptoms do not

necessarily lead to growth (Joseph & Linley, 2005), and there may be no significant relationship between self-reported PTG and level of trauma symptoms (Maercker & Zoellner, 2004). It seems that models that directly address either symptom reduction or PTG may not capture the range of changes that a client coming to therapy would like to make. Although cognitive-behavioral treatments for PTSD symptoms have been established as effective in treating many with PTSD symptoms, helping a client appropriately after trauma may require a clinician to incorporate multiple understandings of trauma as well as a variety of both deficit reduction and strength oriented interventions.

Trauma treatment model integration. As the etiology of abuse-related outcomes is multifaceted, it may not always be possible to focus on a specific event or events in trauma treatment (Briere & Jordan, 2009). As previously discussed, trauma can become complex and layered, as multiple events (e.g., witnessing a family assault or instances of sexual or physical abuse) and adverse conditions that may perpetuate the trauma (e.g., neglect, emotional abuse), may require interventions that derive technique from various models (Briere & Jordan, 2009). Additionally, trauma also may need to be addressed through understanding of the context within which it has occurred (Walsh, 2007), as well as in ways some clients may engage in a relational reliving of aspects of the trauma in session with their therapists (Briere & Lanktree, 2008). Clinicians may have to work simultaneously to address specific traumatic events and to facilitate the client's engagement in and exploration of the therapeutic relationship. As such, appropriate treatment may involve integrating classical cognitive-behavioral treatment (e.g., exposure to the trauma and traumatic emotions, cognitive restructuring) with

relationship-based interventions that activate and allow the individual to process negative interpersonal schema and emotional states linked to those relational memories (Pearlman & Courtois, 2005). Furthermore, engagement of appropriate cultural, family, and social resources may need to be included in order for trauma treatments to be effective (Briere & Scott, 2006; Walsh, 2007). Positive clinical psychology encourages the incorporation of multiple models of treatment (Linley et al., 2006), and this integrated perspective may be critical when working with individuals who have experienced multiple traumas. Thus, the following subsection examines the way in which integrated trauma treatment models address the various effects of trauma as well use interventions that target both pathology and resilience.

To date, the only evidence-based individual model for the treatment of men and women who have experienced different types of child abuse trauma (viz.: physical, emotional, and sexual) is Emotion-Focused Therapy for Trauma (EFTT; Paivio, Jarry, Chagigiorgis, Hall & Ralston, 2010). EFTT was derived from in depth analysis of individual psychotherapy sessions of clients dealing with child abuse related difficulties, and was based on Greenberg and Malcolm's (2002) empirically supported Imaginal Confrontation (IC) model (Paivio et al., 2010). EFTT typically consists of 16-20 weekly hour-long individual therapy sessions that are arranged in phases (Paivio & Pascual-Leone, 2010). The first phase focuses on establishing a strong therapeutic bond and goals for treatment; the second phase centers on reducing shame, avoidance, and self-blame, and increasing affect management; the third phase works towards resolving issues with abusive and neglectful others; and the fourth phase targets the integration of the therapeutic experience and termination (Paivio & Pascual-Leone, 2010). The authors

pull therapeutic strategy from IC, an exposure-based empty chair technique in which the client “confronts” the perpetrator, and Empathic Exploration, a technique in which the client expresses feelings about the trauma to the therapist who in turn models affective regulation through an empathic response (Paivio et al, 2010). The authors found that participants, 45 publically recruited and randomly assigned males and females, many of whom were Caucasian and all of whom had experienced multiple instances of child abuse, showed significant improvements on eight quantitative posttest measures (e.g., of symptoms, self-worth, and interpersonal functioning) after receiving these interventions (Paivio et al., 2010).

In spite of the strength of their findings, Paivio et al. (2010) address some potential limitations of their study. Specifically, they note that the limited sample size, the inclusion of few ethnic minorities in the study, the absence of a control group, and the fact that participating therapists received more supervision than is typical for the type of setting as potential confounds in their research (Paivio et al., 2010). Although nothing has been published on it since 2010, this integrated model of relational and exposure based treatment appears to address some of the challenges in treating multi-event and multi-effect trauma.

There appear to be few models of trauma treatment that incorporate all potential dimensions of trauma’s impact. It appears that addressing various levels of trauma impact may be a crucial task for a clinician working with traumatized clients, though treatment providers also may need to examine the breadth of the traumatic impact in order to be fully effective. Many psychological treatments for trauma, especially those that are evidence-based, focus on ways in which a therapist directly can assist the

individual client; however, traditional individually oriented and deficit-based models for the treatment of trauma symptomatology may not adequately tap into community resources (e.g., community support, religious/spiritual support), which can be naturally strength-based and may more sufficiently address ethnic and cultural values of a traumatized client. Clinicians whose interventions treat only the client's symptomatology may fail to address other factors that are secondary to the individual's traumatic experience (Walsh, 2007). Family and other support systems can be disrupted by traumatic events, and facilitating repair in these areas may be critical for trauma resolution, as these networks can be essential sources of strength for a client (Walsh, 2007). Some cultures (e.g., Latinos) may experience traumas (e.g., rape or sexual abuse) as bringing particular shame to a family due to the victim being seen as impure or damaged (Conradi, Hendricks, & Merino, 2007). As a result, there may be lasting social implications for the individual who experiences the trauma. Some cultures place strong value on the inclusion of family-directed intervention for trauma treatment, and sensitive interventions in this area may have a profound impact on the outcome of treatment (Conradi et al., 2007).

In particular, Bryant-Davis (2005) suggests that adult African American survivors of childhood violence may not be getting the most effective treatment for associated trauma-related symptomatology when clinicians use traditional therapeutic techniques. These interventions, and the counselors who provide them, may be ignoring coping strategies that are sources of resilience within the African American community, including activism, cultural pride, spirituality, reliance on ties with family and other social supports, creativity, transcendence, humor, and confrontation of the perpetrator

(Bryant-Davis, 2005). The prevalence of these coping strategies among African American adults who were victims of childhood violence illustrates the point that in individuals, even those who use psychotherapy as well, actively may seek out alternate means of dealing with trauma. For this reason, Bryant-Davis (2005) recommends that clinicians obtain a respect and understanding of the cultural backgrounds of all clients with whom they work so that these interventions, and likely those specific other cultural groupings, can be appropriately integrated with more traditional therapeutic modalities like talk therapy and medication (Bryant-Davis, 2005).

Many researchers and clinicians believe that empirically supported models should be used when treating clients who have experienced trauma; however, integrated models of treatment cannot always be validated in this manner prior to their implementation (e.g., they are too new to have been thoroughly validated, the model contains elements that cannot be standardized). Relying heavily on research and clinical expertise, Briere and Lanktree have proposed two models for the treatment of complicated trauma reactions: Integrative Treatment of Complex Trauma for Children (ITCT-C; Lanktree & Briere, 2008) ages 8 to 12, and Integrative Treatment of Complex Trauma for Adolescents (ITCT-A; Briere & Lanktree, 2008) ages 13 to 18. Though not manualized or empirically validated through RCTs (as of the date of this document), these models are strongly supported by trauma research (Briere & Lanktree, 2008; Lanktree & Briere, 2008). The protocols provide specific guidelines for the integration of cognitive-behavioral (e.g., exposure and cognitive restructuring), attachment-based, and skills building interventions in the treatment of the variety of symptoms and diagnoses often associated with childhood trauma (Briere & Lanktree, 2008; Lanktree & Briere, 2008). These models

also provide basic recommendations for how the clinician can address sociocultural differences in expectations between him/herself and the client (Briere & Lanktree, 2008; Lanktree & Briere, 2008). Personal views, such as the degree to which therapy focuses on practical (versus more psychological) client issues, how private issues are discussed during treatment, the importance of regular weekly sessions, and therapist self-disclosure can differ greatly between cultures, and it is crucial for the therapist to incorporate an understanding to these issues within treatment (Briere & Lanktree, 2008; Lanktree & Briere, 2008). The therapist cannot overlook the impacts of discrimination and cultural differences; at a minimum, the therapist should consider the impact adverse social conditions and additional traumas, anger and/or anxiety the client may experience towards a therapist of a different culture, and differences in worldview between therapist and client can have during the therapy (Briere & Lanktree, 2008; Lanktree & Briere, 2008).

In a similar research and clinically informed manner, Courtois (2004) has established the Sequencing and Stage-Oriented Treatment model, which offers integrated guidelines for the treatment of chronic post-trauma reactions and emphasizes posttraumatic growth. In this meta-model, treatment is broken into three stages, which are moved through in a developmental manner as treatment progresses (Courtois, 2004). The early stage of treatment focuses on the development of the treatment alliance, regulation of affect, psychoeducation, skill building, and issues of client safety, such as suicidality, non-suicidal self-injury (e.g., cutting, burning), and substance use (Courtois, 2004). The middle stage of treatment, which occurs when a client has learned sufficient coping skills and affect modulation, and he/she possess some life stability, works to

address traumatic material in a detailed manner such that resolution is reached and there are fewer posttraumatic impacts in the client's life (Courtois, 2004). The third stage targets life restructuring and consolidation, addressing self and relational development, as well as enhanced daily living (Courtois, 2004). In this final stage, which borrows from Tedeschi and Calhoun's model of PTG, Courtois (2004) proposes that biological and social deficits, as well as affective disruptions, are reconciled sufficiently such that new emotional learning can take place and usher in a level of functioning that is higher than that found premorbidly (Courtois, 2004).

Although much of the treatment's emphasis generally is on the first stage, this meta-model, which integrates both deficit and strength-based treatment approaches, does not prescribe particular interventions, but rather provides the therapist guiding principles through which he/she can conduct therapy (Courtois, 2004). In addition, although specific models of growth following adversity (e.g., Tedeschi and Calhoun's PTG, Joseph and Linley's organism valuing theory) do not address the notion of facilitating positive change after complex trauma, Courtois (2004) recommends that clinicians address this area of change once a client possesses emotional regulation and social skills, which allow a client to move beyond a pathology focus.

Commonalities across orientations – transtheoretical approaches. Although evidence-based treatment models for trauma typically call for a clinician to provide specific theory-congruent interventions when working with clients who have experienced trauma (e.g., PE, CPT, EFTT), there is research to suggest that other more general treatment elements may play a role in facilitating client change. *Nonspecific* or *common factors* are elements of psychotherapy that cut across theoretical orientations and models,

which are thought to play a role in the client change process regardless of the particular techniques a clinician uses (Lambert & Barley, 2001; Messer & Wampold, 2002; Wampold, 2001; Weinberger, 1995). In fact, Messer and Wampold (2002) suggest that the majority of outcome research supports the idea that common factors, such as the therapeutic alliance, therapist allegiance to a particular theoretical orientation, therapist's empathy, and positive regard of the client, are more effective mechanisms of change than particular sets of interventions for particular problems. Furthermore, there is also literature suggesting that the way in which clinicians deliver treatments may be as important as the treatments themselves (e.g., Prochaska & DiClemente, 1982; Prochaska et al., 1994). The following section explores these transtheoretical elements and mechanisms of change as related to trauma.

In their review of meta-analyses, Ehlers and colleagues (2010) found that the bulk of treatment research seems to indicate that therapeutic elements common to many psychotherapies serve a similarly important function for clinicians treating clients with PTSD and related symptoms. Although current PTSD literature suggests directly addressing trauma memories is an effective means for treating PTSD and associated symptoms (Ehlers et al., 2010), it appears that among all, but the most severe of psychological disorders, common factors are as effective as specific treatments at reducing psychological distress (Stevens, Hynan, & Allen, 2000; Wampold, 2001; Weinberger, 1995;). These elements are believed to be the actual agents of change in psychotherapy regardless of approach (Stevens et al., 2000; Wampold, 2001; Weinberger, 1995). Furthermore, various existing treatment models for trauma appear already to integrate some of these factors into their delivery (e.g., Foa's EP and the importance of

clinician fidelity to the EBP model; Briere and Lanktree's ITCT-A and the direct focus on the therapist client-relationship; Courtois's stage-based model; Tedeschi and Calhoun's model of PTG and the importance of instilling hope through the sense of a more meaningful future).

Of particular note, the strength of the client-therapist relationship appears to be an important common factor when a client has experienced relational trauma. While in general the quality of the therapeutic alliance appears strongly related to positive treatment outcomes across therapeutic orientations (Bachelor & Horvath, 2002; Martin, Garske, & Davis, 2000), this relationship between client and therapist may be especially important when working with adult survivors of child abuse. In a sample of 49 adult females (56% of whom were Caucasian, 21% of whom were African American, 11% of whom were Latino, and 11% of whom were other ethnicities) who had experienced childhood physical or sexual abuse by a caretaker or person in authority, and who also had a diagnosis of PTSD related to the trauma, Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) found that a positive therapeutic alliance in the initial stages of treatment was predictive of PTSD symptom reduction at the end of treatment. Moreover, Keller, Feeney, and Zoellner (2010) found that among a sample of individuals (77% female, 65% Caucasian, 22% African American, 14% "other" ethnicity) treated for PTSD with PE, early therapeutic alliance was associated with both PE treatment adherence and treatment completion.

Cutting across psychotherapeutic orientation is the transtheoretical model of behavioral change, which suggests that modification of psychological and behavioral dysfunction occurs in a multi-stage process that is independent of a client's presenting

problem or sociocultural demographics (Prochaska & DiClemente, 1982; Prochaska et al., 1994, Prochaska & Norcross, 2001). Within this model, clients can be categorized and assisted based on where they are on the treatment spectrum regarding their level of motivation to make change. The six stages of change are precontemplation, contemplation, preparation, action, maintenance and termination, and each stage represents a time period in a client's treatment (including pre-treatment) as well as a specific set of tasks that need to be accomplished before the therapy can progress (Prochaska & Norcross, 2001).

Prior to beginning treatment and even in the early stages of therapeutic work, clients may have little motivation to make changes in their lives. Prochaska and Norcross (2001) note that only 10 to 20% of clients who come to therapy are in a psychological position where they are ready and motivated to take direct action in a manner consistent with the change process. The therapist must consider each client independently, as many are ambivalent about the change process and may still be weighing the pros and cons of psychological intervention (Prochaska & Norcross, 2001). Initially, treatment may require a clinician to join and nurture a client to help him/her understand his/her ambivalence about making a change (Prochaska & Norcross, 2001). Later stages involve the clinician helping the client with his/her contemplation about making change, assisting the client take action to make changes, reflecting on gains made in treatment, and preventing relapse (Prochaska & Norcross, 2001).

This model of change suggests that a clinician needs to be both attentive and flexible to a variety of aspects in the treatment, regardless of his/her orientation. At each step of the change process, clinicians should tailor interventions specifically to match

where in the change process a client is, rather than immediately or haphazardly providing techniques with the client (Prochaska & Norcross, 2001; Prochaska et al., 1994). The adjustment process may be a difficult task for a training clinician working with individuals who have experienced trauma. While research and movement of the field towards a medical model may pressure a training clinician to implement an EBP, the initial therapeutic work with someone who has experienced trauma may need to be focused on building the therapeutic relationship and increasing motivation to make changes, rather than on specific symptom reduction.

Educating trainees to work with trauma. Since its inception, the field of clinical psychology has attempted to understand and address the psychological impact of trauma (Courtois & Gold, 2009). While there have been significant strides in research and the clinical treatment of trauma, especially since the 1970s and the later inclusion of PTSD in DSM-III, there continues to be a disparity between the need for professionals who adequately can treat trauma and the availability of these clinicians (Courtois & Gold, 2009).

One of the main reasons for this disparity between demand and supply may be that graduate training programs lack sufficient emphasis on trauma training in spite of the number of individuals who have experienced at least some trauma (APA, 2004; Bruce, 2005; Courtois & Gold, 2009; DePrince & Newmann, 2011; van der Kolk et al., 2005). In a cross-sectional review of 44 graduate programs in psychology, Bruce (2005) found that only one program offered a course specifically designed to train clinicians in the treatment of trauma. Undeniably, there have been valid efforts by certain schools and organizations to provide recommendations for training individuals to treat trauma (e.g.,

The International Society for Traumatic Stress Studies; The Behavioral Sciences Division of the National Center for PTSD; The University of South Dakota's Disaster Mental Health Institute) and some schools have included coursework dedicated to trauma training, this information seems yet to be included in the core curricula for doctoral students studying psychology (Bruce, 2005; Courtois & Gold, 2009). In spite of the limited direct attention graduate psychology programs may pay to training students in understanding and working with trauma, these new clinicians nonetheless may be required to enter clinical practice with solid skills in this area (Bruce, 2005; Courtois & Gold, 2009).

Litz and Salters-Pedneault (2008), researchers from the National Center for PTSD Behavior Science Division Training Program, provide recommendations for the process of adequately training clinicians to work with PTSD-related trauma. Specifically, the authors suggest that like their program, other training programs teach trainees about the various EBP models, provide active encouragement for trainees to pull elements from different EBP treatments to help address co-occurring disorders and psychosocial treatment barriers, and facilitate creative and integrative conceptualization with both complex and unfamiliar clinical situations (Litz & Salters-Pedneault, 2008).

Building off of the aforementioned recommendations for different programs regarding PTSD treatment training, Courtois and Gold (2009) provide suggestions for how graduate programs in clinical psychology should tailor their didactics to provide students sufficient training for all types of trauma. The authors believe that graduate training should be comprehensive and include didactic instruction in recognizing and understanding the various forms of traumatic events, as well as potential cognitive,

emotional, behavioral, and somatic responses to trauma (Courtois & Gold, 2009). More specifically, Courtois and Gold (2009) believe that specialized instruction be given to trainees and should include focus in areas such as: foundations and trauma theory, the effects of trauma across the lifespan, assessment of trauma, risk and resilience factors, attachment and relational trauma/ child abuse and impacts on development, sexual assault and interpersonal violence, combat trauma, emergency and disaster trauma, and cross-cultural and international issues such as sexual slavery and human trafficking (Courtois & Gold, 2009). Additionally, Litz and Salters-Pedneault (2008) as well as Courtois and Gold (2009) recommend that training should include supervised practical experience in working with specific individuals and groups who have experienced trauma. Litz and Salters-Pedneault (2008) believe that the primary clinical supervisor should be both a mentor as well as someone who oversees the quality of the trainees' well-being and progress towards meeting professional development goals.

Aside from the range of technical skills and model familiarity needed to work with trauma, trainees may face a range of unique emotional demands and may be at risk for developing emotional and psychological difficulties as a result of their exposure to a client's trauma. These potential reactions have been referred to in the literature as *secondary traumatization* (Stamm, 1995), *vicarious traumatization* (McCann & Pearlman, 1990), and *compassion fatigue* (Figley, 1995). All refer to the potential negative (and possibly PTSD-like) outcomes clinicians face when working in a trauma and/or with traumatized individuals (Adams & Riggs, 2008; Courtois & Gold, 2009).

In a study of 129 graduate trainees in psychology programs in Texas, two thirds of whom were from American Psychological Association accredited doctoral programs in

clinical and counseling psychology, Adams and Riggs (2008) found that a trainee's defensive style (e.g., minimizing or denying difficulties) around his/her own emotion management may make him/her more likely to experience vicarious effects when helping a client work with traumatic material. Specifically, the trainees who were overly empathic and self-sacrificing in their defensive style were found to experience significantly higher level of trauma symptomatology than the trainees who used more adaptive coping strategies (e.g., humor, suppression, and sublimation) to manage their own reactions to a client's trauma (Adams & Riggs, 2008). Both Adams and Riggs (2008), and Courtois and Gold (2009) recommended that graduate educators review their programs to determine if students are receiving adequate training in working with trauma, which includes ensuring that sufficient attention is given to training in self-care activities and behaviors.

Purpose of Study and Research Question

Within psychological research and the practice of psychotherapy, there exist a number of different ways to classify trauma. Some definitions are narrow and objective, equating trauma only with events captured by the specific language of PTSD in the DSM. Other interpretations are more idiographic, subjectively defined in terms of both the nature and magnitude of the precipitating stressor, as well as the type of effects that result.

Given the variability of what constitutes trauma, clinicians may have difficulty recognizing what psychological material is traumatic enough to address directly. In addition, the field of clinical psychology is moving in a direction of greater pressure on clinicians to adhere to specific empirically tested models of trauma treatment; however,

trauma research seems to be indicating that effective treatment of most trauma requires that clinicians rely not on any particular model, but rather on techniques derived from a variety of often conflicting models. Appropriate interventions may, for instance, call on a clinician to integrate both psychodynamic and cognitive-behavioral approaches (e.g., ITCT-A), as well as deficit-based and strength-based treatments (e.g., stage three of Courtois' 2004 model) during which a client focuses on dysfunctions and impairments as well as ways in which he/she can move past them to have a more meaningful life.

Unfortunately, while seasoned clinicians often have multiple model familiarity and clinical experience from which they can pull to integrate treatments, research suggests that new clinicians in training may not possess the history of working with clients and models or the more developmentally advanced conceptualization skills needed to match models efficaciously. All this being said, psychology trainees undeniably are providing clinical services to clients who have experienced a wide variety of trauma; however, the training they receive (both didactically and clinically) may not adequately prepare them to work with individuals who have experienced trauma.

The goal of the study was to identify trainees' patterns of responding to client expressions of trauma to better understand therapist responses to clients who have experienced DSM-IV-TR defined traumatic events and those who have experienced effects related to stressful negative life events. The research question was: How do trainee therapists respond to client communications of trauma during psychotherapy sessions?

Chapter II. Method

This chapter provides an overview of the methods used during this study. It begins with a description of and rationale for the design of the study. It then provides information about the participants, the instrumentation, the sampling procedure, and the data collection and data analysis procedures.

Research Design

An inductive or conventional content analysis was appropriate for the study, as the research question was qualitative and exploratory in nature. Rather than deductively testing a hypothesis and asking a “Why” question, qualitative research is in itself inductive, in that its goal is to understand a situation without imposing preexisting supposition on the phenomena being studied (Mertens, 2009; Morrow, 2007). This type of research aims to understand the occurrence of an event or series of interrelated events within the context of its/their natural environment, and to elucidate the process by which this occurrence emerges (Creswell, 2009; Mertens, 2009). More specifically for this study, conventional content analysis was used to examine themes within the data in order to scientifically classify patterns that naturally emerge (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Mertens, 2009; Zhang & Wildemuth, 2009). This approach can be especially helpful in situations where the current theories do not sufficiently explain phenomena in their context, and where more accurate theoretical development might occur through researcher interaction with the data (Mertens, 2009).

Additionally, a treatment process approach was employed to help guide the present research study. This approach was used to name, describe, classify, and count the behavior of the therapist and client, which can be described using a variety of different

categories (Stiles, Honos-Webb, & Knobloch, 1999). These categories include the following: (a) size of the scoring unit, such as single words, phrases, topic episodes, timed intervals of various durations, whole sessions, phases of treatment, whole treatment, and series of treatments; (b) perspective, or view point of the therapist/client; (c) data format and access strategy, such as transcripts, session notes, and audio/videotapes; (d) measure format, such as coding used to classify data into nominal categories, rating, or Q-sort; (e) level of inference, distinguishing the *classical strategy* in which only observable behavior is coded, from the *pragmatic strategy* in which the coders or raters make inferences about the speaker's thoughts, feelings, intentions, or motivations based on the observed behavior; (f) theoretical orientation, ranging from specific orientations to broader applicability; (g) treatment modality, such as individual adult, child, family, group therapy; (h) target person, including the therapist, client, dyad, family, or group as the focus of measurement; (i) communication channel, such as verbal, paralinguistic, or kinesic; and (j) dimension of verbal coding measures, including *content categories* which describe semantic meaning (e.g., "fear"), *speech act categories* which concern the manner in which the speech was conveyed (e.g., reflections, interpretations, questions, and self-disclosures), and *paralinguistic measures* which describe nonverbal behaviors that accompany speech (e.g., hesitations and tonal qualities). The choice of the measure used in the treatment process approach is based on the specific question or topic that is being investigated (Stiles et al., 1999).

In this type of study, the researcher can report measures directly through case studies or analyses of brief segments after he/she applies some of these categories describing the treatment process approach. Typically, however, measures are aggregated

across summarizing unit(s) or a stretch of treatment (Stiles et al., 1999). As such, the frequency of a category in each session may be described, or the average of a rating across a whole treatment (Stiles et al., 1999). A description of how the treatment process approach was applied specifically in this study is provided in the Coding and Data Analysis sections of this chapter.

The present study investigated how trainee therapists actually responded to client communications of trauma during psychotherapy sessions. As explored in the review of the literature, there appear to be a variety of ways in which trauma can be defined, a multitude of techniques whose aim is to reduce distress and improve client functioning, and conflicting recommendations regarding the actual application of therapeutic interventions for clients who have experienced negative life events of any magnitude. It is anticipated that the design of this study will allow researchers to better understand themes across interventions used by therapists, which may be theoretically or atheoretically based. By design, the type of analysis proposed is pan theoretical; it attempts to look at the language and behavior of an individual without being limited by preexisting theoretical constructs, and then identify themes that cut across a variety of diverse clinical situations involving trauma (Mertens, 2009; Viney, 1983).

Participants

Client-participants. In accordance with the recommended guidelines for this type of qualitative and observational research study (Creswell, 2009; Denzin & Lincoln, 1998; Mertens, 2009), purposeful sampling was used to choose and examine 5 psychotherapy cases, which contain sufficient data, from the archival research database of a California university's community counseling centers. The procedures and materials

used in the procurement of research data were approved through Institutional Review Board (IRB) consultation prior to the collection and accessing of client archival data. Prior to their first intake session for psychotherapy, client-participants provided informed written consent to have written records (e.g., treatment summaries, assessment measures) as well as audio/videotaped sessions included in the research database. In turn, therapist-participants also gave consent to have their written/audio/video session and treatment data included in the research database. The therapist-participants in the study were comprised of doctoral and master's level psychology students who were in training practicum rotations at the time of the psychotherapy sessions. The names on all used research data were removed and replaced with research codes.

In order to be included in the study, the clients-participants needed to meet certain inclusion and exclusion criteria. Each client-participant was an adult (i.e., 18 years of age) at the time of intake, was fluent in English, and provided written consent for his or her written and audio/video records to be included in research database (Appendix A). Additionally, the therapists on the selected cases provided written consent for the written and audio/video records to be reviewed (Appendix B). In addition, to be included in this study, sufficient data was needed for each participant, including: videotapes of therapy sessions, the Client Information Adult Form (Appendix C), Telephone Intake Summary (Appendix D), the Intake Evaluation Summary form (Appendix E), and the Treatment Summary form (Appendix F). The clients also needed to have experienced and discussed a traumatic event, or experience in session. Namely, a client must have experienced either a traumatic event that met DSM-IV-TR PTSD A1 criteria or described significant subjective distress based on past experience that did not meet A1 PTSD criteria (i.e., a

Stressful Life Event) to be considered for the study (see Instrumentation section for further details). The client-participant must have completed at least 10 sessions of therapy in order for the researcher to be able to find expressions of trauma that occurred during the therapy sessions. This number of sessions was chosen to ensure that the presenting trauma would be addressed in the course of the therapy. Four of the client-participants met this inclusion criterion, while one completed only eight sessions; however, upon inspection this client-participant has a session dedicated to his presenting trauma within the eight sessions of treatment. As such, this inclusion criterion was adjusted to incorporate that client-participant, who met all other initial inclusion criteria.

Individuals who came to the clinic seeking family, couples, or child/adolescent therapy were excluded from this study. In order to protect confidentiality and to avoid biases in the coding process, therapist-participant dyad did not contain someone the researchers know personally. Prior to collecting any data, the researchers developed a list of individuals/therapists from the videotapes to exclude. Thus, the therapists of participants did not include someone with whom the researchers have had a close social relationship or personal involvement that is independent of engagement in professionally sanctioned activities required of the clinical psychology doctoral program. Additionally, the client-participants were individuals with whom the researchers did not have a personal relationship personal contact. Table 1 summarizes some of the demographic information for each of the client-participants. For a full description of each of the client-participants, based on information taken from the research files, please see the subsequent section.

Table 1

Demographic Information

C-P	Age	Gender	Ethnicity	Trauma Type	Nature of Trauma	Dx info
1	34	M	Caucasian	DSM-IV-TR	Suicide/Robbery	PTSD, Rel. Prob. NOS
2	21	F	Latina	DSM-IV-TR	Child Phys/Emo Abuse	MDD, BPD
3	31	M	Turkish	SLE	Fam. Acculturation Stress	MDD, GAD
4	47	F	European	SLE	Stroke/Blindness	No dx
5	29	M	Korean-American	DSM-IV-TR	Sudden Death of Friend	Social Phobia

Note. CP = Client-Participant; SLE = Stressful Life Event; PTSD = Posttraumatic Stress Disorder; Rel. Prob. NOS. = Relational Problem Not Otherwise Specified; MDD = Major Depressive Disorder; BPD = Borderline Personality Disorder; GAD = Generalized Anxiety Disorder.

Client-Participant 1. Client-Participant 1 (CP1) was a 34-year-old single, European American, Christian male. A high school graduate, he described his occupation as a cinematographer, but he was unemployed at the time of intake. CP1 initially presented to therapy to address symptoms associated with Posttraumatic Stress Disorder (PTSD) and Partner Relational Problems, both of which stemmed from an incident where he and girlfriend were robbed at gunpoint while at home (approximately two years prior to treatment), which were exacerbated by the suicide of his half-brother shortly after the client-participant completed the therapy intake evaluation. Specifically, his symptoms at intake included: panic symptoms (viz., racing heart, sweating, shortness of breath, lightheadedness), hypervigilance, avoidance of thoughts/feelings/places that are reminders of the traumatic events, difficulty concentrating, sleep difficulties, a loss of interest, social withdrawal, and loss of motivation. He also was experiencing significant

interpersonal conflict with his live-in ex-girlfriend due to the belief he was responsible for her “becoming bipolar” after the home invasion. In addition to his presenting symptoms, CP1 had experienced other events during his lifetime that met the magnitude for a PTSD A1 Criterion event (e.g., his younger brother being killed in a farm accident). He also had a long history of poly-substance abuse that was most prominent after the accidental death of another brother while the client-participant was in college. On the clinic intake form, he selected 11 primary presenting problems from a list, including, but not limited to the following: being suspicious of others, feeling down or unhappy, lacking self-confidence, difficulty making or keeping friends, and having difficulty being honest/open.

According to the Termination Summary, the therapist- participant reported using Cognitive-Behaviorally-informed interventions to help CP1 address guilt and other issues in his relationship with his ex-girlfriend, and his PTSD symptoms. Treatment also included a mindfulness component to help CP1 “to be ‘in the moment’” with anxiety management. Treatment lasted 15 sessions and terminated prematurely as result of the client-participant not scheduling follow-up therapy sessions. The therapy session selected for transcription and analysis was session number six.

Client-Participant 2. Client-Participant 2 (CP2) was a 21-year-old married, El Salvadorian, Christian woman. With a high school graduate equivalent education, she immigrated to the United States four years prior to the date of the intake, and was working as a housekeeper. She initially presented for therapy to address symptoms related to recurrent Major Depression (e.g., sadness, anhedonia, guilt/worthlessness, poor concentration, loss of energy, anxiety, suicidal ideation multiple days per week),

interpersonal conflict with her husband, anger, impulsivity, and the presence of few interpersonal relationships. CP2 reported having a history of extensive emotional and physical abuse by her biological mother and grandmother (e.g., being hit, being threatened with knives) from ages 11 to 17, as well as two instances of sexual abuse that occurred during unspecified times in the client-participant's life. On the clinic intake form, the client selected 26 primary presenting problems from a list, including, but not limited to the following, in no particular order: feeling nervous or anxious, needing to learn to relax, family difficulties, afraid of being on your own, feeling angry much of the time, feeling down or unhappy, feeling guilty, thoughts of taking your own life, concerns about emotional stability, difficulty controlling your thoughts, being suspicious of others, difficulty making or keeping friends, and difficulty in sexual relationships. As treatment progressed, CP2 was assigned an additional diagnosis of Borderline Personality Disorder. Both PTSD and Dysthymic Disorder were offered as suggested diagnostic rule-outs [where], though neither was diagnosed during the course of therapy.

According to the Termination Summary for CP2, the therapist-participant reported using Dialectical-Behaviorally-informed interventions for 31-sessions to help the client-participant build emotional regulation skills, distress tolerance skills, communication skills, and reduce suicidal ideation. Treatment terminated prematurely as result of the client-participant's "choice to refuse to attend two [therapy] sessions per week as required by the therapist to meet the standard of care." Per the Termination Summary, the client-participant was "not in a state of crisis at the time of termination" and she was referred out of the clinic. The therapy session selected for transcription and analysis was session number six.

Client-Participant 3. Client-Participant 3 (CP3) was a 31 year-old single, Turkish, Christian Orthodox man. A college student at the time of treatment, he immigrated to the United States 10 years ago to attend an “occupational school.” CP3 initially presented to therapy to address symptoms associated with Major Depression and Generalized Anxiety; the diagnoses were related to the client’s severe difficulties with issues of acculturation and family conflict associated with his living in the United States. CP3’s specific symptoms at intake included: diminished interested in pleasurable activities, difficulty sleeping, fatigue, guilt, poor concentration, and an inability to stop worrying about multiple problems. CP3 reported having psychological difficulties for much of his life (e.g., significant anxiety as a child); however, these have gotten significantly worse over time. Per the therapist’s report, the patient’s anxiety and depressive symptoms stem from guilt he feels about not “being there” for his mother and sister (especially after the death of his father shortly after the client-participant emigrated) and frustrations around issues of acculturation and establishing a close social community of individuals with similar values. Per the therapist’s report, the client-participant also experiences perfectionism related to significant pressures to succeed academically because he emigrated to do so. On the clinic intake form, the client-participant selected 14 primary presenting problems from a list, including, but not limited to the following, in no particular order: feeling down or unhappy, feeling nervous or anxious, needing to learn to relax, concerns about emotional stability, feeling lonely, difficulty making decisions, and difficulty controlling your thoughts.

According to the Termination Summary for this client-participant, the therapist-participant reported using Cognitive-Behaviorally-informed interventions to help CP3

address his tendency “to jump to negative conclusions about himself,” to address his firm beliefs about how he believes he and others “should” act, and perfectionism stemming from beliefs that he is inadequate. The focus of treatment was predominantly on the client-participant’s conflict about whether to stay in the United States or return to Turkey. Treatment lasted nine sessions and was terminated prematurely due to the fact that the client-participant “canceled numerous sessions and was resistant in making a weekly commitment to therapy.” The therapy session selected for transcription and analysis was session number four.

Client-Participant 4. Client-Participant 4 (CP4) was a 47 year-old, single, religious (unspecified denomination), European-American, woman with an Associate’s Degree. At the time of treatment, CP4 was unemployed and waiting to acquire disability benefits. She initially presented to therapy to address symptoms of being easily and frequently moved to tears and skin scratching, both of which began six weeks prior to the intake and after the client-participant had a stroke. The client-participant also had multiple co-morbid medical conditions (e.g., diabetes, neuropathy, balance problems). As a result of her stroke, the client-participant began losing her sight. On the clinic intake form, the client-participant selected 19 primary presenting problems from a list, including, but not limited to the following, in no particular order: feeling down or unhappy, feeling nervous or anxious, needing to learn to relax, concerns about emotional stability, feeling lonely, difficulty making decisions, experiencing guilty feelings, concerns about physical health, and concerns about emotional stability.

The focus of the therapy was on how her stroke and associated blindness brought up thoughts and feelings related to her history of emotional abuse/neglect, and themes

around abandonment and becoming dependent on others again. The course of treatment (e.g., duration, treatment orientation) for this client-participant was unclear, as there was no Termination Summary for the client-participant; however, based on other chart documentation sources (e.g., appointment log, dates and numbers of DVD-recorded sessions) it was estimated that treatment lasted approximately 12 sessions. The therapy session selected for transcription and analysis was session number six.

Client-Participant 5. Client-Participant 5 (CP5) was a 29-year-old single, Korean man, who graduated college and worked in the computer industry. He initially presented to therapy to address symptoms of depression and anxiety related to the recent sudden death of his close friend, which the client-participant reported was the “catalyst” for seeking treatment. On the clinic intake form, the client-participant selected 24 primary presenting problems from a list, including, but not limited to the following, in no particular order: feeling down or unhappy, concerns about emotional stability, problems associated with sexual orientation, feeling guilty, feeling controlled, family difficulties, wondering “Who am I,” feeling nervous or anxious, needing to learn to relax, concerns about emotional stability, feeling lonely, difficulty making decisions, and difficulty controlling your thoughts.

CP5 was given a diagnosis of Social Anxiety related to significant difficulties he was having at work, with symptoms that included: poor concentration, negative thinking, low self-esteem, and excessive worrying, the last of which was predominantly focused on issues of dating and other social situations and contributing to feelings of low self-esteem. The client-participant’s anxiety symptoms represented an exacerbation of a pattern of anxiety symptoms that he had experienced for “years.” He also reported

having a history that included possible drug and alcohol abuse, emotional abuse, and discrimination (e.g., insults, hate crimes), and acculturation issues related to his immigration from South Korea to the United States at age four.

According to the Termination Summary for the client-participant, the therapist-participant reported using Cognitive-Behaviorally-informed interventions to enhance CP5's understanding of the connection between thoughts, feelings, and behaviors, to educate the client-participant about social anxiety, to teach relaxation strategies, to help the client-participant increase assertiveness, and to help him reduce negative-oriented thinking. Per the therapist-participant's report, treatment lasted 15 sessions and was terminated prematurely due to issues with "rapport," "miscommunication," the client-participant being "experienced as slightly argumentative and confrontational," and the client-participant expressing that "he 'hates' (sic) women" and the therapist herself being a woman. The therapy session selected for transcription and analysis was session number 10.

Researcher-participants. Information about the background of each of the three researchers, including their potential biases and hopes for the study, is included in this section. Additionally, similar information is included about the research auditor who is supervising the research process. The inclusion of several researchers and an auditor can be helpful in providing a variety of opinions and perspectives, can control against the biases of any one individual researcher, and may be beneficial in helping to capture the richness of the data being examined (Hill, Thompson, & Williams, 1997).

The primary researcher is a 31 year-old, Caucasian Welsh/German male doctoral student in clinical psychology. His family has lived in the United States for over two

hundred years, he has been brought up in the upper middle class, and he generally conceptualizes clients and conducts psychotherapy from a psychodynamic perspective, incorporating elements from cognitive and strength-based models of treatment. He believes that many clients present to treatment due to difficulties that occur as a result of a combination of problems in early relationships, the manner in which they relate to and manage internal and external conflict, and having subjectively stressful and traumatic experiences throughout their lives. He believes that self-awareness and the ability to relate to difficult psychological material, both occurring within the therapeutic relationship, are core components of the change process.

In his training and experience, this researcher has come to observe that the information provided by psychological theory and research is not always easily absorbed and integrated by students during their training. Students, especially those at the beginning of their careers, seem to want clear models of treatment and specific direction for psychotherapy sessions, especially in an era where there is increasing pressure to adhere to evidence-based models (Binder, 2004). An unfortunate consequence of the increasing body of literature is that many training models (as seen, for example, in the disparity between traditional deficit-based models and growth-based models of positive psychology) seem to be in conflict with one another. He believes that as clinical theory moves away from a dichotomous definition of trauma, training therapists will have increasing difficulty applying theory in practice. For these reasons, he feels it is important to examine how student trainee therapists reconcile these conflicts and actually conduct therapeutic work with clients who have experienced a variety of negative events.

The second researcher is a 31-year old, first-generation Armenian-American female doctoral student in clinical psychology whose parents immigrated to the United States over 30 years ago. She generally conceptualizes clients and conducts psychotherapy from a psychodynamic perspective. Through her training and experience in this theoretical orientation, she has come to believe in the importance of significant human relationships and the effects they have on individuals' view of themselves and of the world. For individuals who have experienced a traumatic event, the importance of this interpersonal connection and relationship is heightened, and the extent to which significant others in the individuals' lives support their need for autonomy and personal competence determines the degree of growth that can be experienced by the individual. The therapeutic relationship is an essential medium of autonomy support for clients who have experienced trauma. Therefore, she believes that, independent of ethnic cultural background, all clients would benefit from therapy that would support the universal need for autonomy, facilitating the human tendency towards posttraumatic growth following an adverse event.

