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Pepperdine University  
Graduate School of Education and Psychology

THEMES IN THERAPY WITH EMERGING ADULTS: A QUALITATIVE STUDY

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

by

Brian Louie, MA

February, 2016

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

This clinical dissertation, written by

Brian Louie, MA

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:

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

Judy Ho, Ph.D.

Joan Rosenberg, Ph.D.

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This dissertation was not possible without the support of several individuals. Dr. Jonathan Mattanah was my thesis advisor while I earned my masters degree in clinical psychology at Towson University. He was the person who introduced me to the concept of emerging adulthood. My continued interest in working in a college environment has been influenced by our work together, and I am thankful for all the support and encouragement he has given me over the years.

The study that was the basis for this dissertation required countless hours of transcribing video recordings of therapy sessions. I was fortunate to have the help of Hannah Reas, Lucy Wall, Jessica Chatterton, Shannon MacLaren, Kat Arenella, and Victoria Nelson, who all performed admirably. I have no doubt that they will all be successful in their future endeavors. I want to especially thank Victoria who committed a substantial amount of her time and effort to assist us.

This dissertation was an opportunity for me to branch out and attempt to perform a qualitative study. The Pepperdine Applied Research Center (PARC) provided the rich data that was necessary, while Dr. Krista Kircanski and Dr. Ani Khatchadourian, former members of the lab, provided invaluable time, advice, and resources to the execution of this project.

I was fortunate to have a dissertation committee of consummate professionals, who all provide me with examples of the kind of psychologist I hope to be someday. Dr. Judy Ho and Dr. Joan Rosenberg generously reviewed the dissertation at its various stages of development, and were instructors in several of my doctoral classes. Their tutelage has pushed me to be a better clinician. Dr. Rosenberg, in particular, was also my clinical supervisor, and I am constantly amazed at the wisdom she imparts to me in all our meetings. Dr. Susan Hall, the chair



of my committee, was an endless source of knowledge with regards to my topic, and helped me to be a more critical investigator. She was unwavering in her commitment to review and provide detailed feedback on many of my drafts, and this dissertation would have been unreadable without her audit. She also provided unconditional encouragement and compassion as I struggled to complete this undertaking, for which I am eternally grateful.

I could have not asked for a better collaborator than Lauren Ford. She originally approached me to join PARC and work together to complete our dissertations using a common sample. Working with her has been a pleasure, and she possesses experience, thoughtfulness, and a work ethic that is inspiring. I am not entirely sure I could have completed this project without her. Thank you, Lauren, for your support through this entire process.

Lastly, the motivation to complete this dissertation could not have been sustained without the love and support of my family. My wife, Sarah, always shared her faith in me and had more patience than should be expected from a reasonable person. Our daughter, Ella, came into our lives while my dissertation was underway. She fills my life with purpose and meaning, and I hope that I can be the father she deserves as she one day makes her own journey to adulthood.

## VITA

BRIAN LOUIE

### **EDUCATION**

**Doctor of Psychology in Clinical Psychology** *May 2016 (expected)*

Pepperdine University, Los Angeles, CA

Dissertation topic (IRB approved): Themes for Therapy in Emerging Adults: A Qualitative Study  
(Chair: Susan Hall, J.D., Ph.D.; Committee: Judy Ho, Ph.D., Joan Rosenberg, Ph.D.)

**Master of Arts in Clinical Psychology** *May 2010*

Towson University, Towson, MD

Thesis topic: Perceived Parental Communication Patterns as Mediators of the Relationship  
Between Attachment and Adjustment In First Year College Students: A Diary Study

**Bachelors in Psychology** *May 2005*

University of California, Berkeley. Berkeley, CA

### **CLINICAL EXPERIENCE**

**Doctoral Psychology Intern (APA accredited internship)** *August 2015 – Present*

*University of the Pacific, Stockton, CA*

*Counseling and Psychological Services*

- Provide psychotherapy services to diverse undergraduate and graduate student populations.
- Carry a caseload of approximately 15 to 20 client hours for brief therapy using a primarily cognitive-behavioral approach. Therapeutic concerns ranged from issues related to adjustment, mood, anxiety, disordered eating behaviors, and trauma.
- Administer two to four intakes per week.
- Co-facilitate weekly process groups and facilitate brief ACT-based skills groups.
- Responsible for emergency response and crisis intervention one hour per week.
- Conduct mandated alcohol and substance use assessments with students referred by campus Student Conduct using the Brief Alcohol Screening and Intervention for College Students (BASICS) semi-structured protocol.
- Plan and coordinate campus wide outreach, including psychoeducational presentations, to student groups, in classrooms, and at tabling events.
- Conduct an integrated assessment of one student regarding diagnostic clarity and personality from a strengths-based perspective.
- Attend seminars on multiculturalism, professionalism, outreach, group therapy, and therapy modalities.
- Attend bi-weekly staff meetings and inter-departmental meetings with student health center staff to coordinate student care.
- Primary Supervisor: Stacie Turks, Psy.D.

**Psychology Practicum Student**

*September 2014 – Present*

*Job Corps, Los Angeles, CA*

- Conduct psychoeducational assessments on a diverse population of disadvantaged transition-age youth (16-24) in order to determine the presence of learning disabilities,

using cognitive and emotional measures, as part of a residential technical training program run by the U.S. Department of Labor.

- Summarize subsequent findings from assessments into agency reports.
- Present findings from assessments to interdisciplinary team to determine appropriate education plans and accommodations.
- Provide weekly individual short-term therapy to a case load of two individual clients using a primarily cognitive-behavioral approach. Therapeutic issues include trauma, mood and anxiety symptoms, as well as comorbid substance use.
- Receive one hour of weekly individual supervision; Two hours of weekly group supervision.
- Supervisor: Joseph Grillo, Ph.D.

### **Student Counseling Extern**

*September 2013 – August 2014*

*Los Angeles Harbor College, Wilmington, CA*

*Life Skills Center*

- Provided individual short-term and long-term therapy in a community college setting to a diverse population of students using an integrated approach that incorporated cognitive-behavioral and humanistic methods. Therapeutic issues included academic adjustment, anxiety, depression, bipolar disorder, substance use, sexual trauma, and chronic health conditions.
- Triageed and counseled students during weekly crisis/walk-in hours.
- Evaluated students for special testing accommodations based on issues related to attention and mental health by conducting intake interviews and administering emotional/behavioral measures.
- Facilitated workshops for students on the following topics: test anxiety, age-appropriate parenting, depression, substance use, and exam preparation.
- Collaborated with representatives from the National Alliance on Mental Illness to bring workshops to campus for students. The topics focused on ways to cope with a family member with mental illness, and their presence were part of activities funded by the California's Mental Health Services Act (MHSA).
- Served as a liaison between Life Skills Center and Extended Opportunity and Programs Services, a campus program that supports students who are educationally disadvantaged.
- Received one hour of weekly individual supervision; Two hours of weekly group supervision; One hour of weekly didactic seminars.
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### **Psychology Practicum Student**

*September 2011 – May 2014*

*Pepperdine Community Counseling Center, Irvine, CA*

*Pepperdine Community Counseling Center, Los Angeles, CA*

- Provided long-term individual and couples therapy to a diverse adult outpatient community population using an integrative approach informed by neuropsychological research, as well as cognitive-behavioral, psychodynamic, and humanistic approaches. Therapeutic issues included a range of mood and anxiety disorders, substance use, and sexual trauma.
- Conducted diagnostic intake interviews and presented client conceptualizations through written reports and case presentations.

- Received one hour of individual supervision that reviewed performance via video recordings; one hour of group supervision; one hour of peer supervision (September 2011 – May 2012).
- Supervisors: Joan Rosenberg, Ph.D. (September 2011 – May 2013) and Bruce Rush, Psy.D. (September 2013 – May 2014).

**Psychology Practicum Student**

*September 2012 – August 2013*

*Long Beach Child and Adolescent Program, Long Beach, CA*

- Provided treatment to a diverse child population (4-18) at an LA County Department of Mental Health community mental health center using parent training and individual-based approaches. Therapeutic issues included a range of concerns, such as externalizing behaviors, ADHD, and symptoms of depression/anxiety.
- Delivered individual therapy to adults participating in the CalWorks welfare program in order to overcome psychological/behavioral barriers to obtaining gainful employment using cognitive-behavioral therapy. Therapeutic issues included mood and anxiety disorders, psychosis, as well as trauma.
- Conducted diagnostic intake interviews and documented results, as well as treatment progress, according to Department of Mental Health guidelines.
- Audited client charts for quality assurance.
- Attended a weekly hour-long seminar on advance cognitive behavioral therapy techniques.
- Received one hour of weekly individual supervision; One and a half hours of group supervision
- Supervisor: Teri Paulsen, Psy.D.

**Intern**

*September 2009 – May 2010*

*Key Point Health Services, Inc., Catonsville, MD*

- Administered intake interviews and individual therapy to an adult community population, which included homeless individuals, using a cognitive-behavioral approach. Therapeutic issues included issues related to mood and anxiety.
- Audited patient records for Code of Maryland Regulations compliance.
- Received one hour of weekly individual supervision; One hour of group supervision
- Supervisor: Linda Wilkens, M.A.

**Co-Facilitator**

*July 2009 – September 2009*

*Towson University, Towson, MD*

- Co-lead smoking cessation group for individuals, who were referred by their cardiologists, as a certified facilitator for a manualized intervention developed by the American Lung Association. The group consisted of seven two-hour sessions with four adults.
- Received one hour of weekly group supervision.
- Supervisor: Elizabeth Katz, Ph.D.

## **TEACHING EXPERIENCE**

### **Instructor**

*September 2014 – Present*

*Los Angeles Harbor College, Los Angeles, CA*

*Life Skills Center*

- Serve as primary instructor for Personal Development 17, a community college class dedicated to preparing students for academic success. The course focuses on developing inter- and intrapersonal skills through participating in weekly assignments and a process group, as well as informing students about campus resources.
- Receive one hour of weekly individual supervision.
- Supervisor: Bonnie Burstein, Ph.D.

### **Teaching Assistant**

*January 2014 – Present*

*Pepperdine University, Los Angeles, CA*

*Department of Psychology*

- Review and provide feedback on cognitive assessment results as well as integrated reports as part of a graduate class in advance psychological assessment.
- Train students in administration of cognitive and projective/performance measures through practice administrations.
- Supervisors: Susan Himelstein, Ph.D. and Carol Keatinge, Ph.D.

### **Teaching Assistant**

*September 2013 – December 2013*

*Los Angeles Harbor College, Los Angeles, CA*

*Life Skills Center*

- Served as a teaching assistant for a college preparation/personal development course, including facilitating small group discussions, serving as a guest lecturer, and grading weekly assignments.
- Supervisor: Joe Exnowski, M.A. and Bonnie Burstein, Ph.D.

### **Graduate Assistant**

*August 2008 – May 2010*

*Towson University, Towson, MD*

*Department of Psychology*

- Provided guest lectures, exam creation, grading, and proctoring for the following undergraduate classes and instructors:
  - Psychopharmacology, Therissa Libby, Ph.D.
  - Introduction to Psychology, John Webster, Ph.D.
  - Infant and Child Development, Ellyn Sheffield, Ph.D.
  - Advanced Experimental Design, Jonathan Mattanah, Ph.D.

## **RESEARCH EXPERIENCE**

### **Research Assistant**

*January 2012 – September 2013*

*Pepperdine University, Los Angeles, CA*

*Pepperdine Applied Research Center*

- Coordinated data collection across community clinics related to treatment outcomes, therapeutic alliance, and video recordings of therapy sessions from training clinicians.
- Trained student therapists and graduate assistants on research protocols and administration of self-report measures.

- Established SPSS databases as well as procedures for data entry.
- Supervised graduate assistants in redaction and data entry activities.
- Supervisor: Susan Hall, J.D., Ph.D.

**Lab Coordinator**

*September 2010 – August 2011*

*University of Southern California, Los Angeles, CA  
Social Psychology Department*

- Coordinated and maintained lab space/lab equipment for social psychology department.
- Coded data and inter-rater reliability for a meta-analysis on women’s mating preferences during their menstrual cycle.
- Measured responses to cold-pressor tasks for a study on the effect of mindfulness on experiential satisfaction.
- Recruited participants and collected data using self-report measures for research studies on dining habits.
- Supervisor: Wendy Wood, Ph.D.

**Research Assistant**

*November 2010 – July 2011*

*Loyola Marymount University, Los Angeles, CA  
Psychology Department*

- Managed a National Institutes of Health funded study on preventing alcohol-related consequences in at-risk college students by increasing use of protective behavioral strategies.
- Developed and administered a brief intervention based on motivational interviewing.
- Scheduled participants and tracked progress through study.
- Screened potential participants by phone.
- Supervisor: Joseph LaBrie, Ph.D.

**Research Assistant**

*July 2009 – May 2010*

*Towson University, Towson, MD  
Psychology Department*

- Created study stimuli with sound-editing software as well as organized recruitment, research assistant training, and data collection for studies investigating preferences for various electronic audio formats.
- Co-wrote sections for a National Institute on Disability and Rehabilitation Research grant submission focused on delivering captioned radio to underserved populations.
- Supervisor: Ellyn Sheffield, Ph.D.

**Research Assistant**

*October 2005 – July 2008*

*Johns Hopkins Bloomberg School of Public Health, Baltimore, MD  
Center for Autism and Development Disabilities Epidemiology*

- Coordinated recruitment and data collection for epidemiological study on pregnant women who have previously given birth to a child with autism.
- Administered structured interviews and questionnaires to adult females referred by collaborating community organizations and autism service providers.
- Collected and prepared biosamples from participants.

- Supervisor: Margaret D. Fallin, Ph.D.

**Research Assistant**

*September 2004 – May 2005*

*University of California, Berkeley. Berkeley, CA*

*Psychology Department*

- Administered demographic questionnaires, structured interviews and assessment tests to adolescents as part of a follow-up to a multimodal treatment study with children with ADHD.
- Established an electronic library of research literature by scanning articles.
- Supervisor: Stephen Hinshaw, Ph.D.

**Research Assistant**

*June 2004 – May 2005*

*University of California, San Francisco. San Francisco, CA*

*Department of Psychiatry*

- Investigated peer relationships in children with ADHD by administering cognitive assessment tests, computer tasks, and coding behavioral interactions with peers.
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**Research Assistant**

*January 2003 – June 2003*

*University of California, Berkeley, Berkeley, CA*

*Department of Psychology*

- Administered behavioral trials on rats using Skinner boxes.
- Fed laboratory rats according to experimentally controlled diet.
- Supervisor: Seth Roberts, Ph.D.

**SCHOLARSHIPS AND AWARDS**

Glen and Gloria Holden Scholarship, Pepperdine University

*September 2011 – 2014*

Psy.D. Contribution to Diversity Scholarship, Pepperdine University

*September 2011 – 2014*

Graduate Student Association Award, Towson University

*May 2009*

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*June 2014*

Society for the Study of Emerging Adulthood

*October 2011*

American Psychological Association

*September 2005*

Campus Representative, Towson University  
2010

*June 2009 – May*

Psi Chi, National Honor Society in Psychology

*September 2005*

**PUBLICATIONS**

Wood, W., Kressel, L., Joshi, P., & **Louie, B.** (2014). Meta-analysis of menstrual cycle effects on women's mate preferences. *Emotion Review*, 6, 229-249. doi: 10.1177/1754073914523073

Hummer, J. F., LaBrie, J. W., Lac, A., & **Louie, B.** (2013). The influence of reflective opposite-sex norms and importance of opposite-sex approval on adjudicated student drinking: Theoretical extensions and implications. *Journal of Student Affairs Research and Practice*, 50(4), 373-392. doi: 10.1515/jsarp-2013-0027

Lee, L., Harrington, R., **Louie, B.**, & Newschaffer, C. (2008). Children with autism: Quality of life and parental concerns. *Journal of Autism and Developmental Disorders*, 38, 1147-1160. doi:10.1007/s10803-007-0491-0

### **POSTERS & PRESENTATIONS**

**Louie, B.B.** & Mattanah, J.F. (2011, October). Parental communication quality as a mediator between attachment and personal-emotional adjustment in college: A diary study. In Connell, J & **Louie, B. B. (Chairs)**, *Family Communication Patterns and Functioning in Emerging Adulthood*. Symposium conducted at the 5<sup>th</sup> Annual Conference on Emerging Adulthood, Providence, RI.

**Louie, B.B.** & Mattanah, J.F. (2011, October). Attachment in emerging adults and its relation to parental communication patterns and college adjustment. Poster presented at the 5<sup>th</sup> Annual Conference on Emerging Adulthood, Providence, RI.

**Louie, B.B.** & Mattanah, J.F. (2010, May). *Parental communication patterns as mediators of the relationship between attachment and college adjustment in the first semester: a diary study*. Poster presented at the Johns Hopkins Bloomberg School of Public Health Student Conference on Addictions, Infectious Diseases, and Public Health, Baltimore, MD.



## ABSTRACT

The path to adulthood has traditionally been marked by demographic transitions, such as graduating from college, attaining employment, becoming married, and having a child. Previous models of development have conceptualized adolescence as a time of identity exploration and consolidation. However, in the US, as well as many other countries, the timeline for attaining the aforementioned markers has been delayed. Additionally, a significant portion of individuals between the ages of 18 to 29, across several counties, report not seeing themselves fully as adults, and ascribing internal changes, such as taking responsibility for one's actions, as more indicative of adulthood status. Emerging adulthood has been conceived as a distinct developmental period between adolescence and adulthood. It has been conceptualized as a time for self-focus, identity exploration, possibilities, instability, and feeling in-between. Research on emerging adulthood has shown this to be a time of increased well-being, as well as increased risk for mental health issues. However, little research has been conducted connecting emerging adulthood with psychotherapy.

The purpose of this study was to qualitatively investigate what themes occurred related to the transition to adulthood among emerging adults who were receiving psychotherapy. The sample consisted of 10 videotaped therapy sessions from an archival database; two sessions for each of five client participants who received services from an outpatient community counseling center. Using an open coding and content analysis approach to analyze transcripts of the taped sessions, two Parent Themes emerged from the sessions, Self-Development and Interpersonal Relationships. These themes and their corresponding content supported existing models of emerging adulthood, and demonstrated that the developmental processes related to this period are relevant to clinicians. Additionally, the findings pointed to potential areas of future research

including the need to study emerging adults who are parents and whether and how feeling in-between adolescence and adulthood relates to clinical presentations in this population.

## Chapter I. Literature Review

### Introduction

In the United States of America (US), and similar post-industrialized nations, nuances and heterogeneity in the path to adulthood have become more prominent over the past several decades. Today, many are afforded the opportunity to prolong joining the workforce by pursuing higher education. In the US, this is evidenced by an increasing rate in the immediate college enrollment rate among high school graduates. Between 1975 and 2010, this rate has ranged from a low of 49% to the most recent high of 70% (U.S. Department of Education, 2012). Related to this trend, the average age for a first marriage (28.7 and 26.5 for men and women, respectively) and first-time parent (24.6 for women) is considerably higher than previous generations (U.S. Census Bureau, 2011, 2012a). As a result of these various changes, many individuals experience a period, starting in their late teens and into their twenties, that is distinctly different from adolescence and adulthood (Arnett, 2007).

A growing body of literature has conceptualized this time as a separate and unique developmental stage and has been termed *emerging adulthood* (Arnett, 2000a). This period has been characterized by three main elements: its demographic diversity, subjective experience of feeling-in-between, as well as its emphasis on identity exploration in regards to one's occupation, worldview, and love (Arnett, 2000a). While these elements have been illustrated through research, their expression continues to be explored in the context of moderating factors, such as race, cultural beliefs, and socioeconomic status. It is not well understood how the developmental challenges and tasks of this time may relate to an emerging adults' psychopathology or adaptive functioning, and how these factors can be addressed within the context of psychotherapy.

This dissertation begins with a review of the literature describing the demographic changes and attitudinal shifts in the United States that have occurred over the past half century. These trends highlighted the need for a new developmental theory, emerging adulthood, to better accommodate such changes. After defining emerging adulthood, the prevalence of mental illness in this population is presented followed by an overview of developmental models of psychopathology regarding the transition to adulthood. This review concludes with a discussion about how emerging adulthood is assessed and understood in the context of psychotherapy.

### **The Pathway to Adulthood**

Several theories of development have conceptualized the journey of becoming an adult as occurring in distinct developmental stages. Generally these models assume universality in the sequence, tasks, and processes that take place across a person's lifespan.

One example of such a model comes from Loevinger, who proposed that one's ego (i.e., conceptualization of the self, others, and the world) was a multifactorial construct consisting of one's ability to control one's impulses, interpersonal style, cognitive style, and conscious preoccupations (Loevinger & Blasi, 1976). She proposed that ego development can be conceptualized as a process that involves seven hierarchical developmental stages, and transitional periods between those stages regarding a person's cognitive and interpersonal style. Of note, these stages were not tied to particular age ranges, and individuals need not progress through all of them over the course of their lives (Hauser, 1976). Pertinent to emerging adulthood, the sixth and seventh stages in this model, *autonomous* and *integrated*, are marked by increasingly sophisticated cognitive styles, such as being able to tolerate paradoxes and ambiguity, respectively. Additionally, individuals in these stages are respectively thought to be consciously preoccupied with role differentiation and one's identity, as opposed to the

preoccupation with achievement and recognition of patterns that takes place in the prior fourth *conscientious* stage.

In contrast to Loevinger's model, Erik Erikson proposed a model in which each stage of development occurred at a particular age range and entailed specific socioculturally informed tasks that were required to be addressed (Erikson, 1950). A developmental crisis was thought to occur at each stage, and its resolution was necessary before individuals could move onto the next stage. Successful resolutions of these crises were theorized to confer competency and functioning, while unsuccessful navigation led to deficits or difficulties in functioning/relating (Erikson, 1968). Several of Erikson's crises are particularly pertinent to early adolescence and young adulthood. Approximately between the ages of 13 to 18 years of age, the hypothesized central task for an adolescent individual was to explore the Identity versus Role Confusion crisis. Successfully resolving the question of "who am I?" was thought to confer a unified sense of self and purpose (Erikson, 1968). Approximately between the ages of 18 to 40, was thought to be characterized by the Intimacy versus Isolation crisis, in which a person explored whether he/she was able to establish close personal relationships (Erikson, 1968). Successfully resolving the question of "can I love?" was theorized to result in positive intimate relationships with friends and significant others. From the ages of 25 to 64, the central task was thought to be the Generativity versus Stagnation (Erikson, 1968). A person who resolved this crisis was thought to have a sense of being productive and having purpose in his/her life.

Critics of the Eriksonian perspective challenge the universal nature of identity development (e.g., see Côté, 1996; Gergen, 1991; Gilligan, 1982, 1993; Josselson, 1988; Sorell & Montgomery, 2001). In particular, they argued that both the process and the outcome of Eriksonian identity development is androcentric, individualistic, and may be an over-

simplification of a dynamic process that differs between genders and among different levels of acculturation (Schwartz & Montgomery, 2002). For example, Gilligan (1982, 1993) and others (Archer, 1985, 1992; Schiedel & Marcia, 1985) argue that the structure, primary processes, and outcome of identity development may differ among young men and young women as they mature in contexts differing in gender-related expectations about self-development. To address this concern, Schwartz and Montgomery (2002) surveyed 357, primarily female (77%), diverse university students in the United States. Participants were given several measures of identity development process and outcome, as well as measures that addressed gender orientation and level of acculturation. Results indicated that identity structure was stable across gender and acculturation; however, the process and outcome of identity development differed depending on a person's gender and level of acculturation (Schwartz & Montgomery, 2002).

These critiques notwithstanding, Erikson's model has generated an abundance of literature on the nature of global identity development. Recently, McLean and Pasupathi (2012) have conceptualized Erikson's theory as branching into two methodological approaches: the identity status model (e.g., Marcia, 1966), and a narrative model of identity. According to McLean and Pasupathi (2012), the status approach focuses on multiple domains of identity development (such as political, religious, occupational, gender, values, and ethnicity) and is oriented from the present to the future. In contrast, the narrative approach to identity development focuses on integrating identity over time based on experiences from the past to the present, and more on prior identity processes than on ongoing development. Synthesizing these two approaches has been suggested as one potential direction for future identity development research (McLean & Pasupathi, 2012; Syed, 2012). Other Erikson-inspired/neo-Eriksonian approaches exist as well. These methods include purpose research, which examines how

developing a sense of purpose relates to identity development, (Hill & Burrow, 2012), as well as identity style, which investigates the approach a person takes towards life decisions that influence identity development (Schwartz, Zamboanga, Luyckx, Meca, & Ritchie, 2013).

Research on adulthood has also examined the role of life events that influence identity development. One phenomenon that has been of interest is the concept of “turning points,” or significant episodes of one’s life that have a lasting impact on a person, especially his/her sense of self (McAdams, 2001). In this vein, social science research has historically examined the path to adulthood through *social, demographic, or role* transitions or marker events (Arnett, 1997; Hagan & Wheaton, 1993; Hogan, 1981; Hogan & Astone, 1986; Marini, 1984; Modell, 1989; Sewell & Hauser, 1975). Past literature examining transitions to adulthood in the United States, where the proposed study will be conducted, has used the following marker events to demarcate an individual’s entrance into this stage of life: completion of postsecondary education, marriage, establishment of an independent household, being married, becoming a parent (often referred to as *first birth*), and obtaining full-time employment. In general, the time at which these events occur for contemporary individuals in the United States has become prolonged. For example, the median age for a first marriage has gradually increased from 1950 to 2011 (U.S. Census Bureau, 2011). For men at first marriage, this has grown from 22.8 to 28.7 years old, while the age of women at first marriage has grown from 20.3 to 26.5 years old, respectively. There has also been an overall increase in the age at which a woman has her first child. The average age has gone from 22.4 years old in 1970 to 25.0 years old in 2006 (Mathews & Hamilton, 2009).

This trend has coincided with a greater amount of people enrolling directly into 2-year and 4-year colleges from high school (U.S. Census Bureau, 2012a). In 1975, 50.8% high school graduates went onto college. This includes 18.2% of the population who enrolled in a 2-year

college, and 32.6% of the population who went onto a 4-year college. By 2010, the number of people who have enrolled in college directly from high school has increased to 68.1%. This includes 26.7% of the population who enrolled in a 2-year college, and 41.4% of the population who went onto a 4-year college. From 1975 to 2010, women, in particular, have seen a large increase in enrollment to 2-year colleges (17.4 to 23.4%) and 4-year colleges (31.6 to 47.0%), as compared to men who enrolled in 2-year colleges (19.0 to 24.7) and 4-year colleges (33.6 to 41.8%). This increase in college enrollment has been observed to correlate with individuals not assuming adult responsibilities. A study that followed a cohort of 17 to 27 years olds (91% and 8% of whom were White and Black, respectively) from 1997 to 2000 found that being in school was negatively correlated with independent residency, financial independence, committed romantic relationships, and parenting (Cohen, Kasen, Chen, Hartmark, & Gordon, 2003).

Along with this research, many other factors have been conceptualized as influencing the transition to adulthood including, race, ethnicity, gender, socioeconomic resources, and sociocultural norms/institutions. These variables are thought to interact to shape transitions by establishing criteria, timing, and legitimacy (Hogan & Astone, 1986). In some ways, modern society has both standardized and individualized the transition to adulthood (Shanahan, 2000). While decreased mortality rates and mandated schooling requirements have made one's life course predictable to some degree for those in industrialized countries like the US, there is considerable personal latitude that an individual can exercise with regards to the path one takes in those more individualistic contexts.