The third researcher is a 29 year-old, Caucasian, Russian-American female of middle socioeconomic who is a doctoral student in clinical psychology. She generally conceptualizes clients and conducts psychotherapy from a cognitive-behavioral perspective. Through her training and experience in this theoretical orientation, this researcher believes that one's interpretation of a situation, often expressed in automatic thoughts, influences one's subsequent emotions, behaviors, and physiological responses. Consistent with the cognitive model, she believes that enduring improvement results from realistically evaluating and modifying biased thinking in one's automatic thoughts, rules,

assumptions, attitudes, and underlying dysfunctional core beliefs about oneself, the world, and others. This researcher is also a proponent of eastern philosophy principles such as Mindfulness practices that have been integrated into cognitive-behavioral-oriented psychotherapeutic treatments such as Dialectical Behavior Therapy. She is supportive of evidence-based treatments and has a general interest in assessing and treating traumatic stress disorders in children and adults. She believes that, while not experienced by everyone, many individuals can benefit from psychotherapy as a means to cognitively reevaluate their schemas that have been challenged by traumatic stress, and subsequently experience posttraumatic growth in the process as they struggle to understand and create new meaning in their lives.

The auditor of the study, who also is the dissertation chair, is a 44-year-old European-American married Christian female. She holds advanced degrees in clinical psychology and law, and she is a tenured associate professor teaching in the field of psychology. She has research interests in the intersection of law and psychology and positive psychology, conducting independent and collaborative research in both areas. She conceptualizes clients primarily from a cognitive-behavioral perspective and incorporates strength-based and systems perspectives into her treatment approach. With regard to this study, the auditor is curious about the ways in which trainees recognize and/or reconcile their understanding of what constitutes trauma and how they apply specific interventions.

Instrumentation

This section describes the instruments that were used in this study. The examined psychotherapy sessions and the demographic information of the participants were

obtained from an archival research database at the counseling centers. The database contains materials and measures completed by all therapists and clients at the initial intake session, as well as at 5 session intervals. These measures were designed to monitor client progress, assess client symptomatology, and evaluate the strength of the client-therapist relationship from both the client's and the therapist's perspective.

Determining a client experience of trauma. In order to investigate the therapist responses to client expressions of trauma of varying degrees and types, it was first determined that the clients included in this study experienced a trauma. For the purposes of this current study, trauma was defined in two ways: based on the nature of the event experienced by the client, and based on the client's subjective perception of an event being traumatic.

As detailed earlier in the review of the literature, the DSM-IV- specifies in the PTSD diagnostic criteria that traumatic events are those which involve "threatened death or serious injury, or other threat to one's physical integrity" (APA, 2004, p. 463). Events that are listed as traumatic include: combat; sexual and physical assault; robbery; being kidnapped; being taken hostage; terrorist attacks; torture; disasters; severe automobile accidents; life-threatening illnesses; witnessing death or serious injury by violent assaults, accidents, war, or disaster; and childhood sexual abuse with or without threatened or actual violence or injury. Researchers and clinicians argue the DSM-IV-TR definition of trauma is limited, and that trauma also includes threats to an individual's psychological integrity because events that are psychologically overwhelming also can lead to as much suffering and distress as those which are physically threatening (Briere & Scott, 2006). Ford and Courtois (2009) add that trauma, which stems exposure to severe stressors that

(a) both are repetitive and chronic; (b) involve harm or abandonment by caregivers or other responsible adults; and (c) that occur at developmentally vulnerable times in an individual's life, such as early childhood or adolescence, can lead to posttraumatic reactions that are more subjective in nature. For this reason, both definitions were be used in this study to guide identifications of trauma discussions in therapy sessions.

Multiple data instruments were examined to determine whether the potential clients have experienced a physical or psychological trauma. First, in the Family Data Section of the Client Information Adult Form, a client needed to 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: separation/divorce, frequent re-location, extended unemployment, adoption, foster care, miscarriage or fertility difficulties, financial strain or instability, inadequate access to healthcare or other services, discrimination (insults, hate crimes, etc.), death and loss, alcohol use or abuse, drug use or abuse, addictions, sexual abuse, physical abuse, emotional abuse, rape/sexual assault, hospitalization for medical problems, hospitalization for emotional/psychiatric problems, diagnosed or suspected mental illness, suicidal thoughts or attempts, self-harm (cutting, burning), debilitating illness, injury, or disability, problems with learning, academic problems (dropout, truancy), frequent fights and arguments, involvement in legal system, criminal activity, or incarceration. These aforementioned experiences were chosen because they would be subsumed under a broad definition of trauma, which includes events that might threaten one's psychological integrity. For half of the participants, one of the following items was indicated: death and loss, sexual abuse, physical abuse, rape/sexual assault, or debilitating illness/injury/or

disability, as these latter categories correspond with the DSM-IV-TR definition of trauma. If the client indicated “yes this happened” in the Family or in the Other column, information from the other following instruments were used to corroborate this information to determine if it impacted the client’s presenting experience of trauma(s). However, all of the participants who were selected for the study identified they had faced the traumatic experience/event themselves.

Second, information from the Telephone Intake Form, from multiple sections of the Intake Evaluation Summary, and from the Treatment Summary were used to corroborate information boxes the client checked on the Client Information Adult Form. The Reason for Referral section of the Telephone Intake Summary provides information about the nature of why the client sought services at one of the counseling clinics. On the Intake Evaluation Summary, the sections of Presenting Problem/Current Condition (Section II), History of The Presenting Problem and Other Psychological Conditions (Section III), Psychosocial History (Section IV), DSM-IV TR Multiaxial Diagnosis (section XIII), and Treatment Recommendations (Section X) were examined. On the Treatment Summary form, the therapist could have indicated that trauma was discussed during the course of the therapy. It may also provide specific diagnostic information that could indicate a client has experienced trauma.

Next, in order to determine if the client has perceived an event as traumatic, the researchers will view videotapes of each participant’s psychotherapy sessions. Specifically, they will search for any discussion of trauma-related material that was indicated on the aforementioned forms. Discussions of trauma identified in videotapes were defined as verbalizations consisting of (a) descriptions of the traumatic event; (b)

evaluative content such as thoughts, beliefs, and attitudes about the traumatic event; and (c) affective content such as one's feelings and emotions about the event (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker et al., 2001). For instance, in the following discussion

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

the client described a specific traumatic event as well as her thoughts and feeling about it. Additional specific examples of what constitutes perception of an event as traumatic can be found in the Coding Manual (Appendix G).

Procedure

Sample selection/data collection. Because of the particular research question being investigated, this study will use purposeful sampling to target the specific participants in the study (Creswell, 2009). An advantage of using a purposeful random sample of participants is that an examination of multiple cases for this study will increase the likelihood of generalizability in spite of the fact that the clients to be included may or may not have been representative of all clients who go to therapy as a whole (Mertens, 2009). However, Creswell (2009) suggests that generalizability is not a critical issue when conducting qualitative research.

In addition, because Creswell (2009) recommends an extensive investigation of 4 or 5 individual cases, 5 individual adult psychotherapy clients that met the inclusion and exclusion criteria were selected from the confidential research database of the university community counseling center. Particular client characteristics and a broad range of

demographic variables (i.e., age, gender, ethnicity, religious affiliations, socioeconomic status) were considered during the sampling to help ensure that the sample obtained were representative of the clinic population (Kazdin, 2003; Mertens, 2009).

First, a complete list of research records was obtained (clients who have terminated their therapy and whose clinical data has been de-identified and entered into the research database). Second, adult English-speaking clients over the age of 18 who participated in individual therapy were selected. Third, the sample was narrowed to include only clients who experienced a trauma (see Instrumentation section) and who had at least eight of their sessions videotaped.

The researcher-participants instructed the research assistants to create a spreadsheet to track all of the potential client-participants (i.e., all clients within the research database) with his/her presenting problem, as identified in the intake clinic paperwork (e.g., Initial Intake Report, Client Information Adult Form, Telephone Intake Summary). The research assistants then indicated if the client had an adequate number of recorded sessions based on search parameters. They also indicated on the spreadsheet if they thought a client met criteria for trauma that was event-based or experience, based on their understanding of the study's methodology. These descriptions were reviewed further by the researcher-participants during the purposeful client-participant selection process to determine if they would meet inclusion criteria for the study. Specifically, the researcher-participants reviewed the entire hard copy record of all potential clients. Through this process, the researcher-participants determined if a potential client-participant case warranted further screening. They instructed the research assistants to watch the session recordings for individuals included at this stage to identify a session

(for each of the potential client-participants) where a discussion of the initially identified trauma took place. The research assistants did this and when they found the trauma discussion, consulted with the researcher-participants for further instruction. The researcher-participants reviewed the sessions him/herself, determining what sessions did meet inclusion criteria and which did not. Specifically, the researcher-participants reviewed the tapes of the selected clients to identify those who definitively met the criterion of discussing their experience of trauma during at least one of the taped psychotherapy sessions. In this study, the first sessions were analyzed for a client discussion of trauma, as the initial responses by the therapist likely is most representative of the framework employed during the course of the treatment.

From the remaining clients who met all aforementioned criteria, 5 were chosen who were determined to be demographically representative (e.g., race/ethnicity, gender, age, religion/spirituality, socioeconomic status) of the population of clients who seek services in the clinics, as well as geographic areas surrounding the counseling clinics. The researchers asked the clinic directors of each of the training clinics for demographic estimates of all clients who have come to treatment in those clinics. This was done to ensure that the demographic variables of the participants included in the research best match the corresponding demographic information for all clients who seek services in the clinics.

In addition, of the 5 participants selected, 3 were chosen on the basis that they met criteria for indicating that they experienced a traumatic event that was physically threatening to them (i.e., one of the following items must be indicated on the Client Information Adult Form: death and loss, sexual abuse, physical abuse, rape/sexual

assault, or debilitating illness/injury/or disability. Two participants were chosen based on their checking at least one box for “Self” for items listed in the Family Data section of the Client Information Adult Form, as these each of these events is a potential precipitant for a participant to meet criteria for having experienced an overwhelming psychological event, which caused distress.

Transcription. Transcription of the sessions was completed by five Master’s-level psychology graduate students, who were recruited on a volunteer basis. Prior to working on with the data for the study, they were taught to transcribe sessions verbatim using a system adapted from Baylor University’s Institute for Oral History. Specific instructions for how these volunteers were to transcribe the sessions can be found in the Coding Manual. Each transcriber also signed a confidentiality agreement (Appendix H).

Coding. The coders for this study consisted of three doctoral level psychology graduate students (the primary researchers for the study). Their research supervisor served as an auditor. Prior to coding the participants’ therapy sessions, the coders and auditor practiced coding until they 75% agreement on practice cases (3 of 4 in agreement). Although this percentage is slightly less than 80%, the level of agreement recommended by Miles and Huberman (1994) for this work, it was the highest non-unanimous percentage possible given the number of coders. The coders were trained to understand the essential concepts, terms, and issues that were relevant to the study (Ryan & Bernard, 2003; Yin, 2003), including how to accurately identify and code each potential occurrence of client discussion of trauma. The coders were also trained on the techniques of the inductive analysis used in this study. Specific instructions for how the coders were trained can be found in the Coding Manual. During each step of the actual

analysis process (viz., establishing the discussion of trauma, assigning codes to talk turns, categorizing and abstracting the themes, checking the theme hierarchy) the researcher-participants and the auditor employed a set of checks and balances to reduce individual biases, which is further discussed in the data analysis section.

Human subjects/ethical considerations. Confidentiality and maintenance of ethical standards for the treatment of research participants was maintained in several ways. First, limits of confidentiality for therapy and for research database inclusion were reviewed as part of the intake procedure for the counseling center. All participants provided informed written consent to have their clinical records (i.e., written and video) included on the research database prior to the initial intake interview to become counseling center clients. In turn, therapists included in the study provided written consent to allow their client records and session videos to be included in the research database. When a clinical case was terminated, all client/therapist clinical information was prepared for entry in the research database. All identifying information was redacted from therapist and clients written documents in order to preserve confidentiality for therapists/clients whose records were transferred to the research database. Both participating therapists and clients were assigned a research number to de-identify them for research purposes (Mertens, 2009). All individuals who handled the transfer of clinical data to the research database completed an Institution Review Board (IRB) certification course (See Appendix I).

In addition to the research data preparation, provisions were made so that those handling the de-identified data will do so in a confidential and ethical manner. Prior to accessing research database content, researchers/coders, and transcribers completed an

IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to ensure adherence to ethical standards of participant research and handling confidential health information (See Appendix J). Further steps were taken to maintain confidentiality by making sure that research coders did not know the research participants or therapists on research videos personally. Finally, one of the benefits of a content analysis methodology is that it is by nature non-invasive and does not require direct engagement of the participants by the researchers (Denzin & Lincoln, 1998). In this study, previously recorded psychotherapy sessions and corresponding written clinical documents were accessed from the archival database.

Data Analysis

First, the data were prepared for an inductive content analysis. The research assistants transcribed the videotaped therapy sessions of the participants the researchers selected for inclusion in the study. Next, the coders reviewed the tapes and highlighted instances where the discussion of trauma criteria were met, noting exact words that represented the trauma, as well as broader descriptions and discussions of the trauma (Zhang & Wildemuth, 2009). They indicated the talk turn where the discussion occurred. After the data preparation, the coders examined the data for specific themes that emerged from the responses of the therapists, in accordance with recommendations for inductive content analysis (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). This typically three-part process involves open coding, creating categories, and abstraction (Elo & Kyngäs, 2007).

The first stage of the data collection and analysis involved each of the three researcher-participants independently watching and reading the transcription of a chosen

therapist-participant's psychotherapy session. Based on the nature of the client-participant selection, each researcher-participant determined a start and stop time for a discussion of trauma to begin and end the open coding process. The researcher-participants then converged and deliberated around this issue, discussing start/stop times until reaching at least two-thirds agreement on this topic. 100% agreement was reached for each session and these decisions were shared with the auditor. The auditor provided feedback to encourage the expansion of time coded for three of the sessions based on her understanding of what constituted a discussion of trauma and how it applied to each of the psychotherapy sessions. The researcher-participants discussed the auditor's feedback and adjusted start and stop times to incorporate additional session content that initially had not been considered as connected to the client-participant's presenting trauma, but upon further reflection was determined to be related to it. The researcher-participants marked these changes on the shared therapy session transcripts. Throughout the data collection and data analysis process, the researcher-participants periodically referred back to their definition of what constituted a discussion of trauma. This step was critical, as the conducting of the coding process (to be discussed below) yielded information that led the research-participants and the auditor to expand the data collection for 2 of the therapy sessions where the impact of trauma was determined to be greater than originally considered.

In the second stage, the researcher-participants completed the open coding process for the trauma segments identified in each psychotherapy session. Each talk turn was examined in a systematic manner to ensure that all session content was thoroughly reviewed. During this step, each researcher-participant documented themes he/she

observed in both the content and process of the therapist-participant responses to the client-participant discussions of trauma.

The following specific techniques were used to identify themes: analyzing repetitions in ideas, concepts, or language, the use of metaphors and analogies, transitions in process, non-verbal behaviors, and the presence of indigenous typologies such as idiosyncratic words and phrases used by the therapist-participant (Ryan & Bernard, 2003). To help control for coding biases in themes found by the research team, each researcher-participant also scrutinized the data that had not been assigned a theme in order to determine if the data could be classified under an established theme or represents a new and separate theme (Ryan & Bernard, 2003). The researcher-participants read through the transcriptions multiple times and watched each corresponding videotaped psychotherapy session, making notes and writing down thoughts and ideas, until each felt he/she had captured the essential headings to accurately capture with codes what was occurring in session. Additionally, each researcher-participant completed this first stage with each client-participant/transcription/session being examined before beginning the next stage of inductive content analysis for each client-participant. The purpose of this last sub-step was to ensure that the findings of steps two and three of the open coding process (i.e., creating categories and abstraction) would not influence what themes the researchers find when open coding for any client-participant.

Again, each researcher-participant completed this process independently for each psychotherapy case and then converged to compare results. Each researcher-participant reviewed a therapy session multiple times and provided a description (the open codes) for each talk turn during the identified trauma segments. Results were tracked and shared on

the collective therapy transcripts. Researcher-participants converged and scrutinized the codes that were assigned for each talk turn; they identified instances where there was not 100% agreement on the coding, deliberating on the coding assigned to these talk turns in order to scrutinize instances of both lumping (minimizing differences between codes identified) and splitting (maximizing differences between codes identified). In these instances, only two-thirds agreement (i.e., 66%) was reached, which is slightly lower than the 80% suggested by Miles and Huberman (1994). As researchers cannot assume that an agreed upon coding system will ensure that the entire body of data is being coded consistently (Zhang & Wildemuth, 2009), this process also played an important role in the generalizability of the findings of the study. This checking process was important for a number of reasons, which included minimizing the impact of coder fatigue on coding (i.e., to reduce/eliminate careless coding, inconsistent coding, or yay/nay-saying), accounting for how pre-existing biases of each of the researcher-participants were influencing how they choose coding themes, and establishing inter-coder verification to sufficiently answer the research question (Zhang & Wildemuth, 2009).

Instances when 100% agreement was not reached after this review of the therapy session were documented in the audit trail and shared with the auditor for her review. When a session was completed, it was submitted to the independent auditor for review. She provided feedback to identify instances where additional open coding could be completed and gave feedback to clarify any disparities found among the researcher-participants. The auditor provided feedback and offered additional information for the researcher-participants to consider, both around these particular instances of non-unanimous agreement as well as for each of the therapy sessions in their entirety. That is,

she reviewed all instances of agreement/disagreement to prevent researcher-participant biases from leading to convergence on codes. Reasons for this convergence on codes included coder fatigue, conceptual biases held by the researchers, and the desire to keep conversations to compare coding brief because of difficulties in coordinating times for the coders to meet. Researcher-participants logged the minutes of these conversations on the audit trail document to reduce the impact of these biases. The auditor provided feedback for each session; feedback was applied retrospectively when a decision was reached regarding how to code a particular phenomenon that emerged in the therapy sessions. As such, the researcher-participants re-examined previously completed sessions and the newer coding was inserted where applicable. At the end of the coding phase, across all participants, there remained only three total instances of non-unanimous (i.e., two-thirds) agreement, just below the aforementioned 80% inter-rater agreement level. That is, for only three talk turns across all participants there were only three specific codes that were assigned that were non-unanimous. The codes assigned to these talk turns were included in the final coding count, as they were corroborated by the auditor.

The third step of the data collection and analysis consisted of each researcher-participant examining the data and determining a hierarchy system for the classification of the assigned codes for all of the therapy sessions. The first component of this process involved the primary researcher-participant creating a spreadsheet (Appendix K). This spreadsheet organized the location of codes, number of occurrences of a code, and descriptions of the nature of the codes (i.e., descriptions of process and content components). The layout of the document allowed the researcher-participants to organize

and track visually the occurrence and prevalence of a code within a particular session, as well as across sessions for each of the therapist-participants. Prevalence rates for codes were not calculated quantitatively, but rather were used to help inform the researcher-participants' understanding of the importance of a particular code and where it might belong in the theme hierarchies (viz., Parent Theme, Category, Sub-theme). The primary researcher-participant distributed this to the other two researcher participants and the auditor.

Construction of the theme hierarchy began with each researcher-participant independently immersing himself/herself in the session transcripts as well as among all of the codes that were identified in the sessions. Preliminary groupings that were similar in nature were grouped together into the Sub-themes that were inductively derived. Decisions regarding how to begin grouping codes together were based both on the frequency of occurrence of a code as well as the interpretations of the researchers. Researcher-participants used a variation of the Ryan and Bernard's (2003) *Cutting and Sorting* technique to move within codes and Sub-themes to establish the higher order Categories that could group the Sub-themes together. A similar technique was used to establish the highest order Parent Themes. Frequency data were considered during this process, and groupings were constructed when they fit for at least two of the participants; however, this process was not purely numerically driven and incorporated clinical judgment of the researcher-participants and auditor as well (see Results section below for a further detailing around how the frequency data were used). Codes that did not have a good fit at any of the levels of the hierarchy were re-abstracted and re-categorized; researcher-participants continued to use the *Cutting and Sorting* technique until codes

could no longer be grouped together or separated and re-grouped to establish groupings that were a better fit or which better reflected the abstraction and categorization of the data. Each researcher-participant continued this process, independently moving back and forth between the specific and more general levels until each he/she could no longer break down categories into smaller units that fall within the broader concepts, and could no longer more broadly define themes (Elo & Kyngäs, 2007). The groupings that were established were understood to be mutually exclusive and exhaustive, and they tied back to the research question (Elo & Kyngäs, 2007).

During the categorization and abstraction processes, researcher-participants took measures to prevent consensual observer drift, a group bias in which researchers modify their findings to reach agreement with another researcher with whom they previously had compared findings (Harris & Lahey, 1982). Each researcher-participant preserved written copies of his/her initial independently derived codes/themes/hierarchies, as well as those established during the group discussion process (Harris & Lahey, 1982).

Once the initial independent hierarchies were constructed, the researcher-participants shared their hierarchies with one another, discussing instances of disagreement and places where data was intuitively expected, but missing from the hierarchy. Namely, they looked for similarities and idiosyncratic analyses that were not shared among all researcher-participants across all analyzed therapy sessions (Hsieh & Shannon, 2005). Initially, there was a disparity among all three researcher-participants with regard to the hierarchies. Non-shared themes were discussed and compared against inter-rater shared themes (e.g., Interpretation vs. Providing Psychoeducation vs. Reframing Client's Struggles) to determine if they could be re-categorized or re-

conceptualized under a mutual heading, or if they represented a distinct categorical aspect that should have been included as a separate branch of the theme hierarchy (Zhang & Wildemuth, 2009). With regard to further disparities in hierarchy categories and abstraction headings (e.g., Potential Therapeutic Disruptions vs. Disruptions in Process vs. Transitions in Process), the researcher-participants discussed these differences in order to either further “lump” groupings or “split” them. Specifically, the researcher-participants would make decisions to further cluster groupings based on similarity or deconstruct and reorganize them based on groupings that appeared to be a better fit for the data. This process was dynamic in nature and occurred both during and after the categorization and abstraction processes. One hundred percent agreement was reached among the researcher participants during this process and the hierarchy was submitted to the auditor.

The auditor reviewed the theme hierarchies and made suggestions around how to reorganize both the process and content themes more cogently and in a manner that more accurately described what was found in the data (e.g., removing the Category ‘Meta-Therapeutic Tasks’ due to it being a part of multiple other groupings and, thus, not necessitating its own). She gave this feedback to the researcher-participants and each independently returned to the data and searched for additional thematic material related to that theme; they then repeated the abstraction process to check the reliability of categories (Elo & Kyngäs, 2007). They then again shared their analyses to compare the final products, discussing differences and re-assigning content until it could no longer be grouped together or separated and re-grouped to establish hierarchy that was more reflective of the data. This hierarchy was again established with 100% agreement and it

was shared with the auditor, who made further modifications. The auditor identified instances where additional content grouping should be included in the content analysis and where existing ones should be modified. This hierarchy was returned to the primary researcher-participant and who continued to work with collaboratively with the auditor to establish the final theme hierarchy. In this back-and-forth process, each made smaller modifications to the language and naming of the hierarchies, splitting content themes from process themes. These modifications were passed back-and-forth three more times until the auditor approved the final version. The three researcher-participants then reviewed the theme hierarchy amongst themselves and reached 100% agreement on the new organization of themes. The theme hierarchies were recorded on a spreadsheet with examples provided for each sub-category (Appendix L). Content Themes, specifically, were derived in the Content Theme Builder (Appendix M).

In order to ensure accountability of the overall research process, the researcher-participants provided an audit trail, or full and clear account of the research process, so that those who review (i.e., the auditor, future readers) this study could/can evaluate its dependability (Lincoln & Guba, 1985). This description of the researcher path included data collection decisions as well as the steps taken to analyze, manage, and report data. Lincoln and Guba (1985) cite Halpern's (1983) recommendations of constructing categories when creating an audit trail, which include (a) raw data; (b) data reduction and analysis products, which include summaries (e.g., condensed notes, quantitative overview) and theoretical notes; (c) data reconstruction and synthesis notes, such as the structure of categories (e.g., themes and relationships) and an integrated report that connects concepts, relationships, and interpretations to existing literature; (d) process

notes, which include methodological notes (e.g., procedures, designs, strategies, rationales), trustworthiness notes (i.e., related to dependability, credibility, and confirmability), and audit trail notes; (e) instrument development information; and (f) materials related to intentions and dispositions, which include personal notes (reflexive notes and motivations) and expectations (predictions and intentions).

Within this dissertation, the first four of Halpern's (1983) categories (a, b, c, d) were tracked. Following the aforementioned audit trail recommendations, the researcher-participants documented in shared electronic document (i.e., a collaborative audit trail) all researcher-participant decisions regarding how data collaboratively were coded (e.g., instances of inter-rater consensus, occurrences of inter-rater disagreement) so that the auditor could understand and review the researcher-participants' judgment process during the auditing phase (Hill et al., 1997; Orwin, 1994). Halpern's (1983) fifth category did not apply to this dissertation. Halpern's (1983) sixth category was implemented through the use of bracketing. Bracketing is a process through which researchers (a) attempt to prevent their assumptions from shaping the data collection and data analysis (e.g., construct development) processes; (b) demonstrate the validity of these methods so that future readers can determine the degree to which purportedly valid studies are free of researcher bias; and (c) provide strategy to facilitate the data collection process (Ahern, 1999). Rather than take measures to eliminate biases, this practice encourages researchers to improve their ability to be reflexive, or aware of the degree to which their preexisting biases impact management of the research data (Ahern, 1999). Ahern recommends that researchers use multiple strategies to facilitate bracketing, which include (a) identifying personal interests that as a researcher, one may take for granted

(e.g., assumptions associated with social demographics such as gender or race, personal interests in undertaking this kind of research; (b) clarifying one's personal value system and other areas of partiality; (c) describing areas of potential situational and relational conflict (e.g., anxiety provoking circumstances, possible interpersonal difficulties); (d) identifying those who serve a gatekeeper function and the degree to which they are disposed favorably to the project; and (e) recognizing feelings that could be an indication of a lack of neutrality in the process. Additionally, the author recommends that the researchers notate anything that is new or surprising in the data collection or analysis (Ahern, 1999).

Based on Ahern's (1999) recommendations, each of the researcher-participants and the auditor used the audit trail document to enhance the reflexivity and bracketing processes. Prior to the study, the researcher-participants began to document the reflexive process independently; they shared this information amongst one another prior to and during the coding process, documenting this information in the audit trail as well. To help further ensure the reliability of the researcher-participants' process and findings, the independent auditor reviewed the final mutually agreed upon theme hierarchy as well as examined the steps the researcher-participants took during the data collection and analysis process. The purpose of this step is to make certain that the findings of the researcher-participants have *dependability* and *confirmability*, which suggest that the research process was consistent in its implementation, and that data, the findings, the interpretations, and the recommendations are internally coherent (Zhang & Wildemuth, 2009). This process involved reviewing raw data and ongoing audit trail notes of the researcher-participants, examining all instances of non-unanimous during the data

collection and analysis processes, evaluating the steps taken by the researchers-participants for fidelity to the original data collection and analysis plan, and assisting the research-participants by directing further review of the data when necessary. When the independent auditor found inaccuracies or discrepancies with the data collection process and the findings of the data analysis, she highlighted areas where the practices of the researchers may have been threatening the dependability and confirmability of the study, making recommendations on structural and procedural changes to reduce the threats. The auditor performed several specific tasks during this process. These duties included (a) reading through all raw material (e.g., transcripts) and determining if the derived themes are reflective of the data and if his/her personal coding strategies match those of the team; (b) questioning disparities in the judgments of the team and providing suggestions for changes to be made in the coding process; and (c) providing comments and facilitating discussions if she feels that the team is excluding potentially relevant information (Hill et al.,1997).

Chapter III. Results

This study investigated the ways in which trainee therapists respond in psychotherapy sessions to clients' discussions of trauma. The purpose of this chapter is to present the results of this study's conventional qualitative content analysis of transcribed therapy sessions to understand how trainee therapists respond to clients' expressions of trauma.

The chapter begins with a description of the four process and five content Parent Themes that emerged across the five sessions, and is followed by a section describing the process and content related themes that emerged within each client-participant's session, which capture the nature of each of the therapist-participants' responses to client discussions of trauma. Generated inductively from the open coding, abstraction, and categorization processes, highest-level Parent Themes are presented with their respective intermediate level Categories and the corresponding Sub-themes from which the intermediate and parent groupings were derived (Appendix L). Specific examples from the therapy transcripts are provided to illustrate the concepts at each of the aforementioned levels. Also, as part of the abstraction/categorization process, the number of occurrences of each code/initial theme within each session was calculated and recorded. As qualitative content analysis typically does not produce counts and statistical significance, these frequency calculations were not used to justify themes, but were used to track and organize codes within the context of sessions. For all of the following results, ellipses (i.e., ...) are used to indicate that some session material was omitted when providing the examples, as it was deemed non-essential for illustration of the concept.

Emergent Themes Across Participants

Process themes across participants. The conventional content analysis of the transcribed psychotherapy sessions yielded four process-based Parent Themes consisting of 13 Categories, which reflect the nature of the responses provided by therapist-participants when the client-participants began to discuss trauma (see Figure 1). The process-based Parent Themes identified were (a) Establishing a Mutual Understanding of the Client’s Experience; (b) Providing Guidance and Support; (c) Encouraging Alternative Processing; and (d) Affecting Session Flow.

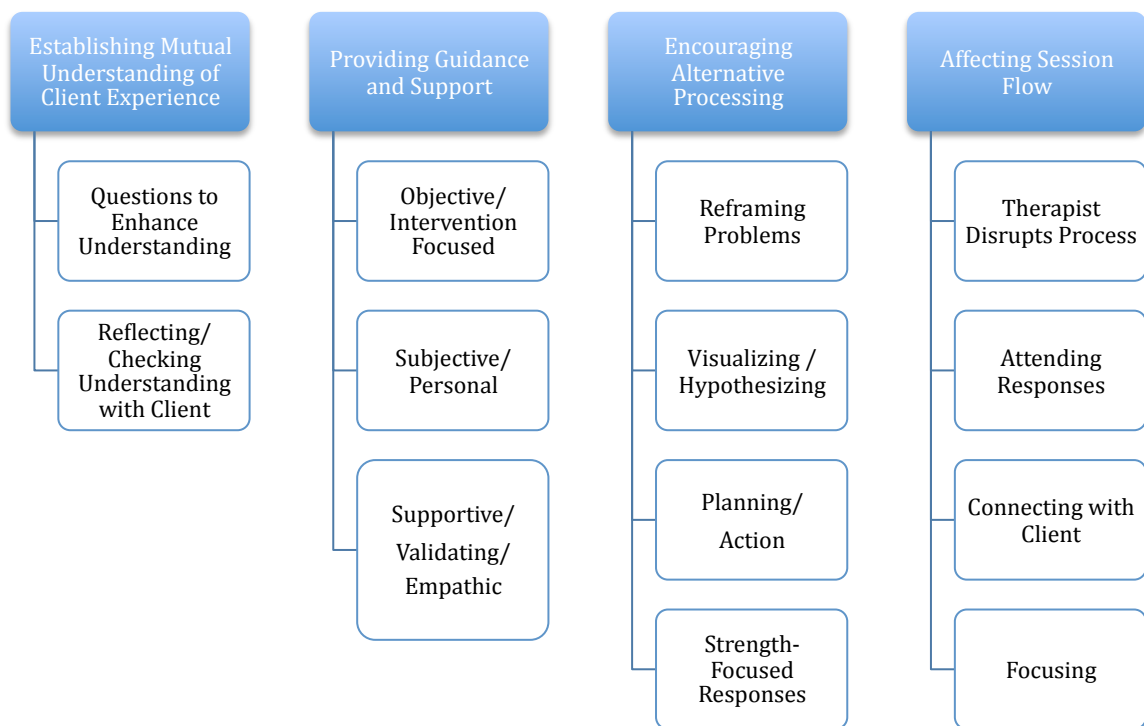


Figure 1. Process-based parent themes and categories across therapist-participants

Establishing a mutual understanding of the client’s experience. The first Parent Theme identified during the content analysis was that of the therapist-participants spending time in sessions working with the clients to establish a shared understanding of

the client-participants' experiences of trauma. This Parent Theme can be defined as processes whose aim is to increase the therapist's awareness of the client's perspective and help the client know that the therapist understands him/her. The establishing a mutual understanding theme comprised two Categories: (a) Questions to enhance therapist understanding; and (b) Reflecting/checking understanding with the client-participants.

Questions to enhance therapist understanding. All therapist-participants spent at least some time during their psychotherapy sessions working with the client-participants to enhance their understanding of the client-participants' traumatic event/experience from the factual perspective of the client-participants (viz., emphasizing discussion of the client-participant's account of the external events and actions surrounding the trauma). Four of them also did this from the subjective emotional perspective of the client-participants (viz., focusing discussion of trauma on the internal experience of the client-participant with regard to the trauma). The specific manner of accomplishing this task appeared to differ slightly across therapist-participants; however, for all pairings, the therapist-participant used probing questions to obtain this mutual understanding. Most notable across pairings were occurrences of the therapist-participants asking close-ended questions to enhance their own clarity about the client-participants' lives and back stories, details of their trauma (e.g., behavior, thoughts, effects, experience), coping skills the client-participants had implemented, as well as about other non-trauma experiences the clients-participants have had. These close-ended questions were predominantly fact-based and appeared to serve the function of helping the therapist-participants obtain a

knowledge-level understanding of an event, as illustrated in the interaction below between Therapist-Participant 2 and CP2,

T131: What about, have you thought at all about, remember we talked about, um, you know, if you killed yourself, then who would be there for your sisters, right?

C131: I know.

T132: Have you thought about that at all, a little bit or--?

C132: Well, I haven't because, I'm really, I just get the idea that with me doing something stupid I'm not gonna help them at all. [T nods] Its gonna make more troubles and not just them, my husband, you know, I can, I got a husband.

T133: ...Right... [T nods]

Other therapist-participants appeared to employ similar closed-ended fact-based lines of questioning, like the one Therapist-Participant 1 asked:

T71: What about for you? You know, your dad's carrying extra stress. Are you carrying extra stress?

In a similar manner, Therapist-Participant 4 asked,

T59: Cause you said you had several frustrating experiences during the day? And maybe you disconnected with them, felt okay, and had the tea?

In addition to a relatively heavy session focus on obtaining facts, the therapist-participants' questions to enhance their understanding of the client-participants' experience often appeared to have been asked in a targeted manner. That is, the questions appeared to be structured in a way to elicit a "yes/no" response from the client-participant to confirm or disconfirm a specific piece of information. Once a client-participant gave a response to a particular question, the researcher-participants typically would follow up either by asking a new question that more broadly gathered information on a possibly similar topic, but which did not probe the original topic for deeper understanding, or by responding with a non-verbal behavior or minimal verbal acknowledgement of the client-participants' responses. This type of responding across

therapist-participants appeared suggestive that the therapist-participants were communicating an understanding of the client-participants' experience, though only through a superficial understanding of information in a particular subject area. This appeared to hold true for both fact-based questions asked as well as the lesser-saturated Category of close-ended emotion-focused questions. This type of targeted questioning is illustrated in the subsequent dialogue between Therapist-Participant 2 and CP2 when the client-participant is discussing how she has been coping recently with difficult emotions:

T136: Well how have you been, you know, how have you been kind of coping with when you're feeling down...What are you doing to handle it, what are you exactly?

C136: Well the interesting thing is [inaudible] I've been pretty busy.

T137: With work and stuff?

C137: Uh-huh. I've been pretty busy with that, so doing you know, whatever I need to do around the house. And work, and just get myself busy.

T138: Okay.

C138: So that I don't dedicate too much time to think about it cause then I start really, getting really sad...My mom husband, he invited us you know to go, cause you know see my mom left him to that reasons, so.

T139: So she, so this is the father of your sisters?

C139: No. [C shakes head and gestures with hands] He's just her husband.

T140: Just her husband. Their stepfather.

C140: Yeah. So she just, you know, kind of left him, just like --

T141: Are they divorced now or no?

C141: No, she just left, you know. Just kinda like that, yeah, that.

T142: Do you like him, is he --?

C142: Well he's a really nice person, so she's just, with my husband he's got a really good relationship...I saw her stuff right there.

T143: Yeah. When was this? Was this like recently?

C143: It was a couple nights ago.

T144: Okay.

This conception manifests similarly in the dialogue between Therapist-Participant 5 and CP5 when the client-participant is discussing the emotional difficulty of attending the funeral of his friend who died:

T236: [T nods] Mm-hmm. Yeah. Do you remember, like what happened when you find out? Like how—like the situation [T waves hands in front of her then clasps hands together] how it happened? [T rests chin on hand facing towards C]

C236 : Uh, it initially doesn't feel real, actually. Get the call and then [C looks down slightly and waves hand near side of head]—it just doesn't feel real. So you don't know exactly—you know what I mean?

T237: Yeah

C237: So it doesn't—it didn't feel real until the funeral actually. It all felt [C waves hand near side of head]—and then you're just—[C groans] the funeral's awful. What is that? I mean—[C chuckles]

T238: Yeah.

C238: Funeral's awful dude

T239: Yeah. Very heavy.

Reflecting/checking understanding with the client. Beyond questions aimed at gathering information from a client-participant about the event/experience of the identified trauma, all therapist-participants gave notable focus to reflecting back information (e.g., facts, feelings) communicated by the client-participants. More specifically, the therapist-participants would check their understanding of facts and feelings a client-participant had communicated in one of 2 ways: (a) by parroting back to the client-participant, in a question form, the exact wording or similar wording used by the client-participant, or (b) by providing a summary of what the client-participant had been discussing prior (three out of 5 therapist-participants responded in the latter manner, with all 5 therapists engaging in some form of the former). The following interaction between Therapist-Participant 3 and CP3 serves as an example of this type of reflective process:

C236: [C adjusts in chair] Well, I want to bring it up at one point to see what their reaction is, you know. Um, and that way I can just know, that you know, hey I don't think they want to come here and –

T: T203: Mm-hmm [T nods]

C204: And then I guess then look for another alternative to uh, figure it out, and I don't know –

T204: Mm-hmm, it sounds like you want to bring it up to them, but you're not sure if you're ready to do it yet.

The following response from Therapist-Participant 1 is an example of a summative statement made by a therapist-participant:

C39: And now he's like owns a house and does all these things that he does. [T adjust in chair] And it's just like you know, so –That's where all the questions come from. Like why? Cause like, if he's gonna – he's made it through all these hard times, you know

T40: Mm-hmm [T nods and smiles]

C40: [C laughs] We don't know if it's a girl. Like some girl, you now what I mean. Cause I know the girl he was dating, but it's just weird, and so – [C looks down at his cup]

T41: So you feel like you have all these unanswered questions about it?

Providing guidance and support. Another Parent Theme that was derived through the inductive content analysis was one of the therapist-participants acting in the role of an expert guide/advisor. It was defined as the therapist acting in the role of advisor/consultant to help reduce client distress, enhance client insight, acknowledge client efforts, and normalize client experience. This advising/guidance Parent Theme was derived from three Categories of (a) Objective/intervention focused, (b) Subjective/Personal, and (c) Supportive/validating/empathic. At times the guidance the therapist-participants provided was objective or data-driven and intervention-focused; nevertheless, for 4 of the 5 therapist-participants the guidance was more heavily based on the therapist-participants' personal opinions than on clinical theory and/or information introduced by the client-participants. Similarly, 4 of the 5 therapist-participants also provided responses to client-participant communications of trauma that included use of supportive/validating/empathic statements.