Accordingly, changes in attitudes towards conventional marker events have accompanied the aforementioned demographic changes. An analysis of five large-scale survey studies on US society's attitudes toward several family issues, among individuals who were 18 years of age or



older, has shown significant changes from the 1960s to 1990s (Thornton & Young-DeMarco, 2004). The results showed that there has been a steady increase in the endorsement of sexual equality and balancing of gender roles. A recent national survey of over 1,029 individuals ages 18 to 29 (61% White, 17% Latino, 12% African American, 5% Asian American, 5% Other) found that over half believed that they would have to sacrifice career goals in order to have a family, and this belief was shared equally among men and women (Arnett & Schwab, 2012). Similarly, a study that interviewed 33 fathers found a theme in which both working parents strived to contribute equally to child care responsibilities (Harrington, Van Deusen, & Ladge, 2010).

Along the lines of such results, Thornton and Young-DeMarco (2004) found that the most recent generations in the US have been more accepting of cohabitation as a viable lifestyle. This may be, in part, be related to their finding of a coinciding view of marriage as less obligatory, and not necessarily essential to having a happy adulthood. An increase in cohabitation may also be related to experiences that emerging adults have had with their family and friends. For example, a study that interviewed 20 young adult heterosexual couples (20% Black, 62.5% White, 15% Hispanic, 2.5% Native American; average age 24 years old) found that those who came from families who experienced divorce were cautious about entering marriage and saw cohabitation as a means to test a relationship before making a deeper commitment (Manning, Cohen, & Smock, 2011). In this same study, couples were more readily able to give examples of difficulties peers had in their cohabitation arrangements, and used these experiences to inform how they would navigate their own future cohabitation relationships.

Additionally, some individuals may be intentionally delaying marriage. Carroll et al. (2009) examined 788 college students from the ages of 18 to 25 (481 women; 79% European

American, 4% African American, 9% Asian American, 3% Latino American, 5% mixed/biracial/other) and found that about two thirds believed that they were not prepared to be married, which required being able to take care of a person other than oneself (Carroll et al., 2009). Half of the participants in this study also reported that they wanted to fully experience being single before becoming married. These kinds of beliefs and attitudes may have been encouraged by parents. For example, one research study found that parents of college students in their 20s had a higher ideal age for marriage than their children (Willoughby, Olson, Carroll, Nelson, & Miller, 2012).

Thus, as societies change, definitions of adulthood, and how it is attained, are bound to shift. Such has been the case for the US and other Western societies, which have created conditions that static stage models of development cannot currently accommodate. The following section, therefore, defines the more recent model regarding the path to adulthood, called emerging adulthood. As part of this discussion, individual definitions and attitudes about the meaning of adulthood are presented in contexts within and outside of the US.

### **The Concept of Emerging Adulthood**

Over the past two decades, there has been a proliferation of writing and research which has focused on the transition to adulthood from the perspective of those who are delayed from achieving these marker events. Jeffrey Arnett's early research in this area involved interviews with college students and non-college peers, in which he found that a significant portion of college students, about two thirds, did not consider themselves to be adults (Arnett, 1997, 1998). While research has tended to overlook the *forgotten half* of individuals in this age range who are not enrolled in tertiary education (William T. Grant Foundation Commission on Work, Family, and Citizenship, 1988), recent research has shown that as much as 40% of this group also do not

consider themselves to be adults (Lowe, Dillon, Rhodes, & Zwiebach, 2013). Given the aforementioned demographic changes in the United States and the phenomenology of those experiencing the transition to adulthood, a new theory, or updated model of development, was needed to better understand this protracted adolescence, which Arnett named emerging adulthood (Arnett, 2000a, p. 469). The term has become well-established in the field and has become so accepted that, an academic organization, the Society for the Study of Emerging Adulthood (SSEA), has been established which hosts biennial conferences and publishes a journal dedicated solely to this distinct population.

Emerging adulthood has been conceptualized as a unique stage of development that is different from adolescence and adulthood. This period was first estimated to take place between 18 and 25 years, but the sense that one is not quite an adult has been reported from individuals who are well into their late twenties and early thirties (Arnett, 2001). Thus, the SSEA estimates the age range for emerging adulthood as between 18 to 29. While this age range is generally accepted as part of the definition of emerging adulthood, it is not a strict cut-off. Delays in achieving adulthood have been observed to take place for individuals in their thirties (Arnett, 2001; Clark, 2007), and a person's age is but one small aspect of emerging adulthood. Subjective experiences, to be discussed in further detail below, are conceptualized as more definitive of this period of life than age.

This developmental stage is proposed to exist whenever there is a period of several years between adolescence (physical sexual maturity) and adulthood (completing secondary schooling and entering stable roles in love, work, and marriage). This period of time is thought to allow for identity exploration in terms of romantic partnership, vocation, and worldviews (Arnett, 2000a). More specifically, Arnett (2011) proposes four beliefs are thought to give rise to emerging

adulthood: (1) a person should be independent before taking on the responsibilities of adulthood, (2) romantic love should be basis of marriage, (3) work/vocation should be expression of a person's identity, and (4) a person should spend the time in their late teens through their mid-twenties on recreation and leisure (Arnett, 2011).

Additionally, Arnett (2001, 2004) has delineated five concepts, or "pillars," that characterize emerging adulthood, which were initially constructed using a mainly White American sample of college students. After describing an individual pillars, a discussion of more recent work about cultural differences/considerations that have been identified in the literature will be addressed, when applicable. After defining these concepts, emerging adulthood will be discussed as a culturally bound theory, which will then be followed by a review of international research about the existence of this developmental stage in other countries.

**Age of identity exploration.** Emerging adulthood is conceptualized as a time when individuals are less dependent on their parents but have not fully assumed the responsibilities of adulthood (Arnett, 2004). This stage of development affords them the opportunity to explore their identity in many different domains and is a central task of this time. In terms of intimate relationships, emerging adults begin to shift their attention to dating partners in the context of lifelong, committed relationships (Arnett, 2004). This contrasts with adolescence, when dating is focused on immediate enjoyment of the here-and-now (Furman, Brown, & Feiring, 1999). Another area of exploration is in regards to a person's career. Whereas adolescents use part-time jobs as a means to support recreational activities (Steinberg & Cauffman, 1995), emerging adults use these kinds of positions, as well as volunteer work, to help them determine their future line of work (Arnett, 2004). Ethnic identity has not been extensively studied in the context of emerging adulthood (Syed & Mitchell, 2013), but there is evidence that it is another aspect of

identity that is explored during this period, as ethnic identity theorists and researchers have focused on this time period, while not necessarily referring to it as emerging adulthood. For example, a four year longitudinal study of 175 college students that consisted of Blacks (10%), Latinos (23%), Whites (37%), Asian-American (30%), found that exploration and commitment to an individual's ethnic group increased linearly during the course of college, and that these trajectories did not differ between ethnicities (Syed & Azmitia, 2009).

**Age of instability.** The exploration that takes place during emerging adulthood creates instability, both in terms of phenomenological experience, as well as demographic aspects life (Arnett, 2004). While individuals may have initial plans for what they would like to do in the future, interests often change. This instability, with regards to future career, is evident by the overwhelming majority, or about three quarters, of college students who change their academic major at least once while in school (Kramer, 1994; Elliott & Elliott, 1985). Emerging adults frequently change their jobs as well as they explore their interests. Among Whites, Blacks, as well as Latino populations, the average person changes their job 11 times over the course of their life, and 7 to 8 of these changes take place between the ages of 18 to 27 (U.S. Census Bureau, 2012b).

Emerging adulthood also has less stability in regards to housing than other stages in life (Arnett, 2004; Benetsky, Burd, & Rapino, 2015). This time is often the first opportunity for individuals to live apart from their parents usually due to college (Goldscheider & Goldscheider, 1999). After this separation, many emerging adults will experience additional changes in residency, as they move in with peers or romantic partners (Arnett, 2004). At the same time, this separation from living their parents is often times not permanent, as about half of college students return home sometime between the ages of 18 to 25 (Goldscheider & Goldscheider,

1999). Ethnic differences have been observed in the number of residency changes that occur during development. For example, the number of moves has been found to lessen in adulthood for Whites and Asians, but not for Black and Latino populations (U.S. Census Bureau, 2012b).

**Age of possibilities.** While emerging adulthood is experienced as an unstable time, it is also experienced as a time when the world is wide-open, and filled with many possibilities for the future (Arnett, 2004). A majority of emerging adulthood believe that they will achieve their goals in life and that the quality of their lives will be better than that of their parents (Arnett, 2004; Arnett & Schwab, 2012). For people who come from households marked by strife, this time is an opportunity to remove oneself from a stressful family environment (Arnett, 2004). While it is not possible to entirely escape family influences, and nor would this be particularly desirable in certain cultural contexts, emerging adulthood is a time when these obligations and responsibilities are at their nadir (Arnett, 2004).

While Arnett has characterized emerging adulthood as a time of optimism (Arnett, 2004), other scholars have argued that this may not necessarily true of ethnic and racial minorities (Syed & Mitchell, 2013). Latino and African-American college students report having more financial difficulty with supporting their education (Arnett & Schwab, 2012) and those from families with lower incomes tend to drop out at higher rates than those from wealthier families (National Center for Education Statistics, 1998). Furthermore, college students from minority groups are more likely to report experiences of discrimination during interpersonal and institutional interactions (Syed, Azmitia, & Cooper, 2011). At the same time, there is evidence that members of racial and ethnic minority groups between the ages of 18 to 29 maintain high aspirations in the face of these challenges, and may be likely to predict that their lives will be better compared to their parents (Arnett & Schwab, 2012; Arnett & Tanner, 2011). Despite these aspirations, there

is evidence that emerging adults under the stress from their minority and financial status sometimes are forced into changing their goals to be more more realistic and obtainable (Cooper, 2011).

**Age of self-focus.** Arnett (2004) distinguishes emerging adulthood as a time when individuals make decisions that primarily concern themselves. Although adolescence is a time in which individuals can be ego-centric (e.g., the personal fable; O'Connor & Nikolic, 1990), teenagers usually are accountable to their parents day by day. In adulthood, individuals have to make decisions that take into consideration the impact they may have on their committed personal relationships, whether they be with their spouse/partner and/or children (Arnett, 2004). Also, while emerging adults often have daily contact with their parents (Arnett & Schwab, 2012) or continue to live with them at home, they have more freedom over their daily schedules (Arnett, 2004). Arnett (2004) conceptualizes this attention toward the self as a means to develop one's identity and self-sufficiency.

Although this is a time for focus on oneself, this does not mean that emerging adults only care about themselves. Many emerging adults have stated that they value their autonomy as much as their community (Arnett, Ramos, & Jensen, 2001). There is growing attention being paid to how emerging adulthood is experienced in cultures that emphasize independence and those that have been conceptualized as being more collectivistic, or oriented towards fulfilling obligations to one's family/community (Syed & Mitchell, 2013). Tamis-LeMonda et al. (2008) have proposed that the individualistic-collectivistic dichotomy that has been used in past research is over-simplistic. They have argued a theoretical framework in which cultural value systems (individualistic/collectivistic) interact dynamically with the developmental goals of the parent (autonomy/relatedness). These interactions then can lead to a conflicting, additive relationship,

or functionally dependent relationships. Thus using this approach, emerging adulthood, and its self-focus features, can be conceived to exist alongside the broad collectivistic values of one's culture.

**Age of feeling in-between.** The last phenomenological feature of emerging adulthood to be discussed is the sense that one is no longer an adolescent, but not quite an adult (Arnett, 2004). The feeling of being in-between among emerging adults is based on Arnett's surveys of individuals between the ages of 18 to 25 years of age in which the majority reported that they felt like adults in some ways, but not in other ways (Arnett, 2001; Arnett, 2004; Arnett & Schwab, 2012). These same studies found that the older a person was, the more likely s/he identified as an adult, especially by the time a person reached his/her late thirties. This feeling of being in-between adulthood and adolescence is likely engendered by the criteria that individuals and the culture in which they live use to define when a person has become an adult. Examples of such criteria are discussed in further detail below.

**Emerging adulthood and cultural context.** The concept of emerging adulthood is inherently a culturally bound theory. How and whether emerging adulthood manifests within collectivistic and other diverse cultures is influenced by numerous factors, such as cultural beliefs, socioeconomic status, and religion. Emerging adulthood is considered to more likely occur in industrialized cultures where education is protracted and marriage is delayed. Arnett (2011) has pointed to countries such as USA, Canada, UK, Australia, New Zealand, several European countries, as well as Japan and South Korea, as examples of nations who have seen similar trends in the past half century. He has also proposed that emerging adulthood can exist in developing nations, albeit for a small group of individuals who are afforded the resources to delay entering adulthood responsibilities (Arnett, 2011). Several studies have been conducted



that asked individuals the same questions that were asked of emerging adults in the US, which has provided evidence that emerging adulthood exists in other countries.

Arnett also has drawn attention for the need to understand the factors that influence the expression and experience of emerging adulthood. Although he has referred to this period as a stage, Arnett (2001) cautioned against rigid constructs that impose universality and homogeneity for how one navigates through this time. Thus, the following section presents early research on how adulthood has been defined within the US following by more recent research conducted outside the US. It is followed by a brief discussion of the commonalities and differences between how countries conceptualize adulthood and weighs the evidence for the existence of an emerging adulthood period within these societies.

### **Definitions of Adulthood in the United States**

The way in which today's US adolescents define adulthood differs, in varying degrees, from the social markers that were described before. Arnett (1997) conducted two seminal studies asking individuals what they believed defined adulthood by surveying 346 US college students, 18 to 23 years old, and 140 individuals between the ages of 21 to 28 years old and of mixed employment and educational status (two-thirds working full-time, one fifth in school). For both studies, 90% or more of the participants were White. A majority of the respondents defined adulthood not by whether they had completed their education, reached full-time employment, were married, or were parents, but rather by more subjective factors. Themes included autonomy, psychological changes, and responsibility. Frequently endorsed role transitions for adulthood were to not need money from their parents, followed by no longer living at home. However, the most frequent criteria included cognitive and behavioral changes, such as having personal beliefs and values that they choose independent of their parents or other influences, and

that they be treated as an equal by them. A majority also believed that being an adult meant taking responsibility for one's actions. When the same participants of these studies were asked whether they believe they had attained adulthood, a majority (63%) of college students reported that in some respects they were adults, but in other respects they were not. The participants across both studies largely endorsed the same criteria for adulthood, but a greater proportion of individuals identified themselves as adults the older they were. Specifically, the majority (71%) of participants, both in college and not in college, who were 25 to 28 years of age, identified themselves as adults.

These definitions of adulthood are not unique to those in their late teens and twenties. When Arnett (2001) asked another US sample of adolescents, emerging adults, and young-to-midlife individuals, over 75% of whom were White, to define adulthood by selecting from items related to individualism, being able to care for one's family, complying with social norms, biological transitions, and legal/chronological transitions, response patterns were similar to one another. All age ranges endorsed criteria related to self-sufficiency, which were the highest rated in determining whether one has becoming an adult. Role transitions, such as marriage and having a child, had the lowest endorsement for across all age groups, even among those who identified as adults and had attained these statuses. There were some differences between age groups, which appeared to be related to the salient experiences of a person's particular stage in life. Biological transitions, such as being able to produce/bear children, were more likely to be endorsed by teenagers. While norm compliance was highly ranked among all the age groups, young-to-middle-aged adults were more likely to regard it as being part of adulthood. Despite these nuances across age groups, the results demonstrated that individualistic changes in

character was the most important factor in differentiating between an adolescent and an adult, and that this attitude was not confined to a particular cohort.

Additional research has shown the diverse range of experiences that can contribute to a person feeling like an adult. A study that examined 726 individuals from ages 18 to 35, examined to what degree they believed they were an adult, as well as to discuss an event in which they felt like an adult (Lowe, Dillon, Rhodes, & Zwiebach, 2013). The sample was particularly diverse in its racial distribution (60.5% White, 12.4% Black, 13.9% Asian, 11.6% Hispanic, and 13.2% Other/Multiracial) and immigrant status (44.6% first or second generation immigrant to US). Similar to past studies, more college students reported that they felt somewhat like an adult, but not entirely (62.7%) compared to non-college peers (43.5%). Experiences that made participants feel like adults were categorized according to how traditional (e.g., marriage, having a child, owning a home) or nontraditional (e.g., traveling, drinking/drug use, taking care of others) they were, as well as the kind of psychological experience that made it significant (e.g., demonstrated self-regulation capacities, responsibility for self/others, reflected appraisals). More than a third of individuals cited a traditional role change as making them feel like an adult, showing that traditional markers still have meaning for some individuals. Specifically, people who had attained traditional markers tended to use them as an example more than those who had not, even when controlling for age and college status. However, a majority of individuals did not endorse these markers, and cited diverse experiences (such as stressful experiences, dressing as an adult, driving, going to a bar), which had not been identified in Arnett's studies, likely because this study offered an open response, rather than a forced choice through checklists. Although this study used a diverse sample of students, no significance differences were found when comparing participants of different ethnicity or immigration status.

Other research indicates that ethnic minority groups in the US have been shown to have similar but different views on what constitutes adulthood compared to White peers. A study that compared African American, Asian Americans, and Latinos to Whites from ages 18 to 29 found that over 70% from all groups endorsed criteria related to independence (Arnett, 2003). All three minority groups were more likely to consider the ability to take care of one's family and complying with social norms as completing a part of adulthood compared to White participants, which may be related to these groups having more collectivistic values and greater concern for others' opinions. A majority of people in these minority groups considered role transitions such as marriage, parenthood, completing education, and obtaining full-time employment, as an important condition of adulthood significantly more than Whites. However, this criterion for adulthood were still endorsed much less than being independent, taking care of one's family, and following social norms. While the researchers found that more African-Americans and Latinos believed that they had reached adulthood compared to Whites in this sample, the differences were due to variations in socioeconomic status, age, and parenthood, rather than ethnic affiliation.

The specific ways that socioeconomic standing is related to different definitions of adulthood have only recently been explored. Silva (2012) interviewed 93 working-class adults in their mid 20s and 30s (Mean age = 26; 17 Black men, 19 Black women, 28 White men, and 29 White women) about what growing up was like for them in this day and age. One of the themes that emerged for some individuals pointed to beliefs that traditional markers were difficult to obtain and made the journey toward adulthood appear to have no ending in sight. A number of these working-class emerging adults had a "therapeutic narrative" to define their transition to adulthood, which was marked by overcoming internal emotional/behavioral struggles.

In sum, this prevailing sense of being in transition to adulthood for several years, along with the aforementioned societal changes, challenges past stage models of development and the exclusive use of marker events, which outline adulthood as immediately following adolescence. When post-adolescent individuals are asked to describe themselves, the majority did not feel like they have achieved adulthood until well into their late twenties. Moreover, across different age ranges, a variety of ethnic groups in the US, and socioeconomic class, the criteria that emerging adults cite as important to becoming an adult relate to internal changes in autonomy, self-sufficiency, and overcoming psychological struggles, rather than objective transition points. At the same time, ethnic minority group members did select some traditional markers as important to being an adult compared to White samples, such as being married, having a child, completing tertiary education, and obtaining full-time employment, though these criteria were weighed far less important than the aforementioned internal changes. Such differences between ethnic groups appeared to be result of differences in socioeconomic status and whether or not a person had reached transitional markers, such as parenthood.

Arnett argues that a new developmental stage, emerging adulthood, is needed to account for these demographic changes and the perspectives of those who feel they are between adolescence and adulthood. The term young adult would seem to be inappropriate to use with individuals from 18 to 29, because this implies that adulthood has recently attained, but a majority of people from this group do not identify as such (Arnett, 2004, 2007). Several recent studies in countries outside of the US are described below to further discuss how individuals within the same age range may endorse similar criteria for the definition of adulthood, but that these criteria may have different cultural meanings.

## **Definitions of Adulthood Outside the United States**

This shift in the definition of adulthood has been observed in several other countries. This section describes research on this topic conducted in Austria, Romania, Spain, Mexico, Argentina, India, and China.

Austria is a European country that has had demographic changes like the United States with regards to increased tertiary education enrollment and age of first marriage (Sirsch, Dreher, Mayr, & Willinger, 2009). A study in Austria examined how adulthood was defined by adolescents (ages 11 to 19), “young adults” (20 to 29), and adults (30 to 35; Sirsch et al., 2009). Similar to studies in the United States, Austrians across all age groups reported that individualism, being able to take care of one’s family, and following social norms were the most important criteria for reaching adulthood, as opposed to biological or legal/chronological statuses. Additionally, a majority (55%) of the participants in the 20 to 29 age range identified themselves as being in between adolescence and adulthood.

Romania is another European country which has shown similar results and some evidence of having an emerging adulthood period. A sample of Romanian college students between the ages of 18 and 27 were asked whether they considered themselves to be adults, what criteria needed to be met in order to be an adult, as well as how important this criteria was (Nelson, 2009). Half of the participants considered themselves to be adults in some respects, but not an adult in other respects. The items that they endorsed as important for becoming an adult loaded onto several factors, including relational maturity, financial independence, norm compliance, family capacities, and role transitions. The most important individual items that they endorsed were accepting responsibility for their actions, avoiding using illegal drugs, choosing their own personal beliefs and values, having an equal relationship with their parents as adults,

and avoid committing smaller crimes, while transitional events/markers (e.g., completing college or becoming a parent) received limited support. Like emerging adults in the United States (Arnett, 2004), those from Romania were also optimistic about their future careers, romantic relationships, financial prospects, and future quality of life (Nelson, 2009).

Several Spanish-speaking countries have also shown some evidence for the existence of emerging adulthood. Both Spain and Mexico has seen increased enrollment in college in their respective populations (Arias & Hernandez, 2007; Del Barrio, Moreno, & Linaza, 2006). A study that compared 720 students from Spain and Mexico, ages 16 to 34, found broad differences between how emerging adults from each country experiences this period of development (Arias & Hernandez, 2007). While the five pillars of emerging adulthood were experienced by these individuals in some form, those from Spain saw this time as being characterized as having more instability and identity exploration than their Mexican counterparts. The authors of the study proposed that this difference may be related to the transition to adulthood that was marked by residing with one's parents for longer periods, greater difficulty with finding long-term employment, as well as taking a longer amount of time to acquire adult roles. This study demonstrates that while emerging adulthood may have similar themes in other countries, there are differences in this experience.

Within Mexico, emerging adulthood has also been observed in an indigenous population which is seeing increased college enrollment among their youth. One study interviewed 14 indigenous Maya students (nine female, five male) who were in the first generation in their families to attend college in Mexico (Manago, 2011). The traditional Maya culture is based on the cargo system, in which interdependence is emphasized within a community, and people with greater economic standing are expected to share their resources with families and neighbors.

Using semi-structured interviews, the study demonstrated that the experience of moving from rural homes to urban colleges resulted in themes related to emerging adulthood and adopting nontraditional values, such as individual autonomy, gender equality, romantic love, and having several choices for adult fulfillment. While being in college opened the students to different roles and choices that were in contrast to the limited options they had at home, they maintained some of their traditional values, such as interdependence with their family.

In Argentina, a developed Latin American country, two longitudinal studies examined whether individuals 20 to 27 years old saw themselves as adults, how they defined adulthood, and how they perceived this period of their lives (Facio, Resett, Micocci, & Mistrorigo, 2007). One cohort showed 45% of the individuals from 25 to 27 and another cohort showed 57% of the cohort from 20 to 21 saw themselves as being an adult in some respects, but not fully, demonstrating a significant number of individuals for a significant period saw themselves as being in-between adulthood and adolescence. As with their counterparts in the United States, Mexico, and Spain, nearly all of Argentinean emerging adults stated that accepting responsibility for one's actions and other indicators of autonomy, as important criteria of adulthood, as opposed to biological or role transitions. In contrast to their US counterparts, this population viewed emerging adulthood as a more stable time, and put more emphasis on focusing on others as an important part of this period of development.

Emerging adulthood has been shown to exist in Asia as well. A study in India examined the differences between of college students and nonstudent, rural-bound peers, from the ages of 18 to 26, in their transition to adulthood (Seiter & Nelson, 2010). Across the entire sample, 61% reported that they considered themselves to be adults, while 26% reported that they were adults in some ways, but not in others. A greater portion of males considered themselves to be adults



and a greater portion of females saw themselves as in-between adulthood and adolescence. The authors speculated these differences may be related to India's cultural view of women as submissive. More college students saw themselves as adults, or partially adults, compared to peers who lived in rural areas and were not in school. College students were optimistic about their future prospects, compared to nonstudent peers. The criteria that were considered necessary and important for adulthood emphasized family capacities and relational maturity, demonstrating how a culture which has more collectivistic values may differentially define adulthood and what capabilities are supposed to be developed during emerging adulthood.

Studies comparing Chinese and American emerging adults have shown different patterns in the proportion of individuals who believe they reached adulthood, as well as what criteria they believe must be met in order to attain this status (Badger, Nelson, & Barry, 2006; Nelson, Badger, & Wu, 2004). These studies showed that a third of American college students indicated that they considered themselves to be adults, compared to over half of Chinese college students (Badger et al., 2006). Two thirds of US college students saw themselves as being adults in some respects, but not entirely, whereas 35% of a sample of college students in China endorsed this belief. This finding suggests that fewer college students in China, albeit a minority, experience a subjective feeling of being in-between adolescence and adulthood than do counterparts in the United States. Although these studies found that a majority of Chinese college students endorsed items relating to independence, such as taking responsibility for one's actions, just like their American peers, these statements may have a different meaning to these individuals because of the greater collectivistic nature of the Chinese culture. Chinese college students also considered norm compliance, family capacities, and role transitions as more necessary to becoming an adult than American counterparts.

Differences between definitions of adulthood can be generational. A study in China compared whether college students 18 to 25 and their parents would consider them to be adults, as well as what was necessary to come an adult (Nelson, Duan, Padilla-Walker, & Luster, 2013). Parents focused less on intrinsic character and more on public behavior than college students, which likely related to older generations observing traditional values of avoiding shame and maintaining *face*. This study also showed that, in less than 10 years, the number of college students who saw themselves as adults decreased from 60% to 22% and the number of students who saw themselves as in-between increased from 35% to 71%, further demonstrating that emerging adulthood is a distinct and relatively new period of development in China, which is being experienced by a growing number of individuals.

In summary, there appears to be sizable groups of individuals between the ages of 18 to 29 across Europe, Latin America, and Asia who sees themselves as being between adolescence and adulthood. Many individuals in these populations endorsed similar criteria for what constituted adulthood as their same-age peers in the US in regards to being autonomous and self-sufficient, and experience this time as an age of self-exploration, possibilities, instability, self-focus, and feeling in-between. At the same time, this research shows that there are nuances in the ways that emerging adulthood is experienced across countries. While Spanish emerging adults experience this time as unstable, it may be to a higher degree compared to emerging adults from Mexico (Facio et al., 2007). Some Asian countries, like China and India, may emphasize the ability to take care of one's family more importantly than counterparts in the US (Badger et al., 2006; Nelson et al., 2004; Nelson et al., 2013; Seiter & Nelson, 2010). Emerging adulthood may also be experienced differently by those within a country. For example, a study in India highlighted how being a woman whether a person sees themselves as an adult or not (Seiter &

Nelson, 2010). Taken together, this body of research demonstrates that the concept of emerging adulthood does not merely apply to the United States, and appears to be represented in other countries across the world. While this developmental stage is growing in its recognition, the mental health needs of emerging adults are just becoming to be understood, and will be explored in the following section.