Objective/intervention focused. Within sessions, most of the therapist-participants dedicated a meaningful portion of the coded time to operating in an advising/guiding role that appeared to be informed by clinical theory/knowledge and/or client-participant established information. Therapist-participant interventions often included working with the client-participants to clarify/develop coping skills, pointing out discrepancies in information presented by the client-participant, having the client-participant weigh evidence for/against a particular idea, having the client-participant compare pros/cons for a decision, rating an emotion's intensity, assigning homework, and having the client-participant take steps to begin tracking thoughts, and having the client-participant begin journaling to manage uncomfortable thoughts/feelings. For example, Therapist-Participant 2 used a specific intervention, weighing the evidence, with CP2:

T220: Right. Well, let's say, let's just talk about what we can maybe do then cause I mean just from hearing you say it's just like, just a minute ago, it sounds like you're just worried though if someone, that someone is going to catch you in that really angry moment and you're not going to be able to deal with it cause [T puts both fists up] they're really angry too and then something inside of you is going to come out and you're going to do something [C nods] stupid as you said, which, even though we know from the evidence [T uncrosses legs, re-crosses legs in opposite direction, wipes hair from face and sits back] that's very unlikely that you'll do that, right?

A similarly natured theory-driven intervention (around the connection between thoughts and feelings) can be seen with Therapist-Participant 3:

T252: So for example, like right now, you might feel really anxious because we are talking about this and its fresh on your mind right now and a lot might be going on and through your head. So from zero to one hundred zero being "I am not anxious" and one hundred being "I'm really anxious", [T using hand gestures and opening hand to C inviting him to respond] right now you might be-?

All therapist-participants also employed the use of Psychoeducation as another type of objective/data driven advising or guiding. Responses of this

nature were coded when the therapist-participants provided the client-participants with psychological information, which was aimed at giving the client-participants a new take-away understanding about their difficulties. An example of the therapist-participant giving this type of psychoeducation can be seen with

Therapist-Participant 4:

T48: Maybe, here is a thought [semi- opens clasped hands]. Maybe when [therapist using left hand to indicate sequential order] several things go wrong that you are not comfortable with and you are feeling upset, maybe you could write a little bit. Then your hands are moving.

C49: [Client has right hand under right side of chin and is nodding] mm-hmm

T49: [Making hand motions in front of her upper chest] you are getting out some of the feelings.

C50: That's a good idea.

T50: ...and maybe that will, that would be something to try rather than sitting...

C51: [Client nodding] mm-hmm

T51: ...and having your hands free because you know that...

T52: ...That there is a connection [hand motions indicating connection] to the things that upset you and your scratching.

Other ways in which the therapist-participants provided objective or intervention-focused responses to the trauma expressions was through the use of rhetorical questioning (used by one therapist-participant), highlighting the mind/body connection (introduced by four of the therapist-participants), reminding the client-participant of other material he/she had not initially thought about that was directly related to the trauma (i.e., giving the client other material to consider; used by three of the therapist-participants), and pointing out patterns (emphasized by 2 of the therapist participants).

Subjective/personal. More frequently than with objective or data-driven interventions, therapist-participants in this study served in a subjective advising and

guiding role when responding to client-participants' expressions of trauma. These statements typically came in the form of the therapist-participant giving advice or an opinion based on his/her personal perspective/beliefs rather than on clinical theory or data introduced by the client-participant with whom he/she was working. Four of the 5 therapist-participants gave overt/direct advice and/or opinions to the client-participant.

An illustration of this concept can be seen in the following response provided by

Therapist-Participant 2 to CP2:

T181: You know, I need to, I'm tell you that you're saying something very important [T taps knee with palm] right now. You're saying that from your side, you recognize that you're different than your family, they're crazy, [T make air quotes around 'crazy'] sounds like, I mean not even in quotes, they sound crazy and they do terrible things and they think its okay to hit their own children and you're, you say you're just not like that, you don't believe that way and thank God you don't. And that, on the other side, they see you, they also know that you're different. But they say it's a negative thing, but you, that you're so angry, and that, you know, cause you do all these things, but that you're, you're not believing what they say, it sounds like. [C nods head] They said that to you but you still believed about yourself, [T points to chest] no I'm the good person here. I'm not angry.

This Category of the therapist-participant offering subjective advice and guidance also can be seen in a response Therapist-Participant 3 gave to CP3:

T207: Though you can't really control what they're going to say or what they want to do. But it comes down to what best fits for you.

This latter example highlights a potential implication of this Category because this therapist-participant is giving advice that is potentially culturally incongruent based on the struggles the client-participant has outlined in the proceeding and subsequent moments in the session. This phenomenon is further detailed in the within-participant section for CP3.

Three of the 5 therapist-participants also provided subjective advice and guidance through the drawing of connections between past and present events and experiences of the client-participants. Although responses of this nature are relatively less subjective than advice giving, they still appeared represent verbal manifestations of the inferences and judgments of the therapist. For example, Therapist-Participant 1 highlighted a potential relationship between the ways in which CP1 handled his current situation and a similar one in his past:

C92: It's the, like, the easiest thing for me to do would have been to sleep in this morning – cause my rents paid for 2 months now, you know, and I have money coming in. I can sleep in every freaking morning, not call my family, ride my bike to the beach, like smoke weed until I started drinking. Find somebody to swank some kind of pills or something. That's what I would have done when I was twenty-one.

T93: Isn't that kinda what you did when your other brother died?

Other less-prominent ways in which all of the therapist-participants would provide guidance to the client-participants included: asking leading questions, answering a question related to the client-participant's struggle based on personal experience/belief, and inferring how the client-participant might be feeling without evidence (i.e., client-participant generated verbalizations of emotion or behaviors signifying the presence of a particular feeling) of the client-participant experiencing the labeled emotion. A prototypical example of this type of subjective advising or guiding response, where the therapist-participant describes how he/she believes the client-participant is feeling and introduces that idea to the client-participant, can be seen in the following response

Therapist-Participant 4 gave to CP4:

C128: ...before I'd be like, 'cause I didn't feel sick. It didn't feel as serious. I don't know whether that- It obviously was extremely serious and but it didn't feel that serious to me because I didn't feel sick. I had roommates...And they were all sicker than I was. I was like getting so

frustrated because I was like in the hospital and I was- but I was hooked up to drugs. I had a pick line [Pointing to right inner arm, bends arm upward]. I went home with a pick line. And the nurse came for 2 weeks to give me antibiotics, but I only realized how serious it was when they told me it would have been my foot.

T128: You know it makes me think [propelling hands forward, widens eyes, looks to the right, propelling hands with open palms to emphasize pattern], your feelings about taking up a bed at the hospital and not being really- worthy of having that bed and your feelings about being a burden to your friends and not really feeling like you deserve that seems to be, sort of a theme.

The apparent objective of this type of response was to have the client-participant look at how his/her thoughts/feelings/actions are part of a larger pattern.

Supportive/validating/empathic. A third Category of the advising or guiding responses the therapist-participants provided is one in which they were supportive of, validating of, or empathic to the client-participants. Four of the 5 therapist-participants appeared to use responses of this nature to communicate recognition, understanding, normalization, and sometimes justification of the emotions expressed by the client-participant. These responses came in the form of an objective mirroring back or summarizing client-participant verbalizations of emotion (as seen with Therapist-Participant 3),

C38: I'm like, I'm feeling too much guilt.

T38: Yeah. That must be really hard. Mm-hmm.

More subjectively, though, these responses also came in the form of responses whose quality appeared to be communicating a therapist-participant's opinion that the client-participant's experience naturally warranted a particular emotion (as seen with Therapist-Participant 2):

C146: I don't know if [inaudible] I don't know, I'm just pretty upset with her.

T147: Well it's understandable because she's, I mean, she's done terrible thing after terrible thing to you and to your family –

Encouraging alternative processing. The third Parent Theme that emerged from the data was that of the therapist-participants having the client-participants re-conceptualize thoughts, feelings, current situations, or past situations. It was defined as therapist purposefully having the client examine a problem/situation/issue from a different perspective. By (a) reframing problems, (b) having the client-participant use visualization, (c) engaging in planning/action, and (d) focusing on strength-based understanding of issues, therapist-participants helped client-participants scrutinize situations in a way that was different than they had been using.

Reframing of problems. The first way therapist-participants responded to have the client-participant process concepts in an alternative manner was by a reframing of the manifesting problem. Therapist-participants provided responses whose aim was to shift client-participants' view of a particular issue away from a less adaptive viewpoint and towards a potentially more helpful perspective. Frequently they accomplished this task through the use of Indigenous Typologies, in this case psychological language and psychologically oriented conceptualizations, to help the client-participant more wholly view a concept and to help reduce a client-participant's level of distress. This type of Indigenous Typology reframing is illustrated with Therapist-Participant 3's response:

T214: [T nods] Mm-hmm. Right. And now you [T using hand gestures] have 2 competing cultures. Here being very individualistic and what is best for you and yourself and back there it is a more collectivistic community oriented. Where you know, people from the community expect you to be back there with your mom.

It can also be seen in Therapist-Participant 4's following interaction with CP4:

T60: [Making hand motions to emphasize clients experiences and

disconnect] And maybe you disconnected with them, felt okay, and had the tea?

C61: [Client nodding] mm-hmm

T61: and then the feelings kind of –

C62: Came up?

T62: ...came up subconsciously [therapist motioning with hands, client nodding in agreement and then maintains eye contact with therapist for a few seconds]. So maybe is you know you are going through frustrating experiences write them down. Even when you are having your cup of tea, do a little writing and see where that takes you. Because maybe putting in a step in between, having you be more conscious of your frustrations and feelings of being upset, um, maybe if you bring it to the consciousness then you won't subconsciously start scratching. [Therapist smiles] It's just a thought –

Alternatively, the therapist-participants accomplished reframing through the use of metaphor, or having client-participant look at the issue from someone else's perspective. Similar to the IT, these types of interventions also appeared focused on changing and/or enhancing a client-participant's understanding of a problem. For example, Therapist-participant 5 attempted to use a metaphor to help Client-Participant 5 consider the magnitude of his friend's suicide:

T289: And, um, we just start thinking about these things more and for you it sounds like it—it, uh, woke you up a lot.

C289: [C nods] Yeah I would say to a certain extent it did. You know what I mean?

T290: Yeah

C290: And to a certain extent it didn't... [C and T laugh]

T291: Well it woke you up in some ways.

C291: Yeah

T292: Yeah. So yeah, again, those are many very powerful reasons for coming in. So um, going back to talk—to, um, you're—the last girlfriend you had? [T gestures toward C]

In this instance, the therapist-participant introduced the concept, but did not attempt to explore or expand on it further when the client-participant expressed some ambivalence. Instead the therapist-participant steered the discussion to a different topic.

Visualizing/Hypothesizing. The second way that therapist-participants gave responses to have the client-participant process concepts in an alternative manner was through facilitating future-oriented cognitive reflection. Therapist-participants accomplished this task through use of hypothetical questions/statements, problem solving, and suggesting possible alternative outcomes for a situation and ways in which the client-participant could alter his/her behavior to achieve that ending. An example of this type of intervention can be seen with the following response Therapist-Participant 3 provided:

T243: Or maybe your sister could help also and maybe help support you, even though she is over there and help with your mom and making her a little less anxious about you being here?

Engaging in planning/action. The third way therapist-participants had client-participants process concepts in an alternative manner was by assisting them in planning or engaging in action-oriented behaviors. In some instances the therapist-participant would have a client-participant systematically seek a solution for a problem (as seen below with CP3):

T143: Or maybe your sister could help also and maybe help support you, even though she is over there and help with your mom and making her a little less anxious about you being here

Alternatively, therapist-participants also worked to help client-participants explore potential consequences for their actions. This type of occurrence consisted of the therapist-participant examining a cause and effect relationship for the actions and results of a client-participant's behavior. An example of this is illustrated in the therapist-participant's response below:

So maybe because other people are branching out you think that your family might be more willing to come here (CP3; T183)

Strength-focused responses. A fourth way therapist-participants had the client-participant process concepts in an alternative manner was through providing strength-focused responses to client-participants' expressions of trauma. These responses involved empowering the client-participant by highlighting strengths in the client-participant, emphasizing his/her own control over making changes in his/her life, purposefully examining positive consequences of an issue that the client-participant had been viewing in a negative deficit-oriented manner, and encouraging the client-participant to draw his/her own conclusions about an issue. The ways in which these types of responses manifested in the therapist-participants' responses were through behaviors that included: validating a client-participant's thoughts/feelings/emotions, reinforcing the client's use of already present coping skills, highlighting a client-participant's strengths, and deferring to the client-participant's own decision-making and ability to make choices (the last of which is illustrated below with Therapist-Participant 3)

T209: And so it sounds like it comes down to your own decision. What you want. If you want to stay here or go back there.

Other strength-focused interventions focused on positively reframing an experience for which the client-participant has only had a negative impression (as exemplified with Therapist-Participant 5 below)

T245: You had all these opportunities that you could've been violent if you wanted to and you, when most of them it sounds like most of them were related to defending yourself.

Therapist-Participant 2 can be seen providing a strength-focused response to CP2, who was detailing her struggles with family and the physical and emotional abuse she experienced:

T252: I know. But what I'm trying to tell you though is that you're right, of course, think about that, if you're a good person why would somebody do bad things to you? [T shakes head] But C, what I'm trying to say is [C takes tissue from box on couch and wipes face] that not everybody can still get through all those things they way you got through them.

Similarly, this type of responding can be seen in Therapist-Participant 5's response while exploring how the death of his friend led CP5 to have significant worries about his future:

T288: [T nods] Yeah. It's—it's very normal when we—someone close to us passes away to start thinking about all these things. I mean, people think about it from time to time anyways, but when these kind of things happen it kind of wakes us up.

Affecting session flow. The final Parent Theme across therapist-participants was found in the interpersonal process dynamics that arose organically between therapist-participant and client-participant pairings, which impacted the flow of the session. Affecting flow was defined as therapist behaviors during the session, which change the process or content of the therapy. Responses of this nature fell into 5 Categories: (a) therapist disrupts process, (b) attending responses, (c) connecting with the client, and (d) focusing.

Therapist disrupts process. The first Category was the tendency of the therapist-participants to engage in behaviors that interrupted processing or halted it altogether. This was the second most prevalent interpersonal process pattern seen in the sessions, and it appeared to be the one that impacted session flow the most. These disruptions occurred in a variety of forms. The first prominent Sub-theme manifestation of this Category occurs in the form of the therapist-participant completing the client-participant's sentence for him/her, as seen with Therapist-Participant 1 (all therapist-participants demonstrated this behavior). In this instance, she inadvertently shifts the focus away from the client-participant's discussion of his father's perspective and onto the client-participant,

C62: But it's, it's not past the point of no return. I mean I can go back and help my dad. But like, my dad, it would break my dad's heart for me to do that. Like he, that's not what –

T63: That's not what you want to do. [T nods]

The second Sub-theme was the therapist-participant interrupting the client-participant to ask a question or make a statement; all 5 therapist-participants demonstrated this behavior. This concept is illustrated below with Therapist-Participant 3 who, in this instance, keeps the conversation fact-focused and appears to impede the client-participant's effort to direct the focus of the conversation towards what he wanted to say,

C34: And the fact that my grandma—she--I think I just found out last time I was there, that she used to dye her hair. Now she stopped dying her hair, I think she kind of, uh, made a wish that if I go back, she will dye it back. I'm like--

T34: Really?

C35: Yeah, and every time she sees me she cries. I'm like—

T35: Mm-hmm.

C36: Just like—

T36: Mm-hmm. Your grandma?

C37: Yeah.

T37: That must be hard.

C38: I'm like, I'm feeling too much guilt.

C39: I mean—

T39: Did it make you feel better at all to hear your mom say that she...you know...doesn't want you to make the decision for them? And—

C40: [client shakes head “no”]

T40: It didn't really mean anything?

and also with Therapist-Participant 1 and CP1 (below).

C13: And then, more and all these kind of people who are all really upset and all of my friends. (2) So, [C sighs] That brought back a lot of stuff, you know just like --

T14: How was it for you? I mean being in (location), going through all of this again.

In the aforementioned instance, the therapist-participant seems to inhibit the spontaneous elaboration to list the consequence of the death of the client-

participant's half-brother in service of having the client-participant more directly reflect on his own emotional experience of the death.

A subtler example of the therapist-participant steering the direction of the conversation was seen across all 5 therapist-participants in statements where the therapist-participant would start a question/statement and either trail off at the end without finishing the thought/sentence or allow the client-participant to finish his/her sentence. This behavior was seen in the responses of most of the therapist-participants and often appeared to alter the direction of the therapy just enough to move it away from the original focus. In these instances, it was unclear if the therapist-participant intended the conversation to continue in the direction in which the client-participant takes the conversation or if the original therapist-participant intended focus of the conversation was abandoned. This concept is illustrated below with Therapist-Participant 5 who (in this instance) appeared initially to be having CP5 reflect on his experience of the death of his friend, though then seemed to move the conversation towards a more distanced discussion of it:

C269: It finally hit me, at the end of the day, at the funeral. You know what I mean? [C reaches into pocket and appears to look at his phone]

T270: Yeah. Mm-hmm. [C puts phone back in pocket and looks back at T]
Yeah, it's really hard to deal with that, especially someone you knew so well and –

C270: Someone young.

T271: Young, right. [C chuckles] Were they close to you—the same age as –

C271: Yeah, same age as me. So—

T272: It's hard, it makes us—I mean not only are we like upset about our friend passing away, but you know, it kinda—it makes you think more about yourself.

The third Sub-theme of this was the therapist-participant using the words “right” and “okay” in a way that potentially communicated that the therapist-participant already knew what the client-participant was going to say as he/she was saying it or as that there was an objectively correct way for the client-participant to view his/her problem (seen below with Therapist-Participant 3 and CP3),

C260: So, I don't know. Maybe I am being too much of a critical thinker and that's why I can't make decisions.

T260: Right.

C261: [C touches forehead] But I am also a driver, which I would say I am more of like a driver, analytical. But I'm finding myself even more critical even more looking at stuff like really far down the road trying to sketch things out, I'm like-

T261: [T nods] Right because you have this big decision you want to make and you're really focused on details.

The fourth form in this Category was the therapist asking multiple questions at once, which four of the therapist-participants did (Therapist-Participant 2 illustrates this concept below):

T98: Did it feel uncomfortable that you couldn't cry? [T taps chest with hand] Like did you feel like you needed to release that and you couldn't? Or it just felt like you were just feeling sad and you just didn't happen? [T gestures with hands in circular motion]

Often resulting from the 2 aforementioned patterns was a new back-and-forth pattern of the therapist-participants and client-participants inferring what they perceived the other was going to say, interrupting the other, and carrying the conversation out in a sequence of complementary sound bites and incomplete sentences, where complete information is not shared by either individual. To varying degrees, this pattern manifested in the responses of all therapist-participants. An example of this type of interaction can be seen in the following sequence between Therapist-Participant 5 and CP5:

C239: [C smiles] Yeah. I had to do the eulogy [C groans]—it's horrible.
[C smiles]
T240: You did a part of the—
C240: I did a part, oh [C exhales loudly and shakes head] awful. See the
dad cry [C smiles] You know?
T241: Yeah.
C241: And that stuff—I don't know anything about like, you see a woman
cry it's a little bit of a, I mean –
T242: [T nods] It's more common.
C242: -- [C smiles] It doesn't break my heart as much as a –
T243: It's hard to see that.
C243: [C smiles] Watching a dad cry, watching a man cry is just [C
groans loudly while smiling]. That's just awful. [C chuckles]
T244: Yeah.
C244: 'Cause they cry in a certain way too. They cry in like a—it's not—
it's not a sob. Like a restrained kind of, uh—you know what I mean? It's
like a –
T245: [T nods] Yeah.

Attending responses. The second Category of process patterns between therapist-participants and client-participants was the tendency of the therapist-participants to use more passive responses to attend to the client-participant. These behaviors were by far the most frequently occurring responses during client-participant discussions of trauma. Different from more active efforts to use a reflective process to obtain informational clarification, these responses by all therapist-participants appeared less purposeful than other more active responses they provided. Nonetheless, these responses appeared to be ways in which the therapist-participants would accomplish tasks of acknowledging what a client-participant had said and tacitly facilitating additional dialogue on the same topic. These types of responses came in the forms of non-verbal behaviors (e.g., nodding in agreement, hand gestures to encourage the client-participant to continue), vocal utterances that communicated the therapist-participant was hearing and/or following what the client-participant was saying (e.g., uh-huh, mm-hmm), and repeating/reflecting back

exactly what the client-percipient was saying (for similar reasons; see the interaction between Therapist-Participant 5 and CP5 below),

C266: ...it starts [noises, unintelligible] and \$hit...[C smiles and gestures by waving hands near head]

T267: ...it's like all rushing up [T gestures by waving hands near head]

The quality of these responses suggested that they were more automatic than responses that required more thinking/premeditation by the therapist-participant. What was unclear was whether or not these interventions in fact used purposefully or if they were employed due to the therapist-participant not knowing how to respond in a more actively engaged manner.

Connecting with the client. A third Category that emerged in the interpersonal process pattern was seen in therapist-participants' efforts to connect or join with the client-participants. This behavior consisted of behaviors by the therapist-participants that appeared to foster a sense of togetherness in the client-participants' struggles and in the solution-finding process, which typically was accomplished through the therapist-participant's use of the exact language that the client-participants used to describe their thoughts/feelings/situations (e.g., reflections of feeling/fact, summarizing statements). Three of the 5 therapist-participants directly mirrored client-participant language, while all five made summarizing statements to connect with the client-participant. This pattern can be seen in the following interaction between Therapist-Participant 4 and CP4:

C37: Uh, what night was that? [Client looking downward and to the left]
Do-do- do-to-do that was Saturday night.

T37: [Therapist slowly nods x1] Saturday night.

Connecting and collaborating could also be seen when a therapist-participant would explicitly use the words "we" or "us" to communicate that the therapist-participant and

client-participant were working together towards a shared objective. This pattern is seen below with Therapist-Participant 3 who, in working with CP3 in service of setting the session focus, highlighted the collaborative nature of the planned therapeutic work:

...And things like that. So how do you feel about making that shift? I mean this is something that, I don't want you to think we are structured and I am going to say what we are going to do. This is something that we will come in, and for example, for the first couple minutes we will talk about things I think we should talk about and anything you think we should talk about. [T using hand gestures] Like for example, today, you know, we really focused on this issue with you family and where you want to be, whereas last week we talked more about studying. So still feel free to bring it what you've been experiencing the past week and what's on your mind.

Focusing. A fourth Category that emerged in the interpersonal process pattern was seen in therapist-participants' responses that fostered focusing during the session. These responses helped to move the client-participant away from discussing material more generally and towards a more specific discussion around his/her own experience. The first pattern of focusing was the therapist-participants' asking for additional facts about something or focusing on more specific informational content (as is seen with Therapist-Participant 2 below),

T98: Did it feel uncomfortable that you couldn't cry? [T taps chest with hand] Like did you feel like you needed to release that and you couldn't? Or it just felt like you were just feeling sad and you just didn't happen? [T gestures with hands in circular motion]

C98: Just, yeah, just feel sad, just didn't cry.

T99: Okay, okay. [T nods] Um, why don't you tell me a little bit about what's going on with your sisters leaving and how that went, cause we haven't really talked about that.

A variant on this pattern can also be seen with Therapist-Participant 2, whose transition in process shifts the conversation away from a discussion about the client-participant's chronic suicidality once CP5 denies she has had any thoughts of harming herself since the previous therapy session. Instead, the therapist-

participant asks CP2 more generally about the effectiveness of the coping skills she has used when feeling down rather than probing for additional information on the topic of client-participant safety (e.g., when she last felt suicidal, how long it lasted, how she coped specifically with suicidality):

T131: What about, have you thought at all about, remember we talked about, um, you know, if you killed yourself, then who would be there for your sisters, right?

T132: Have you thought about that at all, a little bit or –

C132: Well, I haven't because, I'm really, I just get the idea that with me doing something stupid I'm not gonna help them at all. [T nods] Its gonna make more troubles and not just them, my husband, you know, I can, I got a husband.

T133: ...Right... [T nods]

C133: ... and I got a family with him. I can't just think about me, you know.

T134: Right. Well and that they, you know, they love you and need you. You know?

C134: That's right. I can do better, you know, with helping them somehow and instead of me doing something wrong, you know.

T135: Right, right. [T nods]

C135: So—

T136: Well how have you been, you know, how have you been kind of coping with when you're feeling down. It sounds like you've been feeling, like you said, better, but you're kind of handling it. Still a little down.

What are you doing to handle it, what are you exactly?

The second pattern seen with focusing was the therapist-participant shifting the therapeutic process to focus on what the client-participant is thinking/feeling or feeling in session (as exemplified in the exchange below)

C263 : That's just kind of how I was dealing with it until now. Actually still kind of have, you know? Don't mention it until someone brings it up, yeah.

T264: Right. (6) It must be hard even talking about it now.

C264: [C nods] Uh, yeah it is.

The third pattern seen with focusing was the therapist-participant taking time with the client-participant to set a focus for therapy around how specifically to use the sessions. An example of this can be seen below with CP2

T264: You're welcome and I think that's really good that you come, I think it's really helpful and tell me if it is or it isn't but it seems to me that it's helpful for you to come talk about these things, hard things [C looks down and up] and you know we can kinda work on how you feel about them now, how does that sound or how does that feel to you?

C264: About what?

T265: About talking about difficult things in here.

C265: Oh, I think its, I feel good to let it out you know cause I never really talk about it.

Content themes across participants. The conventional content analysis of the transcribed psychotherapy sessions yielded 2 content Parent Themes: (a) Coping, and (b) Client Struggles/Difficulty. The first Parent Theme was comprised of therapist-participant sub-themes/responses that involved a discussion around the ways in which client-participants had been able to physically and emotionally tolerate and/or grow from their traumatic experiences. The second Parent Theme was comprised of therapist-participant sub-themes/responses that involved a direct discussion around the details of how the client-participants had struggled with their traumas. Figure 2 illustrates Parent Themes and Categories found in the process of the sessions across all participants.

Coping	Client Struggles / Difficulty
<ul style="list-style-type: none"> • Family • Focusing on /Supporting Others' Wants/Needs • Psycho-education connecting Thoughts/Feelings/ Behavior • Control • Meaning Making 	<ul style="list-style-type: none"> • Fear/Worry/Anxiety • Frustration

Figure 2. Content-based parent themes and categories across therapist-participants

Coping. The Coping Parent Theme was defined as the therapist works with the client to identify and evaluate the client's use of coping skills to manage difficult thoughts, emotions and situations. Across all client-participants, the Parent Theme of Coping manifested in 5 ways (i.e., Categories): (a) Family, (b) Focusing on / Supporting Wants/Needs of Others, (c) Psychoeducation to Connect Thoughts/Feelings/Behaviors, (d) Control, and (e) Meaning Making.

Family. The first content Sub-theme that appeared across multiple client-participants was Family; four of the therapist-participants examined ways a client-participant's trauma was related to his/her family relationships. The trauma for two of the client-participants resulted directly from actions taken by a family member (i.e., suicide by a sibling; child abuse by a family member). An example of this can be seen in the comments of Therapist-participant 2:

T163:...it seems very painful, obviously I know, that somebody could do this to you and then you had to experience that. The other thing is that its

your, you were saying, that its your own mom. It's your own mom [C nods]...

For the other 2 client-participants, the therapist-participants examined more diffusely how the client-participant's past or present family relationships were exacerbating the client-participant's experience of the trauma. For example, Therapist-Participant 5 highlights how the client-participant's perception of being a burden on others due to her current medical procedures may have origins in her family relationships as a child:

T133: What about as a child and coming into your new family and maybe not feeling worthy?

For all four client-participants, a focus of the trauma discussion was on identifying how the family source(s) played a role in maintaining the distress of the trauma.

Focusing on / supporting wants/needs of others. The next content Sub-theme that manifested across all 5 sessions was that the therapist-participants focused the session on someone other than the client-participant when discussing the trauma. This Sub-theme manifested in 2 ways: (a) the therapist-participant examining a client-participant issue from another person's perspective, and (b) the therapist-participant focusing on examining the struggles of another person (i.e., not the client-participant). For instance, Therapist-Participant 5 focused on the emotional difficulties experienced by the father of the client-participant's deceased friend; the client-participant's discomfort around seeing the father getting upset is processed instead of the client-participant's emotions around the event (i.e., the death of the friend) itself:

C240: I did a part, oh...awful. See the dad cry [C smiles] You know?

T241: Yeah.

C241: And that stuff—I don't know anything about like, you see a woman cry it's a little bit of a, I mean.

T242: [T nods] It's more common...

C243: Watching a dad cry, watching a man cry is just... That's just awful... 'Cause they cry in a certain way too. They cry in like a—it's not—it's not a sob. Like a restrained kind of, uh—you know what I mean... So you know it's like they either try to hold it in or they can't, I don't know... I don't know, that's just the awful side...
T247: Yeah, it's like really depicting how... how badly they feel and how horrible the situation is.

Psychoeducation to connect thoughts/feelings/behaviors. The third content Sub-theme that appeared across multiple participants was the therapist-participant's use of psychoeducation to illustrate for a client-participant the connection between his/her thoughts, emotions, and actions. Three of the 5 therapist-participants explicitly focused on helping the client-participant understand this association. Therapist-participant 2 demonstrates this concept with her response below:

T150: Do you feel, when you're feeling angry, is that, in that moment, is that, [C wipes eyes with tissue] did you have, what were you thinking, when you're feeling really angry, what were the thoughts going on in your mind?

Control. The fourth content Sub-theme, Control, manifested across all five therapist-participants. The therapist-participant responses specifically examined the ways in which the client-participant was handling current symptoms, struggles, and/or stressors, and ways he/she was taking steps to re-establish a sense of empowerment to manage difficult situations. At times therapist questions or comments focused on identifying and/or encouraging the use of specific coping skills, such as with Therapist-Participant 2 (seen below)

T209: Did you try what we talked about, the other time, did you, remember what we talked about last time, like when you feel angry to, when you walk away [C nods], which is I said a good thing, not a bad thing.

In other instances, therapist-participants' discussions of Control more generally examined ways in which a client-participant had acted in response to distressing experiences to

manage or control them. For example, Therapist-Participant 1 highlights how the client has the ability to choose how to react to the death of his brother, and that in this instance he elected not to engage in patterns of past behavior that were problematic for him:

C92: It's the, like, the easiest thing for me to do would have been to sleep in this morning – cause my rents paid for 2 months now, you know, and I have money coming in. I can sleep in every freaking morning, not call my family, ride my bike to the beach, like smoke weed until I started drinking. Find somebody to swank some kind of pills or something. That's what I would have done when I was twenty-one.

T93: Isn't that kinda what you did when your other brother died?

Meaning Making. The fifth content Sub-theme that manifested across all five therapist-participants was Meaning Making. Each of the therapist-participants asked some questions to explore with the client-participant ways in which he/she was conceptualizing his/her difficulties. This type of questioning was aimed at helping the client-participants have a greater awareness of why the stressors/traumas that each had faced was causing him/her such subjective distress. An example of this Sub-theme can be seen in the response to Client-Participant 5 that Therapist-Participant 5 gave (below):

T79: So what would it mean to you to stay here? To make that decision to, that you're gonna stay here, you're gonna find someone here and raise a family here?

Client struggles/difficulty. Across all client-participants, the Parent Theme of Client Struggles/Difficulty manifested in 2 ways (i.e., Sub-themes): (a) Fear/Worry/Anxiety, and (b) Frustration/Anger. This Parent Theme was defined as when the therapist works with the client to explore and process issues with which the client is grappling and which are causing him/her to experience distress.

Fear/anxiety/worry. Within the Parent Theme of Client Struggles/Difficulty, the first content Sub-theme that appeared in responses to trauma across all five therapist-

participants was a focus on client-participant fears, worries, or anxieties. At times this subtheme captured an examination of a more formal symptom of clinical anxiety (as seen below with Therapist-Participant 3):

T252: ...like right now, you might feel really anxious because we are talking about this and its fresh on your mind right now and a lot might be going on and through your head. So from zero to one hundred zero being “I am not anxious” and one hundred being “I’m really anxious”... right now you might be –

Other times, this concept manifested with the therapist-participant looking at client-participant fear or apprehension more generally. This is illustrated in the response of Therapist-participant 4 (below):

T32: [Therapist nods and closes eyes briefly] I can understand your fears and concerns [client nodding] and –

Frustration/anger. The second content Sub-theme that makes up this

Parent Theme and was seen in the therapist-participants’ responses was a discussion around Frustration/Anger. Two of the 5 therapist-participants focused their responses to discussions of trauma on the frustration and/or anger that the client-participants were feeling, which were related to the trauma being discussed.

An example of this can be seen below with Therapist-Participant 4 and CP4:

T59: Cause you said you had several frustrating experiences during the day?

Emergent Themes Within Participants

For each of the client-participants, the session process and its emergent themes is first presented and then followed by the content themes that emerged in the data. As indicated in the Method Section, an emergent concept or topic (in both content and process) was determined to be a pattern only when it was coded

twice or more during a session. The initial patterns formed the Sub-Theme grouping; patterns in Sub-Themes, which were found across multiple client-participants, were grouped under a higher level Category. The same process occurred between Categories and Parent-Themes.

Client-participant 1 session. *Session process.* The trauma discussion within this therapy session began immediately with the client-participant giving background about his brother who recently committed suicide. The client-participant initially indicated that he felt sad, but quickly moved towards providing fact-based background information about his brother and his brother's recent behavior. The therapist-participant alternated between providing minimal verbal acknowledgement type responses (e.g., "Mm-hmm;" occurring 65 times throughout the trauma discussion) and asking closed-ended questions to gather facts (occurring 3 times during the trauma discussion) and clarify an understanding of facts in response to the information the client-participant gives (occurring 5 times during the trauma discussion).

As the session progressed, the therapist-participant attempts to direct the client-participant away from focusing on the facts surrounding his brother's suicide and towards his own emotional responses (Closed questions about emotions, four times during the trauma discussion). In these instances, which continue throughout the therapy session, the client-participant provided either a brief description of a feeling or identified a thought, and immediately moved away from discussing the death of his brother in language with an emotional valance and towards discussing the death either with distanced fact-based language, or from the perspective of others:

C14: It was really sad. You know, it was so sad. You just almost can't believe it. [C wipes face]

T15: Mm-hmm [T nods]

C15: Because truthfully, like out of all of (C's brother)'s times, he's had darker times. [T nods] Like, I don't know, and he just seemed so happy. [C grabs his upper back with his left hand] But, I don't know anybody's tipping point. You know what I mean, it's not for me to determine. [T nods] So, I don't know what happened so much. That we just lost somebody that's a really good person. It's like - And it's real, cause he's not there anytime. It's like [C laughs] you know what I mean? That's when it's real [C clears throat]. Is everyday when you - Like when I call him, my dad's been up since 5:30 working, you know, cause he can't stop working. Cause [inaudible]...

As the discussion continued, the therapist-participant alternated between asking closed-ended fact-based questions and asking close-ended questions about emotions, the latter of which served more to confirm/disconfirm the presence of emotions and less to process those feelings in depth.

The session continued with the client-participant offering additional stories to detail some of the specific experiences he had with his brother as well as to describe the impact of his brother's death on his sister, his father, and his stepmother. In addition to minimal verbal acknowledgements and fact-based question, the therapist-participant, responded to this behavior in variety of ways. First, she incorporated previous information to help the client-participant observe his behavioral patterns (occurring 4 times during the trauma discussion):

T93: Isn't that kinda what you did when your other brother died?

Additionally, the therapist-participant used Indigenous Typologies to help the client-participant view the situation he was discussing in a different manner (occurring 2 times during the trauma discussion), which appeared to be for purposes of getting the client-participant to be less fact-focused in processing the death of his brother (seen below):

T16: Does some quality of it feel unreal to you?

She also used metaphors (occurring 2 times during the trauma discussion) in a similar manner (below):

T73: Cause we talked before about you carrying your stress in your back, and –

These responses also appeared to have been used to help the client-participant frame his situation in an alternative manner in order to elicit different and/or deeper processing of the material. The therapist-participant would often give these responses after the client-participant had finished elaborating on a topic, though at times the therapist-participant would interrupt the client-participant in a manner that appeared to emphasize the aforementioned (occurring 4 times during the trauma discussion).

In addition to the aforementioned process patterns from the session, the therapist-participant used a substantial number of non-verbal behaviors (e.g., nodding, pointing, gesturing with hands) during the session. These behaviors appeared to provide both emphasis for a therapist-participant's statement/point being made and acknowledgement of something the client-participant was saying. Of all the responses provided by this therapist-participant, this type was the most prevalent (occurring 75 times during the trauma discussion).

The trauma discussion concluded at the end of the therapy session. During this time, the therapist-participant provided a summary statement about how the client-participant appeared to focus more on taking care of others than himself, though this immediately shifted into a conversation around the struggles the client-participant's girlfriend was having rather than staying focused on the client-participant's own

behaviors. Finally, the client-participant briefly summarized all the areas in his life that were stressors.

Session content. There were four main content Sub-themes that manifested in the session: Focusing on or Supporting the Wants/needs of Others (occurring 2 times during the trauma discussion), Control (occurring once during the trauma discussion), and Meaning Making (occurring 3 times during the trauma discussion).

The first content pattern, Focusing on or Supporting the Wants/needs of Others, manifested in the therapist-participant's responses that highlighted the client-participant's tendency to engage in this behavior with others in his life. Specifically, the therapist-participant asked the client-participant:

T18: You do a lot of being there for people, are people there for you too?

She also made the following statement to the client participant to illuminate further the patient's tendency to be other-oriented in his life and not to focus on his own perspective:

T79: Because you have this pattern [T gestures with hands] of not really taking care of yourself, but worrying about the people around you. So I want to know what's going on with you? You told me what's going on with your dad, and your step-mom, and your sister, what about for you?

This topic was present throughout the session, and also was reflected in the client-participants' tendency to talk about others' perspectives (versus his own), and the therapist-participant's tacit allowance of the client-participant's focus on others during the session.

A second content Sub-theme that manifested in this session was Coping, or the therapist-participant's focus on exploring with the client-participant strategies he was using to manage the effects of the trauma he experienced. Specifically, the therapist-participant facilitates the client-participant's discussion of ineffective coping strategies of

using drugs and alcohol that he employed in the past when he experienced a similarly traumatic death of a sibling. She says to client-participant:

“T93: Isn’t that kinda what you did when your other brother died?”

A third content Sub-theme that manifested in this session was Family. The conversation with the client-participant focused on issues related to his family and the impact of the trauma on the client-participant’s family. This content Sub-theme was very explicit given the specific nature of the trauma that the client-participant had experienced (i.e., the suicide of his brother) and the fact that it impacted all members of his immediate family.

The fourth content Sub-theme that emerged in this session was Meaning Making. The therapist-participant dedicated some of the session to discussion around helping the client-participant clarify the meaning he had made for his experiences. That is, the therapist-participant assisted CP1 with better understanding what it was about the death of his brother that was impacting him (seen below):

T41: So you feel like you have all these unanswered questions about it?