### **Mental Health Considerations in Emerging Adulthood**

Given the challenges involved in self-identity development involved in emerging adulthood and the inherent instability of this time period, understating the mental health strengths, vulnerabilities and concerns in this period of life is relevant to the practice of psychotherapy. This section begins with discussing the evidence for both increased psychological difficulties and reduced symptoms and adaptive coping in emerging adulthood. After discussing these prevalence rates, it describes different positive and negative developmental trajectory models. A brief explanation of these models is followed by a review of how emerging adulthood has been measured, which may serve a tool for clinicians to evaluate whether a client may be struggling with or meeting the challenges of this developmental stage. The section then concludes with an overview of how mental health needs of emerging adults have been met at the institutional and individual level.

**Mental health status/prevalence rates in emerging adulthood.** Emerging adulthood has been shown to be a time of diverse developmental trajectories that at times appears contradictory. This section reviews literature illustrating increased mental health problems during emerging adulthood, followed by research showing increased rates of well-being.

In one national study, nearly half of emerging adults from 19 to 25 met criteria for a psychiatric diagnosis in the last year (Blanco et al., 2008). This number is exceedingly high,

especially when one considers that that it is close to double the rate of the general adult population (Kessler, Chiu, Demler, & Walters, 2005). Depression is particularly common in emerging adults. The Clark University Poll of Emerging Adults conducted in 2012 found that 32% of their students agreed with the statement “I often feel depressed” (Arnett & Schwab, 2012). The one year prevalence rate for mood disorder ranges is about 11% (Blanco et al., 2008). One in ten college students report having seriously considered suicide in the past year (American College Health Association, 2008). Suicide is the third leading cause of death in adolescents, behind accidents and homicides (National Center for Health Statistics, 2004). In the national Clark University Poll of Emerging Adults, 56% of the 18- to 29-year-olds agreed with the statement “I often feel anxious” (Arnett & Schwab, 2012). Anxiety disorders share a similar one year prevalence rate (around 12%) with depression among emerging adults (Blanco, et al. 2008).

These elevated rates in mental health issues may be related to the fact that the most lifetime mental disorders have their first onset when a person is 24 years old (Kessler, Berglund, et al., 2005). Despite these high prevalence rates, only a fifth of emerging adults in college received treatment of any kind for psychiatric diagnoses (Blanco et al., 2008). This treatment utilization rate is comparable to the general US population, 18% of which reported receiving mental health services in the past year (Kessler, Demler, et al., 2005; Wang et al., 2005). While violent events such as the shootings at Virginia Tech and Northern Illinois University and are relatively rare in occurrence, they have heightened concern and attention toward identifying emerging adults who may be at of harm to self and/or others in order to prevent future tragedy (Fox & Savage, 2009).

With regard to substance use disorders, the prevalence rate for the emerging adulthood group has been found to be about 30%. This is the highest prevalent disorder for this age group

and the rate is twice that of the general adult population (Blanco et al., 2008). A large body of research has shown that increased substance use appears to be normative during this developmental period. Alcohol abuse is particularly frequent among this group. For example, a quarter to a third of college students report having had binge episode in past two weeks (Velazquez et al., 2011). While much of the research on emerging adulthood has focused on individuals in university settings, one study comparing two-year and four-year college students showed that, overall, students across these settings have similar rates of alcohol consumption (Velazquez et al., 2011). Non-college emerging adults have also been observed to have similar rates of substance use, compared to college-attending peers, with some differences between genders and rates of other substance-related problems (Blanco et al., 2008; White, Labouvie, & Papadaratsakis, 2005). Specifically, eighteen-year-old men were found to have higher substance use and related-problems compared to same-age-women (White et al., 2005). College bound students had lower rates of cigarette and marijuana use, and fewer problems related to alcohol and marijuana, compared to non-college peers (White et al., 2005). College students were observed to have a steeper climb in alcohol-related problems from 18 to 21 but a faster deceleration in these problem areas from 21 to 30 compared to non-college peers (White et al., 2005). Non-students also reported having more alcohol and marijuana-related problems at 18 and 30 (White et al., 2005).

Although drug use appears to be common and, on average, increasing in emerging adulthood, the pattern of usage across time can differ from individual to individual. One longitudinal study observing individuals starting at age 13 until 23, found four developmental trajectories for cigarette, marijuana, alcohol use (Tucker, Ellickson, Orlando, Martino, & Klein, 2005). A given person may have a different trajectory pattern across these different substances.

The abstinence trajectory was characterized by no use at all. About 30% of individuals who abstain from using one substance tend to abstain from using all three substances. The most common trajectory that was observed consisted of persistent light-to-moderate use, in which individuals increased their use of a substance in early adolescence, and then decreased their use slightly when they entered the emerging adulthood period. Others were found to exhibit high substance use in early adolescence, which decreased to moderate use by age 23. There was also a group of individuals who showed a steady, linear, increase in their substance use from little to on initial use. When these emerging adults reached 23 years of age, they used alcohol, marijuana, and cigarettes at higher rates than even individuals who used heavily in early adolescence. Individuals who belong to this class are of particular clinical concern, because the mediators for this developmental trajectory are not known at this time. The researchers found that even individuals who reported low, consistent alcohol binges and marijuana use had several substance-related problems, including lower college graduation rates and externalized behavior problems.

While statistics show high prevalence of mental health issues in emerging adulthood, other research shows seemingly paradoxical patterns of increased well-being in emerging adulthood. An overall declining trend of 12-month prevalence rates of disorders, including alcohol use disorders, Post-traumatic Stress Disorder, Major Depression, and phobias has been observed over the course of the emerging adulthood period (Tanner et al., 2007). Depressive symptoms and anger have also been observed to lessen from 18- to 25-years of age (Galambos, Barker, & Krahn, 2006), as well as violent behaviors (Marcus, 2009). While late adolescence is characterized by women having more depressive symptoms than men, on average, women have a rapid decrease of these symptoms during the emerging adulthood period (Galambos et al., 2006;

Tanner et al., 2007). By age 25, no gender differences are observed, and there appears to be gender equality for depression rates from 21 to 26 (Galambos et al., 2006; Tanner et al., 2007). However, the gender disparity returns at age 30 (Galambos et al., 2006; Tanner et al., 2007).

The field of clinical psychology has focused on defining disorders (as in the previous discussion) and measuring outcomes by reduction in symptom severity. From this perspective, given the aforementioned decrease in the prevalence rates of psychopathology, emerging adulthood would seem to be a period of increased well-being. Informed in part by positive psychology as well as other strength-based perspectives, clinical psychological research and clinical practice are integrating positive characteristics into their understanding of how people adapt and improve, including those in emerging adulthood. For example, Benson (2012) has called for an emphasis on the factors that lead to success in young people, rather than solely focusing on what leads to negative outcomes. He outlined a set of outcomes that constitute “thriving” including academic achievement, supporting others/one’s community, and maintaining a healthy lifestyle, but also acknowledged a need for other measures of positive development (Benson, 2012).

As an example of a study taking this orientation toward factors related to growth, Cotton Bronk, Hill, Lapsley, Talib, & Finch (2009) examined the process of searching for purpose as a positive and normative developmental process during emerging adulthood. In their study that compared 153 adolescents, 237 emerging adults, and 416 adults (White = 86%; Black = 4%; Asian/Asian American = 3%; Hispanic/Latino = 3%), those who had identified a purpose in their life tended to experience greater hope and motivation to fulfill these purposes, which then led to greater life satisfaction across all three developmental periods. However, searching for purpose

in one's life was positively correlated with life satisfaction in adolescence and emerging adulthood, and not adulthood.

Research has also highlighted several other predictors for wellness and life satisfaction among emerging adults. A longitudinal US study examined trajectories in a group of individuals between the ages of 18 to 25 from a western Canadian city (Galambos et al., 2006). Findings from this investigation showed several factors related to better well-being. Having educated parents appeared to be one supportive factor. Parent education did not influence initial symptoms, but did lead to more rapid declines. Social support was also found to improve well-being. Employment was correlated with increased self-esteem, and less depressive symptoms. Marriage was also found to promote well-being. Similarly, a longitudinal Australian study with 1,158 participants examined factors that contributed to positive functioning in 19 to 20 year olds, in regards to social competence, satisfaction with life, trust/tolerance of other people, trust in institutions, and engagement with civic duties (O'Connor et al., 2011). Results showed high family socioeconomic status, greater self-control, better school adjustment, high quality parental and peers relationships, and lower emotional reactivity lead to better development in all of these domains.

Finally, another area of interest relates to investigating whether there are subtypes of emerging adults that balance negative and positive well being. One research study found a trend of three classes of emerging adults (Nelson & Padilla-Walker, 2013). A majority of individuals, 63%, were categorized as "well-adjusted," and were characterized as having the highest amount of religious faith and values that were internalized. These positive trends were also accompanied by having lowest amount of drinking, substance use, sexual partners, pornography use, and violent video game use. About a third of emerging adults were classified as "externalizers" and



exhibited the highest levels of drinking, substance use, violent video game use, number of sexual partners, and pornography use. A little less than a tenth of college students were considered to be poorly adjusted. In addition to externalizing issues noted in the previous class, this group also showed higher levels of depression and anxiety. This group also had the poorest relationships with their parents compared to the other two classes. Well-adjusted emerging adults differed from the others by their tendency to rate norm compliance and family capacities as necessary components of adulthood, compared to the other two groups.

**Developmental models and mental health trajectories in emerging adulthood.** To gain a more balanced perspective of the mental health problems and positive functioning encountered in emerging adulthood, this section briefly discusses three models, which describe aspects of emerging adulthood that may potentially impact functioning and mental health. The first is an identity status model that is an application of Erikson's developmental theory. The second is a narrative identity model, which examines how people consolidate stories they have about themselves. The third model is based on the interaction between a person and his/her environment, and it proposes several pathways that may account for mental health difficulties in emerging adulthood.

***Identity status model.*** Based on Erikson's model of identity development, Marcia conceptualized identity formation in adolescence as a process consisting of two orthogonal dimensions. Exploration was defined as the degree to which an individual considers different options in regards to his/her goals and values. Commitments, the extent to which a person is invested in his/her choices once they are made (Marcia, 1966). Four prototypical identity formation statuses were theorized from these dimensions, which have been observed in US and European populations (Schwartz et al., 2011). The achievement status is characterized by

individuals who have thoroughly considered their possibilities and are highly committed to their intended vocation, values, and goals. The theory predicts that people with this status have the highest level identity synthesis and the best functioning among the four statuses. Other individuals do not explore various their choices, but are firm in their selection of particular goals, are considered to be have a foreclosed identity status. The moratorium status is characterized by low commitment to any particular goals, but a wide search in regards to exploring different roles and options for the future. Individuals who are low on their commitments and put little energy into exploring their options are considered to have a diffuse status. Similarly, Josselson (1998) proposed that individuals can be characterized among four identity development pathways: pathmakers, guardians, searchers, and drifters; these pathways are somewhat analogous to achievement, foreclosure, moratorium, and drifters in Marcia's mode, respectively.

Luyckx has expanded Marcia's model by conceptualizing exploration and commitment as multidimensional (Luyckx, Schwartz, Berzonsky, et al., 2008). Exploration is posited to consist of breadth, the amount of choices that are explored, and depth, which is the evaluation of a person's ongoing commitment and choices. Evaluation can take on a maladaptive form, such as when one ruminates. Commitment is further differentiated by the act of making commitments, or degree of one's commitment, and identification with one's commitments, or the extent to which a person defines themselves in relation to his/her choices. Luyckx proposed a dual-cycle is hypothesized to occur in which the dimensions within commitment and exploration mutually influence each other over time. A two-year longitudinal study using a sample of Belgium University students found that concurrent commitment-making and exploration in depth were negatively related (Luyckx, Goossens, & Soenens, 2006). There was also evidence that greater depth of exploration later paved the way for greater identification with one's commitments.

Recent research using this multidimensional approach as a framework has also identified additional identity statuses: carefree diffusion and undifferentiated (Luyckx, Goossens, Soenens, Beyers, & Vansteenkiste, 2005). Carefree diffusion is marked by low commitment, identification, and exploration (Luyckx et al., 2005). The undifferentiated status is comprised of a constellation of commitment and exploration levels which do not fit into the aforementioned categories (Luyckx et al., 2005).

Studies have found that different identity statuses are associated with particular patterns of adjustment and functioning in emerging adults. A three-year longitudinal study among female college students in Belgium examined patterns of adjustment in relation to different identity statuses (Luyckx, Schwartz, Goossens, Soenens, & Beyers, 2008). Individuals with an achievement or foreclosed-type status tended to have an optimal adjustment trajectory, characterized by high initial emotional well-being that gradually rose over time. Those in a state of moratorium were found to be at greater risk for having the lowest levels of self-esteem and highest levels of depressive symptoms, which remained stable over time. A large national cross-sectional study examining US college students from 20 states found similar results (Schwartz et al., 2011). Students who reached achievement and foreclosure statuses had highest satisfaction with life, well-being, and lowest among of health-compromising behaviors. Those who were in moratorium had more depression and anxiety than undifferentiated individuals, perhaps because they were more prone to ruminative exploration and higher on identity confusion. Additionally, those categorized in the diffused status had the lowest self-esteem, satisfaction with their lives, and mental well-being. These students also exhibited a high rate of risky sexual and substance-use related behaviors. Greater identity consolidation has been observed to correlate with lower

levels of health risk behaviors, including substance abuse, risky sexual behaviors, and risky driving (Schwartz et al., 2010).

***Narrative identity model.*** Narratives have also been used to understand identity development, specifically with regard to meaning making and extending Erikson's idea of generativity, or a concern for guiding the next generation (McAdams, 2001, 2006; McAdams & McLean, 2013; McLean, 2005). Narrative identity consists of the stories a person has about him/herself that he/she integrates in the context of present time and their social environment (Singer, 2004). Narrative identity is thought to be a measure of personality, and while themes and events that a person cites as important likely will have some continuity, it is conceptualized to not be as stable as dispositional traits (McAdams, 2006). Along with being influenced by cultural and environmental forces (Syed & Azmitia, 2010), narrative identity may be influenced by developmental stage (McLean, 2005). Narrative approaches have been used as a way to understand identity development during the emerging adulthood. A three-year longitudinal study examined a variety of life stories in first year and senior college students (McAdams et al., 2006). The investigators asked participants to describe 10 life events, including positive points, negative points, turning points, and other memories that were considered significant. While there was continuity for emotional tone as well as themes related to agency and personal development, the results also showed that the cognitive complexity, in terms of being able to report additional perspectives and mixed motivations, increased over time. These results demonstrated that emerging adults have an evolving concept of themselves, which may be used as a marker for development and functioning.

***Person-context interaction model.*** One model of mental health consists of one's ability to adapt to changing context and life circumstances (Masten & Coatsworth, 1995). Mental health

functioning is conceptualized as an interaction between an individual and his/her environment/context, which dynamically influence each other and cannot be separated. Emerging adulthood, being a time that emphasizes identity exploration and increasing autonomy, provides an opportunity for a person to change or continue on their functional trajectory. The following are brief descriptions of five interrelated conceptual models that may account for possible pathways for the continuity or discontinuity of mental health functioning from adolescence to emerging adulthood (Schulenberg & Zarrett, 2006). These models were originally proposed in the context of college adjustment and substance abuse (Schulenberg & Maggs, 2002), but have relevance in conceptualizing a broad relationship between developmental transitions and mental health. Each causal pathway is not necessarily mutually exclusive from one another and, given the diverse outcomes in emerging adulthood, may apply to different subsets of this population or co-occur in different individuals.

*Overload model.* This model proposes that multiple transitions from adolescence to emerging adulthood that occur over short periods of time may overwhelm a person's current capacity to cope with his/her environment (Schulenberg & Maggs, 2002; Schulenberg & Zarrett, 2006). For instance, a person who has graduated high school and is entering college may be expected to have several changes in different domains of his/her life, such as increased responsibility for time management (e.g., scheduling one's classes), establishing new friendships/social relationships, and living on one's own for the first time. As a result of these stressors, a person may develop maladaptive behaviors, such as substance use or emotional/behavioral avoidance, as coping strategies. According to this model, a person may or may not have been functioning well as an adolescent, so there may be continuity or discontinuity in terms of the life course of one's functional adaptation. Interventions for emerging adults who

are experiencing such an overload of their coping capacities may require staggering these responsibilities in some fashion (e.g., living at home for first semester of college or enrolling as a part-time student to reduce amount of stressors) or providing supportive resources (e.g., workshops to offer adaptive strategies). These types of interventions may occur at the parental or institutional level.

*Developmental match-mismatch model.* The transition to emerging adulthood either increases the match, or mismatch, between individuals and their present context, leading to continuities or discontinuities in mental health (Schulenberg & Maggs, 2002; Schulenberg & Zarrett, 2006). For example, the developmental need for identity exploration in an emerging adult who is functioning well may be appropriately matched with his/her entrance into college. Such an environment offers several affordances for experimentation, and may facilitate a continued path of well-being. If the same individual was not allowed to go to college and forced instead to be in an unstimulating work environment, he/she may not be given the opportunity to explore his/her identity. This would potentially be experienced as a mismatch between his/her developmental needs and the environment, which may lead to a discontinuity in their mental health functioning (e.g., depression). The reverse pattern can be envisioned for an adolescent who abuses alcohol and transitions into emerging adulthood. If this individual goes to college and has a roommate who engages in binge drinking, this would be a person-context match. One can imagine that this would likely lead to continued or increased problematic drinking behavior. If this same individual is placed with a roommate who does not engage in alcohol consumption, this would represent a person-context mismatch, and the influence of this peer may result in a disruption or discontinuity in the person's drinking habits. Interventions based on this model would focus on either matching a well-functioning person to an appropriately demanding

environment, or mismatching a person with problematic functioning/behaviors to a context that does not reinforce his/her maladaptive strategies.

*Increased heterogeneity model.* This model proposes that the emerging adulthood transition exacerbates initial individual differences in functioning and may be used to explain continuity between adaption/maladaptation from adolescence to emerging adulthood (Schulenberg & Maggs, 2002). For example, a high school student who had poor study skills will have a difficult time coping academically with the transition to college, and his/her performance in his/her classes may be worse during emerging adulthood. Compare this to another student who has good organization and study skills. One can imagine this individual as continuing to thrive in the college environment and having an upward trajectory for success. An example of treatment using this model would focus on identifying those who are already underperforming or not functioning well in adolescence and providing appropriate supportive services as they transition to emerging adulthood.

*Heightened vulnerability to chance events model.* Emerging adulthood is a time when individuals generally have more opportunities to engage in different exploratory behaviors. As such, these ventures increase the chance that a person will be exposed to both positive and negative novel experiences (Schulenberg & Maggs, 2002). These chance events may have a greater effect on a person who is an emerging adult because he/she may be more receptive or impressionable in this particular time of his/her life. Some experimentation may have negative consequences, such as substance use leading to future abuse or impairment. Other exploration, such as taking a college class on a whim, may lead to personal growth and opportunities that help a person refine his/her interests, as well as his/her identity. Treatment based on this model may involve public health campaigns to spread information about potential risks of particular

experimentation behaviors (e.g., binge drinking), or direct individuals towards counselors who can guide them in their personal explorations.

*Transition as catalyst model.* This model proposes that some health risk behaviors, especially alcohol abuse, may be normative during certain developmental stages (Schulenberg & Maggs, 2002). Alcohol use has been demonstrated to facilitate social relationships in college students (Maggs, 1997). So while an adolescent may initially use alcohol as a way with coping with depression, this same individual may use drinking to meet new people and establish peer relationships as an emerging adult. So although there is continuity in the person's behavior between developmental stages, it serves a different function in a new environmental context. One potential way to act on this information would be to focus on harm reduction, rather than the abstinence of symptoms, given that some of this behavior is to be expected in emerging adulthood.

**Summary.** Several developmental models have been used to examine how identity and mental health may be expressed and interact in emerging adulthood. Identity exploration is a central developmental task of emerging adulthood. Identity status models based on Eriksonian theory have evolved to explore how exploration, identification, and commitment affect development for emerging adults, and they help to explain why some emerging adults experience more anxiety and depressive symptoms than others. Narrative identity reflects how a person consolidates his/her life experiences into a self-concept. Emerging adulthood provides unique experiences that may help a person have a greater sense of agency, as well as offer an opportunity for cognitive complexity and perspective taking. This developmental period may also be seen as a new environment which interacts with a person's adaptive abilities to create continuity or discontinuity in functioning. Each of these models provides a different perspective



on the emerging adulthood experience, which can generate hypotheses to predict developmental outcomes and can offer ideas for treatment interventions. The next section describes measures to help assess whether a person may be an emerging adult, as well as some of the processes that were mentioned above.

### **Assessing Emerging Adulthood Status**

Because the concept of emerging adulthood is relatively new, measures specific to this developmental stage have only recently been developed. Of those that have been specifically developed for emerging adulthood, they have seldom been used as a clinical instrument or as part of psychotherapy. Nonetheless, this section describes what self-report instruments have been used to establish emerging adulthood as a concept, as well as those used for assessing emerging adulthood themes, and identity status, as well as qualitative measures that have been used to examine this developmental period.

**Arnett's measure for assessing criteria for adulthood.** Arnett has used a 39-item questionnaire to assess how individuals define adulthood in several studies (Arnett, 1997, 1998, 2001, 2003). Arnett and other researchers have generally used this measure in an exploratory fashion to assess what individuals believe is important for being an adult, both in the US and other countries (Badger et al., 2006; Nelson, 2009; Nelson et al., 2004; Seiter & Nelson, 2010). Participants are asked to dichotomously rate whether or not a criteria has to be met in order to be considered an adult. The instrument was composed of several subscales that were initially theoretically derived from anthropology and sociology literature, as opposed to factor analysis. These include biological transitions (e.g., capable of bearing/fathering a child), role transitions (e.g., married), chronological transitions (e.g., obtained a college degree), family capacities (e.g., capable of taking care of family members), individualism (e.g., financially independent from

parents), and following social norms (e.g., refrain from drunk driving) and other (e.g., have good control of emotions). The reliability for these scales have been shown to range from moderate to high, though alphas for the individualism subscale have been in inadequate ranges in some studies (Arnett, 2001, 2003). Recent research using this questionnaire in other countries, such as India and China, has generated a factor called relational maturity (Badger et al., 2006; Nelson, 2009; Nelson et al., 2004; Seiter & Nelson, 2010). This factor resembles individualism, but also contains items that emphasize how one should interact with others (e.g., accept responsibilities for actions, have good control over emotions).

Although this measure has not been used specifically with populations who have been receiving mental health services, one study found that college students who identified as adults believed that they had met more criteria for adulthood and had less depressive symptoms compared to their peers who endorsed more criteria consistent with emerging adulthood (Nelson & Barry, 2005). This particular questionnaire may generate useful information for clinicians who hope to understand a client and his/her cultural/personal beliefs surrounding adulthood. Future research assessing the correlations between the results of this questionnaire and clinical presentations/outcomes would also be helpful to inform how to best provide services for emerging adults.

**The Inventory of Dimensions of Emerging Adulthood (IDEA).** The IDEA is a 31-item measure that asks a person to describe whether his/her present life can be described according to six subscales that consist of theoretical aspects of emerging adulthood: identity exploration (e.g., “time of defining yourself”), experimentation/possibilities (e.g., “time of trying out new things”), negativity/instability (e.g., “time of unpredictability”), self-focus (e.g., “time of personal freedom”), feeling in-between (e.g., “time of gradually becoming an adult), as well as an

additional subscale for focus on others (e.g., “time of commitment to others”; Reifman, Colwell, & Arnett, 2007). The IDEA was designed to assess for individual differences in the amount that people identified with emerging adulthood processes.

The measure was created using a sample of college students from a public university in Texas, as well as their friends, families, and acquaintance, who varied ages from 18 to 50 and above. The IDEA has been found to have good internal consistency and good test-retest reliability. Scores for college and non-college attending individuals from the 18 to 23 year old group were found to have the highest levels on the identity exploration, experimentation/possibilities, negativity/instability, and self-focus subscales compared to older (24 to 29, 30 to 29, 50+) and younger (students in 6th to 12th grade) individuals, and that these scores declined with age (Reifman et al., 2007). In this sample, being focused on others showed the opposite trend.

The IDEA has been used to provide evidence for the existence of emerging adulthood in Argentina (Facio et al., 2007), Austria (Sirsch et al., 2009), and Romania (Negru, 2012). A slightly different factor structure was obtained when this measure was administered to emerging adults in Spain and Mexico (Arias & Hernandez, 2007). Seven factors were produced: Adulthood postponement, instability, autonomy, explorations, vision of future and possibilities, worries, and identity moratorium, which the investigators proposed may be due to cultural differences, such as prolonged stays at home.

The IDEA has also inspired creation of culture specific measures of emerging adulthood, such as in Czech Republic (Macek, Bejcek, & Vanickova, 2007), which created items that were culturally relevant to this population. An exploratory factor analysis revealed six pillars of emerging adulthood in this culture: Stability, Self-Focused Orientation, Diffuse Orientation (e.g.,

I'm being irresponsible), Clarity of Values (e.g., I would like to find my place in life), Identity Exploration, and Concern for Others.

The IDEA has not been used in the context of psychotherapy, but the instability subscale has been found to correlate with depressive symptoms and low self-esteem in a study with employed emerging adults (Luyckx, De Witte, & Goossens, 2011). Future research and interventions may be able to examine whether constellations of different subscale scores relate to presenting concerns in treatment.

**The Dimensions of Identity Development Scale (DIDS).** The DIDS was created to measure identity status and expand Marcia's commitment and exploration model for identity development (Luyckx et al., 2005). This measure consists of five-item subscales that correspond with identity dimensions, including making commitments, identifying with one's commitments, exploring in breadth, exploring in depth, and exploring through rumination, which in turn can be used to determine a person's identity status (i.e., achieved, foreclosed, moratorium, diffused, carefree diffused, undifferentiated). The alphas for each of these subscales have repeatedly been shown to have good internal consistency (Luyckx et al., 2005; Luyckx, Schwartz, Berzonsky et al., 2008).

The DIDS used a sample of college students in Belgium for its normative sample (Luyckx et al., 2005), and it has gone on to be used with a representative sample of US college students (Schwartz et al., 2011). Results from these studies confirmed the presence of six identity status types in emerging adults from both countries. Furthermore, these status types were associated with differing levels of well-being among US emerging adults. People who belong to the two diffused types reported the lowest self-esteem, internal locus of control, satisfaction with their lives, and mental well-being. Diffused emerging adults had the worse overall scores, while

the carefree diffused students exhibited more externalizing problems, like riskier sexual practices and substance use. Emerging adults with achieved and foreclosed identity statuses had highest satisfaction with life, and psychological well-being scores. In particular, those endorsing the achievement status had the highest eudemonic well-being, and lowest health-compromising behaviors. Differentiating between emerging adults of different identity status types may be helpful in giving providers indicators for possible targets for interventions. For example, colleges may be able to screen their incoming students and refer students who have a diffuse status-type for workshops or resources to encourage exploration and commitment processes.

**Narrative themes.** As mentioned before, narrative identity has been used as a model to understand the personality development of emerging adults. A basic methodology for measuring narrative identity involves gathering a person's self-reported accounts of important life experiences and coding them for themes and content. These themes may then be extrapolated to understand one's self-concept, as well as overarching cultural/developmental patterns (Wortham, 2001). More specifically, McAdams et al. (2006) examined self-reported turning points in the lives of emerging adults in college by coding narratives for emotional tone, for themes of agency (e.g., achievement, self-mastery, responsibility), communion (e.g., love, friendship, help), and complexity. Results showed that their narrative identities had some stability over the course of their schooling.