C41: Yeah, well, yeah, and that’s natural I’m sure. But, I just, I have questions about the process. Like the last time I used it as such inspiration it changed my life. You know what I mean? It changed so much. And I think you know I can, that’s what - you know it’s like, it gives me perspective. [C wipes face] It’s like when did I change so much. It’s like I couldn’t really keep changing and doing things. And like, I have to be sad for a little while first I think

Client-participant 2 session. *Session process.* This client-participant’s trauma discussion began early in the session with the client-participant sharing that she feels sad, but that she is having difficulty connecting with her emotions in spite of wanting to cry. The therapist-participant responded by asking the client-participant a myriad of closed-ended questions (occurring 56 times during the trauma discussion) to obtain and clarify

facts (occurring 5 times during the trauma discussion), as well as making multiple statements to summarize the facts surrounding the client-participant's experiences (occurring 9 times during the trauma discussion). The therapist-participant responded with substantially more fact-based questions than feeling based questions to obtain emotional information (Open questions about feelings, occurring 2 times during the trauma discussion; Closed questions about feelings, occurring 4 times during the trauma discussion). By acknowledging the client-participant's responses with the words like "okay" and "right" (occurring 47 times during the trauma discussion), such therapist-participant responses seemed to (a) keep the conversation topical and close off further/deeper conversation on a point due to already having received the relevant information for which she was looking, and (b) come across, at times, as if she affirmed what the client-participant told her based on previous knowledge. An example of both of these types of patterns can be seen below:

C99: Well, you know, I got pretty sad, I got really really sad...you know, I can't do anything about it,,so I feel I should just relax...you know, kind of handle it.

T100: Kind of handling it?

C100: Yeah.

T101: Okay. Have they, did they call you, before, after when they got there and everything?

C101: Yeah. They called me the very next day, so...with my parents and my grandma is there, you know, it's just kinda mean, but at the same time she take care of them better than my mom.

T102: She does? Okay.

C102: So anything better than my mom, so it's kinda--[C laughs]

T103: Right. [T nods]

At other times, the therapist-participant incorporated previously obtained information about the client-participant to help the client-participant observe her behavioral patterns (occurring 4 times during the trauma discussion):

In addition to asking factually oriented questions, this therapist-participant tended to ask the client-participant multiple questions at once (occurring 17 times during the trauma discussion) or start questions/sentences without completing them (occurring 13 times during the trauma discussion), as illustrated (respectively) in the 2 examples below:

T239: Do you think that's, you think that's stupid? Do you think, I'm, let's look at, let's think about, all you need to think about what does that say about you as a person though [T points to chest with right hand].

T132: Have you thought about that at all, a little bit or –?

In these instances, understanding what the therapist was asking and how to answer the question was based on the client-participant's interpretation of the question. In other words, the client-participant inferred what the therapist-participant actually was asking, and it was unclear, due to the therapist-participant not following up on the topic (e.g., by asking the other questions from the original sequence), if the therapist-participant, in fact, got all of the information she was intending to get or if she was satisfied with potentially incomplete information. These types of jerky interactions appeared in the opposite manner as well (i.e., where the therapist-participant interfered with the client-participant's self-guided presentation of information). Most notably, there were instances where the therapist-participant would interrupt the client-participant (occurring 4 times during the trauma discussion) or not finish her sentence (occurring once time during the trauma discussion); these appeared to be based on the therapist-participant's inferences around what the client-participant was going to say or ideas she appeared to want the client-participant to assimilate as her own. These instances involved the therapist-participant interrupting the client participant to make a statement or ask another question, or completing the client-participant's statement for her. For example:

C256: So usually you hear those people saying bad words, so when he asked me to get married, I'm like okay, but the day that you put your hand on me I don't care if you're my husband, [T nods] yeah we got married for the church and everything, but I don't care about what's going on, that's dumb.

T257: ...You're gonna leave, right...[T nods]

C257: Or if you say bad words to me [T nods] you know I'm going to wash your mouth with bleach...

Throughout the session, another pattern that manifested in the process of the therapist-participant was her tendency to give advice and provide her opinions to the client-participant (occurring 18 times during the trauma discussion). Sometimes the therapist-participant provided advice/opinions in manner that appeared validating (see below)

C261: Cause I was still this girl going around [C makes circular motion with right hand], I'm not gonna get married with a male [C smiles, T nods] like that, I'm not gonna get married like that... When I told I was gonna get married, he was like [C laughs] 'Well. Who's the guy?'

T262: He's very special, you know.

More often, though, in a manner similar to the aforementioned deductive questioning, the therapist-participant's opinions/advice seemed to be encouraging the client-participant to follow a particular agenda (as seen in the 2 examples below):

T130: Okay, what about, did you think, I noticed that you said, you know, that, there's nothing that you can do about them leaving so its no reason to kill yourself because its not going to change them leaving.

T209: Did you try what we talked about, the other time, did you, remember what we talked about last time, like when you feel angry to, when you walk away [C nods], which is I said a good thing, not a bad thing.

Thus, the therapist-participant appeared somewhat hurried or eager to collect a breadth of topical information in as quick a manner as possible at the expense of fully reciprocal communication and a complete gathering of desired information. Furthermore,

her approach to the therapy session, including the types of questions posed, appeared more deductive in nature than exploratory, suggesting the therapist-participant may have had a predetermined agenda for the client-participant.

Not all of the responses by Therapist-Participant 2 were reductive or oversimplifying of the client-participant's problems, though. Another process pattern that emerged in the session was therapist-participant's use of Indigenous Typologies to help the client-participant alternatively frame her problems (occurring 4 times during the trauma discussion). Specifically (see below), the therapist-participant used this type of language to give rationale for treatment and to help the client-participant understand how tasks accomplished in therapy could be beneficial in her life:

T268: Its practice and its good to let things out in here and then you feel more comfortable out in the real world.

The therapist-participant also used metaphors (occurring 2 times during the trauma discussion) in a similar manner (seen below) to help the client-participant understand the therapeutic tasks differently:

T207: So it helps to bring you down. [T makes descending motion with flat hand in front of body]

One pattern of responding that was particularly salient in during the trauma discussion was the therapist-participant's use of strength-based responses (occurring 14 times during the trauma discussion). Namely, the therapist-participant offered many comments to validate instances where the client-participant had been resilient, where she had positively changed as a result of her experiences, or where she handled struggles in a manner that did not cause her additional distress. An example of this strength-focused responding can be seen in below:

T201: So you're afraid you're going to do something like your, so it sounds then like you had some instance, so for the most part you're never violent then. Let's reframe, let's restate what, [C nods] our whole idea about you. For the most part, even though you've been around a lot of violence in your life [C nods], your first instinct [T points to chest] is not to be violent, right?

In addition, this therapist-participant used a substantial number of non-verbal behaviors during the course of the trauma discussion (occurring 58 times during the trauma discussion) as well as minimal verbal responses (occurring 47 times during the trauma discussion). These behaviors appeared to be used to emphasize what the therapist-participant was saying, to acknowledge of something the client-participant was saying, or to provide another type of validation. Of all the responses provided by this therapist-participant, these were the most prevalent.

The session with this client-participant continued with the therapist-participant focusing the discussion around the client-participant's perception that she, by nature, was a violent person. The therapist-participant's responses were aimed at helping the client-participant gather information for and against this deeply held belief. Additionally, the therapist-participant looked at coping skills the client-participant used to manage violent feelings and her desire to harm herself/others, discussing the client-participant's concerns that she could easily be triggered to engage in violent behavior with others. The therapist-participant provides contradictory information to challenge the client-participant's fears.

Session content. There were eight main content Sub-themes that emerged in this session: Focusing on or Supporting the Wants/needs of Others occurring nine times during the trauma discussion), Control (occurring 5 times during the trauma discussion), Family (occurring 18 times over the course of the trauma discussion), Psychoeducation to Connect Thoughts/feelings/behaviors (occurring 2 times during the trauma discussion),

Fear/Anxiety/Worry (occurring 5 times during the trauma discussion), Frustration/Anger (occurring 3 times during the trauma discussion), Meaning Making (occurring 6 times during the trauma discussion), and Violence (occurring 4 times during the trauma discussion).

The first content Sub-themes, Focusing on or Supporting the Wants/needs of Others, manifested in the therapist-participant's focus on having the client-participant (a) consider a particular issue from the perspective of others in her life; and (b) consider ways in which she can act in a manner that is supportive of others. The former pattern can be seen (below) in the therapist-participant's response that emphasized that the client-participant consider the emotional needs of others in her life:

T134: Right. Well and that they, you know, they love you and need you. You know?

C134: That's right. I can do better, you know, with helping them somehow and instead of me doing something wrong, you know.

The latter pattern can be seen below in the therapist-participant's focus on having the client-participant consider the fact that she would no longer be able to support her siblings if she harmed herself:

T131: What about, have you thought at all about, remember we talked about, um, you know, if you killed yourself, then who would be there for your sisters, right?

The second content Sub-theme that appeared in this session was Control, or the therapist-participant's focus on exploring with the client-participant what actions she had taken or strategies she was using to manage the current effects (e.g., her symptoms of depression) of the trauma she had experienced as a child. An example of this content pattern can be seen below:

T136: Well how have you been, you know, how have you been kind of coping with when you're feeling down. It sounds like you've been feeling, like you said, better, but you're kind of handling it. Still a little down. What are you doing to handle it, what are you exactly?

This content Sub-theme also emerged in the therapist-participant working with the client-participant to have her examine explicitly the ways in which she had been able to exercise control over a situation. Namely, the therapist-participant focuses on this topic as a way to highlight the client-participant's ability to self-regulate her behaviors in situations that have been emotionally triggering for her (see example below):

T205: No. So...have you ever felt out of control, like you might hurt him?...

C206: No, you know I think, what, because he's always, even when he get upset he never really scream at me [T nods] or he never really does things to, you know, cause they always realize that I'm the one whose, even when he say things it really bothers me, he's not this [inaudible], he never say bad words to me [T nods] or he never try to, you know, get aggressive with me [C shuffles hands], so I don't find a reason why I'm gonna start doing something, you know, like...

The third content Sub-theme that surfaced in this session was Family. This therapist-participant spent a considerable amount of time discussing the client-participant's family (e.g., her mother, her grandmother, her sisters) during the therapy session. This appeared to be done as a way for the therapist-participant gather additional contextual/background information about the client-participant.

The fourth content Sub-theme that manifested in the session was the therapist-participant's focus on issues of Fear/Anxiety/Worry. In this session, the client-participant discussed her concerns that she was going to become like others in her family: emotionally volatile and violent with people in her life. The therapist-participant focused

on these concerns, helping the client-participant examine evidence for this particular belief:

T185: Cause you're worried. Is that why, you're worried you're going to do something like your family does?

The fifth content Sub-theme that emerged in the session was the therapist-participant's focus on the pattern of Frustration and Anger. Throughout the session, the client-participant expressed having feelings of anger towards members of her family of origin. The therapist-participant explicitly focused on these feelings during the session to help the client-participant explore them further. An example of this emphasis is seen below:

T187: Okay so then let's look, so in your whole life, you're twenty one, twenty one years and you've gotten, and you've told me, so you, you get angry about things sometimes [C nods], you get really angry, but even in your most angry you've never done anything like your family.

A sixth content Sub-theme that appeared in the session was the therapist-participant's focus on Violence. Namely, the therapist-participant spent time in session focused on the client-participants perception of herself as a violent person, examining her behavior for evidence of this idea. An example of her focusing on this area can be seen in the therapist-participant's commentary below:

T151: I remember you said that before. [T nods] Would you have, I mean I know how she's in El Salvador but, would you, have you ever had the thought of you actually wanting to make a plan to hurt her?

The seventh content Sub-theme that appeared in the session was the therapist-participant's focus on using Psychoeducation to Connect Thoughts/feelings/behaviors. Specifically, the therapist-participant spent time in the session focused on helping the client-participant understand that there was an

interconnected relationship between her thoughts, her emotions, and the actions she took (as illustrated below)

T150: You have to lot to feel angry with her, [T nods] you have a right to feel angry with her. Do you feel, when you're feeling angry, is that, in that moment, is that, [C wipes eyes with tissue] did you have, what were you thinking, when you're feeling really angry, what were the thoughts going on in your mind?

Although this therapist-participant did not overtly state this relationship to the client-participant didactically, she educated her around this concept through direct application of this idea to a specific incident in the client-participant's life.

The eighth and final content Sub-theme that manifested in the session was the therapist-participant's focus on Meaning Making. Specifically, the therapist-participant had the client-participant focus on what it means for her to have come from her family of origin and to not be violent herself. This was illustrated in the therapist-participant's question below:

T239: Do you think that's, you think that's stupid? Do you think, I'm, let's look at, let's think about, all you need to think about what does that say about you as a person though [T points to chest with right hand].

Client-participant 3 session. *Session process.* This client-participant's trauma discussion began with the client-participant relating a recent phone call he had had with his mother. Specifically, the client-participant indicated that his mother was discussing her interest in having the client-participant return to living in his country of origin (where the mother was living). The focus of this therapy session is set early; the client-participant processed differences he had experienced between the cultures of his family of origin and the more Westernized one in which he was living at the time of the therapy session.

The therapist-participant spent the majority of the early part of the session alternating between asking the client-participant close-ended (occurring 16 times during the trauma discussion) and open-ended (occurring 9 times during the trauma discussion) fact-based questions to gather information about the client-participant's behaviors and behaviors of his family; she also made some statements to reflect/clarify a factual understanding of the client-participant's struggles with acculturation and worries he has about not being with his family (occurring 2 times during the trauma discussion). In the aforementioned instances, the therapist-participant appears to gather/clarify factual information; however, once the client-participant gives the information, the therapist-participant typically did not follow up to deepen the client-participant's discussion of the issues being discussed. An example of this pattern can be seen in the exchange below:

C236: [C nods, uses hand gestures] Yeah. I have a right away mood swing there. When I think about that I have a mood swing, right away. You know?

T236: [T nodding] Mm-hmm. And does it happen you know when you're at work and you're not busy are you thinking about it or is it after work, when you are going to bed, or -

C237: [C nods] Yeah. Especially, it will come up at work if I'm not busy or when I'm driving. I'm still constantly thinking about stuff. I, I, I just I'm like I don't want to think about it. If I'm listening to something, like listening to the news, you know, and all that stuff and all the sudden I'm daydreaming and I hate that.

T237: What is something you see as helping you make this decision?

C238: Decision of what?

T238: Whether to stay or to go?

Similarly, questions about the client-participant's feelings also appeared to have limited follow up (as seen below):

T37: That must be hard.

C38: I'm like, I'm feeling too much guilt.

T38: Yeah. That must be really hard. Mm- hmm.

C39: I mean—

T39: Did it make you feel better at all to hear your mom say that she...you know...doesn't want you to make the decision for them? And—

C40: [client shakes head “no”]

T40: It didn't really mean anything?

In other words, the tone throughout much of the trauma conversation suggested that the therapist-participant wanted to obtain factual information (e.g., confirmation the client-participant was having strong reactions) without asking questions or making statements to gather further/deeper information on a subject (e.g., what the nature of the reaction was). This pattern also held true for open-ended (occurring 5 times during the trauma discussion) and closed-ended (occurring 2 times during the trauma discussion) emotionally based questions, both of which occurred less prominently in the session than fact-based questions. One possible explanation for her remaining at more of a surface level was that the therapist-participant did have some previous knowledge of the client-participant's difficulties, which she illustrated when drawing connections between current session material with past information she had obtained (occurring 4 times during the discussion).

A similar pattern that emerged during the trauma discussion was the therapist-participant alternating between the aforementioned style of questioning and responding and using the words “mm-hmm,” “okay,” and “right.” These types of responses made up many of the overall minimal verbal acknowledge statements (occurring 129 total times during the trauma discussion). Furthermore, the connection between these types of responses also appeared more tacitly to inhibit a deepening of the therapeutic discussion; in these instances, the therapist-participant appeared to come across as if she was affirming what the client-participant was telling her based on previous knowledge or based on how she wanted the client-participant to frame his struggles. More prominently,

though, these combinations of utterances appeared to close off deeper discussion around a particular point and allow or turn the conversation to move away from a topic that could be further deepened. An example of this type of pattern can be seen below when the therapist initially appears to be using these minimal verbal acknowledgements to encourage the client to expand on a topic; however, though her use of these utterances, the therapist-participant actually ends up closing off the discussion, moving the client away from how to actually address the struggle and thus, frustrating him and leaving him to believe the therapy is not progressing in the way he would like:

C223: Because I see a lot of people that get married and they're not happy.

T223: Right.

C224: Because they get married because okay, that's what you do when you're T224: Right. Mm-hmm.

C225: So, I don't want to be one of those guys. I want to be married to someone that I like and just be happy. You know? 'Cause I don't have to look outside and still worry about all the other stuff that I'm missing out on now.

T225: It sounds like you have a lot of pressure to stay within your community.

C226: I mean it does. People, people look at you different. Especially they know my family, my father. I think it would be a little shocking to them. A lot more actually, to know that I actually went and married someone out of the community because they know me as a very, you know, serious and driven guy, that you know, knows how to keep things in control. So, I don't know. I, I really-

T226: It sounds like this past week you struggled a lot with this issue.

T227: So it might not solve the problem, it might not be the best thing to do?

C228: Yeah. So I am still confused as much as confused as the first day.

T228: Yeah. And in this past week were there certain times where this was on your mind, more than others?

T229: Yeah. [T tilts head and uses hand gestures] Yeah, in this past week are there certain times that you are thinking about it more or where you became really anxious thinking about it?

C230: I mean no, it's not any greater than any other, before. Its always, it keeps coming up constantly. But I didn't think it bothered me before this week, it was just, same, ya know, the same that's just coming up- me, I cannot decide where to live.

T230: Right.

Another process pattern that emerged in the session was therapist-participant's use of Indigenous Typologies to help the client-participant gain a conceptual framing to

understand the struggles he was reporting in the session (occurring 4 times during the trauma discussion). Specifically, these responses were around issues of acculturation, occurring with the therapist-participant providing specific language (i.e., “individualistic” and “collectivistic”) to help the client-participant understand cultural factors that likely were contributing to his struggles (see example below):

T214: [T nods] Mm-hmm. Right. And now you [T using hand gestures] have 2 competing cultures. Here being very individualistic and what is best for you and yourself and back there it is a more collectivistic community oriented. Where you know, people from the community expect you to be back there with your mom.

Also of note during the trauma discussion was the occurrence of responses by the therapist-participant where she would not finish her sentence (occurring 9 times time during the trauma discussion). These occurred when the client-participant would cut the therapist-participant off, either to finish the therapist-participant’s sentence or to redirect the conversation focus (seen in the example below):

C138: And they got their own values and, um, I don’t—I’m not sure if I wanna—if I’m gonna be able to—if I’m gonna like them because I already have people that I’m close with—I think I—I—the fact is I think I—I don’t know, maybe I just feel more comfortable...being around...uh, people from the community...
C141: ...then the outside because it just—
T141: You share a lot of similar—
C142: Yeah similar stuff. [C adjusts position on couch]

In the aforementioned instance (as well as others of this nature), what remains unclear is whether the client-participant completes the therapist-participant’s thought, or if the therapist-participant chooses not to verbalize fully her initial thought due to having been interrupted. This pattern played out in the opposite manner as well (i.e., the therapist-participant interrupting the client-participant), occurring 3 times during the trauma discussion.

Throughout the trauma discussion, another pattern that manifested in responses of the therapist-participant was her tendency to provide her opinions and give advice to the client-participant (occurring 13 times during the trauma discussion). At times this opinion/advice giving is more subtle, as illustrated in the example below where the therapist-participant introduces the idea of the client-participant possibly moving his family from Turkey to the United States without the client-participant indicating that he wants to do this:

T155: How do you think your family would feel in the culture here?

C156: I think it will be, um, getting used to process for a while...um, but I don't know if staying over there is also gonna be, because a lot of people already, um, the Christians and the Muslim countries they get less and less everyday because they're all going to, you know, Europe. All the Christian countries...

T169: So your family is experiencing that there as a problem?...

C170: Yeah, I mean it's—they always they—the community always you know, i-it's a small community and they always uh, marry between themselves, and...

T175: Mm-hmm. So do you think bringing your family here is an—is an option and something that can happen?

Other times during the session this type of response is more obvious and appeared in service of the therapist-participant validating a decision, opinion, belief, or feeling of the client-participant (see example below):

C103: So, it all, I guess, um depends on the—th-th-the family. How they raise the kids and how much attention they pay to them and it should be fine I think.

T103: [T nods] Mm-hmm, mm-hmm.

C104: So—

T104: Mm-hmm.

C105: I don't know, it's just –

T105: [C shakes head] I agree that a lot of it is parenting.

Also noteworthy about the therapist-participant's responses during the session was the number of non-verbal behaviors in session, which occurred 116 times during the

trauma discussion, and served a function to help encourage further discussion around a topic or provide tacit acknowledgement and/or validation of what the client-participant was communicating (e.g., head nodding). The latter concept manifested more prominently in three direct responses (versus non-verbal behaviors) to validate the client-participant's experience.

The session continued with the therapist-participant helping the client-participant problem solve or identify coping skills he could use to manage anxiety (e.g., distract himself with a movie), though more notable was the focus on encouraging the client-participant to assert his feelings with his mother regarding his desire to remain in the United States. The therapist-participant then abruptly shifted the topic of discussion to addressing the structure of therapy (e.g., stating that the therapy sessions will begin to have an agenda-setting component, asking the client-participant if he would be okay with completing worksheets as homework assignments). She then handed the client-participant worksheets and a "chapter" of psychoeducational material, briefly provided instructions on how to complete the former handouts. The session concluded with three brief conversations about movies, a girl that the client-participant is interested in dating, and the current difficulties he is having with his diet.

Session content. There were seven main content Sub-themes that emerged in this session: Focusing on or Supporting the Wants/Needs of Others (occurring fifteen times during the trauma discussion), Family (occurring 13 times during the trauma discussion), Cultural Values (occurring eight times during the trauma discussion), Fear/Anxiety/Worry (occurring eight times during the trauma discussion), Meaning Making (occurring 3 times during the trauma discussion), Control (occurring 2 times

during the trauma discussion), and Psychoeducation About the Thoughts/Feelings/Behavior Connection (occurring 10 times during the trauma discussion).

The first content Sub-theme, Focusing on or Supporting the Wants/needs of Others, initially appeared in the therapist-participant's focus on the perspectives of client-participant's family members around potentially moving to the United States. While the idea of initiating a discussion around the possibility of his family moving to the United States is introduced by the client-participant, in this action, the therapist-participant shifted the focus of the session away from the client-participant's experience onto exploring and empathizing with the wants/needs of his family:

T155: How do you think your family would feel in the culture here?

Later in the session, the therapist-participant again had the client-participant focus on his family's concerns about issues of diversity in their home country, which also appeared to be a reflection of the therapist-participant's focus on this topic rather than the client-participant's (seen below):

T169: So your family is experiencing that there as a problem?

This focus shift appears to be especially important, as the client expressed during this session that his ongoing worries about what his family members think/feel (to be discussed later) is leading him to experience anxiety.

The aforementioned example also illustrates the second content Sub-theme that emerged in this session: Family. Specifically, the therapist-participant explored pressured the client-participant experiences from his family as a result of their feelings about his having moved to the United States for school nearly a decade earlier. She

responded to the client-participant's discussion of the distress related to his identified traumatic event by encouraging him to assert himself with his family and have a discussion with them about relocating (illustrated below):

T202: Mm-hmm, and you've mentioned before that you wanted to bring it up to your sister, but you didn't. Um, so do you think that, how do you feel about bringing it up now to her next time you talk to her?

Also closely related was the third content Sub-theme, Cultural Values. In this session, the therapist-participant focused a large portion of the session on the client-participant's difficulties around issues of acculturation. Much of the client-participant's presenting struggles (per the report of the therapist-participant as well as the client-participant) center around his concerns about managing competing cultural values of the culture in which he lives and the one from which he originates. The therapist-participant explicitly highlighted this struggle so that she and the client-participant can overtly process this in session:

T214: [T nods] Mm-hmm. Right. And now you [T using hand gestures] have 2 competing cultures. Here being very individualistic and what is best for you and yourself and back there it is a more collectivistic community oriented. Where you know, people from the community expect you to be back there with your mom.

C215: Right [C touches forehead].

T215: [T nodding] Mm-hmm. So do you think about that a lot as well? About what people in the community think you should be--?

The fourth content Sub-theme that emerged in the session was the therapist-participant's focus on issues of Fear/Anxiety/Worry. As introduced above, the client-participant discussed anxiety that stems from his worries about the emotional well-being of his mother, who lives in Turkey. The therapist-participant had the client-participant concentrate on what appears to be the biggest trigger for the client-participant's

worries/anxiety – the issue that is causing him the most distress. This focus is illustrated below:

T53: So you're worrying about her, worrying about you.

The fifth content Sub-theme that manifested in the therapist-participant's response to the client-participant's discussion of his trauma was Meaning Making. The therapist-participant spent time during the session around helping the client-participant clarify the meaning he had made around his experiences of immigrating to the United States and the struggles he has had with acculturation. Specifically, the therapist-participant assisted CP3 explore some of the reasons he is struggling with the idea of moving back to Turkey to be with his family versus continuing to live in the United States (see example below):

T79: So what would it mean to you to stay here? To make that decision to, that you're gonna stay here, you're gonna find someone here and raise a family here?

The sixth content Sub-theme that manifested in the therapist-participant's response to the client-participant's discussion of his trauma was Psychoeducation to Connect Thoughts/Feelings/Behaviors. In the session, the therapist-participant worked with the client-participant to help him understand how his anxiety and his feelings of "depression" impact his behavior. The therapist-participant provided some instruction on the cognitive-behavioral model as well as instruction on how the client can engage in coping behaviors that are aimed at altering his feelings (illustrated below):

T271: And if you find yourself feeling a certain way, it's a way to distract yourself. You know, and kind of stop those negative thoughts that are bothering you and doing something that makes you feel –

The seventh content Sub-theme that appeared in the therapist-participant's response to the client-participant's discussion of his trauma was Control. During the

session, the therapist-participant helps the client-participant understand that CP3 is able to make changes to his behavior, which can improve his mood. When CP3 discusses frustrations around the fact that his stressors feel beyond his ability to change them, the therapist-participant offered a response to help CP3 understand that he is able to re-establish some sense of control in his situation (illustrated below):

T273: It's called behavioral strategies that you can use. It's about changing things in your environment to make you feel better.

Client-participant 4 session. *Session process.* The trauma discussion within this therapy session began with the client-participant discussing her recent stroke. She initially talked about the amount of support she has had from her friends, though expressed having some lingering concerns about her well-being. The therapist-participant offered multiple statements/comments to validate (occurring 7 times during the trauma discussion) and demonstrate understanding and empathy towards (occurring 5 times during the trauma discussion) the client-participant's concerns (see example below):

T32: [Therapist nods and closes eyes briefly] I can understand your fears and concerns [client nodding] and –

The session continued with how the client-participant is managing her scratching behavior, which the therapist-participant attributed to the client-participant's anxiety. Specifically, the therapist-participant asked factual information in a manner similar to a formal functional analysis, attempting to get a sense of a sequence of what occurs cognitively, emotionally, environmentally, and socially that contributes to the client-participant's self-directed violent behavior (i.e., her scratching). The tone of the initial portion of the session is established early and it consisted of the therapist-participant

alternating between asking direct questions, making summative statements, and providing minimal verbal acknowledgement to what the client-participant is saying. Specifically, the therapist-participant (a) asked the client-participant both close-ended fact-based questions (occurring 18 times during the trauma discussion) and open-ended fact-based questions (occurring 12 times during the trauma discussion), and (b) reflected her understanding of facts via summary statements (occurring 3 times during the session). She also provided minimal verbal acknowledgement type responses (e.g., “Mm-hmm;” occurring a total of 44 times throughout the trauma discussion and tapering down in frequency as the session progresses) to validate and/or communicate her understanding of what the client-participant is saying. Furthermore, the therapist-participant periodically would interrupt the client-participant, either by completing her sentence for her (occurring 3 times during the trauma discussion) or by abruptly shifting the session focus or process (e.g., by introducing a new topic; occurring seven times during the session).

An example of this type of integrated dialogue can be seen below:

T34: Is it helping with the scratching?

C35: Yes. Definitely...Definitely. I have no scratches on my legs. The back –

T35: Mm-hmm

C36: ...The back is healing, the stomach [clients looks to the left] I actually attacked the other night.

T36: You did? When was this?

C37: Uh, what night was that? [Client looking downward and to the left] Do-do- do-to-do that was Saturday night.

T37: [Therapist slowly nods x1] Saturday night.

C38: And I –

T38: Was this in your sleep or while you were awake?

C39: ...No, I was awake and I had a very frustrating hour trying to do stuff. I was trying to sort things out and the light was going and I couldn't see and then it was I missed a phone call and it was just like 3 or 4 things in a row...

T39: Mm-hmm

The therapist-participant then identified a coping skill, whose aim is to help the client-participant inhibit the behavior of scratching herself when she feels anxious. The therapist-participant detailed this intervention, providing the client-participant psychoeducation around its use. She continued on this topic until abruptly shifting the focus of the session towards a discussion about the client-participant's upcoming surgery. Again, as with the discussion around the client-participant's scratching behavior, the therapist-participant's responses alternate between close-ended fact-based questions and use of minimal verbal acknowledgement of what the client-participant is saying. At times the therapist-participant's questions were open-ended and feeling-based (occurring 5 times during the trauma discussion) or closed ended though still feeling based (occurring 5 times during the trauma discussion); however, the majority of the questions the therapist-participant asked the client-participant were factually oriented and close-ended. In instances where the therapist-participant concentrated a question on the client-participant's emotions and the client-participant discussed her feelings, the therapist-participant would follow with a question whose function appeared to close off the discussion rather than open it up. An example of this pattern can be seen in the exchange below:

T153: So where have the feelings gone about wanting to give to others?
What have you done with those feelings?

C154: I've still got them. They're there. The wanting to give to others
[nodding to emphasize point] is still there. I mean, I am very frustrated
that I can't do it.

T154: Are you afraid you might lose those friendships if you don't give?

During the course of the session, the therapist-participant asked some questions about her emotions; however, in these instances the client-participant typically would respond by acknowledging the presence of an emotion, and then shift focus away from

the feeling towards a heavily verbose and detailed description about events she experienced without actually getting into further emotional detail. When the client-participant avoided talking about her feelings, the therapist-participant typically did not follow up to probe for deeper emotional processing. An example of this pattern can be seen in the interaction below:

T104: [Using concerned tone] That must be a very painful feeling to know...

C105: That was...

T105: ...That you are somewhat helpless?

C106: Oh, I- I-I...It makes my skin crawl now to think I was back there. But, yeah, it was. And she would say, "Come on, come on, you can do it." And I'm like, "I'm gonna fall over. I'm gonna fall on you and kill you." She said, "If you're gonna fall, I'll move out of the way...Believe me. I will stop you from falling. You're not going to fall it just feels like you're going to." She said... "Just walk 2 steps and you'll be right there."

C107: [Client shaking and then nodding head] And it took an hour, an hour and a half of coaxing but I did do it. And within probably a month (3) I could get up from the chair (2) and walk to the bathroom without my walker or I could walk to the kitchen and make a cup of tea, without my walker. [Therapist nodding, client squeezes legs together with clasped hands between] I couldn't carry the cup of tea, but I could make it.

T107: [smiles and nods] Uh-huh

C109: It's what? [Client shrugs and shakes head] three houses down the alley way? But to me it was like [client raises eyebrows and smiles], "Wow, this is the outside world again." It was like this is wonderful without the walker. But the walker stayed out. Folded up, but it stayed out. And I was doing great-April, March, April, May-Doing wonderful. I walked around the block and I walked around [nods head to emphasize distance] the block by myself. Walked three blocks (3) um, at the beginning of June (3) I broke my toe [tilts head forward downward, slows speech].

T109: Oh. Well that's very painful too.

An additional pattern that manifested in the process of this therapist-participant's responses was her tendency to give the client-participant advice and provide opinions (occurring 12 times during the trauma discussion). The first form of this advice giving occurred in the therapist-participant's suggestions around how the client-participant could

utilize the coping skills the therapist-participant suggested. These types of responses appeared to have a psychological grounding and did not appear to directly reflect the attitude of the therapist-participant (see below):

T48: Maybe, here is a thought [semi- opens clasped hands]. Maybe when [therapist using left hand to indicate sequential order] several things go wrong that you are not comfortable with and you are feeling upset, maybe you could write a little bit. Then your hands are moving.

The other form that this type of advice giving took was in the therapist-participant providing the client-participant advice or feedback based on her own thoughts/feelings. This type of response did not appear to have a psychological grounding and appeared to serve the function of validating the client-participant's beliefs/actions from a personal perspective (as seen below):

C70: Sitting on my hands worked quite well but then I'll do something. I'll have to use my hands and then I forget to sit on them. Right, right [therapist smiles and laughs, client laughs briefly after this]. But, or um, my physical therapist has given me a bag of marbles [making motions with left hand as if playing with marbles] 'cause she wants me to do some occupational therapy work with my left hand. So I actually don't do the therapy she suggested but I hold the marbles in a big and just kind of play with them with –

T70: [Therapist widens eyes and nods] That's excellent.

In the aforementioned instance, the therapist-participant expresses excitement that the client-participant had spontaneously discovered a way to keep her hands busy (which may or may not actually have reduced her scratching behavior); however, in her enthusiasm and concentrate on praising the client-participant for finding a coping skills to manage scratching behavior, the therapist-participant provides an opinion that inadvertently reinforces the client-participant's choice to not follow-through with her recommended physical therapy treatment.

Another process pattern that emerged in the session was therapist-participant's use of Indigenous Typologies (occurring 6 times during the trauma discussion) and metaphors to aid the client-participant in gaining an alternative framing of her current struggles. The first way in which the therapist-participant used Indigenous Typologies was to highlight the connection between the client-participant's thoughts, feelings, and actions. At one point in the session the therapist-participant informs the client-participant:

T52: ...That there is a connection [hand motions indicating connection] to the things that upset you and your scratching.

The therapist-participant appeared to have introduced the term "connection" to help the client-participant better conceptualize the idea that there seemed to be a link between her thoughts, feelings, and actions. A second way in which the therapist-participant used Indigenous Typologies was to underscore the client-participant's tendency to distract/disconnect from uncomfortable emotions. The therapist-participant suggests that the client-participant is not does not appear to be connected with emotions that she believes lead to the client-participant's scratching behavior. The therapist-participant introduces the concept of mental activity that is "subconscious," or outside of the client-participant's awareness, in order to help her more purposefully focus on emotions over which she appears to have limited control:

T61: and then the feelings kind of.

C62: Came up?

T62: ...came up subconsciously...So maybe is you know you are going through frustrating experiences write them down. Even when you are having your cup of tea, do a little writing and see where that takes you. Because maybe putting in a step in between, having you be more conscious of your frustrations and feelings of being upset, um, maybe if

you bring it to the consciousness then you won't subconsciously start scratching...

In addition to Indigenous Typologies, the therapist-participant also used metaphors in a similar manner (occurring 2 times during the trauma discussion) in order to help the client-participant understand therapeutic concepts in an alternative manner. In one instance, the therapist-participant's use of metaphor helps the client-participant see she has control over her emotions and does not need to disconnect from them, as she seems to do typically (seen below):

T72: [Therapist opens palms of clasped hands inward and motions forward] Sort of free your mind a little bit and let go of some of those feelings you're having.

This therapist-participant's responses to the client-participant also included the use of many non-verbal behaviors (occurring 33 times during the session). The behaviors seemed to be used to underscore what the therapist-participant was saying and also to acknowledge something the client-participant was saying. Responses of this nature were the most prevalent in this session.

The session continued with the therapist-participant and client-participant discussing possible parallels between the client-participant's current experiences and an incident that occurred in her past when she was a child. The therapist-participant continued to make comments (e.g., "You must be sad") on which neither the therapist-participant (by facilitating follow-up processing) nor the client-participant (by way of offering information to elaborated on her stated feelings) followed up. In general, this therapist-participant appeared most interested in gathering a factual understanding of the logistics surrounding the client-participant's current life circumstances. At times she did validate the emotional experience of the client-participant; however, by far the majority

of the therapist-participant's verbal responses to the client-participant's trauma were close-ended fact-based questions. The session ended with the therapist-participant and client-participant discussing the CP4's concerns about losing relationships with other people due to her beliefs that her reliance on them for support is antagonizing for them.

Session content. There were seven main content Sub-themes that manifested this session: Being a Burden (occurring 3 times during the session), Focusing on or Supporting the Wants/needs of Others (occurring 5 times during the session), Fear/Anxiety/Worry (occurring 4 times during the session), Loss (occurring 3 times during the session), Meaning Making (occurring 3 times during the session), Psychoeducation to Connect Thoughts/Feelings/Behaviors (occurring 6 times during the session), Family (occurring 3 times during the session), and Control (occurring 14 times during the session).

The first content Sub-theme that manifested at various points in the therapist-participant's response to the client's trauma was Being a Burden. Specifically, the therapist-participant and the client-participant explored the client-participant's belief that her traumatic experience and how she handled its aftermath was making her a burden in the lives of other who were supporting her. In addition to concentrating on the client-participant's here-and-now beliefs, the therapist-participant more generally looked at ways in which these beliefs had manifested at other times in the client-participant's life. The therapist-participant highlights this pattern by stating to the client-participant:

T128: You know it makes me think...your feelings about taking up a bed at the hospital and not being really- worthy of having that bed and your feelings about being a burden to your friends and not really feeling like you deserve that seems to be, sort of a theme.

The second content Sub-theme that emerged in the therapist-participant's responses during the session was Focusing on or Supporting the Wants/needs of Others. Towards the end of the session, the therapist-participant briefly discussed the client-participant's tendency to support others as a way to elicit support back from them without feeling guilty. At one point the therapist-participant questioned the client-participant about this tendency in order to further process this topic and illustrate the client-participant's hesitancy to dedicate attention to her own needs in her life:

T146: Is it that you, metaphorically, that you don't have that bag of potato chips to give to other people to make them continue to help you?

The third content Sub-theme that manifested in the therapist-participant's responses was Fear/Anxiety/Worry. During the session, the therapist-participant and client-participant dedicated time to processing the client-participant's present and past fears about experiences around major illnesses and medical procedures she has had. An instance of this can be seen below where the therapist-participant's focused on this topic is to empathize with the client-participant around the emotional difficulties she has had as a result of those experiences:

C8: But beyond that it's mostly like a grey shadow...gray foggy...and it really is I am not comfortable not seeing what is coming up

T8:...That must be very scary.

C9: Oh yeah... it's scary

The fourth content Sub-theme that appeared in the therapist-participant's response to the client-participant's discussion of her trauma was Meaning Making. The therapist-participant dedicated time in session to help the client-participant better understand some of the meanings she had associated with her experiences. Namely, in this session, the therapist-participant had the client-participant focus on how certain events in her life have

impacted her understanding of herself and others in the world. This concept manifested in 2 ways in the session. First, the therapist-participant and CP1 briefly explore how her stroke has changed her (see below):

T89: Well...all I can think of is that you are going to have a big life change either way.

C90: Oh...It makes what I was complaining about 4 months ago that I couldn't do this and I couldn't do that because of my stroke limitations. It makes them seem like so little. And... if I get my sight back I don't have any limitations anymore...this has been the scariest thing I have ever been through in my life...

Secondly, this concept appeared in the therapist-participant's responses to help CP4 make meaning out of other experiences from her childhood involving how she understood her behavior in her friendships with others.

The fifth content Sub-theme that emerged in the therapist-participant's responses to the client-participant's discussion of her trauma was Psychoeducation to Connect Thoughts/Feelings/Behaviors. In the session, the therapist-participant worked with the client to help her understand the connection between her uncomfortable thoughts and feelings, and her behaviors. As illustrated above within the Category of Control, the therapist-participant aided the client-participant to better clarify the a connection between her self-soothing scratching behavior and her uncomfortable cognitions and emotions. The therapist-participant provided information around connecting with the discomfort these 2 provide and identifying ways to improve distress tolerance.

The sixth content Sub-theme was Family. During this session the therapist-participant spent time exploring ways in which themes from the client-participant's upbringing were manifesting in the struggles she was having as a result of her stroke. The therapist-participant explores this theme both in the past as well as in the present.

The seventh content Sub-theme that appeared in the therapist-participant's responses during the session was Control. When the client-participant discussed her sense that she felt helpless and powerless to enact changes in her life, the therapist-participant helped the client-participant explore ways in which this pattern has affected her. In one instance, the therapist-participant underscored this point with the client-participant:

T146: ...Because you are in sort of a helpless situation and you're going to just receive.

In addition, much of the dialogue during the session is on the theme of Control, focusing on the client-participant's scratching behavior, which she uses to regulate her emotions. The therapist dedicated much of the initial and middle portions of the session to this topic to help the client-participant identify ways in which she can more productively and less destructively manage feelings and better understand her behavior. An example of the therapist-participant's exploration of the client-participant's coping skills can be seen in the interaction below:

C64: Yeah, let's see how it works. I mean we have tried. I have tried quite a few different things.

T64: ...What have you tried?

C65: [Looking to the left] I have tried, lets see, sitting on my hands.

T65: Okay

C66: ...I have tried wearing clothes that I absolutely, to get to anywhere, I would have to be extremely conscious of...what I was doing...or was it actually worth it.

Client-participant 5 session. *Session process.* The discussion of the trauma with CP5 began about half way through the session when the client-participant casually introduces the fact that his friend recently died in an unexpected manner. Although the client-participant indicated having experienced this trauma on his initial clinic

paperwork, the language he uses to discuss this information, and the therapist-participant's response to it, indicate this is the first time during therapy this topic is being discussed. This is notable, as the therapist-participant's first response not only appears to be somewhat of a stylistic continuation of the way in which she had been responding immediately prior to the client-participant's communication on a relatively benign topic (i.e., an interaction marked by informal interactions and casual language), but also it sets the tone for the majority of the trauma discussion that followed. The therapist-participant responded to the client-participant in a nonchalant, almost detached manner when the client-participant discusses his traumatic event; she did not immediately address the significant nature of the trauma or the impact on the client-participant. Instead, the therapist-participant alternates between using minimal verbal utterances (e.g., "right, right," "Mm-hmm," "Yeah. Yeah"), which appeared to almost communicate that she already had an understanding of the client-participant's experience around this issue, and asking close-ended factual questions that are highly topical in nature (as seen below):

C218: Also I had a friend die on me this year, stuff like that, so now I'm feeling the age...and the—the mortality and stuff like that [C chuckles].

That's coming in.

T219: [T nods] Right, right.

C219: So.

T220: Can you tell me a little bit more about your friend?

C220: Uh, [C momentarily looks away from T] my friend passed away maybe about 2 months ago [C looks back at T].

T221: [T nods] Mm-hmm.

C221 : Uh, a guy I knew since, uh—since elementary school and stuff.

T222: [T nods] Right.

C222: Don't know, uh—cause of death is unknown still. It's just—they just found him dead in the bathroom [C shakes head] and the police report said it was unknown. [C appears to sigh slightly] It was pretty traumatic in general. So that's another factor in [C gestures with hand near head] you know...

T223: [T nods] Yeah. Yeah.

As the therapy session continued, the discussion around the trauma seemed to remain at a surface or factual level. This therapist-participant did not ask any questions about the client's emotional experience; instead, much of her understanding of his experience came from empathic emotional statements that inferred the presence of difficult emotions in a general sense without further processing them specifically or in depth with the client-participant (occurring a total of 6 times during the trauma discussion). In these instances, the client-participant's responses seemed to be to either briefly acknowledge the personal emotional component or to ignore the therapist-participant's emotionally evocative statement/question. An example of this pattern can be seen below where the therapist-participant noted that the client-participant may be having difficult feelings, the client-participant briefly acknowledged them, and then he moved towards a more factual account of his experience.

T231: [T nods] Yeah, yeah. It must have been really hard to hear.

C231 : [C shakes head] It wa—it was, yeah, it was pretty traumatic I would say.

T232: [T nods] Yeah.

C232: I mean, it was not like, uh, I mean, I don't know what traumatic means or whatever, but you know. But i-it felt bad [C laughs].

T233: [T nods] Right.

C233: You know what I mean?

T234: [T nods] Yeah. Of course.

This therapist-participant did not follow up to ask more probing questions about the client-participant's feelings or elicit from him open-ended reflections on his own emotional experiences; much of the shared understanding of the client-participant's experience she gets comes from either his spontaneous sharing of information or from the answers to open fact-based questions (occurring once

during the trauma discussion), closed fact-based questions (occurring 3 times during the trauma discussion), and reflecting facts she has already obtained from him (occurring 5 times during the session). In other words, the therapist-participant often appeared to be forming her own impression about how the client-participant was feeling rather than asking him directly.

This lack of follow up around emotional material appeared to also be related to the therapist-participant's tendency to interrupt the client-participant (occurring 3 times during the trauma discussion) or not finish her sentences (occurring 6 times during the trauma discussion), the latter of which allowed the client-participant to, in turn, interrupt the therapist-participant. In instances of both of the aforementioned, the therapist-participant and the client-participant each appeared to be having a conversation that was out of sync, and which did not create space for deeper exploration. In these instances, both the therapist-participant and the client-participant appeared to be talking at the other instead of with the other, each trying to make his/her point. An example of this type of dynamic can be seen below:

C239: [C smiles] Yeah. I had to do the eulogy [C groans]—it's horrible.

[C smiles

T240: You did a part of the—

C240: I did a part, oh [C exhales loudly and shakes head] awful. See the dad cry [C smiles] You know?

T241: Yeah.

C241: And that stuff—I don't know anything about like, you see a woman cry it's a little bit of a, I mean –

T242: [T nods] It's more common.

C242: ...[C smiles] It doesn't break my heart as much as a –

T243: It's hard to see that.

C243: [C smiles] Watching a dad cry, watching a man cry is just [C groans loudly while smiling]. That's just awful. [C chuckles]

In the aforementioned example, the client-participant referenced the difficulties he had in completing the eulogy, though he quickly changes the subject to the discomfort he felt in viewing the father of the deceased friend at the funeral. The therapist-participant appeared to be validating the emotionally heavy nature of delivering a eulogy, the client-participant's initial statement, though the client-participant appeared to be hearing the therapist-participant say that seeing a male cry is more difficult than seeing a female cry because the latter is a more common occurrence. Rather than focusing on the client-participant's original emotional experience, the therapist-participant briefly shifted her focus towards discussing the prevalence rates of crying in men and women. In this back-and-forth conversation where the focus appears perpetually shifting, the therapist-participant did not appear to get a clear sense of what the client-participant's actual struggle with the experience was. The aforementioned interpersonal dynamic was common throughout the rest of the time in session where the two discussed the trauma.

Another process pattern that was present in the session was the therapist-participant's tendency to give her advice/opinion to the client-participant, which occurred 12 times during the trauma discussion. During the discussion around the client-participant's trauma, the therapist made statements and offered advice based on her own subjective experience and which did not appear to be grounded in psychological literature (as seen below)

C241: And that stuff—I don't know anything about like, you see a woman cry it's a little bit of a, I mean.

T242: [T nods] It's more common.

At times during the session, the therapist-participant appeared to be eager to establish a sense of shared experience with the client-participant. She chose words like “we” and “you” (used in the general manner) to highlight this mutuality (3 times during the session). In these instances, the therapist-participant’s statements appeared to have deemphasized helping the client-participant process his experience to focus on normalizing his experience and joining with the client-participant so that he does not become distressed. The example below illustrates how the therapist-participant made a significant effort to join with the client-participant; in doing so, she incorrectly assumed what the client-participant was experiencing and missed an opportunity to have him focus on deeper processing. When he corrects her assumption, she immediately abandons her original statement and uses the word “right” in an effort to re-connect with him (see below):

C278: It kind of refocused you—refocused me to, you know, you know not--not delay shit as much. You know, there’s like a certain sense of urgency...Like you’re not gonna live forever, too.

T279: [T nods] Yeah.

C279: You know what I mean?

T280: ...It starts making you think about all those, like philosophical kind of.

C280: [C shakes head] Not even that, it’s just like even a practical level. Just to think that you’re parents are not gonna live forever too. [C smiles]

T281: [T nods] Right.

During this session, the therapist-participant’s responses included some use of metaphor (occurring 3 times during the trauma discussion) to help the client-participant reframe his experience and discuss it in a less topical and more personal manner. The therapist-participant used specific language to highlight the

intensity of the death of the client-participant's friend; she reflected back to him that to her it appeared as if his emotions were somewhat overwhelming:

T267: ...like all rushing up [T gestures by waving hands near head]

Similarly, the therapist-participant uses metaphor to emphasize the intensity of the experience by highlighting the impact that it has had for the client participant:

T289: And, um, we just start thinking about these things more and for you it sounds like it—it, uh, woke you up a lot.

However, in these instances there was limited follow up to probe these areas more deeply, and the dialogue typically shifted either in process or content.

After briefly discussing the trauma, the therapist-participant abruptly changed the topic of the session, shifting it away from the death of the friend and back to the original focus of the session (i.e., the client-participant's recent dating behavior). Overall, the discussion around trauma encompassed a relatively small portion of the actual session.

Session content. There were 4 main content Sub-themes that emerged in the therapist-participant's responses to the client-participant's trauma discussions in this session: Focusing on or Supporting the Wants/Needs of Others (occurring 3 times during the trauma discussion), Control (occurring 3 times during the trauma discussion), Fear/Worry/Anxiety (occurring 2 times during the trauma discussion), and Meaning Making (occurring six times during the trauma discussion).

The first content Sub-theme, Focusing on or Supporting the Wants/needs of Others, manifested with the therapist-participant's concentration on processing with the client-participant his experience of watching others at his friend's funeral. Specifically, the client-participant discussed how it was difficult for him to witness the father of the

friend crying. This behavior to directly highlight this area of content represented a change in the focus of discussion and came immediately after the client-participant indicated he had to give the eulogy at the friend's funeral. He expressed how difficult it was for him, though did so by attending to content around how it seemed normatively incongruent for him to witness a man crying. The discussion shifted to examine the client-participant's perception of the friend's father's emotions and away from the difficulty the client-participant had with giving the eulogy (illustrated below):

C238: Funeral's awful dude [C smiles].

T239: Yeah. Very heavy.

C239: [C smiles] Yeah. I had to do the eulogy [C groans]—it's horrible.
[C smiles]

T240: You did a part of the—

C240: I did a part, oh [C exhales loudly and shakes head] awful. See the dad cry [C smiles] You know?

T241: Yeah.

C241: And that stuff—I don't know anything about like, you see a woman cry it's a little bit of a, I mean.

T242: [T nods] It's more common.

The second content Sub-theme that manifested in the therapist-participant's responses was Control. While discussing the friend's funeral with the client-participant, the therapist-participant briefly inquired about how the client-participant is handling the death of his friend. This interchange is brief, and consisted of the therapist-participant asking about how the client-participant is coping and managing his feelings. When the client-participant indicated that he has avoided dealing with the death, the therapist-participant acknowledged that dealing with death can be difficult and asked if the client-participant felt he has moved past that (see below):

T254: (5) How did you deal with it?

C254: I dealt with it by—well the way— initially what was comforting to me was just to kind of avoid it...and not talk about it, to just kind of, uh, you know—you know, distract myself and—you know what I mean?

T255: [T nods] Yeah.
C255: And not think about it too much.
T256: [T nods] Right.
C256: So that's –
T257: It's hard to deal with that... So that helped for a while.
C259: That helped for a little while, and then... Yeah. Then I guess, it's been a couple of months now so, you know –
T260: Do you still feel like that's where you're at or has the way you feel about it changed?

In this instance, the therapist-participant does not end up getting information around what specifically the client participant is doing to cope; she only seemed to learn that he was avoiding addressing his feelings and that that type of emotional disengagement is no longer working for him.

The third content Sub-theme that manifested in the session was Fear/Anxiety/Worry. During this trauma discussion the therapist-participant acknowledged that the client-participant was dealing with significant concerns surrounding the death of his friend. While there is limited engagement with emotional material during much of the trauma discussion by both the therapist-participant and the client-participant, the therapist-participant briefly is able to focus the conversation onto CP5's concerns. Namely, she identifies what emotion CP5 is communicating, but does not directly acknowledge himself (see below):

C280: [C shakes head] Not even that, it's just like even a practical level. Just to think that you're parents are not gonna live forever too.
T281: [T nods] Right.
C281: That's also a—you know?
T282: It's scary to think –
C282: Yeah. So you've got to somehow prepare for that too. So you've got what, whatever you're gonna do there. You know?
T283: Yeah.

The fourth content Sub-theme that appeared in the session was Meaning Making. This occurs when the therapist-participant attempts to explore with the client-participant

how he has changed as a result of the friend's death. This is a very brief discussion that the therapist-participant has at the end of the trauma discussion. Specifically, the therapist-participant introduces into discussion the idea that this experience has been significant in that it has forced the client-participant to re-evaluate his values, priorities, and life direction. The client-participant dismissed this concept, indicating that the only thing that has become more salient for him as a result of the experience is that the aftermath of death requires one to address many practical logistics (see below):

T280: ...It starts making you think about all those, like philosophical kind of –

C280: ...Not even that, it's just like even a practical level. Just to think that you're parents are not gonna live forever too. [C smiles]

T281: [T nods] Right.

C281: That's also a—you know?

T282: It's scary to think –

C282: Yeah. So you've got to somehow prepare for that too. So you've got what, whatever you're gonna do there. You know?

T283: Yeah.

C283: Parents are most likely gonna die within, what [C shakes head] the next 10, 20 years? You know?...So what are we—what am I gonna do to mitigate the pain or, uh, not necessarily the pain, but just—just the pain—there's the pain itself, but then the logistics of it.

T285: Yeah.

C285: The, uh.

T286: 'Cause both are important.

C286: Just the paperwork and stuff.

Shortly after the aforementioned exchange, the therapist-participant changes the focus of the session away from the trauma and onto the topic of the client-participant's last romantic relationship.

Chapter IV. Discussion

The research question of this study asked about how trainee therapists respond in session when psychotherapy clients communicate they have experienced trauma. To address this question, the study employed a qualitative inductive content analysis to explore the process and content of therapist responses during discussions of trauma. In examining the psychotherapy sessions for 5 clients who had experienced trauma of varying nature, intensity, and duration, the researcher-participants found some consistencies in the therapists' behaviors. Namely 4 Parent-Themes were found in the process of the therapists' responses: (a) Establishing a Mutual Understanding of the Client's Experience, (b) Providing Guidance and Support, (c) Encouraging Alternative Processing, and (d) Affecting Session Flow. Correspondingly, 2 Parent-Themes were found in the content of the therapists' responses: (a) Coping and (b) Client Struggles/Difficulty. This chapter discusses the Process and Content theme findings of the study as related to recommendations for trauma treatment that are found in the literature. The chapter then describes limitations and potential contributions of the study to the field, and concludes with directions for future research.

Process Themes

Establishing a mutual understanding of the client's experience. In conducting a therapy session, it is important that the therapist have an understanding around when and how to use questions so that they can be helpful to the course of the therapy (Padesky, 1993; Pipes & Davenport, 1999; Weiner & Bornstein, 2009). Questions are frequently only utilized as a means of obtaining specific information (James, Morse, & Howarth, 2010); however, in therapy they can be used to enhance the therapist's

understanding of the client's presenting problem, guiding a broader discovery process (Pipes & Davenport, 1999). With specific regard to trauma treatment it can be especially important that both the client and therapist have a clear understanding of the client's struggles in order to facilitate the therapy in a productive manner (Zoellner et al., 2011). In the sessions that were analyzed, the 5 therapists frequently employed the use of questions (both direct and leading) and clarifications as a means of obtaining information from the client. Given such questioning, 4 of the 5 therapists in the study appeared to be thorough in their information-gathering efforts, obtaining factual information about the clients' experiences. On the other hand, one of the therapists (CP5) asked the client very few questions about the trauma, even though, as indicated by her comments at the beginning of the trauma discussion ("How much did you guys know each other?"), she had a limited understanding of the client-participant's trauma experience. Instead she focused on normalizing the client's experience even though she did not know the details surrounding it. At the same time, as explained further below, it appeared that only two of the therapists had a conceptual appreciation of how trauma impacted the lived experiences of the client-participant, asking questions about how the client-participants understood the trauma and what changes they had experienced in their lives as a result of it. The other three focused more on the specifics of the traumas themselves or on acknowledging that the client experienced emotions without clarifying in what ways the specific facts or emotions had impacted the clients.

From most frequently occurring to least frequently occurring, the nature of the questions the therapist asked were close-ended fact based, open-ended fact based, (infrequently) close-ended feeling based, and (rarely) open-ended feeling-based. Thus, 2

patterns were observed in the way the therapists tailored their efforts to ensure that they understood the clients' experiences: emphasizing facts over emotions, and closed over open-ended questions.

A primary way in which the therapists tended to respond to clients' discussions of trauma was through their emphasis of obtaining factual information over emotional information. That is, for all 5 therapists there was a greater frequency of questions and statements used to obtain information about the trauma as an event than there was to gathering an understanding of how the trauma experience had impacted the clients emotionally (utilizing fact based questions more frequently than emotionally based ones; making statements to clarify facts more often than making statements to clarify feelings).

Trauma treatment typically relies on the client being able to process the traumatic material and memories in manner that promotes his/her emotional engagement with it (Foa, Hembree, & Rothbaum, 2007; Resick et al., 2010). It appears critical that individuals are able to feel emotions that are associated with the trauma in order to allow them to dissipate naturally versus using avoidance behaviors to emotionally and functionally disengage from traumatic material, a common tendency among those who have PTSD (Foa et al., 2007). Moreover, exposure-based treatment for trauma has been shown to be effective with the processing of range of emotions, including: fear, anxiety, rage, anger, sadness, grief, guilt, and shame (Foa et al., 2007). The combination of high levels of individual connectedness with difficult emotions and habituation to them is associated with treatment outcomes that evidence reductions in these symptoms (Jaycox, Foa, & Morral, 1998).

While the importance of emotional engagement is most explicitly detailed in the literature for the treatment of PTSD and the types of trauma that are conducive to its development, this conceptualization can more broadly be applied to subjectively distressing/traumatic experiences that individuals face, like those experienced by client-participants 2 and 3. In fact, direct encouragement to discuss and re-process thoughts and feelings surrounding stressful experiences has been shown to decrease levels of distress, reduce the impact of intrusive and disturbing thoughts, improve mood, enhance emotional regulation and feelings of control, improve resilience, facilitate meaning making and identity development, and improve overall individual psychological and physical functioning (Hemenover, 2003; Lutgendorf & Antoni, 1999; Pennebaker et al., 1988; Pennebaker, 1997). The exploration of affective issues appears to be critical, as clients need to apply new learning to areas in their lives where they experience negative emotions (Pipes & Davenport, 1999). With regard to the current study, it appeared as though the therapists' lack of questions related to emotions (as well as other behaviors to be discussed further below) hindered the clients' abilities to emotionally engage with the processing of their trauma. Furthermore when feelings were discussed, they were often identified for their presence in the client's life, and much less often processed for their impact on the client or others (e.g., "Are you angry?" versus "What do you think it is about this situation that makes you angry?" or "How does your anger affect your relationships?"). Unfortunately, it may be that training therapists lack sufficient understanding around how to utilize questions to facilitate therapeutic objectives (James & Morse, 2007).

The adult trauma literature suggests that novice clinicians also prioritize obtaining factual information over emotionally engaging with the processing of trauma even when utilizing manualized, exposure-based treatments that focus on the client's emotional experience of the trauma. Zoellner et al.'s (2011) study highlights a trend that novice clinicians, who are trying to provide more structured and goal-directed treatment, tend to lose focus on the importance of more general therapeutic skills, such as listening, attending to the client and the therapeutic relationship, and providing support. The authors indicate that when there are specific tasks to be accomplished in trauma therapy work (e.g., adhering to a trauma treatment manual), it can be easy for the clinician to focus too heavily on perfectly understanding and addressing every trauma-related component (i.e., by focusing heavily on obtaining information); however, without continuing to use general clinical skills, the therapist unwittingly can create an environment which lacks a foundation for therapy and which makes it difficult to encourage a client to approach the issues that are feared and avoided (Zoellner et al., 2011). In their study, the authors also found that even in the context of being given a structured treatment model, the therapists drifted away from maintaining fidelity to not just the model, but also the guiding principles of the treatment. That is, the therapists appeared to focus more on gathering and clarifying factual details in a supportive environment (see Providing Guidance and Support Parent Theme discussion that follows for applicability to this study) than they were on assisting their clients in accessing and processing traumatic or difficult emotions.

Of note, is the literature surrounding the treatment of complex trauma. Although much of the adult trauma treatment literature focuses on facilitating the client's emotional

engagement with the trauma early in the treatment (Foa et al., 2007; Resick et al., 2010), the pacing around when to begin emotional processing can be different with clients who have a history of repeated and/or chronic trauma. Specifically, treatment with those individuals may initially focus on tasks such as establishing safety, building the therapeutic relationship, developing coping skills, developing self-care and emotional regulation skills, and psychoeducation prior to emotional processing of the trauma (Briere & Lanktree, 2008; Courtois, 2004; Courtois & Ford, 2009). While Courtois notes that the pre-emotional engagement stage can be the longest of the treatment, Briere and Lanktree (2008) advise that during treatment of complex trauma, therapist encouragement of emotional engagement potentially can occur as early as the third session. As such, there appears to be some variability in guidelines around how clinicians should proceed in their trauma work with clients who have complex trauma. It appears that at least for certain adult clients, it may not be best for a therapist to start emotional processing until later in the treatment.

With regard to the current study, all of the client-participants indicated having experienced themselves events that could have met the threshold for a trauma. Additionally, all were exposed to at least one family member who had experienced that type of event; however, only one client-participant met the definition for complex trauma outlined by Ford and Courtois (2009). Moreover, of the client-participants therapy sessions examined in this study, one was a fourth session, three were sixth sessions, and one was a tenth session of treatment. The current study did not examine explicitly the differences in frequency of fact-based responses versus emotionally-based ones. Additionally, much of the trauma literature highlights the importance of developing a

strong working alliance in trauma therapy, which can take time (Briere & Lanktree, 2008; Courtois, 2004; Keller et al., 2010). Nonetheless, as the trauma literature indicates emotional engagement with the trauma is crucial for symptom resolution, it is important to highlight how the therapists of this study emphasized fact over emotion.

The second pattern observed was that all of the therapists tended to favor using closed-ended questions over open-ended ones, asking the former with a greater frequency than the latter. Typically they used them to solicit new information from the client or to obtain clarification around information for which they already had some understanding. The literature notes how close-ended questions can be leading, offer the client very little opportunity to offer information other than what is being directly targeted (Miller & Rollnick, 2002), and can shift the focus of the therapy away from processing and make it seem more like an interrogation (Weiner & Bornstein, 2009).

At times, the therapists in the current periodically engaged in open-ended questioning and prompting when discussing the clients' trauma and the meaning associated by it. Open-ended question can provide clients with the opportunity to develop and express their perspective, invite elaboration and deep thinking, and provide forward momentum to the therapy (Miller & Rollnick, 2002). In addition, in collaborative therapeutic work open questions can be used to elicit emotion, clarify meaning, and help the client develop insight and explore alternative conceptualizations (Padesky, 1993). Within the context of a therapy session, open-ended questions typically are favored over close-ended ones, especially in the early stages of treatment (Sommers-Flanagan & Sommers-Flanagan, 2008); active listening of a client's experiences can be an important component of building a therapeutic relationship as well as helping the clinician develop

a thorough understanding of the client's struggles (Sommers-Flanagan & Sommers-Flanagan, 2008).

More often, though, the therapists in this study all appeared somewhat hurried or eager to collect a breadth of topical information in as quick a manner as possible at the expense of fully reciprocal communication and a complete gathering of desired information. In addition, the therapists sometimes posed questions that appeared more deductive in nature than exploratory, suggesting they may have had predetermined agendas in the session, that they determined their understanding of the clients' experiences of trauma very early in treatment, and/or that they may have been uncomfortable themselves with discussing traumatic material. The nature of the back-and-forth process in the sessions examined, more often than not, appeared not to guide therapeutic discovery (i.e., inductive inquiries), but rather was deductive in nature. Weiner and Bornstein (2009) caution that over-utilizing questions can create a tacit assumption that the therapist is in charge of what is discussed in session and in how much detail, or even give the impression that once the questions are answered the therapist will provide a neatly packaged solution. This appeared to have led the therapists to affect the flow of the sessions examined (see affecting session flow below).

Another type of questioning that is typically contraindicated is the use of leading questions. In general, question phrasing in therapy typically should not lead a client to respond in a manner that is predetermined by the therapist (James et al., 2010). Embedded within this type of questioning is a tacit assumption that there is a correct way to answer the question (James et al., 2010). As such, a therapist who emphasizes this type of questioning may place undue pressure upon a client, which can actually yield an

effect opposite to that which the therapist actually wants (i.e., less verbal expression; Sommers-Flanagan & Sommers-Flanagan, 2008). Moreover, open and closed presumptive questioning can lead people to agree with the question being asked even if the response is factually incorrect (Sharman & Powell, 2012). Research from the forensic field suggests that in fact-based interviews this type of question is quite common in courtroom cases, occurring at least once during approximately 50% of all interviews (Hughes-Scholes & Powell, 2008).

Of note, both general cognitive-behavioral therapy literature (e.g., Beck & Beck, 2011) and adult trauma treatment literature (e.g., Resick et al., 2010) provide further guidance around the use of questions that are inductive versus those that are deductive. Fundamental to those therapeutic perspectives is the task of guiding discovery through the use of Socratic questioning, a collaborative process by which the therapist and client scientifically examine the client's distorted beliefs that are causing him/her distress (Padesky, 1993). Padesky notes that many examples of competent questioning in therapy consist of the therapist (a) having a predetermined (and often logically cogent) theory about the irrational nature of a client's thoughts, and (b) rationally presenting the client with his/her own logically flawed thinking in service of illustrating how the client's distress is the result of an incorrect conclusion drawn from a non-empirical process (Padesky, 1993). Although this type of implementation of the Socratic Method may be a necessary component in therapeutic work because it helps change minds around specific distressing thoughts, it may not be sufficient for eliciting sustained long-term change (Padesky, 1993). That is, the latter of the 2 relies on the internalization of the open-minded inquisitive process that leads a client towards guiding his/her own discovery to

incorporate work around related cognitive material instead of only teaching a client to be more rational around a particular line of thinking (Padesky, 1993). As such, deductive and/or leading questions may inhibit this type of higher-order or meta-thinking, preventing the generalization of this skill for application to other areas in one's life. An example of the aforementioned rationalizing process is seen Client-Therapist 2's work below:

C238: I don't know. I, you know, the, when this happen she said I was stupid cause someone was trying to hurt me and I just couldn't hurt.

T239: Do you think that's, you think that's stupid? Do you think, I'm, let's look at, let's think about, all you need to think about what does that say about you as a person though

C239: I don't know you know. I, I don't know, it depends, you can say I'm a good person or you can say that I'm stupid.

T240: But what do you think? [T motions to C with right hand in waving movement] Not what somebody else thinks, what does that say, what do you believe that says about you that you didn't hit this person that was, you were defending yourself but you didn't hit her when you could. What does that say about, [T points to chest with right hand] como tu carácter?

C240: I guess I'm pretty good person. [C laughs]

T241: Why, why pretty good person?

C241: I don't know.

In the 5 therapy sessions examined, there were no instances of the type of back-and forth guided discovery through questioning that is described above. In instances where Socratic Questioning could have taken place in a session (i.e., when a therapist-participant would ask the client-participant an initial question about something he/she said for further elaboration), the therapist-participants typically would interrupt what could have become a Socratic Dialogue by providing the client-participant a suggested way of looking at the issue or giving the client-participant a possible conclusion instead of allowing the client-participant to reach that or other possible conclusions on his/her

own. An example of this type of interaction is illustrated below in the discussion between Therapist-Participant 3 and Client-Participant 3:

T231: And what are some of your- when you are thinking about this, whether to stay or go back, what are some of the feelings that come up for you?

C232: Well again, I'm scared of going back and not being able to like it there. That's my main concern that I'm going to go there and I just don't like the, I guess I just don't like the atmosphere there.

T232: [T nods] Mm-hmm. So your feeling is that you're scared and you're thinking "I don't know if I'll like it when I go back?"

C233: [C nods] Yeah.

T233: [T using hand gestures] ... "I'm going to be unhappy." What if that happens?

C234: I mean, I did go back when I stayed here for, when I came here for school for a year, 14 months which I hated and I always wanted to go back and when I did go back it was amazing, I wanted to come back here. I mean-

T234: So you're worried that you will have the same reaction?

Instead of making and pursuing assumptions about a client's experience, the therapist should embrace the uncertainty of the guided discovery and allow the client to reach his/her own conclusions. A hypothetical example of the type of Socratic questioning Padesky suggests might be:

C: I've completely screwed up my life. I haven't done anything right.

Th: Has something happened to lead you to this conclusion or have you felt this way for a long time?

C: I think I see myself more clearly now.

Th: So this is a change in your thinking?

C: Yes. (Pause) I went to that family reunion and I saw my brother and his kids and wife. They all looked so happy. And I realized that my family's not happy. And it's all my fault because of my depression. If they were in my brother's family, they'd be better off.

Th: And so, because you care about your family, you then decided you were a complete failure, that you let them down...

Th: What things would you do differently if you were less depressed or a better father in your own eyes?

C: I think I'd talk to them more, laugh more, encourage them like I see my brother do.

Th: Are these things you could do even when you are depressed?

C: Well, yes, I think I could." (Padesky)

While the current study did not gather frequency data regarding how often the therapists used leading questions, 4 of the 5 therapists did use at least one leading question with their respective clients during their trauma discussion. Furthermore, the study did collect frequency data on a related topic – instances where the therapist filled in a client’s sentence for him/her. All 5 therapists engaged in these behaviors.

Potential consequences of premature intervention or action by the therapist include the therapist’s choosing an approach or technique that is contraindicated or does not match the goals of treatment, making the client feel rushed and misunderstood, and coming across as mechanical and non-exacting in his/her application of interventions to a client’s situation (Sommers-Flanagan & Sommers-Flanagan, 2008). Moreover, perceiving that a therapist is not listening can be one of the biggest reasons for a client to prematurely terminate from treatment (Sommers-Flanagan & Sommers-Flanagan, 2008). Although the therapists in the current study attempted to be supportive, it may have been that issues in the therapeutic relationship led to treatment dropout (discussed further in subsequent sections). This may have been a reflection of the clients’ readiness to discuss the trauma or possibly a reflection of an aspect of trauma work that was being conducted in the session.

Providing guidance and support and encouraging alternative processing.

Multiple models of trauma treatment either overtly or tacitly suggest that a main task of trauma treatment is helping the client develop skills to manage the psychosocial consequences of that trauma (Briere & Lanktree, 2008; Bryant-Davis, 2005; Courtois, 2004; Foa et al., 2007; Resick et al., 2010). These treatment models suggest that educating clients about their trauma and its impact on their lives, and helping them

identify cognitive and behavioral coping skills to rework their understanding of the trauma are important components of trauma treatment. Current trauma treatments (e.g., PE, CPT, Sequencing and Stage Oriented Treatment) instruct the treating clinician to use interventions containing components intended to help clients reframe their struggles, visualizing and planning alternative ways to handle potential future stressors, and connect with inherent strengths and opportunities for growth from the adversity of the trauma, in order to address the avoided stimuli (Courtois, 2004; Foa et al., 2007; Resick et al., 2010). Furthermore, these models indicate that it is critical that the client is able to experience the therapist as empathic and that the therapy space is perceived to be a safe and supportive environment. In the course of this study, it was identified that the therapist-participants provided guidance/support as well as encouraged the client-participants to engage in alternative processing around their trauma. Given their conceptual overlap, these results are discussed in conjunction with each other.

The therapists in the current study provided guidance and support through their use of a combination of objective (e.g., psychoeducation), subjective (e.g., providing opinions, connecting past and present), and supportive or empathic interventions (e.g., “That sounds so hard”) aimed at helping guide the clients to alternatively examine their traumatic events, and assisting them with the development of coping skills to manage the trauma-related sequelae. They provided cognitive interventions to help the client reframe his/her struggles, helped the client problem solve the difficulties he/she had, worked to develop plans for alternative ways to address future challenges, identified connections between past and present information, gave information to help the client better understand his/her presenting issues from a psychological perspective (i.e.,

psychoeducation), explored with the client ways in which his/her trauma had impacted relationships with others in order to improve them, and responded in a manner that highlighted strengths of the client.

In addition to the cognitive interventions listed above, Beck and Beck (2011) suggest that specific interventions, such as reframing a problem, directly examining evidence for and against a belief, and developing a plan for behavioral action (all interventions accomplished by the therapists in this study), can play a crucial role in facilitating a reduction in the client's presenting distress. Also, helping the client draw connections between past and present experiences is recommended in the literature as an important component of psychotherapy (Weiner & Bornstein, 2009). Padesky (1993) noted that therapists should listen for idiosyncratic words (e.g., indigenous typologies), metaphors, and mental imagery, as reflection and utilization of this material can intensify client affective expression and expedite therapeutic gains. In fact, Meichenbaum (2006) has argued that the use of metaphor can play a crucial role in shaping one's narrative around a traumatic event, thus helping guide whether or not an individual will develop PTSD (versus experiencing growth) after trauma (see section on meaning making). Furthermore, this type of abstract language may be especially important in trauma work with non-Caucasian and other non-Western individuals who have experienced trauma, as metaphors can incorporate specific language and other cultural influences that can be central for certain ethnic groups in how they make sense of and cope with trauma (Bryant-Davis, 2005; Rahill, Jean-Giles, Thomlison, & Pinto-Lopez, 2011).

The therapists in this study used the aforesaid linguistic techniques in their sessions to guide alternative processing of the trauma. At times the therapist-participant's

use of idiosyncratic language appeared to help deepen the therapy (Therapist-Participant 3):

T279: And in the next couple weeks, when we work on that, a lot of things might open up for you. You'll be able to use a lot of our strategies in different areas but you know it will take some time. It's a cure that is going to make you feel better tomorrow and that is something we will work on and hopefully you will notice improvement...

C280: Yeah. I think I keep accumulating all the stuff that's happening. If things happen, like I say, I wish I could have done it better, I mean then it just keeps [C points to head] coming in my mind and makes it me, like the next day, I'm like, can I not just be okay? Whatever happens happens. Why are you taking everything so personal and trying to make everything right.

There were also multiple instances during each of the 5 sessions where the therapist was actively engaged in emotional processing around the trauma, at times emphasizing the importance of a connection between past and present experiences (Shedler, 2010). In these moments the therapists typically would provide validating and/or supportive comments (e.g., "That must have been very hard") to empathize with the clients' experiences around the trauma. Responses of this nature did, in fact, appear to facilitate engagement with the emotional components of the trauma, and occurred in the sessions for 4 of the therapists. However, validating and/or supportive comments presented relatively infrequently during the trauma discussions and their impact appeared to be only brief in the discussions, as the session focus typically would immediately shift away from such statements. Thus, there appears to be a need for trainee therapists to balance helping a client explore and develop cognitive and behavioral mechanisms to manage the trauma with processing the emotions that are associated with it.

These strategies are needed because cognitive, emotional (i.e., disengagement or numbing), and behavioral avoidance of trauma related cues (e.g., thoughts, memories,

places) appear to inhibit the resolution of trauma symptoms and reinforce symptoms maintenance in individuals who have experienced trauma (Foa et al., 2007; Resick et al., 2010; Aupperle, Melrose, Stein, & Paulus, 2012). These avoidant coping strategies can prevent individuals who have experience trauma from adequately making intellectual and emotional meaning of the trauma (Aupperle et al., 2012). During the sessions examined, both the therapist-participants and client-participants engaged in behaviors that could be considered colluding with avoidant coping strategies. As noted above, there was a relative lack of emotional questioning by therapists. Another example discussed in the next subsection was the changing of topic away from trauma discussion.

Finally, some supportive behaviors involving psychoeducation exhibited by the therapists in the study were contraindicated in the literature. These included chatting and/or being overly friendly/informal with the client (e.g., the therapists in this study using words like “right” and “okay;” Pipes & Davenport, 1999) and *Therapist Overcontrol* via emotionally rescuing the client, giving direct advice, providing excessive reassurance, focusing on someone other than the client (i.e., making a client’s problem relatively non-existent), and lecturing or overly relying on strategies (e.g., psychoeducation) to talk at the client (Pipes & Davenport, 1999). While there are exceptions that would preclude establishing a hard rule around them (e.g., gathering sufficient family psychosocial and dynamic information to contextualize a client’s problems), in general, the aforementioned behaviors ought to appear minimally, if at all, in a session.

Affecting session flow. In addition to the aforementioned, the therapists examined in the current study engaged in behaviors that impacted the flow of the therapy

session in both positive and negative ways. The ways in which the therapists did this during the session included behaviors that appeared to disrupt the client's processing (e.g., asking multiple questions at once, interrupting the client or completing his/her sentence, changing topics and not finishing sentences/statements), as well as more innocuous and also facilitative behaviors of minimal verbal utterances to attend to what the client was saying, verbally connecting with what the client was saying (e.g., using similar language), and focusing the client in session. The more active responses (e.g., completing the client-participants' sentence for him/her) seemed to have more of an impact on slowing or disengaging the session flow than the more frequent but less active ones (e.g., minimal verbal utterances).

Regarding the problematic types of responses that affected flow, multiple or disjointed questioning is highly discouraged in therapy. These types of over-complex, poorly-sequenced, and multi-layered questions can place a heavy demand on intellectual information processing at the expense of deeper emotional exploration (Pipes & Davenport, 1999; James et al., 2010). An example of this is seen below in the session for Therapist-Participant 1:

T43: Does it bring up any regret for you not being in (location)? Like a feeling that you could have stopped him or helped him if you were there
C43: No, there's not uh, I wasn't that role in his life... You know, I was his brother. He had other people he was closer to they weren't really [inaudible, C clears throat, take sip of water]. I uh, yeah I don't think there's anything anybody could have done.

The structure of the aforementioned line of questioning, which exemplifies this point, appears to force the client-participant to consider three somewhat related, yet conceptually different points simultaneously. As such, his ability to emotionally engage with the material seems to be tacitly suppressed in service of

focusing on cognitively understanding and integrating the information necessary to answer the question in a logical manner. Because of the competing nature of each specific question, the client-participant also may more easily be able to answer “no,” given that at least 2 facts must have been accurate in order for him not to provide this answer. Based on the example above, construction of the circumstances required for a “yes” answer, potentially allowing for deeper discussion on this emotional topic, may have necessitated the therapist-participant to reduce (albeit inadvertently) providing the client-participant ways to not discuss the trauma.

Moreover, Padesky (1993) cautions against asking sequences of relatively unrelated questions whose relevance to the client’s presenting concerns is dubious. An example of this can be seen in responses (below) of Therapist-Participant 2. Therapist-Participant 2 appears to lose focus on the client’s discussion of a trigger to her sadness as she pursues what ultimately becomes information that is therapeutically irrelevant to that situation:

C138: So that I don’t dedicate too much time to think about it cause then I start really, getting really sad. [T is nodding] Like the other night, 2 nights ago, my mom husband, he invited us you know to go, cause you know see my mom left him to that reasons, so –

T139: So she, so this is the father of your sisters?

C139: No. He’s just her husband.

T140: Just her husband. Their stepfather?

C140: Yeah. So she just, you know, kind of left him, just like –

T141: Are they divorced now or no?

C141: No, she just left you know. Just kinda like yeah that—

T142: Do you like him? Is he –

C142: Well, he’s a really nice person, so she’s just, with my husband he’s got really relationship, a good relationship...I just got there and I went to my sister room and that was really bad to, I saw her stuff right there.

T143: Yeah. When was this? Was this like recently?

C143: It was a couple nights ago.

T144: Okay.