In terms of narrative identity themes in the context of psychotherapy, no studies were located that focused specifically on emerging adults. Narrative identity themes have been analyzed to understand clients' perspectives on their own agency while receiving mental health therapy in late adolescence (Gibson & Cartwright, 2013) and adulthood (Adler, Skalina, & McAdams, 2008). For example, Adler (2012) asked an adult outpatient sample to describe how

they felt treatment was affecting them from session to session. The 47 participants (Mean age = 36; 70% female; 70% Caucasian, 9% African American, 9% Asian American, 3% Arab American, 3% Multiracial) receiving outpatient mental health services were asked to record how they were thinking about therapy, the impact treatment was having, and how their thoughts and feelings about therapy changed over time. Narratives were coded for two themes, their agency and their coherence. Increased levels of the former were correlated to better well-being.

**Other qualitative studies.** Qualitative methodology lends itself to an inductive approach. This can be especially helpful in an area of research that is relatively new or not thoroughly examined. A small number of studies have used qualitative methods to help understand emerging adulthood in relation to mental health issues and psychotherapy. Two such studies are presented next. No studies were located that used any formal measures of emerging adult processes in a clinical population.

Marcus, Westra, Eastwood, and Barnes (2012) used a grounded theory and consensual qualitative approach to analyze the blogs of eight individuals (six female) between the ages of 18 to 25 who were describing their experiences with mental health problems. The sample included individuals based in England (five), Ireland (one), US (one), and Columbia (one). Themes were analyzed as they naturally arose in the data, rather than the researchers using preconceived theories. Open coding was first used to identify units of meaning and then these units were continuously re-coded and grouped into a hierarchy of categories until a saturation point was reached, such that additional data added no new information. The researchers found two overarching categories to describe the content of these blogs: “I am powerless” and “I am utterly alone.” Within the “powerless” category, the participants reported being severely disabled by their mental health issues with instances of relief when they engaged in self-care, took

medications, and made blog entries. The “alone” category was characterized by social isolation, including a lack of connection, at times, with mental health professionals. Specifically, providers were sometimes viewed as unresponsive, abandoning, disorganized, intimidating, and unsupportive. The results suggested that emphasis should be placed on improving outreach and awareness of what kind of provider behaviors are undesirable when working with an emerging adulthood population.

The value of increasing provider awareness about the perspective and needs of emerging adults was highlighted in another qualitative study with 12 adolescents and emerging adults (two Whites males, five White females, one Hispanic female, one African-American female, two African American males, and one African American and Hispanic male) who had been placed in a restrictive mental health treatment setting outside their homes (Polvere, 2011). The semi-structured interviews focused on their experiences with being placed in restricted care, as well as receiving a mental health diagnosis. Data was analyzed using a qualitative approach outlined by Miles and Huberman (1994), in which the interview transcripts were initially coded from a system that became refined as the data was analyzed. The codes from the individual interviews were then compared to highlight themes that occurred across the clients. Two overarching themes emerged: Problematic treatment practices and psychosocial impact of placement and diagnosis. The results of the study offered a “counter narrative,” which pointed to a lack of acknowledgment of the perspective of those who were placed in residential treatment facilities. Participants reported several conflicts with practices (e.g., physical restraints) and providers, feeling stigmatized/alienated after treatment, and, in some cases, valuing the knowledge that came with receiving a diagnosis. This study highlights the powerful information that can be

derived from looking at a few select cases of emerging adults experiences with psychotherapy in depth.

**Summary.** Measurements of emerging adulthood have been used to evaluate identity status and identity development, in addition to whether a person's experiences show themes that have previous been proposed as characteristic of this developmental stage. Some qualitative research has been done with emerging adults who received psychotherapy and found that there were periods of relief from symptoms, as well as relief after receiving a diagnosis. At the same time, these studies also found that mental illness can be debilitating, that stigma can follow treatment, and that they perceived some interactions with their providers as unsupportive and negative. There has been little qualitative research that has focused on emerging adults in a clinical context. However, research with adult populations in community care settings has examined agency and coherence themes in psychotherapy as antecedents to positive change (Adler, 2012). On the one hand, the dearth of research in this area is unsurprising, considering that this developmental stage is a relatively new concept. On the other hand, college students, who make up a part of the emerging adulthood population, have been well studied. The current methods for addressing mental health in the context of emerging adulthood are reviewed in the next section.

### **Emerging Adulthood and Psychotherapy**

As previously noted, emerging adulthood is a developmental period that may be marked by transient distress or confusion, or significant mental health concerns, which may require psychological intervention. However, estimates show that only one fifth of emerging adults in college receive treatment of any kind for psychiatric diagnoses (Blanco et al., 2008). Barriers to receiving care include reporting having a lack of time, concerns about privacy, reluctance to



being open emotionally, and financial constraints (Hunt & Eisenberg, 2010). Stigma regarding mental illness has been found to be a barrier for college students seeking help (Hunt & Eisenberg, 2010). More specifically, while college students rated the general public stigma for seeking treatment for mental health as being higher than their own personal views, only personal stigma was negatively associated with seeking help (Eisenberg, Downs, Golberstein, & Zivin, 2009).

To tackle these barriers, most four year institutions have implemented some form of help-seeking intervention. Upon enrolling, colleges often require students to have health insurance, which can make on-campus services more financially accessible (Hunt & Eisenberg, 2010). Another typical form of intervention comes in the form of outreach, whereby counseling centers inform the student body about services that are provided, in an effort to spread awareness and reduce stigma (Hunt & Eisenberg, 2010; Eisenberg, Hunt, & Speer, 2012). Student organizations have also taken the initiative to advocate for mental health services. For example, Active Minds ([www.activeminds.org](http://www.activeminds.org)) is a nation-wide, student-run organization that has over 300 chapters and is dedicated to raising awareness about mental health, reducing stigma, and encouraging seeking treatment.

Screening college students for at-risk behaviors and linking them to mental health services is another promising method that is being explored by universities (Eisenberg et al., 2012). The internet may be a particularly efficient and cost effective way to identify and refer students who would benefit from treatment. For example, a study which used a brief online screener for depression found that those who were at moderate to high risk for suicide, as well as who spoke to an online counselor, were three times more likely to seek therapy than those who only received feedback from their screener results (Haas et al., 2008). Similarly, several hundred

colleges participate in gatekeeper training (Eisenberg et al., 2012). These programs focus on increasing knowledge in individuals who have frequent interactions with a population of interest so that they may identify signs of mental illness, provide referrals, and, in some cases, provide some form of support/intervention. A variety of these gatekeeper training programs exist for specific behaviors, such as Question Persuade Refer, which targets suicide (Quinnett, 1995; Mitchell, Kader, Darrow, Haggerty, & Keating, 2013), and Kognito (n.d.), which focuses on more general mental health issues (Albright & Goldman, 2013). Both programs have been shown to increase self-rated knowledge and referral skills (Albright & Goldman, 2013; Eisenberg et al., 2012).

Despite varied interventions that colleges have to offer to emerging adults, more research is needed on the effectiveness and generalizability of such approaches (Eisenberg et al., 2012). Emerging adults in university settings may have the advantage of being able to conveniently access a range of interconnected services for mental health issues (Eisenberg et al., 2012), but this type of infrastructure can be lacking for emerging adults in the general community (the “forgotten half”). However, a research study examining the feasibility for a preventive intervention for depression in emerging adults in a primary care setting found that in-person motivational interviewing could be integrated with internet-based interventions with adequate fidelity (Van Voorhees et al., 2010).

The scant extant research raises concerns for the emerging adults who actually enter psychotherapy. One study showed found that they tend to participate in outpatient community treatment for less time than other age groups, as well as have higher drop-out rates (Edlund et al., 2002). Thus, it is important for clinicians and researchers to focus on treatment retention approaches. Unfortunately, there are no current clinical trials or published treatment retention

interventions for this population. However, research is being conducted to adapt motivational interviewing to improve treatment retention with transition age youth (Davis, Lidz, Fortuna, Fisher, & Mistler, 2012). Similarly, other well-researched treatments are being adapted for this group, such as Multisystem Therapy for emerging adults who have serious mental health issues as well as the legal system (Davis, n.d.).

Limited research exists on the experiences of emerging adults in therapy as connected to emerging adulthood theory. What research has been done consists of small qualitative studies, two of which will be related here. Kuwabara, Van Voorhees, Gollan, and Alexander (2007) conducted interviews with 15 emerging adults (10 women; seven Caucasian, four African-American, three Asian), from the ages of 18 to 25, who were currently experiencing minor to major depressive symptoms. The researchers identified several themes related to how they experienced depression, healthcare, identity, relationships, and role transition; the latter three appearing particularly relevant to emerging adulthood. Depression symptoms were observed to interrupt identity development by impeding personal growth or when the symptoms came to define the participants. Within the relationship theme, several participants reported being concerned with meeting parents' expectations, which may reflect the tension that comes with separation/individuation in this stage of life. In regard to role transition, identified subthemes included being overwhelming, concerned for the future, in-between, and optimistic. These latter findings demonstrate that developmental tasks related to emerging adulthood may be a source of depressive symptoms, which can be the target of treatment.

Another qualitative study, conducted in Sweden, involved semi-structured-interviews with 17 emerging adults with depression-related diagnoses (14 women; Mean age = 22). Participants were interviewed immediately after ending psychoanalytic treatment, as well as at a

1.5 year follow-up (von Below, Werbart, & Rehnberg, 2010). In exploring their experience with overcoming depression, the investigators found that within the theme of “experience positive change” were subthemes of “finding oneself” and “finding one’s way in life,” which showed the positive impact treatment can have on identity exploration.

There is also limited research investigating how developmental tasks may be related to presenting concerns, and what interventions to use to address them (Josselson, 1994). General suggestions from reputable sources exist about what therapy with this population may entail, without substantial research to back it up. For example, Tanner (n.d.), in an essay for the website, “Changing Sea: The Changing Spirituality of Emerging Adults Project, The Institute for Policy Research & Catholic Studies, Catholic University of America” describes emerging adulthood as a “window of opportunity” for meeting mental health needs because of factors such as brain maturation, the tendency to establish healthy behaviors, increasing levels of independence, and the ongoing natural process identity development. She suggests health education as one strength-based approach for this group, and concludes by stating:

these features of emerging adulthood suggest that we have a great deal to work with if we plan to help emerging adults achieve success, both in terms of becoming independent and also with regard to being mentally healthy. The need for services in emerging adulthood thus requires a focus on both the developmental tasks and the mental health needs of this age group. Facilitating one without helping the other is likely to reduce the effectiveness of efforts to help them.

Emerging adulthood theory suggests that resolving identity issues in individuals may be one way to improve functioning and well-being in face of distressing symptoms. One mechanism that may explain how individuals change through therapy is by a change in narrative identity. A longitudinal study examined changes in mental health, along with personal narratives, among 47 individuals (Mean age = 36; 70% Caucasian) after their treatment sessions (Adler, 2012). Results

from this study found that narratives which contained an increasing sense of agency were followed by improvements in mental health. This study did not examine emerging adults specifically, but since attaining self-sufficiency appears to be an important criterion for adulthood for many groups, and related to the concept of agency.

Other research has demonstrated that it is possible to design interventions which facilitate identity exploration in emerging adults, albeit in non-clinical groups. One controlled study explored how two different interventions, one that focused on formulating goal strivings (emotion-focused) and the other which focused on resolving life dilemmas (cognitive-focused), affected different identity processes in college students (Schwartz, Kurtines, & Montgomery, 2005). Ninety university students (70% Hispanic American, 12.3% non-Hispanic White, 11.1% African-American, 6.7% Other) were assigned to a control, emotion-focused, or cognitive focused condition, each of which consisted of weekly workshops over the course of six to eight weeks. Findings showed that the cognitive-focused intervention increased a person's ability to generate alternatives, while the emotion-focused intervention increased personal expressiveness. This study gives some evidence that interventions can assist emerging adults with developing skills that will assist them in their identity development, but that further research is needed to determine how additional processes might be encouraged.

In summary, while barriers exist for emerging adults receiving mental health services, attention is being placed on promoting ways to facilitate help-seeking and meeting the mental health needs of this population, particularly in college settings. However, once emerging adults are connected with these services, there is little known about how to keep these individuals retained in treatment and how they experience treatment. There is also a lack of research regarding what interventions can be used to help resolve the developmental tasks of this stage,

though changes in narrative identity and identity related processes may be potential targets. Only one qualitative research study was located that examined themes in the 15 emerging adults who experienced depression, and results indicated that their symptoms related to developmental tasks (Kuwabara et al., 2007). In the author's review of the research, no thematic analysis have been done on emerging adults when they are in actual treatment sessions. Thus, further exploratory research is needed to understand the themes that occur with emerging adults while receiving therapy.

### **Purpose of the Current Study**

Given that the experience of emerging adults in psychotherapy has not been thoroughly investigated, it is uncertain how the developmental processes of this stage may present and whether they might be targeted in treatment. Clients often relate important life events and turning points during the general intake and throughout the process of psychotherapy, which may contribute to their narrative identities. With regard to emerging adults specifically, processes and themes of identity exploration, instability, feeling in-between, possibilities, and self-focus may be sources of distress and ongoing stressors that contribute to their presenting concerns. Depending on the nature of the psychotherapy process and other experiences, one might expect that by the end of treatment, clients' understanding or interpretation of these events and experiences may evolve. For example, events that were perceived as distressing may be viewed also as opportunities/catalysts for maturation and change.

Qualitative methods have the potential of uncovering rich details about how emerging adulthood is experienced in the context of psychotherapy. Examining the presence of themes during actual psychotherapy sessions offers the potential to understand the developmental and personal experiences of emerging adults as they are receiving mental health services, which may

potentially help explain previously observed relationships, such as positive identity development and increased well-being. Exploring such content will also expand our understanding of how emerging adulthood may be related to clinical distress and dysfunction. In doing so, these themes may serve as the focus of future research, especially in regards to targets for therapeutic interventions. Therefore, the purpose of this study is to explore themes that emerge from emerging adult clients who are engaged in psychotherapy in an outpatient community setting.

## **Chapter II. Method**

This chapter is an overview of the methods that were utilized in this study. It begins with a description and justification for the study's design, and then delineates information about the participants, measures, sampling procedures, data collection procedures, and approaches to data analysis.

### **Research Design**

An inductive qualitative content analysis was used for the current study, as the research question was exploratory in nature. As opposed to a deductive approach, which tests a hypothesis and seeks to establish causal relationships, qualitative research, are generally inductive, in that it can be used to understand a phenomena without imposing preexisting theories (Mertens, 2009; Morrow, 2007). This form of investigation seeks to understand an event or series of interrelated events within the context of its/their natural environment, and to shed light on the potential process by which this occurrence emerges (Creswell, 2009; Mertens, 2009). For this study, inductive content analysis was used to generate and examine themes within the data concerning emerging adulthood in psychotherapy in order to scientifically classify patterns that naturally emerge (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Mertens, 2009; Zhang & Wildemuth, 2009). This method is particularly appropriate where the current theories do not sufficiently explain phenomena in their context, and has the potential to advance theoretical development through researcher interaction with the data (Mertens, 2009).

The present study investigated what clients at a community clinic in the emerging adulthood age-range discussed during psychotherapy (e.g., how they described themselves/their presenting concerns as relevant to the transition to adulthood. This was done through open coding transcripts of therapy sessions, and then comparing these findings in relation to



developmental tasks and themes of emerging adulthood. As explored in the review of the literature, individuals undergoing the transition to adulthood have diverse trajectories, with some showing declines in well-being while others showing increased well-being. It was anticipated that the design of this study would allow researchers and clinicians to better understand the needs of this age group and the unique issues they may bring to treatment.

## **Participants**

**Client-Participants (CPs).** 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 five psychotherapy cases, which contained sufficient data, from the archival research database of a Southern California university's community counseling centers. The procedures and materials used in the gathering of research data were approved by the university's Institutional Review Board (IRB; see APPENDIX A), and permission was granted by the co-directors who oversaw the archival database (see APPENDIX B) prior to accessing and collecting client data.

Before their first intake session for psychotherapy, participants provided informed written consent to have written records (e.g., treatment summaries, assessment measures) and audio/videotaped sessions included in the research database. Likewise, therapists also gave consent to have their written/audio/video session and treatment data included in the research database. The therapists in the study included 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 redacted and replaced with research codes.

In order to be included in this study, the CPs had to meet certain inclusion and exclusion criteria. Due to the specific developmental period described in the current study, each CP were

within the emerging adult age range, as defined by Arnett (2004) and SSEA (i.e., between the ages of 18-29) at the time of intake. Additionally, the client must have had a presenting problem that appeared to be related to emerging adulthood. Whether or not a presenting problem related to the transition to adulthood was determined by unanimous consensus between the study coders and auditor. Several developmental theories were used as a guide for identifying these issues (e.g., Erikson, Arnett, Marcia), but were not used as rigid or exclusive criteria. Participants were required to be fluent in English and provided written consent for their written and audio/video records to be included in research database (see APPENDIX C). Further, the therapists who were part of the selected cases must have provided written consent for their written and audio/video records to be reviewed (see APPENDIX D). Finally, to be included in this study, sufficient data was needed for each participant, including: video recordings of therapy sessions, Telephone Intake Form (see APPENDIX E), the Client Information Adult Form (see APPENDIX F), and the Intake Evaluation Summary Form (see APPENDIX G). Only clients who were receiving individual therapy, and not family, couples, or child/adolescent therapy, were included in this study. In order to protect confidentiality and to avoid biases in the coding process, therapist-participant dyads did not include someone the researchers knew personally.

The participants consisted of three female and two males whose ages ranged from 20 to 28. Their self-identified ethnicities were Latino/a, Caucasian, and African-American. Primary diagnoses at intake included Anxiety Disorder NOS, Adjustment Disorder with Depressed Mood, and Partner Relational Problem. The following table summarizes their demographic information along with diagnostic information:

Table 1.

*Client-Participant (CP) Demographic Information*

CP	Age	Gender	Ethnicity	Intake Diagnoses	Termination Diagnoses
1	23	Female	Latina	Anxiety D/O NOS, Academic Problem, Borderline Personality Traits, Educational Problems	Cannabis dependence, alcohol abuse, depressive D/O NOS, 300.00 Anxiety D/O NOS, Borderline PD, Education problems
2	29	Female	Caucasian	Anxiety D/O NOS, kidney stone, migraines problems with primary support	Not available
3	23	Male	Latino	Adjustment D/O with depressed mood, acute problems with primary support group, occupational problems, problems related to interaction with the legal system, relational difficulties	Relational problem NOS, Occupational problem, problems with primary support group, occupational problems, financial stress, discord with ex-wife, shared custody of children, relational difficulties
4	20	Male	Caucasian	Partner relational problem, alcohol abuse, frequent arguments with girlfriend, family history of substance abuse and divorce, death of parent, financial strain	Phase of life problem, problems related to social environment
5	28	Female	African-American	Partner-Relational problem social support problem, tense relationship with current boyfriend	Not available

***Client-Participant 1.*** Client-Participant 1 (CP1) identified as a 23-year-old, Latina, female, who did not have a religious-affiliations, and was a full-time student in a graduate program. CP1 reported that she was working at three jobs, as a student-teacher, on-call assistant at a medical center, and a graduate assistant. She stated that she lived at home with two younger siblings and her mother, and that she shared a room with the latter. CP1 referred herself for therapy because she felt overwhelmed with graduate school and that her longstanding history of procrastination was impairing her ability to complete her program. She reported that thinking

about homework resulted in symptoms of panic, including shaking and hyperventilation. CP1 stated that she was using alcohol and marijuana and that their use had caused her to miss classes and avoid schoolwork. She reported a history of self-injurious behaviors (i.e. self-cutting with scissors) and that she had serious thoughts of cutting herself two to three times a week at the time of intake. CP1 also reported a history of visual hallucinations (i.e., black humanoid forms with red eyes and fangs) since childhood that she still “occasionally” experienced. At the time of intake, she had been single for six months, after ending a relationship with her fiancé, who she met in high school.

The therapist’s initial impressions resulted in a diagnosis of an Anxiety Disorder NOS and academic problem, with Borderline Personality features. According to the Treatment Summary, the client’s treatment shifted to focus on depressive symptoms and problematic substance use, as well as a Borderline Personality disorder, which CP1 met full criteria for over the course of treatment. The therapist recorded that a cognitive-behavioral therapy approach was utilized, to which the client was reportedly resistant. Treatment lasted for 28 sessions and the fifth and approximately 25th sessions (based on DVD dates and appointment log) were used for transcription and analysis.

***Client-Participant 2.*** Client-Participant 2 (CP2) self-identified as a 29-year-old Caucasian female with no children. She reported being enrolled in graduate school while working as a preschool teacher. At the time of intake, she was living with her sister and a roommate in an apartment. CP2 referred herself for therapy with the goal of becoming more aware of her behavior and to learn how to approach herself with acceptance, rather than judgment. She also reported that she desired to develop a stronger relationship with her partner, a 49-year-old man with two children (seven and 14 years of age), as he went through a divorce.

CP2 reported that she was raised in a Mormon household but had not been practicing since she was 17-years-old. She described having a history of panic attacks and substance abuse that started when she was 18-years-old.

The therapist's initial diagnostic impressions gave a diagnosis of Anxiety Disorder NOS, medical issues of kidney stones and, occasional migraines, and problems with her primary support group. The course of treatment (e.g., treatment orientation, changes in diagnosis) was unclear, as there was no Termination Summary for CP2. However, based on other documentation sources (i.e., appointment log, dates and numbers of DVD-recorded sessions), it was estimated that treatment lasted approximately 24 sessions. Therapy sessions five and 22 were used for transcription and analysis.

***Client-Participant 3.*** Client-Participant 3 (CP3) self-identified as a 24-year-old single, Christian, Latino male with two children and no previous marriages. At the time of intake, he was employed a repairman, airport employee, and massage therapist as he attended a criminal justice program in college. CP3 reported that he lived with his children, mother, step-father, step-brother, and his step-brother's girlfriend in an apartment. He referred himself for therapy for feelings of depression, as well as difficulties related to trust and assertiveness with others, legal difficulties with the mother of his children, and concerns about being able to provide for his children. CP3 reported experiencing feelings of sadness for the past two months, which followed the ending of a romantic relationship with a female friend. He reported that five years prior to this relationship, the mother of his children had an extra-relational affair with his best-friend, which led him to becoming the primary caregiver to his children. CP3 reported that he considered committing suicide with a handgun five years prior to his first session with the therapist, but threw away the gun after considering the impact it would have on his daughters.

CP3 reported that his parents were born in Guatemala while he and his siblings were born in California. His parents divorced when he was a child as a result of his father having an extramarital affair.

The therapist's initial impressions resulted in a diagnosis of an acute Adjustment disorder with depressed mood and problems with primary support group, occupational problems, relational problems and problems related to interacting with the legal system. According to the Treatment Summary, a humanistic approach was utilized with CP3, and a strong therapeutic alliance was established. The client reportedly improved throughout the course of treatment, and his diagnosis before being transferred consisted of a relational problem NOS, occupational problem, problems with primary support group, occupational problems, financial stress, and discord with ex-wife. Treatment lasted for 41 sessions before transferring to another therapist. The fifth and 25th sessions were used for transcription and analysis.

***Client-Participant 4.*** Client-Participant 4 (CP4) self-identified as a 20-year-old Caucasian male who was enrolled in an undergraduate program as he worked as a manager at a supermarket. CP4 stated that he resided in a house with four to five peers. He was referred to therapy by his girlfriend of two months because she disliked his alcohol use, which reminded her of her own father's alcohol abuse. According to CP4, he typically had two to three drinks per occasion, about two to three times a month. CP4 also reported he had difficulty experiencing and coping with emotions. CP4 reported that his parents divorced when he was 12 and his father, a Vietnam veteran with PTSD, died of a heroin overdose when he was 17. CP4 reported that he did not believe in marriage and did not intend to have children, which was a source of conflict with his current partner.

The therapist's initial diagnostic impressions resulted in a diagnosis of partner relational problem, with a rule out for alcohol abuse, as well as v-code diagnoses for frequent arguments with girlfriend, family history of substance abuse, death of a parent, and financial strain. Four months into treatment, his diagnosis was changed to Attention-Deficit/Hyperactivity disorder, inattentive type, and v-codes for not succeeding in school, financial strain, and history of family problems, with a note that he had ended the relationship with his partner. After two and a half years in treatment, his diagnosis was changed to a phase of life problem, and problems related to the social environment. According to the Treatment Summary, insight-oriented psychodynamic therapy was used to increase CP4's emotional awareness. According to the clinician's notes, he made progress slowly but steadily and was not receptive to cognitive-behavioral interventions when they were introduced at various points during the course of treatment. His diagnosis remained unchanged at the end of treatment, which lasted for 100 sessions (three years). The fifth and 97th sessions were used for transcription and analysis.

***Client-Participant 5.*** Client-Participant 5 (CP5) self-identified as a 28-year-old, African-American, Christian, female who moved to Los Angeles from Kentucky four years ago. At intake, CP5 worked as an accountant and lived in a one-bedroom apartment, where her boyfriend would stay with her for months at a time when he visited Los Angeles. She referred herself for therapy because she reportedly had difficulty opening up to her friends, who she considered to be shallow. She stated she also wanted advice with regards to her boyfriend of four years, who she did not trust. A year prior to the intake, CP5 found that her boyfriend was caring for a child that he may have fathered before their relationship. The boyfriend reportedly did not know whether or not he was the father, but continued to care for the child because he felt attached. CP5 lived with her mother and brother (two years senior) and never knew her biological father. CP5

reported that she was raped by her uncle when she was in third grade, but did not report the incident, nor received any treatment related to the event. She grew up in a neighborhood that exposed to her frequently to violent crimes, and many people she knew were shot of incarcerated.

The therapist diagnosed CP5 as having a partner relational problem, social support problem, and tense relationship with current boyfriend. According to the Treatment Summary, the clinician utilized a psychodynamic approach to help CP5 explore childhood trauma and later utilized a cognitive-behavioral approach to help her communicate her emotions to others, which was well-received. Treatment lasted for 21 sessions and the fifth and 18th sessions were used for transcription and analysis.

**Researcher-Participants.** The researcher-participants for this study were comprised two clinical psychology doctoral students who were responsible for coding the collected data (Coders 1 and 2). A licensed clinical psychologist served as the auditor and supervised the team throughout the data collection, coding, and analysis process. The inclusion of multiple researchers and an auditor assisted in providing diverse perspectives, minimizing biases from individuals, and helping to sufficiently capture the complex nature of the data (Hill, Thompson, & Williams, 1997). The following is a personal description (e.g., background, professional views) provided by each of the coders and auditor in an effort to be transparent and identify potential areas of bias.

**Coder 1.** The primary researcher and dissertation author, identifies as a 32 year-old, heterosexual, Chinese-American male doctoral student in clinical psychology. His family is originally from China, and he is the second generation that has been born in the United States. He has been brought up in the upper middle class, been married for three years, and considers



himself to be agnostic. Coder 1 generally conceptualizes clients and conducts psychotherapy from a cognitive-behavioral perspective. He believes that many clients present to treatment for many reasons, chief among them being that developmental/biological predispositions lead to maladaptive responses to psychological and environmental stressors. Coder 1 believes that, broadly, learning is the primary mechanism for positive change in therapy, be it psychoeducation, self-knowledge, or developing abilities to cope with psychological and environmental stressors. In regards to his own developmental status, Coder 1 views himself mostly as an adult because of the interdependence he shares with his partner. and 15-month-old daughter. Coder 1 believes that taking on these responsibilities partially contributes to his being an adult. However, he does not feel like a “full” adult because he does not support his family through gainful employment.