During the course of the therapy sessions, all 5 of the therapist-participants also impacted the session flow by offering verbalizations that interrupted the client-participants when they were answering a question or processing their experiences. Beck and Beck (2011) suggest that during the course of therapy, especially Cognitive-Behavioral therapy (identified as being provided by 4 of the 5 therapists; see details in subsequent sections), a therapist should feel comfortable interrupting a client from time to time. They indicate that this can be an important component of socializing the client to a more active and directive style of therapy, as well as highlight in-the-moment communications of the client that warrant further examination. Essentially, this intervention is best used when its function is psychoeducational in nature (Beck & Beck, 2011). In the sessions identified, the 5 therapist-participants each interrupted their respective client-participant. However, the function of these interruptions was not to provide socialization to the CBT model, but rather appeared to cut the client off from further discussion on a topic.

A third negative flow pattern observed was that both client and therapist were responsible for changing topics during the course of the therapy session. In all of the therapy sessions examined in the current study a dynamic manifested in the interactions between each client-therapist pair; that is, the 2 briefly would start a discussion on an aspect of the trauma and then shift the focus of the discussion towards a different topic. At times this type of behavior involved overt/abrupt shifts to an entirely different subject (i.e., off of the trauma). More often, though, were subtle instances where either would slowly drift away from the topic of the trauma. This sometimes was in service of either

the therapist-participant obtaining or the client-participant offering contextual information relevant to a more complex understanding of the trauma. At other times, though, this behavior moved the discussion away from discussing the issue for which the client-participant presented to therapy. Because of the non-overt nature of this behavior, it was sometimes difficult to determine if the shift originated with the client-participant or the therapist.

Similarly, the literature seems to suggest that the process of disclosing trauma in therapy takes the form of repeated behaviors of approaching and discussing the traumatic material and then withdrawing from that discussion at least temporarily (Alaggia, 2005; Chaudoir & Fisher, 2010; Lindbald, 2007). Some of this behavior may be related to the client's engagement with the material in order to appropriately address it, while other aspects of it may, in fact, be related to behaviors performed by the therapist.

Regarding the behaviors that affected the flow in a neutral or positive way, the most frequent was minimal verbal utterances. For purposes of this study, it was difficult to determine if minimal verbal utterances were a reflection of listening behavior or if, in fact, they were tacitly used by the therapists to encourage deeper emotional processing, albeit unsuccessfully.

Of note, when therapists appeared to be verbally connecting with what the client was saying (e.g., using similar language), they seemed very attuned to trying to focus on hearing the client. Zoellner et al. (2011) emphasize the crucial nature of using general skills of listening and being supportive when providing trauma-focused clinical work. During the sessions examined, there were multiple instances (e.g., mirroring language, paraphrasing) during which each of the 5 therapists were connecting with what the clients

were discussing; nevertheless, while these types of responses occurred periodically throughout the trauma discussions, they represented deviations from the topic-shifting process pattern that was more often seen in the sessions.

Zoellner et al. (2011) caution that a session's focus can easily shift away from emotional processing and move more towards a directive/guided approach that can inadvertently undermine the treatment itself. They indicate that clinicians who treat trauma must strike a balance between helping the client remain problem focused on the trauma itself without losing sight of relying on therapeutic relational techniques. In fact, if a strong therapeutic alliance is not in place, it can be exceptionally difficult to engage the client in talking about the issues that are both feared and avoided (Zoellner et al., 2011).

One potential reason for this type of difficulty may be a mismatch between a client's readiness to fully discuss trauma and the treatment objectives of the therapist. Research suggests that only 10 to 20% of clients who seek therapy may be ready to take active steps towards change in their lives (Prochaska & Norcross, 2001); the majority clients who come to therapy appear to be in either in the Pre-Contemplation or Contemplation stage of change. The resulting disparity between how the therapist and client desire to proceed in session potentially may result in the therapist perceiving the client as resistant or not ready to change, and/or the client having increased feelings of hesitance about moving forward towards taking a more active approach to change (Prochaska & Norcross, 2001). The Stages of Change literature recommends that prior to completing treatment, therapists evaluate a client's stage of change in order to adjust and tailor aspects of the therapy (e.g., style, intervention type) to match how ready a client is

to make changes in his/her life (Norcross, Krebs, & Prochaska, 2011; Prochaska & Norcross, 2001). This step may be especially critical, given how significant fear and avoidance can be in clients who experience trauma, and how those emotions may impact a client's readiness to engage in trauma treatment (Zoellner et al., 2011). This is a crucial point given the fact that one of the most important therapeutic issues when working with clients who have experienced trauma is dealing with their under-engagement with the traumatic material (Zoellner et al., 2011).

Content Themes

Coping. The first content theme that was found in the therapists' responses to the clients' discussions of trauma focused around the development of coping skills. That is, all of the therapists provided responses that were aimed to either highlight clients' current coping or help the clients develop additional coping skills to reduce their level of emotional distress. More specifically, the therapists in the current study provided responses whose content emphasized subthemes of psychoeducation, taking control over a situation, making a different meaning of the trauma, and, at times, highlighting support from family members.

A focus on coping is similar to what is recommended in the trauma treatment literature. For example, Briere and Lanktree (2008) indicate that trauma treatment should explicitly emphasize developing good coping and problem solving skills to address the trauma and its aftermath. Also, Courtois' (2004) developmental model for trauma treatment begins with developing emotional regulation skills to cope with emotional distress along with establishing rapport, safety and trust, before initiating direct engagement in the traumatic material.

Encouraging engagement in action oriented coping skills (e.g., seeking out support, discussing the trauma) over avoidant coping (e.g., substance use to numb symptoms) appears to play a critical role in helping clients who have experienced trauma (Ford, 2012; Pineles et al., 2011). The rationale behind this recommendation may be related to the sense of helplessness or powerlessness that many who experience trauma feel (as evidenced in the review of the trauma). For this reason, interventions that focus on empowering the client (i.e., taking an active role in managing the effects of the trauma) may be clinically indicated. The current study found that all five of the therapists examined responded to the client with interventions whose aim was to help enhance the client's sense of control.

In this study, all five of the therapists responded to client discussions of trauma by helping them attempt to establish meaning for negative events in their life. How a person views the meaning around a trauma can play an important role in how that trauma impacts the lives of those who experience it. For instance, Schuettler and Boals (2011) found that PTSD symptoms may be best predicted by taking a negative perspective of the event itself. On the other hand, the authors found that greater levels of PTG were related to problem-focused coping and taking a positive perspective on the event. Positive meaning making appears to be critical in alleviating distress after it occurs (Park & Ai, 2006) and play a role in growth after trauma (Tedeschi & Calhoun, 2004). Dahlsgaard et al. (2005) argue that transcendence and finding strength through meaning is a value that cuts across culture, ethnic grouping, and civilizations, playing a foundational role in establishing core values. Thus, the therapist may act as a facilitator in helping the client reprocess unhelpful thinking patterns about the trauma and encouraging the client to

engage in more positive coping strategies, such as those that are action oriented (Hussain & Bushan, 2011).

Encouraging social support also appeared to be an important way in which the therapists in the current study helped the clients cope with their trauma. Among the 5 therapists in the study, three explicitly focused on helping the clients identify people from whom each could get social support (e.g., friends, family). Furthermore, 4 of the 5 therapists appeared to recognize the importance of family in the life of the client with whom they were working; they explicitly shifted or kept the focus of the conversation onto ways in which the client's family was related to the presenting trauma and how the client was coping with it.

This finding was consistent with the literature on coping, which recommends that social support be incorporated in work with those who have experienced trauma, including, but not limited to, college students (Grasso et al., 2011) and current Operation Enduring Freedom / Operation Iraqi Freedom Veterans (OEF/OIF) veterans with PTSD (Pietrzak, Harpaz-Rotem, & Southwick, 2011). Social support is not only important to mental health in general, but it also is relevant to many individuals who face trauma because they can experience a sense of social detachment or disconnectedness that is both the result or and a contributing factor for subsequent behavioral avoidance (Foa et al., 2007; Pietrzak et al. 2011; Purves & Erwin, 2004; Resick et al., 2010).

Another recommended source of social support for coping with trauma is religion and spirituality. These areas can be especially important in helping individuals who have experienced stressful events reduce their distress by relying on coping/support systems that are already in place (Bryant-Davis, 2005). This type of behaviorally focused (versus

intellectually focused) coping may be especially indicated for individuals with lower education levels who have experienced trauma, as action oriented coping (e.g., attending college), positive reappraisals, and spiritual coping appears to be particularly helpful (Ford, 2012; Prati & Pietrantonio, 2009). Among a sample of low income urban Latina, African American, and Caucasian women who had sub-threshold or full PTSD, Ford found that covert self-blame coping correlated with greater levels of depression and dissociation while action-oriented religious coping correlated with lower levels in those areas. Enhancing active spiritual coping may also be particularly important for African American women (Ford, 2012), as the author found that this group self-identified they used religion or spirituality as a means for coping more frequently than the other 2 ethnic groupings.

The literature on religious coping further clarifies that religious coping does not have to include encouraging clients to attend religious services. For instance, among non-western African women who had experienced trauma of torture and rape, engaging private religious behaviors (i.e., those that are informal and do not include formal congregation) has been shown to lead to a reduction in psychological distress that was not seen in individuals who did not engage in those behaviors (Leaman & Gee, 2011). Furthermore, these covert religious practices were shown to moderate the relationship between the torture and the development of PTSD and depression symptoms (Leaman & Gee, 2011). However, only one therapist in the current study discussed religion with the client. It is unclear why the therapists in the current study only minimally discussed this topic. Further evaluation of the research in this area may offer some clarity.

While most clients who come to therapy find it important to discuss religion in some capacity (Sperry & Shafranske, 2005), it may be only that one third of clinicians feel comfortable discussing religious topics (Shafranske & Maloney, 1990). A lack of exposure during graduate school to clients with whom they discuss issues of religious and spiritual concern may lead clinicians to not welcome, to avoid, or to be unaware of the importance of discussion of these issues during therapy (Gold, 2010). There may be some evidence to illustrate this discomfort in the therapist-participants studied. For instance, prior to the discussion of trauma, Client-Participant 5 inquired about the religious nature of the school in which the counseling center where he was receiving therapy was housed. The therapist-participant made a vague response in an effort to clarify this information, but quickly changed the topic and did not ask about why it was important for him. Her response may have demonstrated to the client her discomfort around the topic or unawareness of the importance of discussing religious when processing material that was emotionally relevant to the client (see example below from Therapist-Participant 5):

C321: What was the religion—what’s the religion this is based on again? I forget.

T322: Religion?

C322: Yeah there’s a—[Name of University clinic is associated with] is it [Christian Denomination]?

T322: I don’t know. I know it’s Christian.

C323: I know there’s so many—yeah she was that religion too, which was weird. This religion.

T324: Yeah [T shakes head] I’m not sure the specific, like denomination. I know it’s Christian based. But not sure which one. [T nods] That sounds familiar though, so maybe— maybe you’re right. Um, so before that— that time that you were with (C’s ex- girlfriend) did you have any other, like, you know, situations where you had a relationship or you were dating someone before that?

Other possible reasons for the therapist-participants in the study generally not focusing on these issues during the session have been related to the demographics of the

specific client-participants examined (i.e., two of the client-participants identified as “spiritual,” one identified as “none” for his religious beliefs, one was “unsure,” and one identified as “Christian”) or the religious/spiritual beliefs of the therapist-participants. Although the religious/spiritual beliefs of the therapist-participants were not available to the researchers, research indicates that over 95% of Americans believe in God as compared to only 30 to 50% of mental health providers (Richards & Bergin, 2005). A final reason could have been the fact that only one session was examined for each participant, and that religious/spiritual issues were discussed in other sessions.

Client struggles/difficulty. The second Parent Theme found in the content of the therapy sessions centered on client struggles/difficulties. Four of the 5 therapists in the study responded to client discussions of trauma by explicating, noticing, highlighting, and empathizing with the fact that her corresponding client was struggling in one capacity or another (e.g., “Yeah, that must be really hard.”). As referenced earlier, the trauma literature indicates that therapists who work with trauma need to attend to feelings associated with the trauma. The 4 therapists in the current study who accomplished this at various points in therapy focused on client emotions of fear/anxiety/worry and frustration/anger.

Dedicating therapeutic work to dysfunction and pathology has long been at the core of clinical psychology (Linley et al., 2006; Seligman & Csikszentmihalyi, 2000). However, more recently the field of positive psychology (as well other forms of therapy; e.g., Solution Focused Therapy) has encouraged clinicians not to solely focus on client difficulties or psychopathology, but rather incorporate a focus on recognizing and facilitating greater reliance on factors and abilities that are already present in the client

that may be protective or even facilitate growth/PTG (Linley et al., 2006; Seligman & Csikszentmihalyi, 2000). More modern research has begun to show that giving appropriate focus to an individual's positive attributes can strengthen resilience and stave off the detrimental impact of trauma (Prati & Pietrantonio, 2009; Schuettler & Boals, 2011). For instance, Rauch, Defever, Oetting, Graham-Bermann, and Seng (2011) found that among certain women, higher levels of reported optimism or hopefulness were related to lower levels of PTSD symptoms.

In the current study, 4 of the 5 therapist-participants provided responses throughout their treatment which were strength-focused and which highlighted changes the client-participant was already in the process of making (e.g., "Not everybody can still get through all those things they way you got through them"). Based on the current study, it was unclear if these types of responses were couched in a positive psychology framework, or if they might have represented interventions offered from other treatment orientations, such as behaviorism (i.e., statements to reinforce a client's efforts), a humanistic treatment model (i.e., providing unconditional positive regard), or one that did not view common trauma reactions as strictly pathological. It seems most plausible that those types of responses were guided by a desire to provide empathy and validation of the client's experience, responses that illustrate use of good general clinical skills that are typically taught to training clinicians (Sommers-Flanagan & Sommers-Flanagan, 2008). That is, acknowledging a client's struggle is an important component of most forms of psychotherapy.

Furthermore, it is important that a treating clinician recognize that while certain emotional states can mediate the manifestation of posttraumatic sequelae (e.g., shame,

guilt, helplessness), other emotional states (e.g., fear, anger, sadness) are common or even normal in the context of a traumatic event (Resick et al., 2010). As such, therapy with a population that has experienced trauma should not over-pathologize the presence of all strong emotional states in therapy, especially those which are distressing though not functionally impairing.

Summary of General Study Findings

The results of this study suggest that trainee therapists responded to discussions of trauma in some but not all ways that corresponded with various recommendations from the literature. The positive ways included, but were not limited to: validating the difficulties of the clients' struggles, helping the client reframe and make different meaning from their difficulties, developing coping and problem solving skills, evaluating strengths, and providing support, guidance and psychoeducation.

At the same time, the current literature in the field of trauma work very heavily emphasizes the importance of focusing on the source of and ways in which a trauma manifests (e.g., the event, the cognitive and emotional experience) as the primary mode of treating trauma across theoretical orientations. This study's data suggested that trainee therapists responded by focusing on the details or facts of the client's trauma more often than the client's emotional experience of it. Similarly related, the therapists tended to favor a focus on modifying cognitions and behaviors related to a trauma over emotions surrounding that trauma. Thus, although focusing on trauma factual information is valuable, a review of the trauma treatment literature appears to show that early and appropriately titrated emotional engagement with the trauma may facilitate rapport and normalization around the trauma disclosure process, which, in turn, establishes a

therapeutic setting that is favorable for accomplishing trauma treatment objectives. From a qualitative perspective, the therapists in the study provided relatively few responses to allow the clients to engage and remain engaged with the emotional valence of their presenting traumas. The behaviors seen in the therapists of this study, which may have prevented emotional processing of the trauma, included: spending time problem solving, spending too much time in topical session content, interrupting the client and/or completing the clients' sentences (which may have redirected the client away from a trauma discussion), changing the topic, and keeping the conversation factually oriented. Although such responses are not necessarily problematic, they should be used thoughtfully and with a specific purpose in mind versus potentially and tacitly moving away from trauma processing.

Moreover, in this current study, at least 4 of the 5 clients dropped out of treatment prematurely (termination data was not available for the fifth client). Each of these clients were described as "confrontational and slightly argumentative," to be "resistant to making a commitment to therapy," to have "struggled with wholly committing to the therapist's treatment plan," and to have "terminated because the client did not schedule follow up sessions." Readiness to change (discussed more next), a client's framing of his/her identity around the trauma (e.g., over-identification in a victim role, having concerns that trauma work in therapy could somehow minimize the significance of the trauma experience), therapist knowledge and abilities, and a client's motivation and expectations in therapy (some of which may be culture-bound) such as the expectation of being told what to do versus being listened to, all may have played a factor in the decisions for premature termination.

Clients entering treatment, including those who experience trauma, can present at various stages of readiness to engage in the therapeutic process; thus, treatment needs to be tailored to match this idiosyncratic client state in order for treatment to go forward (Courtois, 2004; Prochaska & DiClemente, 1982; Prochaska & Norcross, 2001; Prochaska et al., 1994). It is not clear whether the therapists in the study gauged each client's stage of readiness to engage in treatment that involved processing their trauma experiences. The current literature very strongly suggests that empirical treatments for trauma are based around the idea that discussions around the traumatic experiences are both helpful and necessary to treat the trauma. Moreover, a client's connection with affect can help motivate him/her to seek and make changes (Pipes & Davenport, 1999). In fact, up to 85% of those who experience trauma strongly desire to share their experiences with others, a process that is directly linked to both psychological and functional improvement (Foa et al., 2007; Purves & Erwin, 2004; Resick et al., 2010). However, for many who experience trauma (irrespective of its nature), the disclosure process can be difficult. In fact, simply initiating the discussion around the traumatic material can, at least temporarily, lead to increased levels of discomfort and symptomatic distress in some clients, as this process can be quite jolting and distressing (Foa et al., 2007; McNulty & Wardle, 1994), as some clients may not yet be ready to self-disclose (Higgins Kessler & Nelson Goff, 2006).

The trainee therapists who were observed in the study appeared to engage in behaviors (albeit perhaps non-consciously) that appeared to keep the client from emotionally connecting with his/her trauma. Perhaps this was to "protect" the client from the emotional distress of discussing the trauma, to shield themselves from their own

emotional activation or potential compassion fatigue. Zoellner et al. (2011) advise that it can be common for therapists, especially those who are new to treating it, to “fragilize” clients who have experienced trauma. Furthermore, the literature on training therapists who work with clients that have experienced trauma indicates that training therapists may be particularly susceptible to the impact of vicarious trauma (Adams & Riggs, 2008). Alternatively, the training therapists may have utilized alternative strategies recommended in general treatment literature, such as a non-directive Humanistic approach or supportive psychotherapy.

Limitations of the Study

One of the main challenges of an inductive content analysis is that the process of conducting it is highly flexible and involves a dynamic interaction between the data and the researchers (Elo & Kyngäs, 2007). The structure and execution of this study was no different; the researcher-participants and auditor attempted to closely adhere to the proposed methodology, in which decisions around how to code and categorize the data were made in a manner that struck a balance between objective analysis and subjective judgment. The researcher-participants and auditor kept a thorough audit trail documenting their steps and decisions to enhance transparency of the study for those interested in how it was conducted.

For example, although bracketing occurred, the researchers and auditor could not eliminate the impact of all preexisting biases and/or personal desires on coding decisions and efforts to reach consensus judgments (Harris & Lahey, 1982). More specifically, the researcher-participants clearly laid out what they believed were their own potential biases might be at the outset of the study; however, throughout the coding process it was

possible that any of the three researcher-participants was able to sway the other 2 with regard to how to code a particular talk turn. This may have been particularly salient in instances where the primary researcher-participant was the sole vote of disagreement (which occurred for only three coded talk turns) around how to code a talk turn, or when any of the three researcher-participants (all of whom were quite busy during the data collection/analysis processes) wanted to complete the coding task as quickly as possible. As such, it is possible there could have been instances where unanimous coding was recorded, but was reached only out of placating demands that existed inside (e.g., fatigue, frustration, subjective judgment based on personal experiences) and outside of the study (e.g., conducting other clinical work, family obligations, completing coursework, scheduling time to “meet” as a lab when each research-participant was living in a different time zone).

While 100% agreement was reached by the researcher-participants around how to code all but three talk-turns for the 5 therapy sessions, additional logistical issues of sharing data may have influenced the final thematic hierarchies. Because the coders lived in different states, all information was shared via email. As such, it could not be guaranteed that each conducted independent data analysis (i.e., without examining the work of the other lab members in which their own interpretations could have been anchored) before they shared their results with one another. Ideally, the coding and categorization/abstraction processes would have taken place in real-time in a face-to-face setting, per the original plans of the data collection/analysis processes, as doing so would have greatly decreased this possibility for behavioral drift amongst the researcher-participants. As such, the results of the study rely very heavily on the expectation that

each of the researcher-participants maintained fidelity to the original methodology of the study, as each indicated he/she did.

To further combat this potential for drift, the researcher-participants (a) chunked the coding and completed it in blocks of time that were not greater than 2 hours, and (b) kept a list of all potential biases that might impact the data collection and analysis processes. These biases were always discussed as they arose during the coding discussions. Major themes were tracked in the Audit Trail document, though an ongoing list of all talk turn discussions was not maintained during the study for the auditor to review. Instead, the auditor saw instances where agreement was not met amongst the team; however, as she had access to all of the coded talk turns and audited each therapy session completely, she was able to provide feedback to limit the impact on subjective biases throughout the entire data collection and data analysis processes. Additional steps that could have been taken might have included a running list of each instance of non-unanimous coding, even when a unanimous coding decision was determined through the researcher-participant deliberation processes. Additionally, the independent auditor, who was provided the audit trail document, served as a check in the entire process. Thus, researchers did their best to understand and take preventative measures to minimize their influence on the data (Ahern, 1999).

Similar to the aforementioned, another potential consequence of the coding process was that that way in which it was executed increased the potential for the research-participants to increase reliability amongst their coding choice, though decrease the accuracy of their coding (i.e., unanimous agreement around how to code a particular talk turn that did not accurately capture what was occurring in the session). As outlined

in the Coding Manual, the inductive content analysis of this study was conducted concurrent with 2 other deductive content analyses (which involved analyzing the same sessions using a closed-coding system). Additionally, the second and third research participants were each a primary research-participant on the other 2 studies. While each session for this study was coded inductively before deductively, it is possible that all three of the researcher-participant coders could have become biased by the coding processes of the other 2 studies and arrived on coding sessions in a manner that homogenized the data. However, because of the post-positivistic nature of the study and how the data were coded and analyzed, some behavioral drift was actually welcome (e.g., “lumpers” and “splitters”). Each of the researcher-participants brought his/her own unique perspective to the coding and data analysis process. Because of this, each may have initially viewed (i.e., coded and analyzed) the data in a way that confirmed his/her perspective. Furthermore, each may also have been impacted by the concurrent use of alternative coding systems that were used for the other studies. If the aforementioned were the case, though, the unique nature of the inter-related concurrent studies may also have served as a safeguard against behavior drift that made the data less accurate. In fact, throughout the coding and data analysis process, there occurred countless instances in which a final decision around how to code a single talk turn took a significant amount of deliberation (as illustrated in both the coded session transcripts and the Audit Trail), as the researcher-participants (and later the independent auditor) continuously strived towards accuracy over ease of coding.

Nonetheless, retrospectively it would be very difficult to differentiate between the types of individual influence that enhanced the findings from that which superficially

appeared helpful, but which more covertly may have adversely impacted the findings. An example of this was the handling of the coded material that did not neatly fit into an identified category. In these instances during the data analysis, the researcher-participants needed to go back and forth between the data and the identified codes to check the validity of fit into the designated categories. As this process was not linear in nature, there was increasing opportunity for biases to impact the content derived from the data. For instance, the determination of what would be considered a fact and what would be considered an emotion was, at times, difficult to define (e.g., when the therapist-participant would say “that sounds hard”). In discussions like these regarding constructs that were difficult to classify, albeit this only happened a few times during the data collection/analysis, it was not uncommon one of the researcher-participants to align with one position and at the end of the discussion reverse that stance and take the other position. For this reason, it was critical for those involved in the data analysis to identify their own biases, as well as those of the other 2 research-participants (respectively), and attempt to counter their potential negative impact through use of compensatory strategies and an internal auditing process. From this perspective, the research team and auditor did their best to maintain neutrality, a critical part of conducting an inductive analysis where it can be easy to “find” patterns in the data that support pre-existing biases

Another related limitation of the study was the time/resources available to the researcher-participants. For instance, the recruiting of session transcribers was limited by those who were able to see the advertisement for the position and those who were interested in volunteering their time for that process. Moreover, 2 of the 3 researcher-participants left the state to complete pre-doctoral internships. As such, all involved in

the study had an interest in selecting participants and getting the sessions transcribed as quickly as possible. Thus, coding practice may have been artificially limited due to the time required for the researcher-participants to address other aspects of completing this study. Additionally, there were only enough researchers to construct one team that was comprised of individuals who were invested in the study being completed as efficiently as possible. With additional time and potentially money available to the researcher-participants, additional modifications could have been made to strengthen the study's findings (see Future Directions for Research and Practice section for a detailed description how to address these limitations).

Taking steps to minimize the impact of pre-existing biases was especially important for the primary researcher-participant, who oversaw the execution of the study. As identified in the method section, prior to the study the primary researcher self-identified a potential bias around possibly “finding” results that indicated training therapists tended to favor cognitive and behavioral interventions over emotionally focused ones. The results of the current study indicated a tendency for training clinicians to do that. Of note, 4 of the 5 therapists identified themselves as having used cognitive-behavioral interventions in therapy with their respective client. Interestingly, Beck and Beck (2011) note that one of the common myths of CBT is that the therapy neglects to address the role of emotion during treatment; however, this is a misconception about the treatment model. Beck and Beck suggest that emotional change and helping clients become more aware of their emotions and how they are triggered is a central component of CBT; however, as noted by Shedler (2010), in CBT, cognitions and beliefs typically are more heavily emphasized than emotions. This type of theoretical anchoring may

account for some of the tendency for therapists, who are training in trauma treatment models, to shy away from engaging the client in emotional processing (Zoellner et al., 2011).

An additional limitation of the study is that it attempted to identify the subjective experience of another based on observable and identifiable external cues. Within psychological research and clinical practice, the construct of *trauma* contains both objective and subjective components. Although the term often refers to a specific identifiable event, more difficult to pinpoint is the degree to which an individual has an experience that he/she perceives as traumatic if it is not specifically verbalized. Through examining psychotherapy session videotapes and written transcripts, the researchers attempted to gather information that was based around these subjective experiences of trauma using descriptions of the traumatic event, evaluative content such as thoughts, attitudes, and beliefs about the traumatic event, and affective content, such as one's feelings and thoughts about the traumatic event (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker et al., 2001). However, the researchers only could identify subjective traumatic distress if (a) a client chose to verbalize thoughts or feelings about his/her trauma to the therapist, and (b) if they (the researcher-participants) agreed that the particular cognitive and affective content expressed by a client constituted a subjective experience of trauma.

Regarding client verbalizations, some people do not feel comfortable discussing their trauma(s) directly with another person. Briere and Scott (2006) affirm that avoidance symptoms of trauma can manifest in a manner that is cognitive (avoiding thoughts, memories or feelings associated with the trauma), behavioral (avoiding places

or people that might trigger distressing memories), dissociative (amnesia of the stressor), and/or partly physiological (emotionally numbing). As such, this study intentionally excluded clients whose expressions of trauma were non-verbal, not verbalized, or avoided. This fact may illustrate an important limitation to the findings of the current study: the researcher-participants for the current study chose participants, in part, based on the clients' ability to identify an event or experience as having been traumatic for him/her. It may be that therapy with clients who do not self-identify as having experienced trauma, though who upon inspection in fact have experienced trauma, may look different than that with those who are aware they have experienced trauma (e.g., the latter may be more psychologically minded or have better developed introspective abilities). Also, the way that a therapist frames a problem or treatment can affect how an individual presents in session. Individuals who are conceptually "primed" to understand their trauma in a particular way may look far different from treatment as usual with that group. For example, introducing a client to viewing his/her trauma symptoms through the lens of the PTSD diagnosis is the clinician's prescribed first step in providing either of the "gold standard" PTSD treatments (Foa et al., 2007; Resick et al., 2010).

In addition, the current study may have missed those expressions that the researchers did not recognize as experiences of subjective trauma. The ability to identify another's experience as subjectively traumatic can be a difficult task, and likely requires that a clinician/researcher have a comprehensive understanding of a variety of different types and manifestations of trauma (Courtois & Gold, 2009; Weathers & Keane, 2007). Unfortunately, as both Courtois and Gold (2009), and Bruce (2005) highlight, most doctoral training programs in clinical psychology lack curriculum-based instruction that

could better familiarize student trainees with trauma theory. This study attempted to address these possible deficits through a review of the trauma literature and collaboration during the participant selection process; however, the researchers, who are in a relatively early stage of their professional training, still may have been limited in their understanding of and ability to identify subjective trauma. Nevertheless, this limitation may be a reflection of more global difficulties in the assessment and diagnosis of trauma that go beyond possible shortcomings in clinical training programs. Although the ability to gauge the probability of something being traumatic for another person may improve with trauma education and clinical experience, even veteran clinicians may not be able to recognize and understand trauma from a client's perspective when appraising its presence/absence without client corroboration.

An additional limitation of the study is that there is no specific data available (other than through obtaining their own retrospective account) around how the treating therapists were supervised around how to treat the clients in the study or what the level of training was for the therapists who provided the treatment. Because there were no indicators in the chart documentation from which the cases were pulled regarding the level of training of the therapists (e.g., first-year, second-year, third-year), there was no way in the study to give greater or lesser emphasis to the results from one therapist over another based on level of training.

In that vein, because of the "blind" nature of therapist selection, there was no true way to identify if there were any therapist factors (e.g., years of experience; having experienced trauma themselves) that might have influenced the way in which a particular therapist responded to a client's discussion of trauma. This may be a particularly

important aspect to examine for 2 reasons. First, treatment from a cognitive-behavioral perspective (the orientation identified by 4 of the 5 therapists) often involves matching treatments with particular diagnoses. As only one of the client-participants examined met criteria for an overt trauma disorder (PTSD), it might have been that some of the therapist-participants' responses were informed by that treatment model. A limitation from this perspective is that the results of the study may be influenced by the orientation of the majority of the treating therapists. That is, in general, training therapists who explicitly identify as cognitive-behavioral may respond to trauma differently in session than trainees from other orientations (e.g., humanistic, psychodynamic), as well as from trainees who have not yet begun to crystallize their therapeutic orientation. With that said, however, the therapists who self-identified as cognitive-behavioral therapist did not always appear to be providing treatment from that orientation. Second, it may be that even among training clinicians, how treatments manifest in session may look different across participants and across orientations. For example, clients and therapists may differ in their interaction with each other depending on the client's particular diagnostic presentation. Because of the differing diagnostic presentations of the client-participants, there is not a way to determine if the diagnoses had an impact on the therapists' responses to trauma during the sessions.

Finally, this study only looked at one session and the discussion tacitly relies on the (albeit probable) assumption that the sessions were representative of the therapy work in general that each therapist conducted. There is no information gathered in this study about whether or not any therapist changed her approach in any way after the session that was viewed was conducted.

Contributions of this Study

The overarching goal of this study was to examine the clinical responses training therapists made during sessions involving discussions about trauma, in order to better understand how they respond to individuals that have experienced trauma. It is hoped that this study will contribute to the existing literature on trauma treatment and help further bridge the gap between psychotherapy research and practice.

The first contribution that this study can make to the field of trauma treatment is through the elucidation around what components of recommended treatment training therapists are using. Although the literature contains ample information about how training therapists *ought to* provide treatment to those who experience trauma, there is little research that suggests exactly *how* therapists in training accomplish this task. This study examined how actual trainee therapists responded to clients who were discussing both DSM-IV type trauma and stressful life events. Four of the 5 therapists examined explicitly identified that they provided Cognitive-Behavioral treatment with the participants (there was no data regarding the treatment approach for Therapist-Participant 4). Based on the data, the sessions for those who identified having used treatment from that orientation did include specific aspects from that treatment models (e.g., evidence for/against technique, keeping a thought log, connecting thoughts/feelings/behaviors, identifying coping skills). However, none of the therapists used a cognitive-behaviorally focused trauma treatment (e.g., PE, CPT), or followed a formal cognitive behavioral treatment protocol. Instead, those therapists appeared to use therapy that integrated supportive, cognitive, and behavioral elements, but lacked incorporation of emotions. This finding, in fact appeared true for the other therapist (who did not identify an

orientation) as well; her therapy session appeared to contain similar cognitive, behavioral, and supportive elements.

Although examining the degree to which the therapists diverged from formalized trauma treatment was beyond the scope of this study, an implication of this study's findings is that a greater emphasis needs to be placed on educating and train new therapists around trauma, as well as theoretical strategies and techniques to use, prior to allowing them to begin working with clients (Courtois, 2004). This includes the need for the field first to recognize the lack of standardization around both academic and clinical training in this area (Courtois, 2001; Courtois, 2004; Hatcher & Lassiter, 2007). Further pressure to modify training objectives must be placed on practicum, internship, and externship placement supervisors, as well as on training faculty; each of the aforementioned offers a unique training opportunity where new clinicians can have unrivaled access to supervised clinical experience (Courtois 2001; Courtois, 2004; Hatcher & Lassiter, 2007). This process might begin with an introduction to the subjective and objective components of trauma, a list of the many types of trauma that are noted in the literature, information about resilience and PTG, and information about coping strategies and differences among various ethnic groupings and cultures. Next, clinicians would receive explicit training around the potential implications that trauma can have on one's religious practices and spirituality. Therapists need to be comfortable having abstract and deeply metaphysical discussions with individuals whose understanding of humanity, the universe as a whole, etc. may have been shattered by trauma. This discussion might also necessitate training clinicians to have a broad understanding of how clients from different groupings employ spiritual and ritualistic

practices during difficult times, as these clinicians may be required to incorporate into treatment or refer clients to resources that are already present within a client's community. Finally, the aforementioned should take place within the context of both academic and supervised clinical training.

A second primary implication of the study's results related to data concerning the high dropout rates among the clients in this study. As noted above, there appears to be a need to help trainee therapists assess and address readiness to/stages of change and dropout prevention as a part of working with those who have experienced trauma. In addition, there appeared to be a disconnect between dropout rates and therapist belief about the therapeutic relationship. At least three of the therapists indicated having "easily established rapport" or "good rapport." Understanding this disparity is crucial because it may speak to a mismatch between the therapists' understanding of the clients' engagement in the treatment and their relationship, and it may have implications for (a) how training therapists conceptualize and understand the therapeutic components that constitute rapport, (b) where a client is with regard to readiness to change, (c) how training therapists frame treatment "failures," and (d) how training therapists develop skills around self-monitoring their own behavior to improve their clinical skill and adherence to recommended treatment strategies.

There may be further implications with regard to how training clinicians work with individuals from a CBT orientation. For certain depressed clients (often concurrent in individuals who experience trauma), an explicit focus on pointing out thinking deficits can lead to ruptures in the therapeutic alliance and may lead some adults to terminate CBT treatment prematurely (Seligman et al., 2006). As such, additional training around

the common misconceptions of CBT, the important role of emotion in CBT, the role of avoidance after trauma, and implications trauma on trust and therapeutic alliance building may all need to be formalized within trauma treatment training.

Moreover, while having good rapport can be an important component for therapy, it is not sufficient for working with individuals who experienced trauma. Forming a working therapeutic alliance with traumatized individuals can be particularly challenging given the highly distressing nature of discussing trauma and the implications that experiencing trauma can have on one's ability to trust others (Pearlman & Courtois, 2005; Ursano et al, 2004). However, doing so may play a crucial role in trauma treatment adherence and completion (Keller et al., 2010).

The implications of these results suggest that training programs and supervisors should be aware that training clinicians, even when well-intended, might, in service of providing valid interventions (e.g., empathizing, focusing on coping skills, discuss growth), avoid facilitating in-session engagement (by both client and therapist) with potentially distressing material. If this potentially natural emotional, psychological, or relational protective process is not addressed through didactic training or supervision, trainees may inadvertently undermine the process through which trauma resolution appears to be accomplished (i.e., via emotional engagement with the traumatic material).

Future Directions for Research and Practice

The overall hope of this research study is that it can inform the development of transtheoretical treatment recommendations to aid training clinicians in developing rapport, assessing stages of change, supporting and empowering client growth, understanding clients' objective and subjective experiences of trauma and facilitating

client emotional engagement in sessions, while not inadvertently intervening in a manner that undermines the very thing they are hoping to achieve with therapy. It is reasonable to presume that with the proper guidance around how to better understand what trauma is, and a set of clear and concrete in-session tasks, new therapists can be trained to be competent and clinically congruent in their responses during trauma treatment. This section details these tasks.

The information provided should first include some of the general mistakes training therapists make as well a set of specific behaviors that the therapist should not perform, which are derived in part from the results of the current study. A non-exhaustive list might include: include instructions to encourage the training therapist do the following: ask only one question at a time, gather as many relevant facts as possible around the trauma during the initial intake interview(s) so that the clinician can focus predominantly on processing the trauma when it is being discussed in session (versus shifting back-and-forth between processing and gathering/clarifying information), attempt to use open ended questions during therapeutic processing, maintain the session focus to increase depth (versus shifting from topic to topic), probe deeper when a client acknowledges that an emotion is present (e.g., “What is it about that that makes you sad?”), not to share personal experiences and rarely give direct advice, to prioritize and sequence in session tasks (e.g., building rapport, assessing and developing coping skills, processing the trauma), and validate the client’s experience and help him/her grow from it. More generally, therapists should consider the notion that any action of the therapist has the potential of interfering with emotional processing of trauma, which is congruent with a recommendation of PE treatment for PTSD (Foa et al., 2007).

Second, it would be helpful to evaluate where a client was with regard to his/her Stage of Change. New clinicians could be educated around ways in which they may be engaging in an aspect of treatment (e.g., encouraging a discussion of trauma; giving psychoeducation) before the client is ready to receive the intervention. Although the PTSD treatment literature indicates that the working alliance is formed through engagement with a treatment protocol and thus, trauma treatment begins immediately after conducting the trauma intake evaluation (Foa et al., 2007; Resick et al., 2010), it may be that more generally, individuals who work with clients that have experienced trauma need to have increased awareness of a client's readiness to change. Beginning therapists may assume that all clients are ready to change (as tacitly indicated with PTSD treatment models), and thus ignore the fact that the trauma treatment may necessitate a long period for the client to begin to trust the therapist, or that it is important to establish goals for treatment that are clear to both therapist and client.

Third, a study could be developed to evaluate the utility of this approach. For example, a random sample of individuals who experienced trauma and were seeking treatment would be invited to participate in a clinical research study. They would be randomly assigned to a treatment group (with therapists who received the aforementioned education/information) and a treatment-as-usual group (assigned to therapists who did not receive the information). Fidelity to the recommendations would be measured by an independent coding process (e.g., trained coders). The study participants would be administered standardized measures at each session to better understand how trauma impacted them (e.g., symptom ratings, a PTG scale) and whether or not they changed across time, and how they might have impacted the therapy. For example, this study

might include administration of a Stages of Change measure to incorporate the clients' perceptions of where he/she was in that process and how that potentially impacted the study's results. Additionally, because of the potential variability of how therapeutic orientation and client diagnosis potentially can impact the therapists' response to trauma, it could be helpful to examine clients who met criteria for only one diagnosis at the time of evaluation (e.g., PTSD, BPD), as well as to examine only therapists who align with a particular treatment orientation (e.g., CBT). Accounting for all of the abovementioned differences among clients and therapists (i.e., large sample with good statistical power), the 2 groups could be compared post-treatment to determine if there was any benefit (e.g., greater symptom reduction, longer treatment retention) to offering the aforementioned education to the providing therapists.

Finally, the research findings could benefit from post-study interviews with both the clients and therapists, asking them to identify what was helpful and problematic for them in the therapy sessions. This might include having the therapists in the study provide descriptions of the nature of the therapeutic alliance and stage of change for each client throughout the course of therapy. The therapists may also be asked to describe the treatment they provided and give their rationale for providing that treatment. Alternatively, the therapists could be shown their video tapes and asked to provide line-by-line process commentary regarding their in-session decisions and if/how they tied to any greater conceptualization of the client and his/her difficulties. The study could potentially examine how their perceptions of what they were providing matched or differed from what they were actually doing in session.