**Coder 2.** The second researcher is a 25-year-old, Caucasian, female clinical psychology doctoral student. She was born and raised in a middle-class family in the southwestern part of the United States. Coder 2 was raised in a Catholic family, however she considers herself to be agnostic. Coder 2 generally conceptualizes and treats clients, from an integrative perspective; including positive psychology, humanistic, and cognitive-behavioral techniques. More specifically, she believes that unhelpful or distorted ways of thinking, in combination with a tendency to buy into or “fuse” with those systems of thought can strongly influence affect, behavior, and general functioning. Accordingly, she believes that the identification and modification of various levels of thought, rapport and empathy in the relationship, emotion regulation skill-building, and a strong therapeutic alliance in therapy will contribute to improvements in mood and behavior. Consistent with this perspective, Coder 2 also views the therapeutic relationship and a sense of authenticity as necessary elements upon which such

change can occur. She conceptualizes adulthood as a subjective state of being rather than defining it through the achievement of delineated milestones.

The auditor of the study, who is also the dissertation chair, is a European-American, Christian female who is married. She has a doctoral degree in psychology as well as a terminal law degree and is a tenured, associate professor of clinical psychology. She teaches courses and conceptualizes cases first through third wave cognitive-behavioral theories, informed by systems, developmental and strength-based approaches. Her research lab focuses on psychotherapy process research and she enjoys mentoring the emerging adults in her work. Accordingly, she supports the use of and research on mindfulness and acceptance techniques in personal and professional settings, and believes that such approaches are helpful with therapists and clients across the developmental spectrum, including those in emerging adulthood.

## **Procedure**

**Sample selection and data collection.** Because of the particular research question being investigated, this study used purposeful sampling to target the specific participants to be included 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 increased the likelihood of generalizability in spite of the fact that the included clients were not necessarily representative of all emerging adults who go to therapy as a whole (Mertens, 2009). However, generalizability is not necessarily critical when conducting qualitative research (Creswell, 1998). Since, four or five individual cases have been recommended for in qualitative research (Creswell, 1998), five individual adult psychotherapy clients that met the inclusion and exclusion criteria were from the confidential research database of the university community counseling center. A broad range of client characteristics and demographic variables (i.e., age, gender, ethnicity, religious affiliations,

socioeconomic status) were considered when selecting CPs to help ensure that the sample was diverse and representative of the clinic population (Kazdin, 2003; Mertens, 2009). Therapist characteristics were not considered as they were not the focus of this study.

In order to purposefully sample, a complete list of research records were obtained (clients who have terminated their therapy and whose clinical data has been de-identified and entered into the research database). Using these records, adult English-speaking clients between the age of 18 and 29 who participated in individual therapy were selected. Client self-report on two data instruments were used to determine whether potential CPs meet the study criteria related to age at intake. In the Caller Information section of the Telephone Intake Form (see APPENDIX E) and in the Personal Data section of the Client Information Adult Form (see APPENDIX F), a client must have indicated that his or her age was between 18 and 29. This information was corroborated by the noted age on the Client Intake Evaluation Summary (see APPENDIX G).

The sample was narrowed to include only clients who had presenting concerns related to emerging adulthood. Multiple data instruments were examined to determine whether the potential CPs met the inclusion criteria related to written reports of emerging adulthood concerns; however, the inclusion criterion did not extend to the content of the taped therapy sessions. During this phase of sample selection, emerging adulthood concerns were broadly construed and derived from several developmental theories that outline characteristics that may be indicative of this age group (e.g., Erikson, Marcia, Loevinger), rather than being strictly related to the five pillars of Arnett's theory. For example, in the Current Difficulties section of the Client Information Adult Form, the CP may have selected at least one of the following: housing instability (Arnett), wondering "who am I," (Erikson, Marcia, Loevinger), difficulty with school or work (Arnett, Erikson, Marcia), concerns about finances (Arnett), family

difficulties (Erikson, Arnett), breakup of a relationship (Erikson, Arnett), difficulty making or keeping friends (Erikson, Arnett), difficulty making decisions (Marcia, Arnett, Loevinger), or feeling conflicted about attraction to members of the same sex (Erikson).

Similarly, information from the Telephone Intake Form (see APPENDIX E), from multiple sections of the Client Intake Evaluation Summary (see APPENDIX G), and from the Treatment Summary (see APPENDIX H) were used to corroborate information boxes the client endorsed on the Client Information Adult Form and/or to gather more information. The Reason for Referral section of the Telephone Intake Summary provided information about reasons why clients were referred to one of the counseling clinics. On the Client 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.

From the remaining clients, the researchers selected two of their recorded sessions to be transcribed. The first session came from the beginning phase of treatment, which was defined as among the first quarter of therapy appointments. This time frame was selected in order to obtain information about initial concerns with which emerging adults presented in therapy. When possible, this was the fifth session that the client had met with the therapist, in order to approximate standardization across clients. The second session came from the end phase of treatment for each client, defined as a session after the second half of therapy appointments. The intention behind this criterion was to observe any changes in presenting concerns across the course of treatment for emerging adults. When possible, the third to last session of therapy was used. Given the exploratory nature of this study, we had no inclusion criteria regarding the

content of these sessions. Once these sessions were selected, they were transcribed and subsequently coded. Therefore, a total of ten sessions were transcribed and coded for the purpose of this study.

Of these participants, client characteristics and demographics were examined in order to create a diverse sample that varied across age (based on year of birth or reported age at intake), gender, race/ethnicity, and religion/spirituality. The sample had no more than three persons of one gender, at least three major ethnic or cultural groups represented, at least three religious/spiritual orientations included, and at least one participant in each of the following age ranges: 18-21, 22-25, 26-29. This demographic information was obtained through clinic forms included in the archival database. The Telephone Intake (see APPENDIX E) was examined for age and gender while the client's religion/spirituality, ethnicity/race, and disability status was found in either the optional Social Cultural section of the Client Information Adult Form (see APPENDIX F) or within Cultural Factors & Role of Religion in Client's Life (Section F) section of the Client Intake Evaluation Summary (see APPENDIX G).

***Transcription.*** Transcription of the sessions were completed by four master-level psychology graduate students and a bachelor-level psychology undergraduate student, 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 transcribed the sessions can be found in the Research Project Transcription and Coding Manual (see APPENDIX I).

***Coding.*** The coders for this study consisted of two 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 were 100% in agreement on practice cases (2 out of 2 in agreement). The coders were trained to understand the essential concepts, terms, and issues that are relevant to the study (Ryan & Bernard, 2003; Yin, 2009), including how to accurately identify and code potential occurrences of emerging adulthood-related content. The coders were each trained on the techniques of the coding method to be used in this study. Specific instructions for how the coders were trained can be found in the Research Project Transcription Coding Manual (see APPENDIX I).

*Human subjects/ethical considerations.* Confidentiality and maintenance of ethical standards for the treatment of research participants were maintained in several ways. First, limits of confidentiality for therapy and for research database inclusion were reviewed as part of the standard 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 clients of the counseling center (see APPENDIX C). Additionally, the therapists who were included in this study provided written consent to allow their records and session videos to be included in the research database (see APPENDIX D). When a clinical case was terminated, all client/therapist clinical information was processed according to a manualized procedure 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. Participating therapists and clients were assigned a research number to de-identify them for research purpose. All individuals who transferred clinical data to the research database completed an Institution Review Board (IRB) certification course (see APPENDIX J).

In addition to the research data preparation, provisions were made so that those handling the de-identified data did 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 they adhered to ethical standards of participant research and handling confidential health information (see APPENDIX K). 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, there was no direct engagement by the researchers with the CPs. In this study, previously recorded psychotherapy sessions and corresponding written clinical documents were accessed from the archival database.

### **Data Analysis Approach**

Before coding, data was prepared for an inductive content analysis. Research assistants transcribed the videotaped therapy sessions of the selected CPs. They noted the session numbers to be utilized for coding. After the data preparation, the coders examined the data for specific themes connected to emerging adulthood/the transition to adulthood that arose from CPs, in accordance with recommendations for inductive content analysis (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). This process typically consists of three parts: open coding, creating categories, and abstraction (Elo & Kyngäs, 2008).

More specifically, open coding began by the researchers reading through each transcription many times while making notes and writing down thoughts and ideas, until each felt he or she had captured the essential headings to describe aspects that answer the research question (Elo & Kyngäs, 2008). In some cases, a client-participant talk-turn may have been coded multiple times for different content. For example, in his latter session CP3 stated that:

It's like I said, [unintelligible]... a pleasure there. Told you, spend more time with them two, I'm like.. They're the one calling, they're like yeah, you're making up stuff. But that, [shakes his head] there you go...that's what pisses me off. I'm like, you know what? Just take care of business, and that's it. And all she cares is that I'm throwing her name around. I just walked away, and I'm like "F-U", and I just...walked out of the store.

This dialogue to was coded for content related to the CP experiencing anger, as well as having a conflict with an ex-partner. After coding each individual session, the researchers met to compare their coding with one another in order to evaluate them for similarity as well as to identify idiosyncratic analyses (Hseih & Shannon, 2005). The checking process was important for a number of reasons, which included minimizing the impact of fatigue from coding, accounting for biases of each of the coders, and establishing inter-coder verification (Zhang & Wildemuth, 2009). In cases when there were disparities or inconsistencies in categories, the researchers independently returned to the data and searched for additional thematic content related to respective theme and repeated the abstraction process to verify the reliability of categories (Elo & Kyngäs, 2008). Non-shared themes were compared against inter-rater shared themes to determine if they could be conceptualized under a mutual heading, or if they were distinct, such that they should be included as a separate branch of the theme hierarchy (Zhang & Wildemuth, 2009). The researchers reached the highest possible non-unanimous agreement (i.e., 100 percent) before a category was considered accurate.

To help ensure reliability of the researchers' process and findings, the independent auditor reviewed the transcripts, the coded the sessions, and reviewed the codes/notes of the two researchers after each individual session had been initially coded. The purpose of this step was to make certain that the findings of the researchers had dependability and confirmability, which suggested that the research process was consistent in its implementation, and that data, the analysis, the interpretations, and the recommendations were internally coherent (Zhang &



Wildemuth, 2009). The researchers then reviewed the transcripts and the codes again and made changes based on feedback from the auditor.

The abstraction process consisted of the primary researcher going back and forth between category codes and grouping them into subcategories (more specific), intermediate categories (general), and (more general) parent categories, all of which tied back to the research question. The primary researcher went back and forth in consultation with the other research and auditor on the organization of this hierarchy to discuss its confirmability. The hierarchy of themes that was generated from the analysis process is described in detail in the next section.

### **Chapter III. Results**

This study used an open coding approach to investigate the themes related to the transition to adulthood that five diverse emerging adulthood clients reported in two of their psychotherapy sessions. The purpose of this chapter is to present the results of this study's conventional qualitative content analysis of transcribed therapy sessions to understand what themes emerging adults expressed while receiving psychotherapy.

The chapter begins with a description of the two Parent Themes that emerged across the ten sessions, and is followed by a section describing the Intermediate Categories within each respective Parent Theme, and the respective subcategories that comprised them. After describing the general categorical hierarchy, a within-participant analysis describes the subcategories that emerged within each CP's session, which was used to capture the thematic content related to emerging adulthood. More specifically, subcategories were identified if the content theme showed at least two times in a transcript. Subcategories were then grouped into unifying Intermediate Categories.

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 subcategories from which the intermediate and parent groupings were derived (see APPENDIX L). Descriptions of these themes, intermediate categories, and subcategories are delineated, and specific examples from the therapy transcripts are provided in order to help illustrate certain groupings and concepts that may not be self-explanatory. Additionally, 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**

The conventional inductive content analysis yielded two content-based Parent Themes that addressed content observed across the five participants. These themes were: Self-Development and Interpersonal Relationships.

**Self-Development.** The Self-Development Parent Theme can be defined as content (e.g., behaviors, emotions, and thoughts) that were focused primarily on the CP's personal areas of growth and challenge (e.g., identity development, self-regulation) which related to their transition to adulthood. This Parent Theme, which appeared for all five participants 183 times, was further separated into 20 subcategory themes, which were organized into five Intermediate Categories based on the general domain of the concern, including (a) Behavioral Regulation, (b) Life Management Skills, (c) Emotional Experience, (d) Professional Development, and (e) Self-Concept (see APPENDIX M).

**Behavioral Regulation.** The Behavior Regulation Intermediate Category included content regarding clients' expressed abilities to monitor and modulate their thoughts and behaviors, as well as the resulting consequences of these efforts. Three CPs discussed content related to this Intermediate Category 29 times, which consisted of three subcategory themes including (a) Substance Abuse, (b) Impulse Control, and (c) Diet and Exercise. The Substance abuse subcategory emerged from content related to substance use and the consequences of this

usage. It appeared for three of the CPs thirteen times. For example, CP3 discussed using cigarettes and energy drinks as a way to manage stress:

C26: I don't know [Diverts eye contact for a brief moment]. Right now, well, right now I just found me a cigarette. So I had one of those. I'm like, cuz that's when I—when I get stressed, I'll buy me a pack of cigarettes and I'll—with one cigarette...

T27: You're cool [Very low volume].

C27: ...I'm cool, and everything, everything is alright. So I didn't buy it, I found it. So I'm like, Alright you know I'll smoke it and buy me a Red Bull.

This CP, as was the general case with the other clients, generally described decreasing his substance use, either recently or since his was a teenager. Impulse Control contained content related to monitoring thoughts and how the CP reacted to these thoughts. CP2 was the only client whose content applied to this category, which appeared four times. She discussed being able to keep herself from intruding on her partner's privacy:

C37: [laughs] Hey! I did not go through his phone.

T38: Yay! [smiles] Is that good?

C38: [laughs] I thought it was worth telling you that I just didn't have any desire

T39: You had no desire to?

C39: Yeah...well you kinda said the magic words. I kept thinking about what you said about, um, whatever you keep looking for you're gonna find.

T40: [Nods] Mm-hmm

C40: And it just made me realize like "Ok, like I really have this choice to change this behavior if I can and start to ya know just create, just try to create some new patterns. Try to not be driven by the same impulses, I guess? To, or same fears. And try to see how I could be stronger than that or...I don't want it to be a huge fight. Like if it was such a huge fight with myself though, I would just check 'em...

T41: Right.

C41: Cuz that would torture me

T42: Yeah.

C42: But um...Yeah, I guess I'm just trying to allow myself to really [clears throat]...Also it's part of me allowing myself to be loved by [Partner] and realizing that I'm more important...

Diet and Exercise was a category that included clients' efforts to control what they consumed and their physical activity. Two CPs, CP4 and CP3, discussed this theme 12 times in their

sessions, and reported that increasing their physical activity and monitoring their diet had improved their wellbeing.

*Life Management Skills.* The Life Management Skills Intermediate Category included content related to client discussions of practical skills related to daily activities or life transitions. The Life Management Skills Intermediate Category, which was observed across three CPs 65 times, was comprised of five subcategories: (a) Money Management, (b) Time Management Difficulties, (c) Time Management Interventions, (d) Study Environment, (e) and Housing Transition. The Money Management subcategory included content related to finances and how CPs spent or regulated how they spent money. Three CPs, CP5, CP1, and CP4 discussed material related to this category twelve times. For example, CP4 discussed how he was able to afford having access to a Jacuzzi:

C130: It's cool that, like uh, that I can do that. And they have a Jacuzzi. And it's awesome. That's honestly the biggest reason I joined, was that...when I used to have that at my old house...I had a Jacuzzi and a pool - so expensive every time I wanted to heat it up...er, if I wanted to keep it heated - it would...our electric bill went up like 400 dollars-

T131: Wow....

C131: ...so it was like split between 4 people, 100 dollars a person, and that's just to use the Jacuzzi more - so 40 bucks a month for a gym and a Jacuzzi - or a hundred bucks a month just for a Jacuzzi at home.

CP1 was the sole source of three subcategories within the Life Management Skills Intermediate Category. The Time Management Difficulties subcategory included content related to difficulties with making appointments, meeting deadlines, and turning in school assignments, which emerged 38 times. The Time Management Interventions subcategory, which included content related to her efforts to improve her time management, was mentioned five times. The Study Environment subcategory pertained to her selecting and managing her environment to study for school, and this was discussed five times. CP4 was the only CP for whom the Housing Transition

subcategory emerged, which involved material related to managing moving from one place of residence to another, and occurred five times.

***Emotional Experience.*** The Emotional Experience Intermediate Category was formed to describe 28 reports from three CPs of the emotions they reported experiencing and their ability to recognize, cope, and regulate with these emotions. Emotions that were explicitly identified by the clients or inferred through inter-rater agreement were separately coded. The Emotional Experience Intermediate Category emerged from four CPs and consisted of five subcategories: (a) Anger, (b) Anxiety, (c) Not Understanding Source of Emotions, (d) Improvements in Emotional Regulation, and (e) Suicide.

The Anger subcategory included instances in which two CPs reported having difficulty managing their anger, a total of five times. The Anxiety Subcategory included content about difficulties CPs had with managing worry, and this was mentioned by only CP5 seven times. Not Understanding Source of Emotions included content discussed by one CP three times about not understanding what was influencing her mood state. She said that she would cry on certain occasions, including while hiking or watching TV, but did not know why. Improvements in Emotional Experience was a subcategory that was created from CP reports that they believed they were better managing their emotions. This category appeared for CP1 and CP2 seven times. Suicide was a category that emerged from CP reports of suicidal thoughts or suicidal behaviors, which were considered a maladaptive coping response to distressing emotions. CP1 was the only CP to express suicidal thoughts in the transcribed sessions, and this theme occurred six times.

***Professional Development.*** The Professional Development Intermediate Category included content themes related to education and work, which occurred 28 times across four CPs. It was comprised of three subcategories: (a) Dissatisfaction with Work/School, (b) Education and

Career Goals, and (c) Confidence in Job Skills. The Dissatisfaction with Work/School subcategory emerged from content related to CP reports that they were unhappy with their school or work environment. CP5 and CP3 discussed material related to this category 11 times. The Education and Career Goals subcategory focused on content related to CPs' future plans with regards to their education and work. Three CPs, CP3, CP2, and CP5 discussed this theme in their sessions, for a total of nine times. The Confidence in Job Skills theme related to a CP's report of being proud of his abilities related to work. CP4 was the only individual in the study sample to discuss this theme, and did so eight times.

*Self-Concept.* The Self-Concept Intermediate Category included themes related to how CPs identified him/herself or processes related to self-perception. Four CPs discussed content related to this time for a total of 28 times. The four Subcategories that comprised this Intermediate Category included: (a) Self-Examination; (b) Disconnect From Self-Concept and Actual Behavior; (c) Coping with Aging; and (d) Spiritual Identity. Self-Examination was a subcategory that emerged from one CP discussing a process in which she reflected on her behaviors and their attitudes and re-evaluated them. For example, CP2, the only participant to discuss this issue on six occasions, talked about how she overcame a "panic disorder" in the past by questioning and testing her food preferences:

C241: You know when I was going through the panic disorder I thought yeah, because I had this theory about panic, that actually I think my friend had found written somewhere. But, the whole thing about panic disorder is, your body's saying like you're living a life, whose life are you living? Not yours. And you're gonna have to break it down piece by piece and then look at everything you're doing and figure out if it's resonating, what parts are really resonating with your core and who you are, or who everyone else thought you should be, or who you thought you should be, the big idea you have of yourself. And I think that's what happens when these women with 3 kids wake up one day and have panic disorder and they're freaking out...and it's, they wake up in a life where they just can't do it anymore and you're just gonna have to start, like, turning over the stones, like the parts of everything that makes you, and...I had to do that even, maybe I told you

this, with food I liked. I started trying every food and just going like you know am I not eating this cuz like growing up I shouldn't eat this? And then my everything, my whole world [sweeping motion with her arms] expanded to like sushi and even fish, I mean just to eat...I never ate fish.

The Disconnect From Self-Concept and Actual Behavior subcategory included content in which CP5 described a disconnection between how she saw herself and how she actually behaved, which occurred six times. CP5. For example, she described having difficulty with singing, although she saw herself as more competent:

C41: Like when it comes to singing. It's so bad because it's kind of like I was saying. It's hard to go from what you normally sound like to sounding like this now. Like what the fuck? As opposed to if I was just starting out and it was like, This is what I sound like. Oh wait, I'll fix it. It's kind of like, Why am I a level one when I'm really a level nine? It's like that and it- So when you hear level one you're like- you're like horrified. What the fuck? Even the fact that you can't do it by yourself is just out of control. Cause it's like normally with no problem, effortless, easy. Now it's like ok I have to really get in my brain and be like, Ok, we're gonna do this and we're gonna be calm. You know. You don't have to think about it. It's kind of like- I just never had to think about it so I don't know how to operate with this nervousness.

Coping with Aging was a subcategory that involved the process of coming to terms with physical aging. This category only occurred for CP4, who experienced distress over his hair thinning and the steps he considered to address this issue, for a total of nine times.

The Spiritual Identity subcategory that was formed based on content related to one CP discussing the role of religion and spiritual practices in her life, which occurred 12 times.

**Interpersonal Relationships.** The Interpersonal Relationships Parent Theme was defined as content (CP reported experiences, behaviors, emotions, and thoughts) that focused on client interactions with and perceptions of other individuals. All five CPs discussed a relationship they had with a specific individual or specific individuals in their sessions a total of 460 times. Three Intermediate Categories were used to describe the relationship of the individual(s) to the CP, namely (a) Peer/Work Relationship, (b) Partner Relationship, and (c) Family Relationship. A



total of 21 Subcategories that were subsumed under their respective Intermediate Categories described the nature of the issue that was discussed within the context of the relationship (see APPENDIX N).

***Peer/Work Relationship.*** The Peer/Work Relationship Intermediate Category included themes that involved relationships CPs had with peers and those encountered in the workplace, including friends, roommates, classmates, co-workers, and supervisors. The five following subcategories emerged within this Intermediate Category from 69 talk turns: (a) Meeting Classmates Expectations, (b) Difficulties Sharing Chores/Resources, (c) Personal Boundaries, (d) Moving Away from Friends, and (e) Unhappy with Supervisor. The Meeting Classmates Expectations subcategory appeared for only CP1, who described not contributing to a group project in graduate school according to a schedule set by her and her classmates four times. Difficulties Sharing Chores/Resources was a subcategory that included content related to CPs who reported issues with sharing chores and household goods with roommates. This was an issue that only appeared for CP1 eleven times. The Personal Boundaries subcategory emerged from four of the CPs 45 times, based on content related to individuals' efforts to negotiate privacy and emotional distance from peers. For example, CP5 described not wanting to get to know her roommate or engaging in any social interactions with him:

T15: Mh-hmm [Therapist nods and leans forward again] So what you're afraid of is that if he knows- if he hears what you're doing then you think he's going to get closer to you?

C15: Heck no. I just don't want him to know, you know what I mean? (??) I don't want him to know nothing about me. I don't want him to know what kind of music I like. I don't want him to know nothing [Client laughs and covers face]. Like I don't even- I don't even know why. I just don't. I would prefer for him not to know nothing. Like just see me coming up, I pay my rent on time. Sometimes early. That's all you need to know. [inaudible] Cause I don't care what you do. Like I'm not like that and my boyfriend like, "so where does he work? and is-" I don't know what the fuck he thought we were doing. I don't care if he thinks I'm

doing drugs. I don't give a shit. He ain't knocking on my door. He ain't bothering me. [inaudible] That's all I care about.

Moving Away From Friends was a subcategory that was coded for content related to a physical separation from friends. This occurred for CP4 two times in his second coded session, as he was moving out of the state for work and to be with his parents. Unhappy With Supervisor was a Category that related to content one CP who expressed dissatisfaction with her supervisor seven times.

***Partner Relationship.*** The Partner Relationship Intermediate Category included themes that involved relationships four CPs had with their significant others. The following eight subcategories emerged within this Intermediate Category from 194 talk turns: (a) Partner Not Tending to Client, (b) Communication Issue, (c) Money Management, (d) Ambivalence/Questioning Commitment, (d) Trust Issues, (e) Open Facilitative Communication, (f) Partner's Professional Progression, and (g) Family Planning.

Partner Not Tending to Client was a category that comprised instances when a CP discussed not receiving attention or priority from their partner. This subcategory was observed in two CPs eleven times. The Communication Issues subcategory included verbal arguments and content related to CPs having difficulties expressing themselves or understanding their partner's expressions, which was observed in three CPs 56 times. Money Management was a category that involved CPs discussing financial challenges they had with their partner, and occurred in one CP a total of seven times. The Ambivalence/Questioning Commitment subcategory was a theme that emerged from CPs' reports that they were unsure of whether or not they wanted to stay in their relationship. This theme emerged for two CPs 25 times.

Trust Issues was a subcategory that was coded for content related to either CPs expressing distrust of their partner, or a partner who was reported to distrust a CP. This

subcategory came from the session content of two CPs 50 times. For example, CP5 discussed how she does not trust her partner to continue to have a professional relationship with his ex-partner:

T74: So this woman has... she was actually like sort of involved in helping him to move up in a certain way?

C74: Yeah to try to help him close the deal. And he's like, I know you don't believe it, but she has been a great help. And I said, I do believe it. I accept that help because when you get paid, she gets paid. You're the only one naive in this little box. You think I don't expect that too? You know?

The Open Facilitative Communication subcategory included a client and partner openly discussing private matters in a way that promoted intimacy and bonding. This category was present only for appeared for CP2 in the earliest session, in which she described her boyfriend and her openly talking about their ongoing experiences in therapy two times. Partner's Professional Progression was a subcategory that included discussion a client had about the course of their partner's education or career. This theme was mentioned by three CPs a total of nine times. The Family Planning subcategory emerged from content related to a client discussing having children. CP2 was the only CP to discuss this theme, which occurred 36 times.

***Family Relationship.*** The Family Relationship Intermediate Category included themes that involved relationships all five CPs had with their immediate family members, extended family, family members of significant others. The following nine subcategories were included, based on 195 talk turns: (a) Challenges with Blending families, (b) Challenges With Co-Parenting, (c) Communication Issue, (d) Trust Issues, (e) Family Support, (f) Family of Origin, (g) Grief over Parental Death, and (h) Family Boundaries.

The Challenges with Blending Families subcategory included conflicts two CPs described involving their partner's previous significant other and children from that relationship

over the course of 59 talk turns. As an example, CP2 described being angry that her partner's former significant other was not sharing caregiving responsibilities for their children equally:

C33: Yeah, so, we'll see, I don't know. But you know what might come up, like yesterday I got pissed at [my partner] because (3) he, when [his daughter] was getting picked up by [his ex-partner] on Saturday, you know she'd had some car problems, and it was very nice of him, he'd made her, we were eating bread and all of these great leftovers from his party, with olive oil and speck, and incredible cheeses, and it was laying on the table when she showed up in the back and he like made her a little sandwich to take out, and I was like, oh, well that's nice. Um, but then I didn't know that at the same time Sunday, yesterday, he's also out there for [his son] to stay the night and like take him to cello the next day, which is like her fucking day.

Challenges with Co-parenting was a subcategory that included content related to conflicts one CP reported having with an ex-partner in relation to their children. CP2 discussed concerns he was having with how his ex-partner, the biological mother to his two daughters, treated his children a total of 72 times. He described one of his daughters not wanting to stay over at his ex-partner's place of residence:

C55: I was watering the plants. And then she came outside and she said "Look, Daddy! I'm like, I'm gonna start telling people that I don't wanna go with my mom no more. I wanna stay here with you!"

T56: Hmm?

C56: I'm like...why you want to do that for? She's like "I don't know"...I'm like, OK? So I was cutting, cutting the leaves and everything, and this person that passed through the, passed through the (2) patio, she'll say "No mommy, I just want to stay with dad", or some version, something like that...

The Communication Issues subcategory included verbal arguments and content related to one CP having difficulties expressing himself or understanding expressions from their family members, which occurred 15 times. Trust Issues was a subcategory that was coded for content related to a CP either expressing distrust of their family members, or a family member who was reported to distrust him, which was observed nine times. The Family Support subcategory emerged based on the tangible/emotional support that was reportedly provided to three CPs by a

family member, a total of 14 times. Family of Origin was subcategory that included session content that focused on three CPs recalling how they were treated by their family during their early childhood. This was observed across three CPs nine times. Grief Over Parental Death was a subcategory that emerged from one CP discussing his thoughts and feelings regarding the death of his father for 15 talk turns.

Finally, the Family Boundaries subcategory included one CP who had to negotiate time spent with family members versus a significant other. CP1, a total of two times, described being concerned about coming home late to her mother because she was spending time with her boyfriend:

C11: And if I tell him, then he's gonna like, come back with some logical argument that's gonna piss me off even more because he's gonna be right, and it's like, well, that still doesn't, like I just don't wanna deal with it and then, [he was] coming home late, I was afraid my mom was gonna be mad, like we'll be up or something else where she's just gonna be mad at me, it's been a while since she's got mad at me for coming home late so it's kinda, I kinda feel like it's coming.

### **Emergent Themes Within Participants**

For each of the CPs, the content themes that emerged in the data are presented in this section. As indicated in the Method Section, an emergent concept or topic was determined to be a pattern only when it was coded twice or more during a participant's chosen sessions.

#### **Client-Participant 1.**

*Early session themes.* CP1 identified as a 23-year-old Latina Female. She referred herself for therapy for emotional distress she experienced after breaking up with her fiancé of 6 years and because she was having difficulty with graduate school. From a total of 124 talk turns emerged five subcategory themes (64 times; 51.61% of session) related to emerging adulthood that occurred in the 5th session: Time Management Difficulties (28 times; 22.58% of session), Money Management (10 times; 8.06% of session), Study Environment (two times; 1.61% of

session), Substance Use (two times; 1.61% of session), and Meeting Classmates Expectations (three times; 2.42% of session).

Four of the subcategory themes belonged to the Self-Development Parent Theme. Time Management Difficulties was the most frequent subcategory that occurred within this parent theme. CP1 had difficulty completing schools assignments and committing to a study schedule. She described procrastinating on her assignments several times during the sessions. For example:

C46: Um, well a typical day would be like, get up, do whatever I have to do. I know in the back of my mind I have to do something, so whether it be just writing a paragraph or a page. Um, I would go through my day knowing I have to do it, I get home at night, and I probably, depending on how tired I was, I'd be like, Uh, I probably should do this but I don't need to really do it till next week so maybe I'll just go to bed. Or something. That's usually typical or if it's like getting closer and closer, like say it's due Monday and it's like Satur -- no, that's bad cuz I'll probably go out Saturday. So if it's due Friday and it's like Wednesday, I'm like ok, I'll still do it or I'll do, if I have to do a page, I'll probably do a paragraph. You know, it's like ok well then I'll do the rest tomorrow. I'll pick it up tomorrow.

The therapist and client discussed ways that different forms of technology may assist the client with improving her time management. The client reported being somewhat familiar with the capabilities of accessible technologies (e.g., her phone's ability with a calendar/reminders, online applications with reminders), but had not attempted to utilize them. Themes related to the Study Environment subcategory were briefly discussed for two talk turns. The client talked about her preferences in terms of where she would complete schoolwork, including listening to music and studying at home, rather than a library or quiet setting.

The second most frequent subcategory theme that emerged from the session pertained to the Money Management subcategory. While discussing how to organize her schedule, CP1 expressed frustration that she was unable to purchase books for her classes because she was waiting for her school's financial aid department to disperse her student loan:

T84: So finding something that is a good balance for you, and you know, you're the only one who knows what that might be. And certainly looking through your assignments, I think it's really important for you to map out what your assignments are, have some kind of representation of it.

C84: Yeah, definitely. I don't even have the books yet, hopefully at the end of the month, by the end of the week I'll get my books.

T85: Well I understand that if you haven't gotten your financial aid yet.

C85: Yeah, I hate that it takes forever. I remember, in September, school started the second, I didn't get my financial aid till like the end of September, beginning of October.

She went on to say that she had little money in her checking account and she needed her financial aid to pay for her other costs of living.

Substance Use was a subcategory that was also discussed for two talk turns. The therapist followed up on a self-report measure the client completed that included an item on her recent alcohol use:

T12: Um, and the other stuff that you marked was obviously the you feel annoyed by people who criticize your drinking or drug use, and we've talked about that, too. Still having people do that? Is this Dawn still, or?

C12: Um, I haven't really actually heard anything from anyone in the last couple weeks. Um, cuz I think that I wasn't doing it every night, like I kinda cut back on it and just went back to the weekends and stuff. So, I haven't really heard anything. But still, if it comes up, I still get annoyed.

CP1 continued by reporting that her drinking behaviors had changed. Specifically, she commented on the high the cost of alcohol and that she ordered "heavy, hard" drinks in order to get more out of her spending.

In regards to the Interpersonal Relationships Parent Theme, Meeting Classmate Expectations was the only respective subcategory that was observed, and in the context of a Peer Relationship Intermediate Category. For three talk turns, CP1 discussed that she was not meeting the deadlines set by her and her classmates for a group project and that she was concerned about how they perceived her:

C107: Cuz it's like, it's, I do feel bad, I do feel bad that that's what I was thinking. I was already thinking, like, Well, what did I do that I couldn't go, that I didn't do it? I'm like Ok, well I know what I did, but you know, what could have, and I'm like Well, they did know I was pretty sick, they see me last week, and they see me last night too and I was still pretty sick and so they, maybe they can kinda understand that I've been really sick and I'm still sick, and I didn't really have the energy to do it, and you know I have to work and they know I have to work on the weekends. I didn't work this weekend, but they don't know that, I could just say I worked, you know, so I'm like, Uh. So it's already-

T108: I think to some degree that it's because you don't like the fact that your classmates are gonna be judging you for not getting the stuff done.

C108: Yeah, like people thinking bad about me.

T109: Mm-hmm. So one way of getting them not to think bad about you is to convince them...

C109: [yelling] To feel sorry for me!

This brief exchange was the only time content related to this category was coded.

*Latter session themes.* There were twelve subcategory themes that emerged in the 28th session from 61.98% of 121 talk turns. This included Time Management Difficulties (10 times; 8.26% of session), Time Management Interventions (five times, 4.13% of session), Money Management (seven times; 5.79% of session), Suicide (six times; 4.96% of session), Improvements in emotional regulation (two times, 1.65% of session ), Partner Not Tending to Client (two times, 1.65% of session) Partner's Professional Progression (two times, 1.65% of session), Communication Issue (12 times; 9.92% of session), Family Boundaries (two times, 1.65% of session ), Ambivalence/Questioning Commitment (two times, 1.65% of session), Difficulties Sharing Chores/Resources (11 times; 9.09% of session), and Family Support (11 times; 9.09% of session).

One third or four of the twelve subcategories belonged to the Self-Development Parent Theme. Consistent with her earlier session, Time Management Difficulties, was the most frequently occurring theme related to the Life Management Skills Intermediate Category in this session toward the end of her treatment. CP1 reported that she continued to turn in her work late,



though not as late as when she first started receiving treatment. Time Management Interventions, emerged in connection with this discussion, as CP1 described using “monkey stickers” as a kind of reward for adhering to her behavioral intervention plan. How she implemented this reward was not elaborated. She described the reward as “weird,” but it was not discussed why she thought this way or the impact it had on her ability to change her behavior.

Two subcategories were observed that pertained to the Emotional Experience Intermediate Category. Suicide was a subcategory theme whose content emerged early in the session, as the therapist reviewed CP1’s answers to a self-report measure. She discussed having thoughts of killing herself after an unpleasant interaction with her boyfriend:

T12: Mm-hmm. What did you think about doing? I mean, was there something there that you thought about crashing into or?

C12: No actually. Cuz I wanted to drive off the side of the road, but there was nothing there, like there was just this long stretch of road, and it's like, cuz it cuts between this, lake-lake, lake, lake-lake, I don't know, it's a really weird name but it just cuts through this huge park so there's no, there's no..fence. [client chuckles].

T13: Mm-hmm.

C13: There's a fence, there's a ditch [giggles], but there's really nothing to crash into.

After the therapist conducted a brief risk assessment with CP1, this content theme did not appear again in the session. Another subcategory, Improvements in Emotional Regulation, did not appear related to the topic of suicide, but occurred during a discussion regarding CP1 managing her emotions while she procrastinated on her schoolwork:

T19: I mean, you've already gone and talked with this professor and basically told her your secret [laughs], that you're a procrastinator and so she's gonna see it coming if you show up and go, And I didn't get it done. So...

C19: I'm not [mumbles], I still got a whole three hours.

T20: [Therapist laughs]. Ok.

C20: It's not, like, I'm not getting it done, it's just, I'm just not tripping over it.

CP1 went on to say that she enjoyed reading on topics related to her homework, but not actually that material that was assigned.

Eight subcategories belonged to the Interpersonal Relationship Parent theme and four of these were coded as part of the Partner Relationship Intermediate Category. Communication Issues was a subcategory that occurred within the context of CP1's relationship with her significant other. CP1 described that she was reluctant to share when she has been hurt by her partner because she expected him to use a rational argument to remove any blame from himself. At the same time, she indicated that she expected her partner to know when she was upset, as in the following example:

C77: It's hard to argue. Cuz his whole thing is, he always comes back with an argument like - For example that night, he would have - his argument if I would have said something to him, um, was, would be, You were watching tv. You were sitting up at the edge of the bed watching tv. You weren't laying down, you weren't trying to cuddle up with me so I figured that you wouldn't want to. That you just wanted to - that you were comfortable where you were and that wouldn't bother you. So that's why I didn't do anything. And that's understandable, I can see how he'd understand that. But at the same time it's like, [Client crosses arms] Hello, I'm at the edge of the bed, not with you, like what do you think is going on, you know? So then he would have turned around and been like, Well why didn't you tell me (something)?

Another aspect of CP1's romantic relationship was captured by the Partner Not Tending to Client subcategory, which emerged when CP1 described the incident that was the impetus for her having suicidal thoughts. She described how her boyfriend was not giving her attention, despite asking her to stay with him for the evening:

T6: Mm-hmm, what were you mad about?

C6: Well, cuz I didn't -- I was tired, I didn't feel good, and I just wanted to go home but he wanted me to stay, and I kinda wanted to stay too and it was like 11 o'clock already, it was late, and I need to make an appearance at home, you know, people are awake, to like see me, and he's like, "Oh, just stay, just stay," and I'm like, Alright, fine, I'll stay. And then I stayed and then he immediately, he was like " Oh, I'm gonna go outside to smoke a cigarette" and Uch, you know if you're gonna leave, I might as well just go. Cuz you're gonna be out there a while, I might as well just leave. And he's like, "No, no, no" and like of course I'm gonna go back at it again, so no matter if I'm gonna stay, he still goes outside. Well like ok, fine, jerk, you know? And then he comes back in and I'm waiting for him and he just lays down and I wanna cuddle with him, and he just kinda like, he lays

down and turns over. I'm like, What's the point of this? Like what's the point of me staying? I'm just kinda watching him like, Hello? And then I move a little bit and he turns around and he's like, "What's wrong?" I'm like, Why are you ignoring me?

This theme appeared in the beginning of the session and did not appear again once the therapist had completed assessing CP1 for risk for self-harm.

The Money Management subcategory represented another conflict in CP1's relationship with her boyfriend. CP1 described him as being irresponsible with using his money. In one instance, she described his misuse of funds as detracting from the quality of time they spent together:

C97: Ya know? So, so I just get frustrated. So when I found out he had no money I'm like, "What happened?" Like we were supposed to, like we had, we weren't gonna be all creative, but we were gonna get some pizza, gonna get some soda...get a movie, and then just have, like, a drink or something and just spent some time together this weekend, and we couldn't do any of that because he didn't have any money for it. Like he even told me he budgeted for it, and put money aside for it, but he didn't have it.

CP1 also stated that she was forced to purchase household goods for his partner because of his lack of income. The client was also dissatisfied with her partner's education, which emerged from the Partner's Professional Progression subcategory. This theme was briefly mentioned by CP1 when she reported that she was not content that he had not taken steps to complete his GED. A subcategory related to Ambivalence/Questioning Commitment was also observed in this session. CP1 stated that she and her boyfriend believed that their relationship would not "last forever" and she expressed ambivalence about whether she wanted to continue to be romantically involved with him.

Two subcategories were observed in relation to the Family Relationship Intermediate Category, subsumed under the Interpersonal Relationship Parent Theme. The Family Support subcategory was the most frequently mentioned theme within this particular relationship. CP1

described her family as providing with her financial support and that she would take items, such as toilet paper, from her home to use at her boyfriend's residence. She also described her mother's attempts to support her studying:

C59: I'm being awarded - She's - I'm being awarded for showing up on time with her. Cuz she already told me, If I'm not there by 4:30 she ain't feeding me.

T60: Ok, I mean that's good too, showing up on time, that's been kinda hard for you. Maintaining a good schedule is kinda hard, so ok. But, at some point...

C60: Well it's not like I'm not doing it. You know, I sit with her for about an hour, eating whatever, talking, bonding and then that's when I start doing homework. And I do a good like, hour and a half of homework.

Family Boundaries was another subcategory that was briefly observed in the session. CP1 described feeling pressured to go home instead of spending the night with her boyfriend. She reported that her family expecting to her, and she expressed concern that her mother would be mad at her for not making an appearance.

One subcategory emerged that belonged to the Peer/Work Relationship Intermediate Category, which comprised the Interpersonal Relationships Parent Theme. CP1 explained that she and her boyfriend were having conflict with the latter's roommates, who would use items such as food and other household goods they had purchased for themselves, without asking or informing them. She also described disagreements regarding how to divide up chores, such as cleaning the bathroom and taking out the trash.

*Session comparisons.* The first coded session was the fifth time CP1 had met with her therapist. The client's time management skills were a predominant topic of coded discussions, which also impacted how she utilized therapy, in that CP1 and the therapist discussed her regular pattern of being late to her therapy appointments. CP1 attributed her tardiness to external factors, such as traffic, and her therapist did not further explore the topic with her in the session. Additionally, CP1 was not aware of her class schedule, and at the end of the session, she

requested that she be able to contact the therapist to reschedule her appointment once she could confirm her availabilities. The second analyzed session occurred approximately one year and two months after the first session. While a significant amount of time had passed between these two sessions, it appeared that CP1 continued to have some difficulty with time management, specifically finishing her schoolwork on time. She noted that instead of turning her work in after the semester had finished, she was now turning in her assignments days after the due date. CP1 appeared to experience little anxiety over impending assignments. While she described as her mother as being supportive of her efforts to complete her homework on time by making her food, the therapist questioned whether this was offering reinforcement prematurely. Additionally, avoiding her mother's reprimands appeared to be a partial motivator for CP1 to focus on her schoolwork. The client emphasized that she believed that ultimately she was responsible for herself and her attempts to achieve her goals.

The second coded session was also marked by an increase in the discussions about interpersonal relationships compared to the session which occurred much earlier in treatment. Money management issues that started in the area of self-development extended to CP1's relationship with her significant other. Her family offered some support in terms of finances and assistance with her time management issues.

While CP1 reported some improved emotional regulation in regards to anxiety related to procrastination in the latter session, suicide was briefly assessed at beginning of the meeting. By the end of treatment, CP1 received additional diagnoses of a Depressive Disorder Not Otherwise Specified, Cannabis Dependence, and Alcohol Abuse. The number of emerging adulthood related themes grew from five to eleven between the two recorded sessions. The latter session had an increased number of themes related to her interpersonal relationships. The client was

terminated from therapy because she did not adhere to a treatment agreement that stipulated that she attend her appointments on time, which reflected that time management issues continued to be a theme in her psychotherapy process.

### **Client-Participant 2.**

*Early session themes.* CP2 self-identified as a 29-year-old, Caucasian female. She referred herself for therapy to help her become less judgmental of herself and more accepting of herself as a person. From a total of 282 talk turns in the fifth session emerged twelve subcategory themes which comprised 29.79% (84 times) of the session. They included Substance Use (three times; 1.06% of session), Impulse Control (four times; 1.42% of session), Not Understanding Source of Emotions (three times; 1.06% of session), Improvements in Emotional Regulation (five times; 1.77% of session), Career Aspirations (two times; 1.06% of session), Self-Examination (six times; 2.13% of session), Spiritual Exploration (12 times; 4.26% of session), Unhappy with Supervisor Behavior (seven times; 2.48% of session), Family Planning (36 times; 12.77% of session), Open Facilitative Communication (two times; 1.06% of session), Partner's Professional Progression (five times; 1.77%), and Personal Boundaries (two times; 1.06% of session).

Seven subcategories belonged to the Self-Development Parent Theme. Of these seven, two were subsumed under the Behavioral Regulation Intermediate Category. The first such subcategory that was observed in this session was for Substance Use. CP2 mentioned that she was drinking wine while having a conversation with her boyfriend, and that she wore particular outfits when she went out to drink alcohol. The other subcategory theme that emerged was Impulse Control. As was illustrated above when delineating the emerging themes across the participants, CP2 reported that she had thoughts about looking at her boyfriend's phone because

she was concerned that he was having conversations with other women, but that she was aware of her thoughts and did not act on them.

Two subcategories belonged to the Emotional Experience Intermediate Category that comprised the Self-Development Parent Theme. Not Understanding Source of Emotions was a subcategory that was observed when CP2 described crying in several situations, such as while she was hiking, returning to her home in the evening, and while watching television, but she reportedly did not know why she had these feelings. The therapist did not explore the potential meaning of these behaviors. Despite not being able to identify the source of some of these emotional expressions, Improvements In Emotional Regulation was another subcategory that was coded in this sessions. CP2 stated that she was better at coping with her emotions in the past, in part because she took a different perspective when interacting with others. For example, she described how she reacted to her training supervisor:

C214: Like with my teacher, that I feel (2), like our communication is off - how I don't like engage in, "Do you have a problem with me? Are you OK? Did I do something?" In the past maybe I would have been frustrated, this would have been like an older version of myself, a younger version of myself. I would have gotten so worked up, I would have been crying, about like to my mom, like, "I just don't get it! She treats me this way." I would have projected more of like she's...

T215: So you took it more personally.

C215: Yeah. Yes, thank you. I just don't, I'm not taking as many things personally, I guess.

Later in the session, CP2 reported that there were times when she cried, she believed that she was crying less than before and that she was managing her emotions better.

Two subcategories that comprised the Self-Concept Intermediate Category from the Self-Development Parent Theme were identified in this session. The Spiritual Exploration subcategory theme was observed when CP2 described how she was raised in a Mormon household but did not identify with the beliefs of her community. Over time, she explained that

she became “Jack Mormon,” meaning that she called herself Mormon but did not uphold the religion’s beliefs and practices. At the time of the session, CP2 reported that practices like Yoga and hiking were now expressions of her spirituality.

The other subcategory that belongs to the Self-Concept Intermediate Category that emerged in this session was Self-Examination. CP2 reflected on her past experiences and how they influenced her as a person. As mentioned when describing the category hierarchies, she reported that she engaged in trying new foods because she realized her eating preferences were influenced by her upbringing. She also reflected on how her struggles with anxiety as a teenager had made her a stronger person:

C252: That's there for the most part, I think that's helped me develop a more positive sense of self but it really took time to move away from that. That was something I felt then at the time too, I felt like I needed space to move in-between those experiences and like now. Sometimes I felt too close to them.

T253: If you hadn't had those experiences do you think you'd be a different person today?

C253: Yeah, yeah, definitely. Maybe one I wouldn't like so much.

T254: Mm-hmm

C254: Not that I like myself all the time, ya know? But um, yeah, I feel really good about my experience.

Career Aspirations, a subcategory subsumed under the Professional Development Intermediate Category from the Self-Development Parent Theme, emerged briefly toward the end of the session when she described her goal to write a children’s book as a potential topic for the next appointment. She talked about being particularly inspired while on vacation but not continuing to explore this endeavor:

T231: Well, the last time I was able to work on it was at Christmas. Whenever I go on vacations I feel flooded with ideas for like children's books or like things will come to me as I'm falling asleep. It's that creative energy that's just free to flow when you don't have things you have to do, or for me that's how it manifests. But, its, I still think about it a lot. I got this new laptop from [my boyfriend], and my other one was so junky I couldn't even take it anywhere with me. And now so I put some of this stuff from the book on there and I've been like looking at it. I



kind of opened it and looked at our outline of...I felt, it was such a beautiful thing when we were writing it. It was amazing. My friend, she teaches at a university in [a southern state], and so I was the one just bringing in things that like I had, cuz I read a lot of [uses air quotes] spiritual books and bringing in the parts of them that helped me. And then she was bringing in this whole, I mean she's just a brilliant writer and...

T232: Those books are big right now, or, I think they always will be because there are always people looking for a way to be healthier or find themselves

C232: Yeah. But, [my friend] I think is done. She kind of expressed that it won't ever happen on her part, I guess.

T233: Could you do it on your own?

C233: We could do it [smiles]

T234: [laughs] That's a whole new life path.

C234: Attach your...are you getting your PhD?

T235: My PsyD

C235: Oh, you could get your PsyD on it.

T236: Yeah [laughs] PsyD, um.

C236: I don't know. But, that's like a dream, we'll have to talk about that actually would be an interesting thing to explore cuz I feel like it's always been my deep down desire to write my whole life, and then I've gone through a phase...I've just started to talk about it more. I still don't talk about it too much to [my boyfriend] because he's a writer.

Family Planning subcategory occurred when CP2 recalled a conversation she had with her partner about having children together. She was pleasantly surprised when her boyfriend was open to the conversation and agreed that they should have children together. CP2's partner was separated from his wife, but not divorced, which was discussed as a potential source of distress when planning to have children. A part of the Family Planning theme content also included some ambivalence about having a firm timeline for having children and completing her graduate degree and being more flexible and open:

T84: Right. So what do you, what do you think about that timeline?

C84: I think, part of me doesn't want to have a timeline cuz it's the timelines that keep you from being present in life. I think that, considering like another life, the most important things to think about are the, just making sure, I can clear the energy from the ex, as much as I can especially if I were to carry a baby. Not to have to deal with that negative emotional energy. It's unfair, it's not...because we are two adults, I think it would be better if you know we made a good choice...

The Open Facilitative Communication subcategory briefly occurred within the context of discussions about CP2's relationship with her romantic partner as well. She reported that both of them discussed their experiences in individual therapy with one another. Partner's Professional Progression was a subcategory that emerged when CP2 reflected on her boyfriend's career. CP2 reported that she found her partner's commitment to his job as attractive and that she was grateful for his success.

Two subcategories belonging to the Peer/Work Relationships Intermediate Category emerged in this session. The Unhappy with Supervisor subcategory was observed when CP2 described working under a school teacher as part of her professional training. She reported that she disagreed with her teaching approach because of the negative impact it had on the children in the class:

C21: Yeah. I feel like I have to like hold the light [holds hand in the air as if carrying a light] in the classroom. That's the only way I can really describe it cuz she's negative and she's not real. The kids can never get any kind of human connection with her.

At the same time, CP2 stated that she felt that she could not openly express this to her supervisor, because she wanted to receive a recommendation from her. The subcategory Personal Boundaries emerged within the context of general peer relationships. She described herself as learning from her past experiences and the need to focus on herself and her own personal needs:

C220: I feel good. I feel so proud of myself. You know what it was? I think I got to a point as I approached 30 where I realized, if I don't give my life something, everyone else is gonna, I'm gonna allow all of my energy to be drained and everyone else's life. Part of that came from my experience as a nanny. Like, OK, I love these kids, am I gonna like nanny these kids for the rest of their life [shakes her head in the negative], having never given myself anything?

T221: You've given so much

C221: So part of it was kind of realizing that I didn't say no, I was always there for everybody.

*Latter session themes.* From a total of 280 talk turns emerged five subcategory themes (39 times; 13.93% of session) in the 22<sup>nd</sup> session. This included Challenges with Blending Families (23 times; 8.21% of session), Trust Issues (five times; 1.79% of session), Family of Origin (four times; 1.43% of session), Anger (three times; 1.07% of session), and Substance Use (four times; 1.43% of session).

Two subcategories belonged to the Self-Development Parent Theme. Anger, a subcategory of the Emotional Experience Intermediate Category, emerged as she described her personal experiences with the emotion. CP2 described herself as a “beast” in the past in terms of her anger in that she had physical altercations with her siblings. While she described still experiencing anger, she reported that it was manifesting verbally and she saw this as better management of this emotion:

C137: My family wouldn't say that though, my family knows like the beast inside of me.

T138: Yeah?

C138: How, like, fierce I can become. How, um, and I can only describe it by feeling like it's like a wild animal in me, if it's like provoked

T139: That's still there?

C138: I think you might remember like I talked about this when I got into a big fight with my sister?

T140:[Nods]

C140: A long time ago, and, was about to hit her and really hurt her, and instead I just said the cruelest things to like really break her

T141: Right, but that was, that was different.

C141: But it's the same...at least now I'm in control. When I was growing up with my siblings, I would fight them back.

The other subcategory theme belonging to Self-Development Parent Theme that was observed was Substance Use. This theme, which was also subsumed under the Behavioral Regulation Intermediate Category, CP2 described her previous drug use as starting during her senior year of

high school and continuing into her freshman year at college. She shared insights regarding her substance abuse as a way to explore herself and connect with her peers:

C240: Yeah, they would...and they never really gave like a reason. It was just like you can't do this. And like everything they told me I can't do I had to do. But also, the reason that I gave myself, that I was very clear about then was, I felt like I really wanted to connect with other people and the only way I would be able to know their experience and make that connection is if I did, if I tried drugs. Not to like become addicted, but there was a curiosity that I needed to like, at least try heroine I could know what it was like. And I kinda still feel like that's OK. I still kinda feel like that's part of my personality. Like why I wanted to try ayahuasca.

The three other subcategories that emerged in the session were coded under the Interpersonal Relationship Parent Theme. Challenges with Blending Families occurred in the context of a Family Relationship Intermediate Category. CP2 reported that there were numerous occasions when she believed that her significant other's ex-partner was not sharing equal caregiving responsibilities for the children of that relationship. As a result, CP2 saw this as encroaching on time she would like to spend alone with her partner. For example:

C41: Oh, well it was easy until he started offering the time I expected, ya know, to be with him after this whole period where like we weren't going to be able to go on a hike as planned, it's our Sunday thing. Um, because he's gonna take his kid to cello when [my significant other's former partner] is completely available and it's her day to do it.

Trust Issues was a subcategory that occurred in the context of her relationship with her partner. CP2 reported that at times she felt threatened by his partner's previous significant other in that she would cause the end of the CPs current relationship. However, she was also able to maintain her trust in her partner by thinking about the reasons that past relationship did not last:

C113 Uh, it helps because I think I needed to be reminded that there's nothing that he's like going back to. You know, there's nothing real, legitimate that he would actually leave me to go back to. Ya know? There was no, there are no great memories and happy times, it was a really hard struggle. And then it makes me feel like, fuck. What kind of man was I with to just stay there? That's crazy! But, I can be more accepting of that. I think it would have been harder for me if he would have been really in love.