Other recommendations for future research concern methodological changes to the current study. A study could reduce the potential for researcher-participant bias by having the coding and categorization/abstraction completed by a second group of individuals who were not directly involved in the outcome of the study. These individuals would have sufficient training to be able to conduct the aforementioned processes. Their coding and analyses could be used in conjunction with the findings of the current researcher-participants (a) to provide additional data points from which to draw conclusions, and (b) as a check against the inherent biases of each of the original researcher-participants. A second auditor could also be used to minimize bias (and possibly enhance accuracy) further. Furthermore, the therapists in the current study could have their sessions qualitatively analyzed over time in order to get a broader sense of the course of the therapy, to counter-balance any findings from this study that might have been unique to the particular sessions or the therapists examined.

Additionally, as the current researcher-participants and auditor engaged in much deliberation around how to code and analyze the data, it is likely that all would have benefitted from additional practice with the processes prior to using them on the participant sessions studied. In doing this, the researcher-participants and auditor potentially could have encountered session data that improved future session coding/analyzing (e.g., findings that were more comprehensively described, identification of difficult to code material that could have been overlooked in the actual coding process) and decreased deliberation time during data collection/analysis (and thus researcher-participant fatigue related to maintaining a long process).

From that perspective, with additional resources available (e.g., time, money), the research-participants could have considered collaborating with experts in psychology and ethnic diversity during the coding and data analysis processes. Those with knowledge about the cultural backgrounds from which each of the participants came could provide an additional level of scrutiny around how to understand the data. For instance, they potentially could point out important aspects of a client-participant's behavior, which appeared benign to the current research-participants, but which reflected manifested aspects of trauma that were culturally unique (e.g., specific connotations of words used) and overlooked by the research-participants and auditor due to their limited understanding of the cultural backgrounds of the client-participants.

In addition to the abovementioned, the therapists in the current study could also be invited to engage in member checks to reveal missing information, and thus increase the trustworthiness of the results; however member checks should be used with care, as this practice has been called into question in sensitive health and mental health care settings. This type of practice has the potential to cause harm (e.g., re-exposing them to painful memories and emotions), and the potential is high for the data to be compromised by participants who do not want to say negative things about their experience or who have had phenomenological changes in their experience based on their experiences since the therapy (Goldblatt, Karnieli-Miller, & Neumann, 2011).

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APPENDIX A

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.

_____ and/or _____
 Signature of client, 18 or older Signature of parent or guardian
 (Or name of client, if a minor)

 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 Translator
Representative/Witness

Date of signing

APPENDIX B

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 2 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. Mesha 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 C

Client Information Adult Form

ID # _____

CLIENT INFORMATION **ADULT FORM

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: ____/____/____

MARITAL STATUS: MARRIED SINGLE HOW LONG? _____

DIVORCED COHABITATING PREVIOUS MARRIAGES? _____

SEPARATED WIDOWED 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

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHOLOGIST, PSYCHIATRIST, MARRIAGE COUNSELING, GROUP THERAPY, ETC.)

DATE

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

- | | |
|---|--|
| <input type="checkbox"/> ELEMENTARY/MIDDLE SCHOOL: LIST GRADE _____ | <input type="checkbox"/> VOCATIONAL TRAINING: LIST TRADE _____ |
| <input type="checkbox"/> HIGH SCHOOL: LIST GRADE _____ | <input type="checkbox"/> COLLEGE: LIST YEARS _____ |
| <input type="checkbox"/> GED | <input type="checkbox"/> GRADUATE EDUCATION: LIST YEARS OR DEGREE EARNED _____ |
| <input type="checkbox"/> HS DIPLOMA | |
| <input type="checkbox"/> CURRENTLY IN SCHOOL? SCHOOL/LOCATION:
_____ | |

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATES/DURATION
-----------	----------------------	----------------

REVISION DATE 5/18/2006

2

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, PLEASE CHECK THE "NO" BOX. IF YOU ARE UNSURE WHETHER OR NOT THE EXPERIENCE OCCURRED FOR YOU OR IN YOUR FAMILY AT

CLIENT INFORMATION **ADULT FORM

SOME TIME, PLEASE CHECK THE "UNSURE" BOX. IF THE EXPERIENCE HAPPENED TO YOU OR IN YOUR FAMILY AT ANY POINT, PLEASE CHECK THE "YES" BOX.

	SELF			FAMILY			PLEASE INDICATE WHICH FAMILY MEMBER(S)
	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	
WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, INCLUDING YOURSELF, STRUGGLED WITH:							
SEPARATION/DIVORCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT RE-LOCATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EXTENDED UNEMPLOYMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADOPTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FOSTER CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FINANCIAL STRAIN OR INSTABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEATH AND LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DRUG USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADDICTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PHYSICAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMOTIONAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RAPE/SEXUAL ASSAULT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIAGNOSED OR SUSPECTED MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SUICIDAL THOUGHTS OR ATTEMPTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SELF HARM (CUTTING, BURNING)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEBILITATING ILLNESS, INJURY, OR DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PROBLEMS WITH LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT FIGHTS AND ARGUMENTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INVOLVEMENT IN LEGAL SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CRIMINAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INCARCERATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 UNHAPPY | <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 CONFLICTED 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 HONEST/OPEN | <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 D

Telephone Intake Form

ID# _____

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

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

- 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 VIDEO AND ~~SOMETIMES AUDIO TAPED SAMPLES OF THEIR SESSIONS DURING SUPERVISION.~~
- (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 PARKING ARRANGEMENTS.~~
- I CONTACTED THE REFERRAL SOURCE AND THANKED THEM.
- (PER CLINIC POLICY) I SCHEDULED THE INTAKE SESSION.
DATE: _____
TIME: _____
THERAPIST: _____

sample

APPENDIX E

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)

Revised 12/2007

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

Revised 12/2007

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 G

Coding Manual

RESEARCH PROJECT CODING MANUAL

This training manual is intended to describe the methods of transcription and coding that will be utilized for the team's dissertation research projects. The specific therapy tapes used in the projects will be of clients and therapists at Pepperdine University clinics selected based on inclusion/exclusion criteria (e.g., individual adult clients representing diverse ethnicities, genders, religions, and presenting issues). Renee Sloane, Ani Khatchadourian, and Chris Howells (researcher-participants) will be using this data for their respective dissertations to gain a more in-depth understanding of how clients discuss trauma in therapy. Research assistants will transcribe videotaped psychotherapy sessions containing discussions of trauma identified by the researcher-participants.

This manual has 4 sections:

- I. CODING TIMING OF TRAUMA DISCUSSION INSTRUCTIONS
- II. TRANSCRIPTION INSTRUCTIONS
- III. CODING OVERVIEW
- IV. CODING STEPS FOR RESEARCHER-PARTICIPANTS

I. CODING TIMING OF TRAUMA DISCUSSION INSTRUCTIONS

The first step involves the researcher-participants identifying when trauma discussions take place during the videotapes psychotherapy session. This involves understanding the definitions of trauma as well as discussions about it.

Definition of Trauma

A broad definition of trauma includes threats to one's psychological integrity (Briere & Scott, 2006), as well as one's reactions and responses to the events themselves (Hall & Sales, 2008). Briere and Scott (2006) suggest that trauma applies to both threats to *psychological* integrity and threats to *physical* integrity, whereas definitions of trauma in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA], 2000) only apply to threatened *physical* integrity to meet criteria for a traumatic stress diagnosis.

To capture the more conservative definition of trauma as an event that threatens one's physical integrity (Briere & Scott, 2006), traumatic events consistent with DSM-IV-TR criteria in the Family Data Section of the Client Information Adult Form include: Death and Loss, Sexual Abuse, Physical Abuse, Rape/Sexual Assault, Debilitating Illness Injury, or Disability. Events subsumed under the more broad definition of trauma include events that may threaten one's psychological integrity, such as Emotional Abuse and Separation/Divorce.

II. TRANSCRIPTION INSTRUCTIONS
(adapted from Baylor University’s Institute for Oral History -
http://www3.baylor.edu/Oral_History/Styleguiderev.htm)

Research assistants will transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of therapist and/or client statements to then be coded. 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 gestures 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, use 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 2 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 2 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. Don't 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 2 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:

Coder:

Client #:

Date of Session:

C = Client

T = Therapist

Verbatim Transcript of Session	Initial Coding Impressions
T1:	
C1:	
T2 :	
C2:	
T3:	
C3:	
T4:	
C4:	
T5:	
C5:	

VERBATIM TRANSCRIPT FOR CODING TRAINING

William Miller Therapy Session from APA Series III-Behavioral Health and Counseling

Therapist: Dr. William Richard Miller
Client: Ms. S

Session Number: 1
Date of Session: xx/xx/xxxx

Introduction: This session was included in a training video for APA, entitled, “Behavioral Health and Health Counseling: William Richard Miller, PhD, Drug and Alcohol Abuse,” and was hosted by Jon Carlson, PsyD, EdD. The session that follows was transcribed verbatim, for the purposes of coder training for Pepperdine University as a part of the Positive Psychology PARC Lab supervised by Susan Hall, JD, PhD. This format will be followed for future transcribed sessions to be utilized in the actual research.

T = Therapist; C = Client

Verbatim Transcript of Session	Initial Coding Impressions
[Content Removed for dissertation publication]	

III. CODING OVERVIEW

The third step of the process involves the researcher-participant engaging in three distinct coding processes to be completed in the following order: (a) open coding for themes related to trauma, (b) therapist use of autonomy support factors, and (c) therapist use of Calhoun and Tedeschi’s (1999) recommended counseling strategies. Operational definitions and codes relevant to each process are discussed in the following sections.

A. Open Coding:

Open coding is a three-part inductive process that involves examining data and organizing it categorically and hierarchically so that it can be organized in a manner that clusters specific groupings of ideas into categories that become increasingly broad. The specific steps of the process involve: (a) identifying themes, (b) creating categories, and (c) abstraction. The researcher begins this process by examining the data and noting themes that emerge naturally.

During the first step, the researcher-participant should simultaneously watch the videotapes while reading through the corresponding section in the session transcript.

The researcher-participant should make notes and write down all thoughts/ideas about specific themes that emerge in both the content and the process of the therapy session, which answer the research question, in the margins of the transcript. The researcher participant should complete the first stage of this process as many times as necessary (i.e., multiple passes over the data) until he/she feels he/she has captured all of the relevant themes. The following techniques will be used to identify themes: analyzing repetitions in ideas, concepts, or language, the use of metaphors and analogies, transitions in process, non-verbal behaviors, and the presence of indigenous typologies (Ryan & Bernard, 2003).

Non-Exhaustive List of Open Coding Techniques to Identify Themes During Open Coding

Codes	Examples	Comments
<i>Repetitions in Ideas, Concepts, or Language</i>	a) T1: “That sounds really scary” b) T8:”It sounds like you felt afraid”	Consist of topics and language that occurs and reoccurs in the content of the therapist responses (e.g., particular words or phrases).
<i>The Use of Metaphors and Analogies</i>	T: “I wonder if, as your thoughts come to you, you could imagine them as leaves floating by in a stream, passing in and out of consciousness”	This represents therapist’s use of symbolic imagery to illustrate or explain thoughts, feelings, behaviors, or experiences in a manner that schematically resonates with the client.
<i>Transitions in Process</i>	T: “While you were talking about your feelings about the car accident, it reminds me of the time we discussed the death of your father” T5: “You seem to be getting physically uncomfortable. Would it be helpful if we stopped so that you could use some of the relaxation techniques we practiced?”	These consist of naturally occurring shifts or changes in speech. These can include changes in topic, pauses, changes in voice tone, or other verbal or non-verbal behaviors that modify the client-therapist process.
<i>Non-verbal</i>	T: (silence), (nodding) or	These might include therapist

<i>Behaviors</i>	“Um-hmm”	silences, gestures, and auditory indications of agreement and disagreement
<i>Indigenous Typologies</i>	T: “What you’re describing is a flashback, and it can consist of feeling as if you are re-experiencing the traumatic event”	These are expressions that are idiomatic and/or colloquial to the speaker. They may reflect culturally, religiously, regionally, etc., specific use of words and phrases that have been used by the therapist, but which may originate from either the therapist or the client.

Then, the researcher-participant should scrutinize data that does not already appear to have been assigned to a theme to determine whether themes appear to be missing. As multiple participants/transcriptions/sessions are being examined in this study, the researcher-participant should complete this first stage with each examined participant/transcript/session before proceeding to the second stage.

During the second stage, the researcher-participant works to organize individual themes from all transcripts and videotaped sessions categorically into clusters. Themes that are specific in nature should be grouped together based on similarities. The researcher-participant should pay attention both to similarities and dissimilarities among themes added to a cluster.

During the third stage, abstraction, the researcher-participant begins the process of abstraction, or arranging themes from the transcripts and videotaped sessions hierarchically. Specific sub-themes should be compared and grouped together into more abstract and broader categories that represent an overarching parent theme for the combined themes. The researcher-participants independently each should continue this process, moving back-and-forth between the specific subcategory level and more general levels until each one can no longer break down categories into smaller units that fall within the broader concepts, and can no longer more broadly define themes. At the end of the abstraction process, researcher-participants should compare their hierarchies with one another to evaluate them for similarity as well as disparity. Non-shared themes that are found in this checking process should be analyzed to determine if they can be re-conceptualized under a different theme, or re-categorized under a different category or branch in the hierarchy.

B. Autonomy Supportive Factors:

The second step of the coding process involves the researcher-participant coding autonomy supportive behaviors of the therapist. Operational definitions, codes, and examples of autonomy supportive behaviors can be found in the table below for the researcher-participant to use in coding therapist behaviors in the transcribed sessions: (a)

“Unconditional positive regard,” (b) “Empathy,” (c) Egalitarianism/Providing choices,” (d) “Psychoeducation,” (e) “Empowerment”, and (f) “Core Values.”

Coding System for Identifying Therapist Autonomy Supportive Factors

Identifying Use of Autonomy Supportive Factor *Unconditional Positive Regard*

Code	Example	Comments
<i>Validation</i> (Code UPR)	T: “Of course you are going to feel angry towards the man who violated you.”	The therapist explicitly states that the client is entitled to think, feel, and/or behave in the way that he or she is or wants to

Identifying Use of Autonomy Supportive Factor *Empathy*

Codes	Examples	Comments
<i>Reflecting Fact</i> (Code EMP1a)	T: “So what I’m hearing is that you kind of grew up in a warzone.” T: “What you’re saying is that there was never really someone you could look up to when you were growing up.”	The therapist reflects or rephrases or restates the client’s content or <i>factual</i> utterance Differential: EMP4a takes precedence over EMP1a if therapist response could be interpreted as both
<i>Reflecting Emotion</i> (Code EMP1b)	T: “It sounds like you felt ashamed when you told your mother about what your step-father was doing to you.”	The therapist reflects or rephrases or restates the client’s feelings or <i>emotional</i> utterance about client’s own experience Differential: EMP4b takes precedence over EMP1b if therapist response could be interpreted as both
<i>Reflecting Ambiguous Fact/Feeling</i> (Code EMP1c)	T: “It must have been really hard for you to go through that at such a young age.” T: “You seem to have a pattern of worrying about others.”	The therapist reflects or rephrases or restates the client’s verbalizations about client’s own experience; the verbalizations are neither clearly a fact nor an emotion.
<i>Nonverbal</i>	T: “I notice that when	The therapist reflects or rephrases or

<p>Referent (Code EMP2)</p>	<p>you talk about what your step-father did to you, you quickly change the subject and look away from me.”</p>	<p>restates the client’s aspects of <i>nonverbal</i> behavior</p>
<p>Shared Feeling or Experience (Code EMP3)</p>	<p>T: “There was a time after my mother passed away that I had a hard time seeing other mothers and daughters spend time together.”</p>	<p>Therapist self-discloses, making an explicit statement that he or she either shares the client’s emotion or has had/would have a similar experience</p>
<p>Understanding of Content – Cognitive (Code EMP4aTx:Ty)</p>	<p>T: “So I’m curious, how much time do you spend thinking about your step-father?” C: “I usually can’t fall asleep every night because my memories of him are on my mind.” T: “Wow, so you do think about him quite a bit.”</p>	<p>The therapist verbally communicates accurate understanding of the client’s <i>thoughts</i> or <i>situation</i> by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client (both parts must be present within 2 consecutive therapist verbal talk-turns to receive this code) Differential: This is a higher order conveyance of empathy than EMP1a; EMP4a takes precedence if therapist response could be interpreted as both.</p>
<p>Understanding of Meaning – Affective (Code EMP4bTx:Ty)</p>	<p>T: “What was that like for you? How did it feel to have people afraid of you?” C: “It felt really empowering.” T: “So part of you liked that people were afraid of you.”</p>	<p>The therapist verbally communicates accurate understanding of the client’s <i>feelings</i> by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client (both parts must be present within 2 consecutive therapist verbal talk-turns to receive this code) Differential: This is a higher order conveyance of empathy than EMP1b; EMP4b takes precedence if therapist response could be interpreted as both.</p>
<p>Understanding of Meaning – Ambiguous Fact/Feeling</p>	<p>T: “So did you feel like you worried about him all the time?”</p>	<p>The therapist verbally communicates accurate understanding of the client’s verbalizations by probing, with explicit questions, to understand more</p>

	<p>C: “Um, I’m not sure. I feel like I was just always worrying about everything.”</p> <p>T: “Yeah. Hmm, so it sounds like you felt like you could never have peace of mind.”</p>	<p>fully and reflecting verbal understanding back to client; the verbalizations are neither clearly a fact nor an emotion (both parts must be present within 2 consecutive therapist verbal talk-turns to receive this code).</p> <p>Differential: This is a higher order conveyance of empathy than EMP1c; EMP4c takes precedence if therapist response could be interpreted as both.</p>
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Identifying Use of Autonomy Supportive Factor *Egalitarianism/Providing Choices*

Codes	Examples	Comments
<p><i>Providing Choices – Therapeutic Material</i> (Code EgPc1)</p>	<p>T: “So, I’m curious what you would like to talk about today?”</p> <p>T: “We don’t have to talk about that if you’re uncomfortable with it. We can talk about anything you’d like.”</p>	<p>Therapist provides choices or allows client to direct decision-making in the context of material being discussed in sessions</p> <p>Note: This code relates to material <i>within</i> the therapy session</p>
<p><i>Providing Choices – Administrative</i> (Code EgPc2)</p>	<p>T: “Well, I can either be really directive with you, or I can take more of a ‘sit back and listen’ approach. It’s up to you.”</p> <p>T: “Would you feel more comfortable coming in every other week instead?”</p>	<p>Therapist provides choices or allows client to direct decision-making in the context of issues related to the delivery of psychotherapy services, such as appointment time, intervention options, etc.</p>

Identifying Use of Autonomy Supportive Factor *Psychoeducation*

Codes	Examples	Comments
<p><i>Providing Information – Symptoms, Theory,</i></p>	<p>T: “It is common for people who have been through what you have to avoid certain triggers of memories</p>	<p>Therapist provides information that helps to clarify the cause or effect of client’s symptoms and presenting problem in order for client to</p>

<p>Treatment (Code PSY)</p>	<p>of the event.”</p> <p>T: “It sounds like everything you’re experiencing is connected, and explains how you got here in one piece.”</p> <p>T: “There is a type of therapy approach called mindfulness skills training that might be really helpful for you to be in the present moment and not worry so much about the future.”</p> <p>T: “Having that psychological assessment done can really help clarify some of the symptoms you have been experiencing.”</p>	<p>become more aware and in control of his or her experience; therapist provides information regarding prognosis and/or treatment (or any additional services related to treatment) fully and carefully so that client may have awareness and control of his or her own experience; therapist provides information regarding a psychological theory</p>
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Identifying Use of Autonomy Supportive Factor *Empowerment*

Codes	Examples	Comments
<p>Conveying Confidence in Ability to Make Changes – Competence (Code EPW1)</p>	<p>T: “I remember you told me that you left your dad’s house as a teen because of the abuse. I really believe that if you could do that then, you can walk away from our current abusive relationship as well.”</p> <p>T: “You learned very early on to be a strong and independent woman.”</p>	<p>Therapist verbally communicates confidence in the client’s ability to make changes in a positive direction and/or reinforces strengths and positive characteristics of the client</p>
<p>Emphasizing Control (Code EPW2)</p>	<p>T: “What do you think the best decision would be for you?”</p> <p>T: “Well, how do <i>you</i> think you should handle the</p>	<p>Therapist directly acknowledges or emphasizes the client’s freedom of choice, autonomy, and right to make decisions. Therapist emphasizes or implies that no one, including therapist, knows client as</p>

	<p>situation with your brother?”</p> <p>T: “You are the only one that can decide that for yourself.”</p>	<p>well as he or she knows him- or herself. Therapist refrains from an authoritarian approach of being directing or ordering and instead promotes the decision-making abilities of the client</p>
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Identifying Use of Autonomy Supportive Factor Core Values

Codes	Examples	Comments
<p><i>Identifying/Clarifying Personal Values</i> (Code CV1)</p>	<p>T: “So it sounds to me like it is really important for you to be close to your family and feel like you are really connected with them.”</p> <p>T: “When you look at your life today, there are some things you like, like your integrity.”</p> <p>T: “I’m curious how much do you not trust other people?”</p>	<p>Therapist helps client explore what is most important to him or her, what sort of person he or she is or wants to be, what is significant and meaningful, and what he or she wants his or her life to stand for</p> <p>Note: This code may overlap with EMP1a or EMP1b</p>
<p><i>Committed Action – Setting Goals</i> (Code CV2a)</p>	<p>T: “This week, your goal can be to spend three nights with our parents, even though it might feel uncomfortable for you at first and you might start feeling anxious.”</p> <p>T: “I’m curious how you envision that changing for you?”</p>	<p>Therapist helps client set behavioral goals that are guided by his or her values</p>
<p><i>Committed Action – Effective Action</i> (Code CV2b)</p>	<p>T: “In order for you to meet your goal, what are the kinds of things you will need to that day to prepare for dinner with your parents?”</p>	<p>Therapist helps client articulate plan and steps to take effective action to achieve goals</p>

C. The third step of the process involves the researcher-participant coding the use of Calhoun and Tedeschi’s (1999) counseling strategies.

Operational definitions, codes, and examples of the following counseling strategies recommended by Calhoun and Tedeschi (1999) are located in the table below for the researcher-participant to use in coding therapist responses in the transcribed trauma discussions: (a) “Focus on listening without necessarily trying to solve”, (b) “Label growth when it is there”, (c) “Events that are too horrible”, and (d) “Choosing the right words”.

Coding System for Identifying Calhoun and Tedeschi’s (1999) Counseling Strategies

Identifying Use of a Counseling Strategy *Focus on listening without trying to solve*

Codes	Examples	Comments
<i>Minimal Encouraging</i> (Code FL1)	T: “Uh-um” or “Yes”, or nodding	Consist of all short utterances that the therapist does automatically such as saying “Uh-um” or “Yes”, or nodding
<i>Direct Encouraging</i> (Code FL2)	T: “Go on... Tell me more about that night of the rape.”	The therapist explicitly encourages the other to continue talking, such as saying “Go on”, “Continue, or “Tell me more”
<i>Reflecting Fact</i> (Code FL3a)	T: “So you went to your mother’s house after the rape, and then called the police.”	The therapist reflects or rephrases or restates the client’s content or <i>factual</i> utterance in one’s own words Note: Reflection should occur within 2 consecutive therapist talk turns immediately following client’s talk turn
<i>Reflecting Emotion</i> (Code FL3b)	T: “So you were feeling really scared at the time you decided to go to your mother’s house before calling the police.”	The therapist reflects or rephrases or restates the client’s feelings or <i>emotional</i> utterance in one’s own words Note: Reflection should occur within 2 consecutive therapist talk turns immediately following client’s talk turn
<i>Reflecting Ambiguous Fact/Emotion</i>		

(Code FL3c)		
<i>Nonverbal Referent</i> (Code FL3d)	T: “I’m noticing that as you’re telling me about the rape, you’re really anxious—you’re shaking and it’s hard for you to look at me.”	The therapist reflects or rephrases or restates the client’s aspects of <i>nonverbal</i> behavior in one’s own words
<i>Questioning on Fact- Open</i> Code FL4aF-O	T: “So you had been drinking a lot that night at the bar. Can you tell me more about that?”	Open questions are defined as those in which the therapist requests clarification or exploration without purposely limiting the nature of the response; excludes rhetorical questions
<i>Questioning on Fact- Closed</i> Code FL4cF-C	T: “How many drinks did you have that night?”	Closed questions elicit specific and limited information from the client, usually requesting a one- or two-word answer such as “yes” or “no” as confirmation of the therapist’s previous statement; excludes rhetorical questions
<i>Questioning on Emotion-Open</i> Code FL4bE-O	T: “How were you feeling that night before you started drinking at the bar?”	Open questions are defined as those in which the therapist requests clarification or exploration without purposely limiting the nature of the response; excludes rhetorical questions
<i>Questioning on Emotion-Closed</i> Code FL4dE-C	T: “Were you feeling sad or lonely at the time you went to the bar?”	Closed questions elicit specific and limited information from the client, usually requesting a one- or two-word answer such as “yes” or “no” as confirmation of the therapist’s previous statement; excludes rhetorical questions
<i>Questioning on Ambiguous Fact/Emotion</i> Code FL4amb-C/O		
<i>Trying to solve-Treatment</i>	T: “Next time you are starting to feel panic	Therapist provides a treatment focused recommendation as to an

<p>Intervention Code FLTS-T</p>	<p>before a work meeting, I want you to stop what you are doing and take 10 deep breaths.”</p>	<p>appropriate choice of action regarding a situation or problem</p>
<p>Trying to solve- Personal advice/ Opinions Code FLTS-A</p>	<p>T: “I don’t think it’s a good idea for you to leave the bar alone after having so many drinks.”</p>	<p>Therapist provides a personal judgment, belief, or conclusion held with confidence but not necessarily substantiated by positive knowledge or proof</p>
<p>Trying to solve- Ambiguous Code FLTS- Amb</p>	<p>T: “I really like the idea of you calling your mother twice per week in order to increase contact with her and to reduce your stress with the child care.”</p>	<p>Therapist provides what may appear to be both personal judgment and a therapeutic intervention.</p>
<p>Not Otherwise Specified Code NOS</p>	<p>T: “I really like the idea of you calling your mother twice per week in order to increase contact with her and to reduce your stress with the child care.”</p>	<p>Any therapist response that does not fit into a <i>any</i> specific PTG recommendation category, but appears closely related enough to warrant attention and further analysis</p>

Identifying Use of a Counseling Strategy *Label growth when it is there*

Codes	Examples	Comments
<p>Therapist verbalized positive changes that the client identified as already present (Code LGa)</p>	<p>C: In the past six months I’ve noticed that my wife has been more patient with me and has been really supportive. I am starting to realize that maybe I have underestimated her.” T: “So through this experience, your wife has been more supportive than you otherwise thought her to be.”</p>	<p>Positive changes are defined as a transformation or transition from one state, condition, or phase to another, tending towards progress or improvement</p>

<p><i>Therapist reframed the way the client viewed certain events</i> (Code LGb)</p>	<p>C: In the past six months I've noticed that my wife has been more patient with me and has been really supportive. I am starting to realize that maybe I have underestimated her.” T: “It sounds like one of the things you are discovering is that, at least in some ways, your illness and discomfort have served to bring you and your wife a little closer together.”</p>	<p>Reframe is defined as to look at, present, or think of (thoughts, beliefs, ideas, relationships, etc.) in a new, positive way</p>
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Identifying Use of a Counseling Strategy *Events that are too horrible*

Codes	Examples	Comments
<p><i>Therapist shared with the client that some individuals stated they have changed in some positive ways as they coped with their trauma</i> (Code EHa)</p>	<p>T: “Some people have found that through their struggle with their grief over the loss of their spouse, they have experienced some positive changes in their lives.”</p>	<p>Change in positive ways is defined as transforming from one state, condition, or phase to another, tending towards progress or improvement</p>
<p><i>Therapist elicited whether the client thought that this was possible for him/her given what he/she has gone through</i> (Code EHb)</p>	<p>T: “Some people have found that through their struggle with their grief over the loss of their spouse, they have experienced some positive changes in their lives. Have you ever felt that way given what you have gone through?”</p>	<p>Change in positive ways is defined as transforming from one state, condition, or phase to another, tending towards progress or improvement</p>

Identifying Use of a Counseling Strategy *Choosing the right words*

Codes	Examples	Comments
<p><i>Therapist reinforced the positive interpretations of</i></p>	<p>C: Since Amanda's death, I've been</p>	<p>Reinforced is defined as the therapist emphasizes, stresses,</p>

<p><i>growth or positive changes coming from the struggle with trauma when the client made them</i> (Code CWa)</p>	<p>trying to help other women who have lost a child by creating a support group.” T: “It seems that your struggle with Amanda’s death has led you to be more committed to helping others avoid your kind of pain.”</p>	<p>or supports when the client explains a positive meaning, significance, or change resulting from his or her struggle with trauma; the term “positive” refers specifically to indications of growth rather than just returning to psychological baseline Note: CWa differs from CWb in that CWa is client-initiated</p>
<p><i>Therapist chose to label or identify client statements reflecting posttraumatic growth with words that reflected the individual’s struggle to survive and come to terms with the event, as opposed to the event itself</i> (Code CWb)</p>	<p>C: Amanda’s death led me to become more aware of the simple things in life that I took advantage of before, like the importance of spending time with my nieces and nephews.” T: “Your <i>struggle</i> with the pain produced by Amanda’s loss has led you to be more committed to spending time with your family.”</p>	<p>Label is defined as the therapist describing or recognizing client statements reflecting his or her struggle to survive. Words synonymous with <i>struggle</i> include <i>strive, carry on, fight, wrestle, grapple, battle, contend, go up against, or put up a fight</i>. Coming to terms with the event is defined as starting to accept and deal with a difficult situation Note: CWb differs from CWa in that CWb is therapist-initiated</p>

Coding Steps for Researcher-Participants

1. Watch the videotape of trauma discussions and read the transcript all of the way through to make sure that the transcript is accurate. Familiarize yourself with the content and process of the session.
2. 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**.
3. Familiarize yourself with the open coding steps of (a) identifying themes, (b) creating categories, and (c) abstraction. Then, begin the coding process, simultaneously using

reading the written session transcriptions and watching the corresponding session videotape

4. Familiarize yourself with coding steps for (a) use of Calhoun and Tedeschi's counseling strategies and (b) autonomy support factors.
5. Begin the directed coding process for (a) use of Calhoun and Tedeschi's counseling strategies and (b) autonomy support factors.
6. Individually, read the transcript again in detail by looking at each statement (T1, T2, etc.) and write your coding impressions on the right hand column of the transcript sheet.
7. Meet with team of coders to discuss codes and determine inter-rater reliability. Codes that meet (66%) agreement will be chosen as final codes and recorded on data tracking sheet.
8. Provide auditor with final codes to determine whether the data reflective of the codes has been abstracted by the coders. The auditor will facilitate discussion with the coders regarding discrepancies that arise with the team's judgment, and provide suggestions for changes.
9. Final codes will be entered into the Excel data-tracking sheet for further analysis.

APPENDIX H

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, Christopher J. Howells, M.A., Ani Khatchadourian, M.A., and Renee Sloane, 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 I

Protecting Human Research Participants Certification



APPENDIX J

HIPAA Certification



Certificate of Completion

This is to certify that

Christopher Howells

has completed the

HIPAA Training on

Thursday, September 11, 2008

Reference No: 4627

APPENDIX K

Coding Frequency Tracking

Sub-Categories	Participant 1	<i>Talk Turn</i>	<i>Frequency</i>
Minimal Verbal Acknowledgement	3, 4, 6, 8, 10, 11, 13, 15, 17, 19, 20, 21, 24, 26, 28, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 42, 44, 45, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 64, 65, 66, 67, 68, 69, 75, 76, 77, 80, 81, 82, 83, 85, 86, 88, 89, 91, 92, 94, 95, 98, 100		65
Non-verbal Behavior Reflect Thoughts/Feelings blend	4, 6, 8, 9, 10, 11, 12, 13, 15, 17, 19, 20, 21, 23, 24, 26, 27, 28, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 66, 67, 68, 69, 70, 71, 75, 76, 77, 78, 80, 81, 82, 83, 85, 86, 87, 88, 89, 90, 91, 92, 94, 95		75

Reflect Fact	46, 54, 90	3
Reflect Feeling	63	1
Reflect Thoughts/Feelings Blend		
Reflective Listening	12, 47	2
Summarizing Statement About Facts	18, 70, 87	3
Summarizing Statements About Ct's Experience	41	1
Asking Multiple Questions at Once	43, 71, 74	3
Clarifying Fact Question (closed) or statement	7, 12, 21, 22, 93	5
Drawing Connections	74	1
Hypothetical Question		
Hypothetical Statement		
Repeating / Persisting on a Question	79	1
Question Thought/Feeling Blend	79 (closed)	1
Questioning for Facts Open		
Questioning for Facts Closed	5, 29, 74	3
Questioning on Feeling / Emotional Experience Open		
Questioning on Feeling / Emotional Experience Closed	16, 25, 43, 54	4
Rhetorical Question		
Empathic statement/response		
Encouraging more detail		
Therapist inferring client's feeling		
Validating Feelings/Response		
Answering Client's Question re: how to think about something		
Bringing back to client experience	18, 71, 79	3
Focus on Affect in the Room	25, 43, 54	3
Joining/collaborating statements		
Mirroring client's language		
Therapist Completes Client's sentence	63	1
Therapist Doesn't Finish Sentence/statement	54, 87	2
Therapist Interrupts Client	22, 41, 79, 87	4
Therapist offering opinion / advice		
Administrative Tasks		
Assigning Homework		
Th bringing in Previous Info reported by ct	25, 47, 87, 93	4
Emphasizing ct's choice	63	1

Encouraging ct self-exploration		
Focus on Mind/Body Connection	72, 73	2
Focus on Session Structure	99	1
Having ct consider others' perspectives		
Indigenous Typology	16, 79	2
Indigenous Typology Description	"unreal" (16), "pattern" (79),	3
Labeling Ct's feelings		
Metaphor	71, 73	2
Metaphor's Description	"carrying stress" (71, 73)	2
Normalizing Ct experience		
Positive Reframing / Highlighting Strength		
Problem Solving		
Providing Specific Interventions	pointing out discrepancies (87),	2
Psychoeducation	74	1
Nature of Psychoeducation	To connect mind/body (74)	1
Repetitive Theme/focus		
Subtle confrontation		
Transition in Process (TIP)	14, 18, 25, 43, 72, 93	6
Transition in Process Description	Clarification of emotion (14), Return to ct experience in room (18), Return to ct experience in room (25), Return to ct experience in room (43), Return to ct experience in room (54), Focus on mind/body connection (72), Commenting on a pattern (93),	
Focus of the session (overview)		
My analyses, thoughts, interpretations	Th does not f/u on affect questions not answered, use of non-specific emotion language "stress," 2 traumas and minimal focus on the traumas themselves, back-and-forth dynamic of interrupting / not finishing thoughts/sentences by ct and th, A lot of thinking about what I would do in the talk turns, tired, can't recall how to code, worried about getting findings that are helpful, Other Stuff?	

Sub-Categories	Participant 2 <i>Talk Turn</i>	<i>Frequency</i>
Minimal Verbal Acknowledgement	94, 95, 97, 99 101, 102, 103, 113, 115, 118, 119, 120, 122, 123, 124, 126, 127, 133, 134, 135, 138, 144, 158, 160, 161, 162, 164, 166, 176, 177, 179, 184, 194, 204, 219, 220, 225, 226, 230, 233, 234, 235, 237, 248, 256, 258, 260, 266	47
Non-verbal Behavior	93, 97, 98, 99, 103, 113, 115, 119, 120, 133, 135, 144, 145, 149, 150, 151, 161, 164, 166, 168, 172, 173, 176, 177, 179, 180, 181, 182, 188, 193, 194, 196, 199, 201, 204, 207, 208, 213, 219, 220, 223, 225, 226, 229, 234, 235, 237, 238, 239, 240, 245, 248, 249, 252, 253, 254, 257, 259	58
Reflect Thoughts/Feelings blend	207	1

	91, 93, 102, 114, 130, 145, 146, 147, 163, 167, 171, 172, 180, 181, 182, 185, 187, 192, 196, 197, 201, 202, 211, 218, 221, 222, 228, 236, 237, 238, 243, 249, 257, 259, 266	35
Reflect Fact		
Reflect Feeling	91, 136, 148, 149, 150, 155, 163, 181, 183, 187, 188, 263	12
Reflect Thoughts/Feelings Blend		
Reflective Listening		
Summarizing Statement About Facts	129, 148, 163, 182, 187, 195, 196, 245, 253	9
Summarizing Statements About Ct's Experience	163, 182	2
Asking Multiple Questions at Once	98, 131, 132, 136, 142, 143, 150, 151, 157, 168, 217, 223, 224, 239, 240, 245, 250	17
Clarifying Fact Question (closed) or statement	116, 140, 156, 175, 190	5
Drawing Connections		
Hypothetical Question	217	1
Hypothetical Statement		
Repeating / Persisting on a Question	246	1
Question Thought/Feeling Blend	91, 251	2
Questioning for Facts Open	93, 121, 143, 151, 152, 157, 170, 214, 238, 240, 241, 245	12
Questioning for Facts Closed	100, 101, 104, 105, 106, 108, 109, 110, 111, 112, 117, 125, 128, 131, 132, 137, 139, 142, 143, 151, 153, 154, 159, 165, 168, 174, 185, 186, 189, 191, 193, 195, 197, 198, 199, 202, 201, 203, 204, 205, 206, 213, 215, 217, 220, 221, 222, 223, 224, 228, 231, 232, 239, 246, 247, 255	56
Questioning on Feeling / Emotional Experience Open	136, 216	2
Questioning on Feeling / Emotional Experience Closed	96, 98, 142, 169	4
Rhetorical Question	204	1
Empathic statement/response	148, 149, 155	3
Encouraging more detail		
Therapist inferring client's feeling	163	1
Validating Feelings/Response	147, 148, 150, 163, 181, 252	6

Answering Client's Question re: how to think about something		
Bringing back to client experience		
Focus on Affect in the Room	92, 163, 168	3
Joining/collaborating statements		
Mirroring client's language	100, 140, 244	3
Therapist Completes Client's sentence	153	1
Therapist Doesn't Finish Sentence/statement	93, 117, 125, 132, 136, 142, 145, 150, 151, 166, 168, 183, 213	13
Therapist Interrupts Client	185, 228, 232, 257	4
Therapist offering opinion / advice	91, 147, 150, 173, 181, 197, 209, 212, 250, 252, 253, 254, 259, 262, 263, 264, 267, 268	18
Administrative Tasks	264 (asking about ct exp of therapy)	1
Assigning Homework		
Th bringing in Previous Info reported by ct	106, 107, 150, 209	4
Emphasizing ct's choice		
Encouraging ct self-exploration	241, 250	2
Focus on Mind/Body Connection		
Focus on Session Structure	264	1
Having ct consider others' perspectives		
Indigenous Typology	98, 136, 267	3
Indigenous Typology Description	"release" (98), "coping" (136), "practice" (267, 268)	4
Labeling Ct's feelings		
Metaphor	207, 208	2
Metaphor's Description	"bring you down" (207), "come down from there" (209)	2
Normalizing Ct experience		
Positive Reframing / Highlighting Strength	148, 181, 182, 197, 201, 203, 236, 240, 245, 249, 252, 253, 254, 259	14
Problem Solving		

Providing Specific Interventions	evidence for/against (198, 220), previous intervention reinforced (215, 267)	4
Psychoeducation	267, 268	2
Nature of Psychoeducation	To help ct see that session is a place to practice difficult tasks (267 268)	2
Repetitive Theme/focus	107 (on details recalled), 134 (love), on ct's experience in the room (168), violence (196, 199, 201, 203, 237), rhetorical questioning (204), calming down (208), having ct weigh evidence (220), hypothetical behavioral planning (223), what does this mean about you? (238, 240, 245, 250), Positively reframing things (259)	17
Subtle confrontation	243	1
Transition in Process (TIP)	99, 101, 114, 130, 136, 150, 151, 163, 167, 198, 201, 209, 213, 217, 263	15
Transition in Process Description	Asked a different fact-based question (99), Asked a different fact-based question (101), Teaching ct English (114), To give advice (130), To ask about ct's current, coping (136), to ask ct about what she was feeling at a time in the past (150), to assess for SI (151), To focus on what Th was hearing ct say, to validate, to focus on something ct said earlier (167), to examine evidence for/against (198), To positively reframe (201), To ask about coping skills taught (209), asked ct if she recalls what Th said in past (213), to ask about how ct would handle a hypothetical situation (217), To end session (263),	

Focus of the session (overview)
<p data-bbox="280 1276 609 1350">My analyses, thoughts, interpretations</p>

This therapist is very informal with the client, Spends a lot of time reviewing the BDI with ct, Th's Spanish used with the ct is only intermittently helpful, Th semantically uses "right" as if she already knows the answers to her questions, Not following up with emotion questions beyond first level responses, "You have the right to be/feel," Leading and rhetorical questions, Th appears to be telling pt "here's how it is," Repetition on themes brought up by ct, checked in ith t re: how the therapy process is going, back-and-forth dynamic of interrupting / not finishing thoughts/sentences by ct and th.