The last subcategory theme that was present in this session that comprised the Interpersonal Relationship Parent theme was Family of Origin. CP2 described having to take on the responsibilities of a parent and caring for her siblings from a young age. While she believed that this “took away her childhood,” she also expressed having accepted these experiences, and reconciling with her mother to some extent:

T208: Nothing that she'd talk to you about? She never sat you down and said I'm sorry? Thank you?

C208: Not thank you, but like I'm sorry.

T209: Did she do that to all your siblings? Or just you?

C209: Probably just me

T210: When you were a kid? Or just recently?

C210: Um, no, more like late teens, early 20s. She always, she's probably apologized recently too, but

T211: For that?

C211: Not as much anymore. She apologizes for everything that happened and it's just like, I always have to like remind her that I'm grateful for the life experiences...like if this wouldn't have happened mom, then I wouldn't be able to appreciate this (points with finger) happening.

*Session comparisons.* CP2's first coded session, which was the fifth time the CP and therapist had met, focused on issues related to family planning. She reported that her partner largely appeared to be collaborative and supportive as they speculated about having children in the future. The client also reported on a conversation she had with her partner about having children and the potential effect this change would have on her career. By the second coded session, which was the 28<sup>th</sup> time they had met, CP2 did not discuss how her professional plans had been affected, but was focused more on the challenges that came with her blending into her partner's family, such as expressing frustration with the way that her partner's former significant other was impinging on their time together. Being able to trust her partner was a challenge for CP2 in both sessions. In the earlier sessions she had a thought about investigating who he had been speaking to by examining his phone, and in the latter session she reported having thoughts

about her significant other returning to his previous partner. However, in both these cases, CP2 demonstrated the ability to examine her thoughts and assert her confidence in her relationship with her boyfriend.

CP2 discussed drinking alcohol with her significant other in the early session, with no apparent consequences. When she talked about substance use in the latter session, it was to describe her past use as an adolescent, which she reported was a means to connect with others socially. The CP went on to explain that she had found other ways to connect with others (e.g., through hiking).

Although the first session contained some content about CP2's relationship with her training supervisor, this topic was not discussed during the later session. The early session also contained content wherein CP2 discussed her career aspirations and a process of self-discovery that was prompted by an examination of her spiritual beliefs and childhood upbringing. In both sessions there were brief discussions related to regulating emotions. In the earlier session, the client reported that she was less prone to crying than she was in the past, yet still experienced tearfulness that she could not explain. There was no mention of crying in the second session as there was in the earlier session, but CP2 reported a similar pattern in regards to how she expressed her anger. She explained that she was physically aggressive when she was younger, and that her anger was now expressed verbally, albeit in a "cruel" manner. While the client appeared to be content with how she regulated this emotion, she also described herself as having a "beast" inside her. This particular client did not have a treatment summary, so it is unknown how/whether these particular issues were resolved.

### **Client-Participant 3.**

*Early session themes.* From 288 talk turns in the fifth session emerged six subcategory themes (66 times; 22.92% of session): Substance Use (three times; 1.04% of session), Losing Interest in School (seven times; 2.43% of session), Education Goal (two times; 0.69% of session), Communication Issue (15 times; 5.21% of session), Trust Issues (four times; 1.39% of session), and Personal Boundaries (35 times; 12.15% of session).

Three subcategory themes were related to the Self-Development Parent Theme. The Substance Use subcategory was part of the Behavioral Regulation Intermediate Category, and Losing Interest in School and Education Goal subcategories were part of the Professional Development Intermediate Category. CP3 briefly discussed using an energy drink and cigarettes as his way of managing stress over an argument he had with his mother just before session. The therapist did not explore how often the client engaged in this behavior and whether he experienced any particular consequences from it. Losing Interest in School was a subcategory that emerged when CP3 discussed the possibility of returning to school to complete his bachelor's degree. He stated that he was reluctant to enroll in a school he attended in the past because it had opened "too many fields" he was not happy with the quality of the education, along with recent changes in their attendance policy. This theme followed a brief discussion of the Education Goal subcategory theme, in which CP3 described his plans for school:

T67: So what are you thinking of doing? Cuz it sounds like you have a few concerns about the school.

C67: Yeah. Well [Smiles] I'm already in it, so, uh I'm gonna pump it up for til March and see what're the next classes. If I see that, you know—I'm just gonna go for my AA. I'm not gonna—I don't want the BA from there.

T68: Okay. [Nods].

C68: Mm hmm. So I'm just gonna max it out to the AA and that's it.

The Interpersonal Relationship Parent Theme was observed in three subcategory themes.

Two subcategories, Communication Issues and Trust Issues, occurred in the context of the

Family Relationship Intermediate Category while the Personal Boundaries subcategory emerged in the context of the Peer/Work Relationship Intermediate Category. The Communication Issues subcategory was coded during a discussion in which CP3 reported that he had an argument with his mother. He stated that his brother's ex-girlfriend had contacted him asking the client for personal information about his sibling. CP3 reportedly informed his mother, out of concern for his brother, and was taken aback by her reaction:

C29: Oh, she was pissed off. She's like, "Why are you still talking to her and woop-dee-doo and woop dee-them?" And you know what, I'm calling you to let you know that they're going for your son after child support since you care so much about him. I'm like, "It's nice of me to call you and let you know what's going on."

T30: Right.

C30: ...I'm like, "But if you are gonna—" Like I said, [Unintelligible] she's tryna go off on me, and that's when I said, "You know what, Eff you," and I just clicked.

The Trust Issues subcategory also occurred while the client talked about this incident with his mother. CP3 reported that his family did not trust him. They believed that he had an extra-relational affair with his brother's ex-girlfriend and questioned anytime that he spent with her.

Finally, the most frequently observed theme was a Personal Boundary subcategory that emerged in the context of CP3's relationship with his co-workers. He reported that he avoided conversations with his peers because their conversations bored him. Additionally, he reported that a past affair between his ex-partner and his friend had affected how much personal information he disclosed to people with whom he worked:

T126: So what do you— What's this wall that you have up? [Gestures to an invisible wall with hand]. Can you describe it a little bit more?

C126: (3) Not letting people in. And um, not knowing what I think. I'm like, They think- I make people think that they know what, you know...

T127: What you think? [Chuckles].

C127: What I think, but they don't know— they don't know nothing about me. It's just I throw myself a different person. Like at work I'm a different, they think I'm crazy. [Chuckles and smiles].

T128: Mmm.



C128: Cuz some of the stories that I read from school. So they think I'm kinda, some sick guy that is reading, um murder cases.

T129: Mm-hmm.

C129: So they're like, You're a sick dude. [Both chuckle]. So that is the way I present myself at work...

T130: Mm-hmm.

C130: I'm like, they know I'm a single dad, but that's about it. They don't know nothing else about me. They just think I'm a single dad and I'm sick for reading the stories that I read [Gestures down with hand]. And (2) in school, about the same thing. I just go in there and just take notes and they know I'm a single dad as well and that's about it. They don't know nothing what goes on in my house. What I do— I'm like, they know where I work and that's about it.

T131: It's like they don't know the real you?

C131: Exactly. They see the fake [client's name].

T132: What would it mean if they did?

C132: Mmm. [Pause (3)]. I don't know. I guess it's just that wall it, I'm protecting myself, you know, from getting hurt again so I give them my fake [client's name] and you know, if that [client's name] gets hurt then I won't get hurt.

The therapist helped the client to recognize that this way of interacting with others made him lonely, but that he was ambivalent about changing these behaviors.

*Latter session themes.* From 245 talk turns in the 25<sup>th</sup> session emerged four subcategory themes (82 times; 33.47% of session): Anger (two times; 0.82% of session), Diet and exercise (five times; 2.04% of session), Challenges with Co-Parenting (72 times; 29.39% of session), and Communication Issues (three times; 1.22% of session).

Two subcategories had content that was coded as part of the Self-Development Parent Theme, Anger and Diet and Exercise. They were subsumed under the Emotional Experience and Behavioral Regulation Intermediate Categories, respectively. The Anger subcategory, which was the least frequently occurring theme, was briefly mentioned when CP3 described having a conversation with his ex-partner over concerns the client had about his two daughters. CP3 was concerned that his daughters were being neglected by their mother, which led to an argument. The client reported that during the course of the conversation his ex-partner asked if he was threatening her, which led him leaving the conversation in anger. The Diet and Exercise

subcategory emerged toward the end of the session when the client discussed that he was biking and exercising with his brother and friends. He stated that the activities were helpful in reducing his stress.

The Interpersonal Relationships Parent Theme was expressed through two subcategory themes, Challenges with Co-Parenting and Communication Issues, which both belonged to the Family Relationship Intermediate Theme. The most frequently occurring theme was Challenges with Co-Parenting. CP3 had a number of concerns about how his ex-partner was caring for their two daughters including his daughters having lice, being aggressive toward their peers at school, and one of his daughters telling him, through a note, that she did not want to go back to her mother. CP3 wanted to address some of these issues through referring the children for psychotherapy, but reported having difficulty getting agreement from the mother:

C78: [nods] They, I think they need it.

T79: What do you think they'll get out of it?

C79: Talking to someone else...

T80: Um, how do you think that would be good for them?

C80: Well, [child's name] I know she, she'll, she'll let it out...towards me. [Other child's name] the one that's more, the one that needs more...probably the one on one with someone else - that is not me or her.

T81: [nods]

C81: Um, tried talking to the school. They're like, "well we need MediCal, man. We need you to take care of it between you and your ex." I'm like is that a, is that the, is that the answer from the school? And supposedly a "psychologist" [uses air quotes when saying the word psychologist] I'm like...

T82: Yeah...that...you mean - what do you mean they said by you'd have to take care of it? Like, in what way?

C82: That I needed to talk to...talk to [ex-partner's name]. I'm like you, you and your ex and your kids need to get together... I'm like? [surprised expression]

T83: You mean to solve the problem?

C83: Exactly. Mm hmm.

T84: [nods] Uh huh, yeah. [smirks]

C84: They already seen the confrontation between me and her...I'm like, in the school, where we just like [throws hands up in air]

T85: Right, right.

The client did not elaborate on the details of the “confrontation,” but this and other occasions described in the session comprised the Communications Issues subcategory theme that was observed. In general, CP3 reported having difficulty resolving disagreements with his ex-wife about how to parent their daughters.

*Session comparisons.* The early session that was transcribed contained interpersonal conflict with regards to CP3’s mother and his family as well as reluctance to be open about himself with his co-workers. There was some discussion regarding the steps the client would take in order to address the latter issue or address his overall motivation to achieve them. By the later session, the focus of coded discussions was on the well-being of his two daughters and the conflict he was having with his ex-partner. Consistent with the shift of topics between sessions from work relationship issues to conflicts over co-parenting, the therapist removed the initial diagnosis from Adjustment Disorder to Relational Problem NOS yet retained his psychosocial stressors, such as occupational problems and problems with primary support group.

At the early session, the client reported that he was using cigarettes and energy drinks to cope with stress that he experienced after an interpersonal interaction with his mother. While he did report marijuana use as a teenager, CP3 did not report any substance use at his intake or at his latter session. CP3 stated that he was using exercise as a way to relieve stress in the 25th session. He was not diagnosed with a substance use related disorder during the course of treatment.

#### **Client-Participant 4.**

*Early session themes.* From 180 talk turns in the fifth session emerged four subcategory themes (75 times; 41.67%): Substance Use (three times; 1.60% of session), Trust Issues (seven times; 3.72%), Communication Issue (42 times; 22.34% of session), and

Ambivalence/Questioning Commitment (23 times; 12.23% of session), all of which were observed while the client discussed his relationship with his girlfriend.

The Self-Development Parent Theme was observed in one subcategory, Substance Use, which was also part of the Behavioral Regulation Intermediate Category. CP4 recalled that in the past his current girlfriend wanted him to discontinue his alcohol use, but that she was ambivalent as to whether she would end their relationship if he did not change his drinking behaviors. He stated that he declined to stop his alcohol consumption but that when he tried to break up their relationship, his partner wanted to continue seeing him. CP4 did not describe any negative consequences from his drinking. His telephone intake showed that he believed that his girlfriend wanted him to stop drinking because her father had had an alcohol abuse problem.

Three subcategories subsumed under the Partner Relationship Intermediate Category and the Interpersonal Relationship Parent Theme. The Communication Issue Subcategory was coded when the client discussed an interaction with his girlfriend. He stated that she had written a poem, but was receiving contradictory messages from her as to whether he should read it:

C35: And finally, I said, after going back and forth saying, "You sure, I kind of want to read it now, if you wrote something that's about us I kind of want to know how you feel." And she's like, "No, no." And I said, "Ok, fine, keep it." And - um, later - she got up and threw it at me and said "read," not threw it at me handed it to me

T36: She brought it to you.

C36: Yeah, said, "Read it." So ok. And I read it and I told her the only part in it that made me upset - you know I'm not upset that she judges herself to her, to my ex-boyfriend, or, Freudian slip, um ex-girlfriends, but - I mean, ya know...of course it doesn't make me happy, it makes me kind of sad she does that to herself, but I'm not upset about that. The only part I got upset about was what I told her, and she just wanted to keep going into it, into it, "No you're mad at me. I can tell that you are mad at me." I said, "No - I'm," you know, "I'm not -"

T37: And then again the next day she's...

C37: Then she's thinking I'm mad at her still...

T38: ...are you mad? Calls you...and, and the whole time how are you feeling really?

C38: [shrugs] I'm just trying to get a sense of what's going on, I guess...I wasn't

mad at her -

T39: Are you mad?

C39: No, I wasn't...

T40: Are you...sad?

C40: What made me mad is, that she left...and then I got upset...and, I wasn't sad, I'm not mad - I could care less about the letter, I mean, I forgot half of what it said.

The client went on to explain that he was displeased with the frequency of their arguments and that he was unsure how to resolve them. He stated that their arguments would often involve his girlfriend insisting that he was angry or dissatisfied with her, when he reportedly did not have these feelings or beliefs. CP4 described his partner as being insecure because of his past relationships with other women, and this content partially comprised the Trust Issues subcategory. The client also described his girlfriend as being jealous of him socializing with a female roommate, although CP4 reported that he had no feelings of attraction toward this person. The client considered the possibility of ending his relationship with his partner, and this content was coded as part of the Ambivalence/Questioning Commitment subcategory. One impediment that he reported to taking this action is that both he and his girlfriend volunteered at the same organization, but CP4 did not elaborate on why this arrangement would compel him stay in the relationship. However, he stated that he had difficulty seeing himself with his partner long-term:

C144: Yeah. Well, I don't know what I'm gonna do. I mean I don't honestly know what's the best...if it's just gotten to the end? I mean...I can't picture - ya know, if...this isn't the perfect relationship - but I know I can't picture this happening...I mean, if we end up being together for a year - I can't picture myself getting into an argument every week with her - that's not...that's not something I would want to do - or am willing to put myself through.

This theme was briefly followed by the client stating that he wanted to stay in the relationship in order to have “stability.” This remark was made at the end of the session, and the therapist and client did not have time to explore its meaning or implications.

*Latter session themes.* From 146 talk turns in the 97<sup>th</sup> session emerged eleven subcategory themes: Housing Transition (five times; 3.39% of session), Confidence in Job Skills (eight times; 5.41% of session), Money Management (seven times; 4.73% of session), Diet and Exercise (seven times; 4.73% of session), Concern with Thinning Hair (nine times; 6.08% of session), Moving away from friends (two times; 1.35% of session), Personal Boundaries (three times, 2.03% of session), Family Support (three times, 2.03% of session), Grief over parental death (15 times; 10.14% of session) and, Family of Origin (two times; 1.35% of session).

Five subcategories in this session were related to the Self-Development Parent Theme. Two of these subcategories belonged to the Life Management Skills Intermediate Category. At the beginning of the session, CP4 described that he was moving out of his house, and likely would be moving out of state with his mother and step-father. This discussion content comprised the Housing Transition subcategory. The client appeared optimistic and accepting of having to move his residence. Money Management was the second subcategory that belonged to the Life Management Skills Category. Throughout the session CP4 briefly mentioned how he was spending his money and his finances in general. He discussed needing to complete a health drink because of the cost of the beverage, wanting more money from his current job, sharing the cost of a Jacuzzi with friends in the past, and saving money through a gym membership. The desire to spend money on a gym membership was related to the Diet and Exercise subcategory that emerged in the context of a Behavioral Regulation Intermediate Category. CP4 stated that he was focusing on eating healthier and exercising more. Part of these behaviors was connected to the Concern with Thinning Hair subcategory, which was coded as belonging to the Emotional Experience Intermediate Category. The client reported that he was uncomfortable with his hair loss:

T109: What's embarrassing about it?  
C109: That I am, [throws hands up] 23 and I have to buy Rogaine.  
T110: You don't have to...  
C110: I don't have to, but if I want to maintain, ya know...this beauty [smiles]  
T111: [laughs]  
C111: ...I need to get it. Cuz I know hair's the, like first thing that people look at. Hair, teeth and eyes.  
T112: Mmm. Is there something wrong with wanting to look good?  
C112: No...if there is then I'd be a very wrong person [smiles]  
T113: [laughs]  
C113: [laughs] Um, no - there isn't, but it's, it's like, uh, it's kinda like - it goes back to me accepting that I have other problems that normal people don't have. That the normal, ya know, like...  
T114: Correct me if I'm wrong, but...I think the product Rogaine has made billions of dollars.  
C114: Well, yeah - I'm sure. But...still, it's kinda like, hmmm..and...  
T115: ...and the whole hair ...  
C115: ...and old people - it's hard! [laughs, sighs] Ya know, the pictures in the commercials even are, like, 40 year-old guys...

CP4 then went on to describe a social interaction with a male peer whom he admired for his physical attractiveness, which made him resolve to exercise, eat better, and buy hair growth products. Despite his concern about growing older, CP4 appeared secure in his job skills. A Confidence in Job Skills subcategory theme emerged as he talked about his position as a bartender. He described himself as being talented with putting on “flair” performances and that he could teach his co-workers these same skills.

Six subcategories were a part of the Interpersonal Relationships Parent Theme in CP4’s latter session. When discussing his housing transition, two subcategories related to the Peer/Work Relationship Intermediate Category were observed. He described one of his roommates as a close friend who was moving out of the house, which was coded as Moving Away From Friends subcategory theme. CP4 discussed that he would make sure to make the most of their remaining time together. The aforementioned relationship was in contrast to

another roommate, for whom the Personal Boundaries subcategory theme emerged. The client described this peer as irresponsible and that CP4 did not like his behavior when he drank alcohol.

The four remaining subcategory themes subsumed under the Interpersonal Relationship Parent Theme occurred in the context of the Family Relationship Intermediate Category. When CP4 discussed moving out of his house, he briefly mentioned feeling “bad” about having to “split up” his dog and his roommate’s dog, and that he treated them like people. Later in the session, when the client described having confidence in his job-related skills, a Family Support subcategory theme briefly emerged as he discussed his mother and friends’ engagement with his work:

C47: So...um, so yeah - my mom wanted to go - she's all...and I haven't told her yet - but I know she'll be...that's all she's been waiting for - she wants to see me in a flair concert

T48: [laughs]

C48: ...because I take her to go see all my roommates, and my um, my friends that do it at Friday's - but I never get to be in it. So all my friends wanna go see me do it now. So I'm excited. [nods]

This brief discussion led to CP4 briefly reminiscing on his mother providing support to him in the past by attending his music performances, although he did not specify how old he was when this took place. The session then shifted topic toward Father’s Day, which was in the near future. The client discussed having mixed feelings about the holiday. He reported that he was relieved that his father passed away as a teenager because his parent was suffering physically, but that he wished that they had a closer relationship. CP4 explained his distance as part of his developmental growth:

C79: That it, it wound up being - like, 15, 16, 17 - where, you want to distance yourself from your parents. You want to go out and have your own fun and start becoming, you know start becoming who you are. That age when, you know, where you know now I'd have a little more - just - maturity to deal with it.



The therapist asked the client whether his father would be proud of the person he became. CP4's answer was coded as a Family of Origin subcategory theme, as he explained that he believed that at certain points he was more successful professionally and emotionally than both of his parents.

*Session comparisons.* Nearly three years had passed between the two coded sessions. CP4 initially referred himself for therapy because he reportedly had difficulty recognizing and expressing his emotions. The four themes that emerged from the first coded session mostly focused on CP4's relationship conflict and communication struggles with his girlfriend. While the client considered ending the relationship, he was ambivalent about making a decision. By the second coded session, CP4 had broken off his relationship with his partner.

The number of themes that were observed in the latter session increased from four to eleven. In the 97<sup>th</sup> session, he discussed another life transition, a move from California to another state. The client appeared comfortable with his housing transition, despite having to separate from a roommate and his dog. In addition, he reflected on his relationship with his father, who had passed away. The client appeared confident in his personal accomplishments and his work-related abilities. Whereas alcohol use was a source of conflict between him and his girlfriend in the earlier session, at the latter session, serving alcohol was a means of employment for the client. The therapist initially diagnosed CP4 with a partner relational problem and at termination this diagnosis had been changed to a phase of life problem. The therapist noted that at termination he had increased his "self-awareness" and was "integrating various aspects of his personality."

### **Client-Participant 5.**

*Early session themes.* From 147 talk turns in the fifth session emerged five subcategory themes (63 times; 42.86% of session): Anger (three times; 2.04% of session), Trust Issues (36 times; 24.49% of session), Challenges with Blending Families (19 times; 12.93% of session), Communication Issue (two times; 1.36% of session), and Family of Origin (three times; 2.04% of session).

The Self-Development Parent Theme was expressed by one subcategory, though it occurred within the context of an interpersonal interaction. The first was Anger, which was subsumed under the Emotional Experience Intermediate Category. CP5 described experiencing anger and irritability toward her partner for the way he was handling the relationship between his ex-partner and the ex-partner's daughter. She explained that she had difficulty managing her emotions in their interactions with one another:

C145: Now this is just the worst. It's just the worst. And it's just bad because of him, the way he's handling it. It's not the mom, it ain't the child, it's the way he's handling it. I try not to turn it onto me, but it's not conducive with my personality. I don't know what the fuck? Even when we're not talking about it, I'm so on it (Cuts out). Yesterday, (unintelligible), he's just joking, and I'm like snappy, I need to calm down, I need to conceal this info, which I'm not good at.

Four subcategories were observed in this session that belonged to the Interpersonal Relationship Parent theme. Two occurred within the Partner Relationship Intermediate Category. Trust was the most frequently appearing theme among these subcategories. CP5 recently found that her boyfriend had a child four years ago from a previous relationship. Although the partner stated that there was a paternity test showing that that he was not the biological father of the child, he reportedly wanted to be involved in the child's life. CP5 stated several times during the session that she was unsure of whether she could trust her partner:

C67: Yeah. Like for years, yeah... and it's to a point where he really wants me to believe him, but I'm like Dude, I do not trust...I'm not a suspicious person, but once you mess it up, it's kind of like... (cuts out). I wish I could believe you, cuz it would make my life way easier, you know what I'm sayin'? You know but it's like, it's to the point where now it's like, I really don't know what to believe. I wish I could say I don't care, but I kinda do. You know?

The daughter's biological mother was described as manipulative by CP5, and she expressed that she was unsure whether or not her boyfriend would be faithful to her or his former partner. CP5 was also suspicious that her boyfriend would spend time with the daughter and ex-partner without telling CP5 beforehand. This conflict with her boyfriend was also expressed as a Communication Issue subcategory. CP5 reported that her boyfriend refused to talk about circumstances that took place between him and his previous partner. Additionally, CP5 stated that her partner had difficulty expressing his need, such as what he would prefer to eat for dinner.

C117: He's not...I try with little stuff, like, I'll be like, So what do you want to eat? I don't know, what do you want? And I be like, No. Sometimes I'll be like, Dude, you are human too. We don't just go where I want to go. What do you want? We are not going to eat until you say something, so you better say something.

The Interpersonal Relationship Parent Theme also occurred as two subcategories within the Family Relationship Intermediate Category. The presence of her boyfriend's ex-partner led to content related to Challenges with Blending Families. CP5 appeared to have difficulty accepting that her boyfriend's ex-partner would be involved in their lives and wished that she would go away. CP5 expressed concern that interacting with was going to interfere with the progression of their relationship, as seen below:

C105: Cuz I feel like, how we going to move on with our lives when we've got this thorn in the back? He don't see it like that because she, (cuts out), but unless you get another person, let us have a family, man. It'll be a situation where, she ain't going to outright do anything. But, it's a situation where she will be kind of jealous now. She'll be happy for us, but she'll want to make sure is taken care of, her's is first, cuz she was first. You know what I'm sayin'? So it's just going to be more calls. More, Hey, don't forget about us, and what about, She wants to say..., it's going to be more.

While discussing the ongoing situation with her partner, CP5 briefly reflected on her upbringing, and a Family of Origin subcategory theme emerged. She described her mother as helping her to be an independent person by not allowing her to depend on the parent while she grew up. CP5 did not provide examples or provide details on specific ways that her mother helped her to be “self-sufficient.”

***Latter session themes.*** From 182 talk turns in the 18<sup>th</sup> session emerged nine subcategory themes (45 times; 24.73% of session): Disconnect From Self-Concept and Actual Behavior (six times; 3.30% of session), Dissatisfied with Work (four times; 2.20% of session), Career Aspirations (five times; 2.75% of session), Anxiety (five times; 2.75% of session), Money Management (two times; 1.10% of session), Personal Boundaries (five times; 2.75% of session), Partner Not Tending to Client (nine times; 4.95% of session), Partner's Professional Progression (two times; 1.10% of session), and Trust Issues (seven times; 3.85% of session).

Five subcategory themes were connected to the Self-Development Parent Theme. Two of these themes, Anxiety and Money Management, belonged to the Emotional Experience and Behavioral Regulation Intermediate Categories, respectively. The Anxiety subcategory emerged as CP5 discussed her experience with a homework assignment given in therapy in a previous session. The assignment required her to practice singing to herself, although the goal of the task was not explicitly stated within the session. CP5 expressed concern about how others would perceive her if she were to do the task, which prevented from her engaging in the activity. The Money Management subcategory theme emerged briefly at the end of session when CP5 stated that she would pay for her current therapy session only after she received her monthly salary next week.

The three remaining subcategory themes that belonged to the Self-Development Parent Theme came from two intermediate categories. Two subcategories, Dissatisfied with Work and Career Aspirations, fell under the Professional Development Intermediate Category, while the Disconnect From Self-Concept and Actual Behavior belonged to the Self-Concept Intermediate Category. The Dissatisfied with Work subcategory theme emerged as CP5 reported that she wanted to quit her job and that several aspects of her work displeased her, including the amount she was paid and feeling like she was “stuck.” She stated that she had limited time for herself after a workday and that being at work felt like she was “wasting away.” Part of this perception may have been related to the disparity between CP5’s job as an accountant at a travel agency and her desire to be a singer. This goal emerged as a Career Aspiration subcategory theme for CP5, which was important to her because it would come from honing her talents. However, the client also expressed some uncertainty about her future profession and she was unsure of how well she was using her time to network with others in the music industry:

C135 Because like for example, I didn't want to come out here based on my looks. I just didn't. You know what I'm saying? If I get something because of it, great. I want to have a skill. Something that I can bank on. Ok I took make up and I didn't really necessarily want to do that but it's kinda like, I'm gonna get some skill. I'm not gonna be coming out here just because like, Oh I'm cute. What can happen to me? Yea, you can die. Like all type of shit can happen you don't have no direction. So I feel like I don't have no direction so it's kinda like- I'm like having to sit around people and meet people that I probably don't need to meet. Like it's harder for me to weed them out. You know what I mean? That's why I'm saying it's kinda bleeding over in to everything.