Participant 3

Sub-Categories	Talk Turn	Frequency
	100, 101, 102, 103, 104, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 142, 143, 144, 146, 147, 148, 150, 151, 152, 153, 154, 156, 157, 158, 159, 160, 162, 163, 164, 165, 166, 168, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 186, 187, 188, 189, 190, 192, 193, 194, 195, 196, 197, 198, 199, 200, 202, 203, 204, 205, 109, 210, 211, 213, 214, 215, 217, 218, 219, 222, 223, 224, 228, 229, 230, 232, 236, 239, 244, 247, 255, 256, 258, 260, 263, 264, 265, 268, 270, 275, 276, 278, 281, 282,	
Minimal Verbal Acknowledgement	283, 284, 287	129
	68, 94, 95, 96, 97, 99, 100, 101, 102, 103, 105, 107, 109, 110, 111, 112, 113, 115, 116, 117, 118, 119, 121, 122, 123, 124, 126, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 138, 139, 140, 142, 143, 144, 146, 147, 148, 151, 152, 153, 154, 156, 157, 158, 159, 160, 162, 164, 165, 166, 167, 168, 170, 171, 172, 173, 174, 175, 176, 177, 178, 180, 182, 185, 186, 187, 188, 189, 190, 192, 193, 194, 195, 196, 197, 198, 199, 200, 203, 205, 206, 208, 209, 210, 211, 214, 215, 224, 229, 232, 233, 236, 239, 247, 250, 253, 255, 256, 258, 261, 263, 264, 270, 274, 275, 276, 277,	
Non-verbal Behavior	279, 282	116
Reflect Thoughts/Feelings blend	125, 134	2

	100, 101, 116, 141, 183, 201, 202, 204, 206, 209, 210, 214, 219, 225, 227, 228, 232, 239, 240, 246, 248, 249, 258, 261, 267	25
Reflect Fact		
Reflect Feeling	38, 221, 232, 240, 257, 258, 274	7
Reflect Thoughts/Feelings Blend	191, 226	2
Reflective Listening		
Summarizing Statement About Facts		
Summarizing Statements About Ct's Experience		
Asking Multiple Questions at Once	235	1
Clarifying Fact Question (closed) or statement	216, 238	2
Drawing Connections		
Hypothetical Question	205, 233, 251	3
Hypothetical Statement	101	1
Repeating / Persisting on a Question		
Question Thought/Feeling Blend	18, 211, 229, 240, 245	5
Questioning for Facts Open	57, 65, 79, 149, 195, 206, 233, 237, 240	9
Questioning for Facts Closed	40, 45, 98, 134, 169, 175, 215, 227, 234, 235, 236, 241, 242, 255, 274, 280	16
Questioning on Feeling / Emotional Experience Open	23, 117, 185, 202, 266	5
Questioning on Feeling / Emotional Experience Closed	39, 235	2
Rhetorical Question		
Empathic statement/response		
Encouraging more detail		
Therapist inferring client's feeling	31	1
Validating Feelings/Response	38, 221, 248	3

Answering Client's Question re: how to think about something		
Bringing back to client experience		
Focus on Affect in the Room		
Joining/collaborating statements	"we" (250)	1
Mirroring client's language	98, 134, 167	3
Therapist Completes Client's sentence	42, 167, 280	3
Therapist Doesn't Finish Sentence/statement	42, 116, 141, 145, 180, 183, 191, 235, 236	9
Therapist Interrupts Client	141, 226, 227	3
Therapist offering opinion / advice	69, 105, 145, 175, 201, 208, 214, 239, 243, 249, 269, 270, 277	13
Administrative Tasks		
Assigning Homework		
Th bringing in Previous Info reported by ct		
Emphasizing ct's choice	206	1
Encouraging ct self-exploration		
Focus on Mind/Body Connection		
Focus on Session Structure	249, 250, 251, 268, 286	5
Having ct consider others' perspectives	155 (family)	1
Indigenous Typology	214, 273, 279, 287	4
Indigenous Typology Description	"individualistic / collectivistic" (214), "behavioral strategies" (273), "open up for you" 297), "cognitive behavioral" (287)	4
Labeling Ct's feelings		
Metaphor		
Metaphor's Description		
Normalizing Ct experience		
Positive Reframing / Highlighting Strength		
Problem Solving	202	1

Providing Specific Interventions	pros/cons exploration (65), having ct bring pen/notebook for handouts (249), assigning homework (251)	3
Psychoeducation	251, 252, 253, 268, 269, 270, 271, 273, 279, 286	10
Nature of Psychoeducation	to highlight connection between thoughts/feelings, bx (251, 252, 253, 268, 269, 270, 273, 279, 286); to educate around a specific intervention to change thoughts/feelings/bx (271),	10
Repetitive Theme/focus	relocation (45, 79), worry (53, 100, 209), comparing countries/cultures (65, 106, 149, 214, 251), community (125, 149), having ct do what he would like / discuss his desire to stay in US (207, 240, 241, 243, 277, 271, 274), taking care / responsibility of (245, 246), Psychoeducation (251, 252, 253, 268, 269, 270, 273, 279, 286)	30
Subtle confrontation		
Transition in Process (TIP)	79, 226, 228, 237, 240, 249	6
Transition in Process Description	Ask about meaning of staying in US (79), move out of content to focus on ct's struggles this week - specific to general (226, 228), to ask about what's helpful in decision making process (237), Th abruptly returns to having ct speak to family about his desire to stay living in US (240), to end session (249),	
Focus of the session (overview)		

**My analyses, thoughts,
interpretations**

back-and-forth dynamic of interrupting / not finishing thoughts/sentences by ct and th., Maybe this is culturally competent w/in Armenian culture, Th explores having ct move his family to US (pursues this strongly), Th is getting cut off by the ct and does not always appear to be getting her questions answered, Th recommends ct do what he wants to do independent of his family,

Sub-Categories	Participant 4 <i>Talk Turn</i>	<i>Frequency</i>
Minimal Verbal Acknowledgement	28, 29 30, 33, 35, 39, 42, 43, 46, 47, 53, 58, 65, 66, 67, 70, 72, 76, 77, 79, 80, 84, 90, 91, 94, 95, 96, 97, 100, 101, 103, 106, 107, 108, 109, 113, 114, 116, 135, 136, 139, 142, 150, 157, 158	44
Non-verbal Behavior Reflect Thoughts/Feelings blend	31, 32, 37, 40, 43, 44, 45, 47, 48, 52, 53, 55, 58, 60, 63, 64, 66, 67, 70, 72, 77, 85, 87, 94, 96, 97, 103, 107, 108, 109, 113, 114, 123	33

Reflect Fact	44, 90, 118, 151, 152	5
Reflect Feeling	104, 128, 130, 140, 156	5
Reflect Thoughts/Feelings Blend	132	1
Reflective Listening		
Summarizing Statement About Facts	89, 102	2
Summarizing Statements About Ct's Experience	151	1
Asking Multiple Questions at Once	82,	1
Clarifying Fact Question (closed) or statement	78, 111, 123	3
Drawing Connections	98	1
Hypothetical Question		
Hypothetical Statement	62	1
Repeating / Persisting on a Question	67, 131, 132	3
Question Thought/Feeling Blend	99, 126, 134, 153	4
Questioning for Facts Open	36, 64, 67, 75, 119, 122, 128, 129, 131, 143, 145, 155	12
Questioning for Facts Closed	36, 38, 40, 41, 45, 59, 68, 74, 83, 92, 93, 112, 124, 125, 144, 146, 159, 160	18
Questioning on Feeling / Emotional Experience Open	96, 149	2
Questioning on Feeling / Emotional Experience Closed	86, 87, 133, 154	4
Rhetorical Question		
Empathic statement/response	81, 90, 115, 117, 120	5
Encouraging more detail		
Therapist inferring client's feeling	156	1
Validating Feelings/Response	31, 32, 70, 90, 104, 118, 140	7

Answering Client's Question re: how to think about something		
Bringing back to client experience		
Focus on Affect in the Room		
Joining/collaborating statements	"we" (63)	1
Mirroring client's language	37, 99	2
Therapist Completes Client's sentence	40, 83, 92	3
Therapist Doesn't Finish Sentence/statement	148, 151	2
Therapist Interrupts Client	34, 68, 92, 102, 112, 125, 127	7
Therapist offering opinion / advice	31, 48, 50, 55, 57, 67, 70, 73, 89, 128, 129, 152	12
Administrative Tasks	159, 160 (helping ct out of the office)	2
Assigning Homework		
Th bringing in Previous Info reported by ct	98, 128, 141	3
Emphasizing ct's choice	62	1
Encouraging ct self-exploration	131	1
Focus on Mind/Body Connection	52	1
Focus on Session Structure		
Having ct consider others' perspectives		
Indigenous Typology	52, 55, 60, 62, 138	5
Indigenous Typology Description	"connection" (52), "technique" (55), "disconnected" (60), "subconsciously/consciousness" (62), "parallel" (138), "what have you done with those feelings?" (153)	6
Labeling Ct's feelings	81	1
Metaphor	72, 146	2
Metaphor's Description	"Free your mind a little bit and let go of some of those feelings" (72), "you don't have that bag of potato chips to give to other people to make them continue to help you" (146)	2
Normalizing Ct experience		
Positive Reframing / Highlighting Strength	85, 88	2
Problem Solving		

Providing Specific Interventions	Journaling (48), connecting past and present (98, 128, 133)	4
Psychoeducation	52, 55, 57, 127	4
Nature of Psychoeducation	to connect thoughts/feelings/bx (52); to emphasize intervention to change thoughts/feelings/bx (55, 57, 127)	4
Repetitive Theme/focus	Focus on ct's coping (45, 48, 52, 62, 71, 153), psychoeducation (55, 57, 127), theme of loss (127), ct feeling like a "burden" (128), fear (154)	12
Subtle confrontation		
Transition in Process (TIP)	34, 44, 74, 98, 126, 128, 141, 146, 151, 159	10
Transition in Process Description	To ask how a medication is helping with a sx other than those ct is talking about (34), To focus on ct's coping (44), To ask when pt's surgery is (74), to connect past and present around being "clumsy" (98), To highlight theme of loss (126), to identify theme of ct feeling like a burden (128), To bring in past info (141), to reflect on current situation (146), to highlight changes ct has made (151, 155), to end session (159),	

Focus of the session (overview)
<p>My analyses, thoughts, interpretations</p>

back-and-forth dynamic of interrupting / not finishing thoughts/sentences by ct and th., "right" - as if knows the answer already, much of the session is content driven and operates in a Q & A fashion, Th repeats herself in a variety of ways around the journaling intervention,

Sub-Categories	Participant 5 <i>Talk Turn</i>	<i>Frequency</i>
Minimal Verbal Acknowledgement	219, 221, 223, 225, 226, 227, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 241, 244, 245, 246, 247, 249, 251, 252, 253, 255, 256, 262, 263, 264, 265, 266, 268, 270, 274, 275, 276, 277, 278, 279, 281, 283, 284, 285, 287, 288, 290	47
Non-verbal Behavior	219, 221, 223, 224, 227, 230, 231, 232, 233, 234, 236, 237, 242, 245, 246, 249, 251, 252, 255, 256, 262, 263, 265, 266, 267, 268, 270, 271, 275, 276, 277, 279, 280, 281, 288, 290	36
Reflect Thoughts/Feelings blend	259	1

Reflect Fact	228, 261, 270, 289, 291	5
Reflect Feeling	243, 272	2
Reflect Thoughts/Feelings Blend	239, 269, 270	3
Reflective Listening		
Summarizing Statement About Facts		
Summarizing Statements About Ct's Experience		
Asking Multiple Questions at Once		
Clarifying Fact Question (closed) or statement		
Drawing Connections		
Hypothetical Question		
Hypothetical Statement		
Repeating / Persisting on a Question		
Question Thought/Feeling Blend	254, 259	2
Questioning for Facts Open	236	1
Questioning for Facts Closed	229, 270, 271	3
Questioning on Feeling / Emotional Experience Open		
Questioning on Feeling / Emotional Experience Closed		
Rhetorical Question		
Empathic statement/response	224	1
Encouraging more detail	220	1
Therapist inferring client's feeling		
Validating Feelings/Response	231, 234, 257, 264, 274	5

Answering Client's Question re: how to think about something	234, 241, 280, 290	4
Bringing back to client experience	254	1
Focus on Affect in the Room	264	1
Joining/collaborating statements	272, 288, 289 -- ("we")	3
Mirroring client's language		
Therapist Completes Client's sentence	242, 243	2
Therapist Doesn't Finish Sentence/statement	236, 239, 270, 271, 280, 282	6
Therapist Interrupts Client	267, 269, 282	3
Therapist offering opinion / advice	242, 243, 247, 257, 270, 272, 273, 274, 280, 282, 286, 288	12
Administrative Tasks		
Assigning Homework		
Th bringing in Previous Info reported by ct		
Emphasizing ct's choice		
Encouraging ct self-exploration		
Focus on Mind/Body Connection		
Focus on Session Structure		
Having ct consider others' perspectives		
Indigenous Typology		
Indigenous Typology Description		
Labeling Ct's feelings		
Metaphor	267, 289, 291	3
Metaphor's Description	"it's like all rushing up." (267), "woke you up" (289, 291)	3
Normalizing Ct experience	288	1
Positive Reframing / Highlighting Strength	291	1
Problem Solving		

Providing Specific Interventions		
Psychoeducation		
Nature of Psychoeducation		
Repetitive Theme/focus		
Subtle confrontation		
Transition in Process (TIP)	236, 254, 264, 270, 274	5
Transition in Process Description	Asks fact question about situation surrounding friend's death (236), bring back to how ct handled friend's death (254), to bring to affect in the room (264), away from affect to Q fact (271), for Th to give opinion about death/loss and how she would deal with it (272), to thank ct for sharing his experience (274),	

Focus of the session (overview)
<p>My analyses, thoughts, interpretations</p>

back-and-forth dynamic of interrupting / not finishing thoughts/sentences by ct and th., "right" - as if knows the answer already, much of the session is dedicate to the pt's details/content, Th appears to be trying very hard to normalize ct's experience, Th's focus appears to be more on emotion and ct's on experiencing stress related to the logistics of dealing with someone dying, ct and th appear to be engaging in a flirtatious manner, Th uses her opinion to inform the way she encourages ct around how to handle the trauma, Session only briefly focuses on the trauma and Th abruptly shifts focus on session back to discussing ct's issues of trying to find a girlfriend, ct appears to create points of intervention where appears to have questions, but they go unanswered; Therapist (232) misses an opportunity to bring the therapy deeper to communicate the traumatic nature of the friend's death.

APPENDIX L

Theme Hierarchies

Parent Theme	Categories	Sub-Themes	Sub-Theme Description	Sub-Theme Example Quote:
<p>Establishing a Mutual Understanding of Client Experience - processes whose aim is to increase the therapist's awareness of the client's perspective and help the client know that the therapist understands him/her</p>	<p>Questioning to enhance their understanding</p>	<p>Question Fact Closed</p>	<p>Therapist asks a closed-ended fact-based Question</p>	<p>So has his brother—your brother- in-laws brother moved to Spain? (CP3; T179)</p>
		<p>Question Fact Open</p>	<p>Therapist asks an open-ended fact-based Question</p>	<p>Now what is your community like here? (CP3; T149)</p>
		<p>Encouraging more detail</p>	<p>Therapist elicits more details from the client</p>	<p>Can you tell me a little more about your friend? (CP5, T220)</p>
		<p>Question Feeling Closed</p>	<p>Therapist asks a close-ended feeling-based Question</p>	<p>Does it bring up any regret for you not being in (location)? (CP1; T43)</p>



	Question Feeling Open	Therapist asks an open-ended feeling-based Question	Um, so do you think that, how do you feel about bringing it up now to her next time you talk to her? (CP3; T202)
	Question Thought/Feelin g Blend (closed and open)	Therapist asks an open/closed Question about something not clearly fact or feeling	What horrified you about it? (CP4; T99)
Reflecting / checking understanding with client	Clarifying Facts (closed Question or statement)	Therapist follows up to probe for additional specific detail	Cause you said you had several frustrating experiences during the day? (CP4; T59)
	Reflect Thought/Feelin g Blend	Therapist mirrors back client's words that describe something not clearly fact/emotion	So it helps to bring you down. (CP2; T207)
	Reflective Listening	Therapist more comprehensivel y repeats back statements of client	C: Not like totally okay, but just, you know, kind of handle it; T: Kind of handling it? (CP2; T100)



Reflect Fact In similar/alternate words, Therapist mirrors back facts expressed by client
 It sounds like you have a lot of pressure to stay within your community. (CP3; T225)

Reflect Feeling In similar/alternate words, Therapist mirrors back feelings expressed by client
 So it kind of depressed you in that situation. (CP3; T257)

Summarizing Facts Therapist provides summary of fact-based info given by client
C: I tried A, B, C, and D; **T:** It sounds like you tried a few different things

Summarizing Feelings Therapist provides summary of feeling-based info given by client
C: And that's really sad. I'm really gonna, you know, just get on my nerves and [T touches face] I feel like I'm going to punch her or something, cause, you know?; **T:** You felt really upset, I know. (CP2; T149)

Providing Guidance and Support - The therapist acting in the role of advisor/consultant to help reduce client distress, enhance client insight, acknowledge client efforts, and normalize client experience

Objective/Intervention Focused

Using Specific Interventions

Specific theoretical interventions are utilized by the Therapist

I want you to think of it this way, so we have all this evidence, right? (CP2; T198)

Providing Psychoeducation

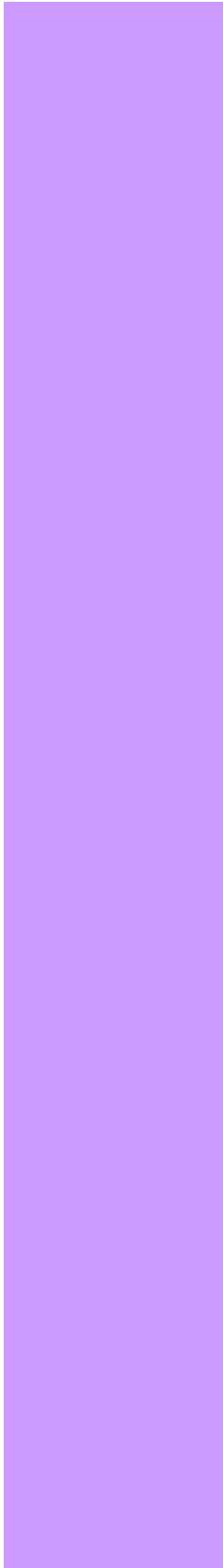
Therapist gives research-driven psychoeducation

If you find yourself feeling a certain way, it's a way to distract yourself and stop those negative thoughts that are leading to that. (CP3; T271)

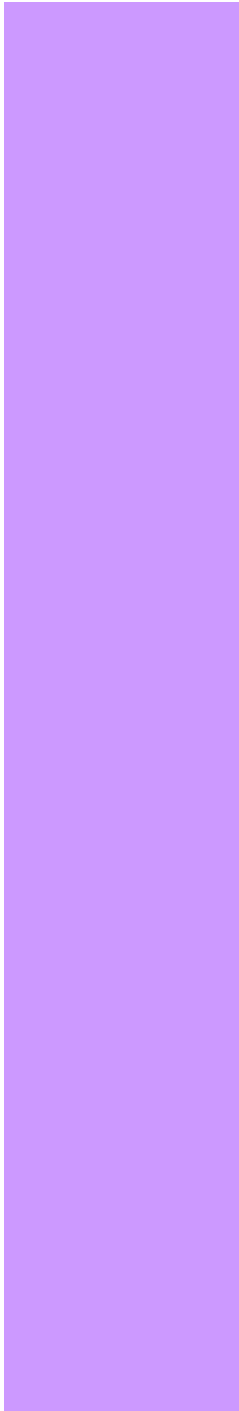
Rhetorical Question

Therapist uses rhetorical or leading questions to summarize client info provided and guide client decisions/choices

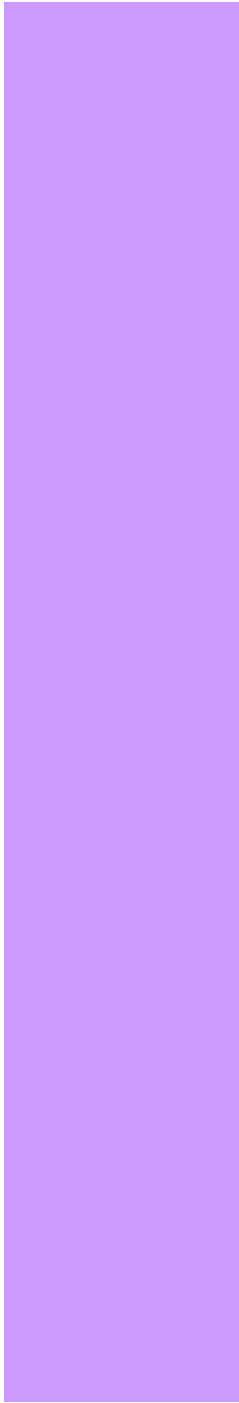
T: But do you ever, do, have you ever felt like you're gonna hurt him, like try to hurt him?; C: No; T: No. Okay. So is it, have you ever felt out of control, like you might hurt him? (CP2; T205)



		Mind/Body connection	Therapist highlights connections between mental/physical distress	There's a connection to the things that upset you and your scratching. (CP4, T52)
		Giving client other material to consider	Therapist ties in similar material that has been provided by client	Do you think bringing your family here is something that can happen? (CP3; T175).
		To point out patterns	Therapist highlights repetitions in the client's thinking/behavior	Because you have this pattern of not really taking care of yourself (CP1, T79)
Subjective/Personal	Providing Opinions		Therapist gives his/her own opinion about something	He's very special, you know. (CP2; T262)
		Giving Advice	Therapist gives client advice not based on data/research	Or maybe your sister could help also and maybe help support you, even though she is over there and help with your mom and making her a little less anxious about you being here? (CP3; T243)



Drawing Connections between past and present	Therapist explicitly links past/present experiences of client based on therapist's evaluation	Isn't that kinda what you did when your other brother died? (CP3; T93)
Asking Leading Question	Therapist steers client in a pre-determined direction	What about as a child and coming into your new family and maybe not feeling worthy? (CP4; T133)
Labeling Ct's feelings	Therapist gives suggestions of feelings client appears to be experiencing Therapist giving answers to client Questions, which are based on personal life/opinions/beliefs	It sounds very scary to me (CP4; T81)
Answering Question from personal experience		C: You know what I mean?; T: Yeah, of course (CP5; T234)
Therapist inferring client feeling	Therapist speculating about what client could be feeling	That must have been, in some ways, comforting (CP3; T31)



Supportive/Validating/Empathic

Normalizing
Ct's experience

Normalizing
client's
experience

Yeah. It's—it's
very normal
when we—
someone close
to us passes
away to start
thinking about
all these things.
(CP5; T288)

Empathic
Statement
/Response

Statement that
communicates
understanding
of client's
experience

Must have been
terrifying (CP2;
T155)

**Validating
Feelings/Response**

Therapist
statement to
justify client's
experience

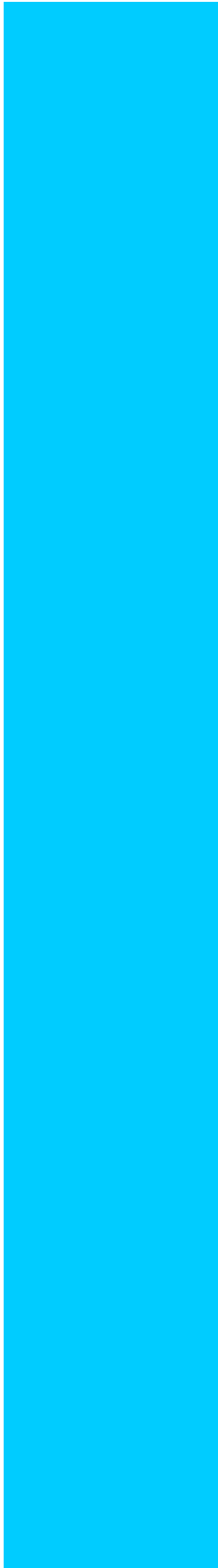
But even the
thought of
losing a toe.
That's a loss
(CP4; T127)

**Giving
Opinion to
Validate
Emotion**

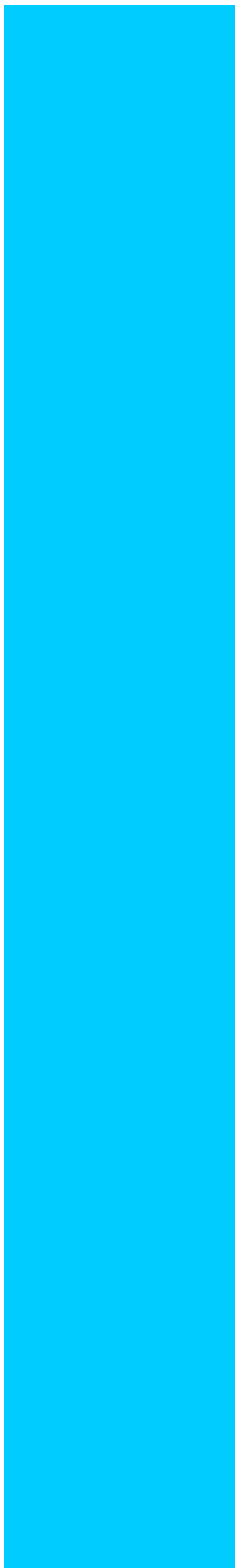
Therapist
justifies client's
experience
based on
therapist's
opinion

You recognize
that you're
different than
your family,
they're crazy,
[T make air
quotes around
'crazy'] sounds
like, I mean not
even in quotes,
they sound
crazy and they
do terrible
things (CP2;
T181)

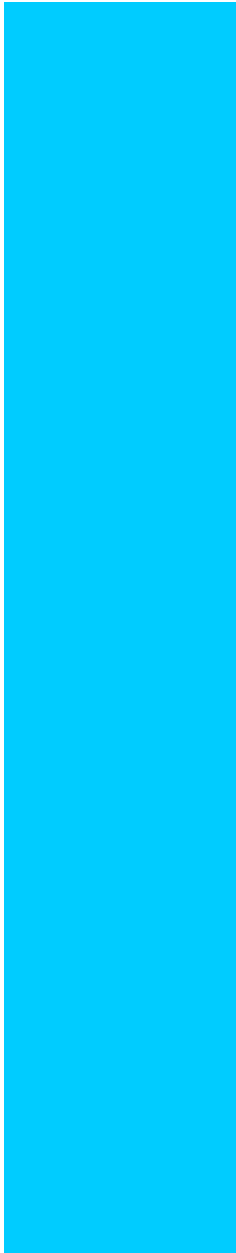
<p>Encouraging Alternative Processing - Therapist purposefully having the client examine a problem/situation/issue from a different perspective</p>	<p>Reframing of Problems</p>	<p>Having client consider others' perspective</p>	<p>Therapist encouraging client to shift perspective</p>	<p>How did—how do they survive in—in Istanbul if they don't work and aren't married? (CP3; T195)</p>
		<p>Indigenous Typology - to introduce psychological concepts</p>	<p>Therapist communicates psychological constructs and language</p>	<p>It's called behavioral strategies that you can use. It's about changing things in your environment to make you feel better. (CP3; T273)</p>
	<p>Metaphor</p>		<p>Therapist uses metaphor to illustrate a concept</p>	<p>Is it that you, metaphorically, that you don't have that bag of potato chips to give to other people to make them continue to help you? Because you are in sort of a helpless situation and you're going to just receive-- (CP4; T146)</p>



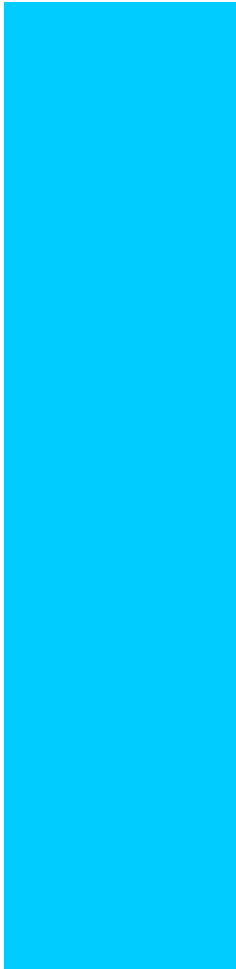
Visualizing/Hypothesizing	Hypothetical Question	Therapist asks a what if... Question	And what would happen if she started yelling at you or approaching you and was aggressive, what would you do? (CP2; T223)
	Hypothetical Statement	Therapist suggests the occurrence of something that has not happened	So maybe is you know you are going through frustrating experiences write them down. Even when you are having your cup of tea, do a little writing and see where that takes you. (CP4; T62)
Planning / Action	Problem Solving	Therapist helps client systematically seek a solution for a problem	Or maybe your sister could help also and maybe help support you, even though she is over there and help with your mom and making her a little less anxious about you being here (CP3; T143)



Strength-focused Responding	Suggesting Possible Outcome	Therapist helps client explore potential consequences for actions taken	So maybe because other people are branching out you think that your family might be more willing to come here (CP3; T183)
	Defer to client's decision making	Therapist encourages client to choose him/herself	And so it sounds like it comes down to your own decision. What you want. If you want to stay here, or go back there. (CP3; T206)
	reinforce client's solution	Therapist validates client's efforts/decision Therapist uses language to show he/she and client are working together towards a common objective	So that's a very solid belief then, [T taps right fist into left palm] and that's stayed with you all this time (CP2; T249) So those questions of "why?" is what we will be looking at in our sessions together. (CP3; T285)
collaborating with client			



thank client for discussing something	Therapist verbally acknowledges difficulty of client discussing topic	Thank you for sharing that with me - I know it was difficult (CP5; T274)
emphasize client's choice	Therapist highlights that a decision is the client's to make	That's not what you want to do. (CP1; T63)
Reinforce client's use of coping	Therapist validates client's efforts	So it's good to try. Remember I said it's like practice in here. (CP2; T267)
highlighting client's strengths	Therapist points out factors of resiliency or positive consequences of actions/behaviors/experiences of client	You're saying that from your side, you recognize that you're different than your family (CP2; T181)
acknowledge client's positive qualities	Therapist highlights beneficial attributes of the client	That's what's so amazing and great about you (CP2; T253)



Affecting Session Flow -
Therapist's behaviors during the session which change the process or content of the therapy

Therapist Disrupts Process

positive reframe

Encouraging client self-exploration

Therapist Completes Client Sentence

Therapist Interrupts Ct

Therapist helps the client examine a thought/feeling/situation from a positive perspective
Therapist helps client take charge of his/her own exploration and purposeful meaning making around an idea/situation

Therapist infers what the client is going to say and completes the client's sentence
Therapist starts speaking and by doing so, prevents the client from finishing his/her statement

You had all these opportunities that you could've been violent if you wanted to and you, when most of them it sounds like most of them were related to defending yourself (CP2; T245)

What would it mean to you to stay here? (CP3; T79)

C: You see a woman cry it's a little bit of a, I mean -- T: It's more common. (CP5; T242)

C: then the outside because it just-- T: You share a lot of similar-- (CP3; T141)



		Well how have you been, you know, how have you been kind of coping with when you're feeling down. It sounds like you've been feeling, like you said, better, but you're kind of handling it. Still a little down. What are you doing to handle it, what are you exactly? (CP2; T146)
Therapist asks multiple Questions at once	Therapist asks more than one question in sequence Therapist begins a question/statement, but trails off (e.g., decreased volume, stops speaking) before the thought has been completed	
Therapist does not finish thought/sentence/Question		T: But they are watching your - - C; Uh-huh; T: Okay (CP2; T126)
		C: So, I don't know. Maybe I am being too much of a critical thinker and that's why I can't make decisions. T: Right (CP3; T260)
Therapist responds "right" or "okay" as if knows the answer	The therapist uses the words "right," "okay," or "exactly" after a client makes a statement	

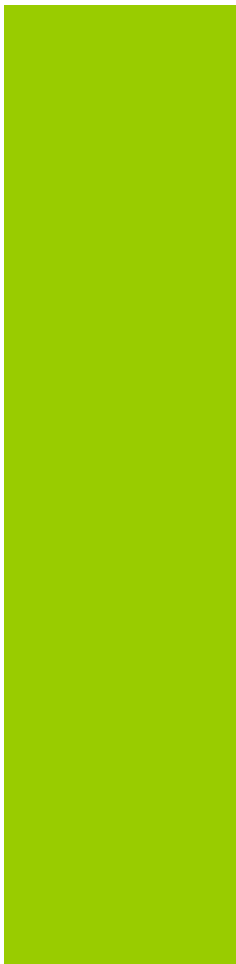


Attending Responses	Minimal Verbal Acknowledgments	Utterances communicating that the therapist is following what the client is saying Therapist nods, points, uses hand gestures while making a verbal point or to suggest	Mm-hmm; uh-huh; right
	Non-Verbal Behaviors	he/she hears the client	(Therapist nods head)
Connecting with client	Mirroring client's language	Therapist uses the same language as the client to illustrate a mutual understanding of a phenomenon	C: Not like totally okay, but just, you know, kind of handle it; T: Kind of handling it? (CP2; T100)
	Joining statements	Therapist uses words, such as we and us, to communicate shared perspective/engagement on a topic/task Therapist makes	It's hard, it makes us—I mean not only are we like upset about our friend passing away, but you know, it kinda—it makes you think more about yourself. (CP5; T272)
	Therapist acknowledging difficulty of talking about something	statement to validate magnitude of topic being discussed	I can only imagine how hard it is to talk about it. (CP5; T274)



Focusing	To emphasize here-and-now experience/affect in the room	Therapist shifts process to have client reflect on his/her current experience in the room	And so what is, [T taps chest with hand] what's the feeling in your body when that's happening? (CP2; T92)
	To focus on affect	Therapist directs client to focus on affect experienced in here-and-now	So you said your sister cried like once and that's it and she moved on. Do you kind of envy that, or? (CP1; T54)
	Staying focused on processing	Therapist redirects client to process information	Does some quality of it feel unreal to you? (CP1; T16)
	Setting session/therapy focus	Therapist spends time discussing how to structure therapy	It seems to me that it's helpful for you to come talk about these things, hard things, and you know we can kinda work on how you feel about them now, how does that sound or how does that feel to you? (CP2; T264)

Parent Theme	Sub-themes	Category Description	Category Example Quote:
<p>Coping - therapist works with client to identify and evaluate client's use of coping skills to manage difficult thoughts/emotions/situations</p>	<p>Family</p>	<p>Therapist's discussion with the client is on the topic of the client's family</p>	<p>Why don't you tell me a little bit about what's going on with your sisters leaving and how that went. (CP2; T99)</p>
	<p>Focusing on/ Supporting Others' Wants/Needs</p>	<p>Therapist emphasizes that client consider the perspectives/wants/needs of others</p>	<p>You do a lot of being there for other people (CP1; T18) And if you find yourself feeling a certain way, it's a way to distract yourself. You know, and kind of stop those negative</p>
	<p>Psychoeducation to Connect Thoughts/ Feelings/ Behaviors</p>	<p>Therapist focuses on connection between thoughts/feelings/behaviors</p>	<p>negative thoughts that are bothering you and doing something that makes you feel. (CP3; T271)</p>



Control

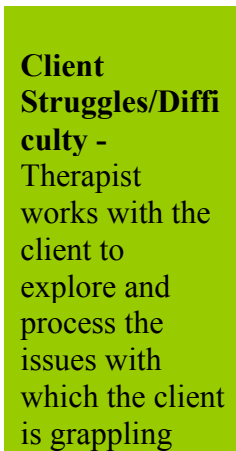
The therapist focuses on helping the client look at ways in which he/she is attempting to control a situation, feelings, thoughts, etc.

Did you try what we talked about, the other time, did you, remember what we talked about last time, like when you feel angry to, when you walk away (CP2; T208)

Meaning Making

The therapist works with the client to explore and process the deeper meaning behind an experience, which is causing the client distress.

So what would it mean to you to stay here? To make that decision to, that you're gonna stay here, you're gonna find someone here and raise a family here? (CP3; T79)



Client Struggles/Difficulty -

Therapist works with the client to explore and process the issues with which the client is grappling

Fear/Worry/Anxiety

Therapist focuses discussion with client on Fears/Worries/Anxieties

So you're worrying about her, worrying about you. (CP3; T53)



**Frustration/A
nger**

Therapist
focuses
discussion on
the client's
experience of
anger/frustratio
n

...So maybe is
you know you
are going
through
frustrating
experiences
write them
down. Even
when you are
having your
cup of tea, do a
little writing
and see where
that takes you.
(CP4; T62)

APPENDIX M

Content Theme Builder

Content Topic	P1	P2	P3	P4	P5
Being a burden				128, 130, 133	
Cultural Values			65, 69, 214, 251, 116, 125, 149, 161 23, 39, 53, 155, 169, 179,		
Focusing on /Supporting Others' Wants/Needs	18, 79,	99, 125, 129, 130, 131, 134, 148, 164, 254,	195, 201, 205, 209, 210, 215, 240, 245, 246	141, 146, 152, 153, 154 44, 48, 49, 55, 57, 62, 64, 67, 68, 71, 72, 105,	242, 247, 248 254, 257, 259
Control	90, 93	136, 205, 208, 209, 245	273, 279	146, 151,	
Family	5, 7, 29,	99, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 116, 117, 167, 245,	11, 23, 36, 39, 79, 155, 169, 175, 183, 201, 202, 240, 250	133, 134, 140 53, 226, 229, 232,	
Fear/Worry/Anxiety		183, 185, 196, 201, 220, 150, 187, 208	234, 251, 259, 267	32, 81, 99, 154	282, 288
Frustration/Anger				59, 60 126, 127, 154	
Loss					260, 261, 280, 288,
Meaning Making	21, 22, 41	40, 164, 239, 240, 244, 246,	57, 79, 283	89, 134, 145,	289, 291

			249, 250, 251, 252, 253, 268,	48, 52, 55, 56, 57, 62
Psychoeducation to connect thoughts/feelings/behaviors		91, 150	269, 271, 273, 287	
Stress	71, 72, 73 74			
Violence		151, 195, 196, 245,		
Physical Pain - this was her trauma/aliment so it was natural they'd be talking about it				82, 110 231, 243, 264, 270, 272, 274
Hard - this was just a repetitive word the therapist used, not a theme				