Part of CP5’s uncertainty about her career appeared related to how she saw herself. CP5 reported that she saw herself as a much more talented singer than when she actually practiced. During the session a Disconnect From Self-Concept and Actual Behavior subcategory emerged. The therapist proposed that the client had unreasonable expectations of herself and that she judged herself harshly. CP5 agreed, and recognized the attitude was negatively impacting her:

C61: No I believe you. Because, because what you said today, it was a perfect example of how I feel- like just because I did it then, now it's like- Now it's like I really do feel like, Fuck it. You know what I'm saying? So- And really being like that is kind of getting me- It's bleeding over in to the rest of my life. It's like fucking up the rest of my life cause it's like- It could be so much easier if I didn't set these certain standards for myself, you know what I'm saying?

The Interpersonal Relationships Parent Theme was expressed through four subcategory themes. Three of these subcategory themes, Partner Not Tending to Client, Partner's Career, and Trust Issues, were subsumed under the Partner Relationship Intermediate Category, while one subcategory theme, Personal Boundaries, belonged to the Peer/Work Relationship Category. The not Partner Not Tending to Client subcategory appeared in relation to different situations during the session. CP5 reported that she believed that her partner was prioritizing his singing career and leaving her at home. Additionally, she described that her boyfriend did not generally think of her first and put his own needs above hers. For example, CP5's boyfriend stole a computer from work and the client was upset that he was using it for himself and not sharing:

C88: Like he should've thought about me as soon as you fucking stole it. If you're gonna steal somebody's shit- I don't give a damn you stole her pencil. You shoulda been like, "You need a pencil? Cause now I got an extra one." But your first thought was, How can I keep something for me? The fuck? [Client laughs] I guess cause I'd never think about that. Like I was saying about- If I have it, I may not know who to give it to but eventually I'd do it. Like if something pops up like "Oh I got an extra."

CP5 also expressed dissatisfaction with her boyfriend's singing career, which emerged as a Partner's Career subcategory. She stated that she was unhappy that he was not more successful and that she had to help her boyfriend with travel costs and other spending.

The session also contained content related to Trust Issues between CP5 and her boyfriend. She reported that her boyfriend did not trust her to spend time with other men, and wanted her to stay at home. CP5 saw this as a double standard, as her boyfriend's singing job required him to be out of town and interact with other women. The Personal Boundaries

subcategory theme occurred in the context of CP5's relationship with her roommate. CP5 reported that she had no interest in interacting with her roommate and becoming friends with him. She described a desire to be by herself and not engaging with him:

T14: Mh-hmm, Um, do you not like the roommate?

C14: No I like him. Yea I like him. [Client nods]. Like I'm just the type of person, I knew that I didn't want a roommate that was anything like me cause I didn't want to be friends. I just wanted to live there you know. And um I don't let him befriend me but I'm cordial like- if they like, "You want something to eat? We cooked something" I'd be like, "No." [Client shakes head] Because I know that's gonna require me to sit at the table. Like I don't want to. Like I just want to be alone. I don't like- I'm not talkative. I'm not antisocial. But I'm not gonna just say, "Hey what are y'all doing? Let's sit down and watch TV together." Like it ain't gonna be like that. Like, you know what I mean?

*Session comparisons.* The first coded session was the fifth time the client met with her therapist. The main topic that was discussed was CP5's boyfriend and how his relationship with his daughter and former partner were impacting the client. CP5 reported having difficulty trusting her significant other, as well as adjusting to the presence of the other members of the blended family. By the 18th session, the number of topics increased from five to nine. There appeared to be continued conflict between the client and her boyfriend. Although trust remained an issue between the couple, CP5 did not express concern about her partner's fidelity. Rather she stated that her boyfriend did not seem to trust her with other men, that she was not satisfied with the progression of his career, and that he was not prioritizing her. The second recorded session also focused on CP5's personal development, such as her career aspirations. CP5 stated that she was discontent with her job and felt stuck, but also unsure of where to direct herself in terms of her profession. This particular issue was not present in the earlier session.

Finally, CP5 continued to struggle with regulating her emotions. While regulating her anger was discussed in the earlier session, regulating anxiety related to performance

and social judgment was the more dominant theme by the later session. The client reported that she had to delay paying for her therapy for the latter session, although it could not be determined what other challenges she may be having with managing her money. As there was no treatment summary for this client, it was unknown what additional diagnoses CP5 may have received and resolved over the course of treatment. However, the persistence of the initial primary diagnosis of a partner-relational problem was apparent from the 18<sup>th</sup> session.



## **Chapter IV. Discussion**

The purpose of this qualitative study was to explore what themes occurred in individual psychotherapy with a diverse sample of emerging adults receiving treatment at an outpatient university-based community clinic. This question was investigated using an inductive content analysis to examine the content of therapy sessions. Five clients between the ages of 18 to 29 who initially presented with some concern related to the transition to adulthood were selected from a confidential research database of closed psychotherapy cases. Two sessions from each CP were transcribed and analyzed. From these ten total sessions emerged thematic overlap in topics that were discussed. More specifically, two Parent Themes were found in the content of the clients' discussions, Self-Development and Interpersonal Relationships, which were comprised of a total of 42 subcategories. The Self-Development Parent Theme contained five Intermediate Categories (Behavior Regulation, Life Management Skills, Emotional Experience, Professional Development, and Self-Concept), while the Interpersonal Relationship Parent Theme contained three Intermediate Categories (Peer/Work Relationship, Partner Relationship, and Family Relationship). This chapter discusses the Parent Themes, along with their corresponding intermediate categories and subcategories, first in relation to the emerging adulthood literature and then with other developmental models. Comparisons in Parent Themes between sessions are then described. This discussion is then followed by a description of the limitations of this study, the potential contributions of this study, and concludes with suggestions for future research.

### **Parent Themes and Arnett's Theory of Emerging Adulthood**

Whereas traditional developmental models have conceptualized adolescence as a time for identity formation and adulthood as a time for developing intimacy with significant others (e.g., Erikson), emerging adulthood has been conceived as new category that spans the time in

between adolescence and adulthood. It has been defined, in part, as one of self-discovery and one characterized by more mature and intimate relationships towards others (Arnett, 2006). Two parent themes identified among the content discussed by CPs in this study, Self-Development and Interpersonal Relationships, highlighted ways in which emerging adulthood themes may present in psychotherapy and reflected aspects of Arnett's formulation of this developmental stage, Marcia's identity status model of develop, and several person-context interaction models.

The discussion of Parent Themes focuses on comparing the results to Arnett's conceptualization of the transition to adulthood because emerging adulthood is a relatively new theory in developmental psychology research, and little qualitative research has been done examining how/if the themes that individuals in this age group bring to therapy reflect the developmental tasks in this model. While there has been growing acceptance for emerging adulthood as a distinct stage, other researchers have contested its utility and universality (Côté, 2014). This study did not aim to prove or disprove the theory, but explore to what themes appeared in therapy sessions with emerging adults.

**Self-Development.** The Self-Development Parent Theme that emerged in this study focused on building different capacities and aspects of one's identity in the transition to adulthood, including Behavior Regulation, Emotional Experience, Life Management Skills, Professional Development, and Self-Concept. This theme was robust in that it emerged for all five participants within and across all 10 therapy sessions. The diversity of different intermediate categories demonstrates the kinds of developmental tasks that occur for emerging adults across broad domains. In many ways this Self-Development Parent Theme was consistent with many key aspects of Arnett's conceptualization of emerging adulthood (Arnett, 2004). Self-Development was characterized by content that focused on developing capacities to be an adult,

which is akin to Arnett's age of self-focus concept. Developing facets of one's identity also shares a connection with Arnett's idea that emerging adulthood is an age of identity exploration and age of possibilities. Challenges with navigating these developmental tasks could be related to emerging adulthood as an age of instability. The following discussion of the Self-Development Parent Theme is organized by Arnett's domains of emerging adulthood.

*Age of self-focus.* With regards to being an age of self-focus, emerging adulthood is thought of as a time when individuals move towards becoming independent from their parents and their responsibilities shift more towards taking care of themselves (Arnett, 2004). When past research has asked transitioning individuals across different ethnic groups in the US what constituted adulthood, items related to individualism, such as being self-sufficient, taking responsibilities for one's actions, and being less reliant on one's parents, were among the highest rated criteria (Arnett, 1997, 2001, 2003). Research on emerging adults outside the US have found variations in what defines an adult, such as greater emphasis on family capacities in collectivistic cultures; however taking responsibility for one's actions was still a common feature among their criteria (Badger et al., 2006; Nelson et al., 2004; Nelson et al., 2013; Seiter & Nelson, 2010). The need to take responsibility for oneself and one's actions was seen in the themes of several therapy sessions, including the Self-Development Parent Theme and different respective intermediate categories in this study including Behavioral Regulation, Emotional Experience, and Life Management Skills, which are discussed next.

Three clients in this study discussed their challenges with Behavioral Regulation including, Substance Use, Impulse Control, and Diet and Exercise. Increased and frequent substance use may be somewhat normative during Emerging Adulthood, especially alcohol use (Velasquez et al., 2011). As many as a third of individuals during emerging adulthood period

have been observed to meet criteria for substance use disorders (Blanco et al., 2008). Substance use is of clinical concern to therapists, as even low amounts of substance use has been found to correlate with problems such as externalizing behavior issues, and academic dysfunction (Tucker et al., 2005).

The first finding in this study with regards to Behavioral Regulation showed some of the potential problematic consequences of substance use in emerging adulthood, and uniquely revealed the impact such use can have on therapy sessions. Two CPs were diagnosed with substance abuse related problems. CP1 was diagnosed with a cannabis dependence and alcohol abuse, which were conceptualized by her therapist as contributing, in part, to her chief complaint regarding academic procrastination (i.e., spending time using substances rather than studying). Despite this relationship, CP1 did not discuss her substance use in the two sessions that were examined. Among the three CPs who actually discussed content related to substance use in their sessions (alcohol abuse at early session, not at later session), CP3 was the only one to be diagnosed with substance related issue. Regarding externalizing behavior issues, CP3's alcohol use was a source of conflict with his partner. This finding was in contrast to CP2, whose drug use was a means to socialize with peers in adolescence, and was later exchanged for healthier activities (e.g., hiking). For one client, CP3, a 23-year-old Latino male, his use of cigarettes and an energy drink reportedly influenced the client's ability to engage in the session. Other research on energy drinks use in college students has found their use to be associated with other problem behaviors (Miller, 2008), although this was not assessed in the transcribed session. While CPs presented with substance related issues either in their adolescence or around their initial sessions, these problems did not persist in the latter session or by termination of treatment.

Emerging adulthood has been observed to be a time of increased substance use (Blanco et al., 2008). Research has also shown that substance use typically goes down for most individuals transitioning to adulthood the older they become (White et al., 2005). This trend appeared to be the case for CPs who discussed their substance use in sessions. CP2 described using substances as an adolescent and in college, but reported that in the latter session, when she was 29-years-old, that she stopped her usage. CP3, a 20-year-old Caucasian male was diagnosed with alcohol abuse at the beginning of treatment but was not at the end of treatment, three years later. It should be noted that while CP1, a 23-year-old Latina female, did not discuss substance use in any of her sessions, her intake indicated that her substance use, partially contributed to her academic procrastination. When she was discharged from treatment for missing appointments, her diagnosis included cannabis dependence and alcohol abuse, which were not present at her intake. There was no obvious trend in this study regarding differences in substance use based on gender, although research has shown that males in this age range report overall more substance use issues than females (McCabe, et al., 2007; Chen, & Jacobson, 2012). In this study, there were also not clear ethnic/racial differences in substance use behaviors among the CPs, although previous research has shown that Caucasian and Latino individuals tend to abuse substances in this age range at higher rates than African-Americans (McCabe, et al., 2007; Chen, & Jacobson, 2012). Taken together, these findings bolster previous research suggesting that emerging adult clients, particularly those at the younger end of this transitional period, are susceptible to substance use issues, and may present as targets for treatment, as well as barriers to retention.

The second finding from this study in relation to Behavioral Regulation (specifically being able to inhibit inappropriate or unhelpful behaviors) may be a capacity that facilitates taking responsibility for oneself. Impulse Control was a subcategory that emerged for one CP in

this study. CP2's report that she was able to prevent herself from using her partner's cellular phone to look up any private conversations he may have had with other women. The client reported that she was able to exert self-control over her initial thoughts because of the work she had done in therapy with monitoring and challenging her thoughts. While greater executive control over one's actions increases during emerging adulthood, in relation to prefrontal cortex development (Casey, Jones, & Hare, 2008; Simpson, 2008), this example demonstrated the potential that psychotherapy has to help emerging adults build skills in regulating their behavior, in order to better prepare them for the transition to adulthood.

The third finding from the current study that related to Behavioral Regulation was the subcategory theme of Diet and Exercise that emerged in sessions with two clients, CP3 and CP4. While CP3 focused on regular exercise as a means to relieve stress from interpersonal conflict he was having with his ex-partner, CP4 used his exercise and diet as a way of addressing his concern that he was becoming older and wanting to maintain an attractive appearance. Diet and exercise may be areas of concern for emerging adults, as one epidemiological study has shown that these behaviors may be susceptible to changing for the worse during this period (Nelson, Story, Larson, Neumark-Szatiner, & Lytle, 2008). More frequent exercise has been shown to help emerging adults have increased life satisfaction (Maher et al., 2013) and reduced depressive symptoms (McPhie & Rawana, 2015). Although none of the CPs' in this study targeted these behaviors as part of their treatment plan, changing an emerging adult's eating habits and exercise activity may be two areas that can be targeted in treatment to improve presenting symptoms and impart coping skills for the future.

In addition to behavioral capacities, the development of practical skills reflects another important aspect of the age of self-focus. Arnett viewed emerging adulthood as a period when

responsibilities to others are at their lowest, while responsibilities to take care of oneself increase (Arnett, 2004). This study also found that emerging adults acquire new responsibilities as a result of becoming more independent and self-reliant. However, developing new skills was an area of challenge for three clients, and in some cases targets of treatment. These skills, while not exhaustive of the myriad responsibilities and related skills that come with adulthood, are described below.

Becoming financially independent from one's parents has consistently been observed to be among the top criteria for adulthood among emerging adults and their parents in the US (Arnett, 1997, 1998, 2003; Nelson & Barry, 2005; Nelson et al., 2007; Padilla-Walker, Nelson, & Carroll, 2012), and even among collectivistic cultures financial independence is viewed an important means to support one's family (Fuligni, 2007). Among the CPs in this study, Money Management was discussed by three. Their age ranges spanned from 20 to 28 years old, included females and one male, and consisted of Latino, Caucasian, and African-American CPs. This wide range of demographic variables suggests that financial matters likely are a common concern to many emerging adults of diverse backgrounds. One CP, CP2, discussed struggling to budget her income while relying on school financial aid, and two working client participants wanted more money from their job or did not apparently have enough to pay for one of their therapy sessions. In none of these sessions was money management discussed as a specific skill to develop, merely the lack thereof as a source of stress. While some financial burden and stress may be unavoidable, emerging adulthood may be a time of particular stress in this area, as some individuals are responsible for their finances for the first time. Recent research has focused on pending behaviors and attitudes on emerging adults in college (Gutter & Copur, 2011; Jorgensen & Savla, 2010), but there is less research in this area with those who are not attending school.

One research study found that financial behaviors in college students were influenced by parental modeling and direct learning (Shim, Barber, Card, Xiao, & Serido, 2010). Psychotherapy may be a fertile environment to examine an emerging adult's attitudes and corresponding spending, saving and earning behaviors, as well as to potentially change them, inasmuch as they are a source of concern for the client.

Adjusting to college was another source of clinical concern for one individual, CP1, who procrastinated on her graduate school projects. Her treatment goals focused on improving her time management skills through different behavioral interventions and changing her study environment. Academic procrastination is a common occurrence in college students, both at the undergraduate and graduate level, and may be related to the acquisition of new practical skills, as well as beliefs students have about their own ability to regulate their behavior (Klassen, Krawchuk, & Rajani, 2008; Onwuegbuzie, 2004). Clinicians can expect procrastination to be among the issues emerging adults bring into therapy, especially for those in school. Learning new skills as well as addressing cognitions related to self-efficacy have been used as treatment approaches to procrastination (Rozental & Carlbring, 2014), which may have the potential to have long-lasting and positive effects on an emerging adult's functioning and sense of self.

*Age of instability and age of possibilities.* Emerging adulthood has been observed to be an age of instability, as evidenced by research that has shown that individuals in this age range change jobs/careers frequently (U.S. Census Bureau, 2012b) and tend to move between residences several times during this period compared to other points in their lives (Benetsky et al., 2015). Similar to other emerging adults, CP3 discussed considering changing his educational goals and CP5 spoke about wanting to leave her job. CP5 was particularly unhappy with her place of employment, and appeared to be particularly concerned that she did not want to be like



her “old” co-workers (Arnett, 2004). CP4’s materials also showed that he started therapy as a manager of a grocery store and worked as a bartender near the end of treatment. The instability that comes changing one’s career frequently may not necessarily be experienced as stress as it pertains to one’s desire to find a job that is an expression of identity (Arnett, 2004). For emerging adults, like CP5, who may have believed that she happened upon her job, staying in the position may have diminished her sense of the possibilities for her future that are also an important component of this developmental stage. Thus, these results indicate that emerging adults may experience a change in career in the course of treatment, and that therapists should view these transitions as a normative part of their development, which can be validated by therapists.

In terms of moving residences, only one participant, CP4, explicitly discussed living in a different place during the coded sessions. CP5 had recently moved from out of state, but she did not discuss this transition in her transcribed session. Whether other CPs experienced moves or were impacted by their frequency could not be determined precisely from the information that was available. The two of the five clients who were found to have moved or were planning to move, share experiences that have been noted with other emerging adults. Clinicians working with this age group should be prepared to offer referrals and resources for individuals who need to continue their care with another provider because of their relocation.

While moving could be a potential source of distress for some emerging adults, the client who experienced a housing transition, CP4, had a positive attitude toward this change as an opportunity to move for more family support and potentially better employment. This outlook may be an example of how emerging adulthood can be viewed as part of it being an age of possibilities (Arnett, 2004) for some individuals. Arnett noted that many emerging adults have an

optimistic attitude toward the future, such as endorsing the belief that their lives will be better than their parents, that they will be happily married, and financially successful (Arnett, 2000b). CP4's perspective demonstrated how this kind of positive outlook may be a source of resiliency in the face of significant life changes (i.e., moving to another state), as well as his reported emotional and material support from this mother. Other participants did not express optimistic sentiments about the future. This may be because the focus on many sessions was on ongoing challenges and discord, instead of looking toward the future. Previous research on resiliency on emerging adults has found that individuals who experienced hardship and dysfunction in emerging adulthood showed good functioning in adulthood if they planned deliberately, had adult support, and were thinking in terms of the future (Burt & Paysnick, 2012; Masten, Obradović, & Burt, 2006). Resiliency to the instability of emerging adulthood was not as readily apparent in the emergent themes of the other CPs. However, CP3, who initially broke up with a romantic partner at the start of his treatment, experienced less depressive symptoms at the end of treatment by focusing on problem-solving skills and his personal strengths. Taken together, optimism and the acquisition of practical skills, as forms of resiliency, appear to be potential strengths to target in future interventions with this population to help cope with ongoing instability in their lives.

Identifying resources for assisting emerging adults in dealing with the age of instability and supporting positive aspects of the age of possibilities is important for researchers and clinicians, as emerging adulthood is a time of increased psychological distress. This is evidenced by the majority of individuals having their first onset of mental illness at age 24 (Kessler, Berglund, et al., 2005) and emerging adults having a rate of psychiatric diagnoses that is twice the general adult population (Kessler, Chiu, et al., 2005). At their intakes, two of the five CPs

were diagnosed with anxiety disorder not otherwise specified, one was diagnosed with an adjustment disorder with depressed mood, and the remaining two were diagnosed with partner-relational problems.

These CPs reported having difficulty coping with situational stressors in their lives (i.e., homework assignments, relationship conflict, recently being single). While the general trend is for anger and depressive symptoms to diminish over time in emerging adulthood (Galambos et al., 2006), as one might expect when stressors naturally resolve, emotional regulation can still be a challenge for emerging adults in psychotherapy. These three clients-participants, whose ages spanned ranged from 23 to 29 years old, discussed challenges with modulating and understanding their emotions. CP1 discussed experiencing anger and being hurtful while arguing with her sister, CP2 described becoming tearful, although she could not identify the cause of her dysphoria, and CP5 reported experiencing anxiety regarding performing an assignment from therapy. Furthermore, CP1 demonstrated an extreme form of emotional dysregulation, as she had suicidal thoughts in response to a conflict she had with her boyfriend. The CP did not appear to be at high risk to harm herself, which is in contrast to the one in ten emerging adults in college who have seriously contemplated suicide (American College Health Association, 2008).

Perhaps paradoxically, emerging adulthood has been shown to be a time of increased well-being (Tanner et al., 2007), and some of the same CPs who reported struggling with their emotions also reported improvements regulating their affect. Specifically, CP1 and CP2 stated that they were better able to manage their anger and tearfulness, respectively, but it appeared to be attributed to becoming older, rather than an intervention in psychotherapy. In sum, although this research suggests that some emotional capacities may improve as a result of maturation,

emerging adults, even those at the tail end of this age range, can struggle with recognizing and modulating their affect.

*Age of identity exploration.* Emerging adulthood has also been defined as an age of identity exploration. In other words, emerging adulthood has been conceptualized as an institutionalized moratorium for identity exploration (Côté, 2006). The client participants in the present study highlighted the disappointment and frustration that can come with the journey towards finding oneself. Informing Arnett's model, Marcia's identity status model, which was derived from Erikson's theory, conceptualized identity formation as the product of how thoroughly an individual explored his/her options for identity, including domains of career or area of concentration in college, romantic partners, spiritual beliefs/values, etc., and how committed a person was with his/her choice. In the present study, identity exploration emerged from the Self-Development Parent Theme in the form of Professional Development and Self-Concept intermediate categories, which are described next. Aspects of identity that did not emerge from client discussions in psychotherapy included gender identity, sexual orientation, ethnic identity, and political identity. This may be due to the primary reasons the CPs were referred for treatment, none of which focused on those matters. It is also possible that these topics were discussed in other therapy sessions that were not transcribed, or that they were not discussed because of the therapists' comfort surrounding these issues.

For those transitioning to adulthood, work is seen as an opportunity to explore one's identity and future profession (Arnett, 2004). This mindset is in contrast to adolescence, when work is seen as a means to an end to earn money (Steinberg & Cauffman, 1995; Taylor 2005). Four of the five client participants in this study discussed their Professional Development in their sessions. Two CPs stated that they were dissatisfied with their jobs or ongoing education. CP5

was notably unhappy with her accounting job and did not see herself as “old” as her co-workers and desired to change her job. Such findings are not unexpected, as emerging adulthood has been found to be a time of frequent career changes (Carless & Arnup, 2011; U.S. Census Bureau, 2012b). These results show that an emerging adult’s profession is another facet of identity exploration that may be present when working with this age group.

The Self-Concept intermediate category was another example of identity exploration that was observed, albeit in different forms, which is consistent with the varied nature and domains of identity development. CP2 described how she arrived at her current spiritual identity, first by questioning her Mormon practices and beliefs, followed by using drugs as a means to connect with people, and most currently then using hiking and yoga to connect with her environment. She also described experimenting with trying different foods as a means of self-exploration. This retelling appeared to resemble a narrative, in which her identity was formed through an understanding of how her past had contributed to her current-self McLean & Pasupathi (2012). From these two sessions it was not possible to determine whether her spiritual identity evolved, although past research has shown that emerging adults narratives tend to become more sophisticated with age (McAdams et al., 2006). Psychotherapy may offer an environment for emerging adults to construct narrative identities and fulfill an important task of this developmental stage.

Other CPs had difficulty accepting their current limitations in terms of talents or aging appearance. CP5 expressed frustration with the realization that she was underperforming compared to how she saw herself as a singer. While emerging adulthood is a time for identity exploration, this CP demonstrated that individuals may encounter disappointment and frustration when one’s self-perception is in contrast to her actual self. Similarly, CP4 experienced distress

when confronted by his own hair loss, which he did not expect to occur when he was 23-years-old. This study shows that for some emerging adults, the process of physical aging may be a concern in terms of their self-perception, and can spur behavioral changes. In the case of CP4, his concern about losing his hair caused him to reflect on his physical appearance and served as a motivation to exercise more and eat better.

**Interpersonal Relationships.** The second Parent Theme that emerged in this study focused on interpersonal relationships. Investigators have theorized the role that different social relationships play across different stages of development. Arnett's conceptualization of emerging adulthood as a time of Self-Focus and Identity Exploration includes distancing from one's parents in order to transition to adulthood, while engaging in greater intimate relationships with friends and romantic partners (Arnett, 2011). Similarly, Erikson theorized that peer relationships in adolescence helped individuals consolidate their identity while romantic and work relationships in adulthood promoted a sense that one was capable of being loved and having a purpose in life, respectively (Erikson, 1968).

In general, interpersonal relationships in Emerging Adulthood are marked by increasing intimacy and maturity than compared to those in adolescence (Arnett, 2004, 2011). Much of the emerging adult literature concerning interpersonal relationships has focused on parents, peers, and romantic partners. Yet, in the present study, a wider variety of relationships was discussed during psychotherapy sessions, notably relationships with parents, peers, romantic partners, co-workers and supervisors, and their children. These latter two relationships have not been as well-studied, and demonstrate the diverse interpersonal trajectories of emerging adulthood. What follows is a description of the various relationships that were discussed in CP in relation to emerging adulthood literature.

*Relationship with parents.* Emerging adulthood is conceptualized as a time for individuals to separate from their parents, often times by moving out, in order to transition to taking on the responsibilities of adulthood. While emerging adults still rely on their parents for support, they are generally less beholden to them (e.g., not having to follow curfews, not having to report on daily activities). Despite becoming more independent from their parents, many emerging adults report feeling closer to their parents once they move out of the home (Aquilino, 2006; Whiteman, McHale, & Crouter, 2011), which may be a natural function of increased filial maturity, or the understanding that one's parents are individuals with their own histories and limitations (Birditt, Fingerman, Lefkowitz, & Dush, 2008). CP1 and CP4 described disliking the amount of responsibility that their mothers gave them during their childhood and adolescence, yet also expressed some appreciation for having become independent people as a result of these struggles. In one of CP4's last therapy session, he appeared to have an understanding of the flaws of both his parents, which was accompanied by the hope that he would be more successful than them, a common sentiment among emerging adults (Arnett, 2004). These realizations may have been the product of typical maturation processes, and they also may have been due to increased insight that was promoted in therapy, although the latter was not observed directly in the present study.

While emerging adults are individuating themselves from their parents, they can be reliant on them for economic support (Padilla-Walker et al., 2012). In this study, parents reportedly assisted CPs by providing money, making meals, and cheering them on at their job. Many broad forms of parental support have been observed for emerging adults, such as emotional support, practical support, financial support, giving advice, and providing social interaction (Fingerman, Miller, Birditt, & Zarit, 2009), but not all were present in this study.

Furthermore, not all the CPs in this study experienced their parents as supportive. Client-participants described having arguments with their parents, not feeling trusted by them, and being obligated to check in with them. Research has shown that the shift from adolescence to an emerging adult can be a challenge for parents in terms of allowing more privacy and independence (Aquilino, 2006), especially when their child still resides at home (White, 2002). Not being given the opportunity to exert one's growing independence can be difficult for emerging adults when parents do not acknowledge their children's transitioning status, as they can feel as if they are being treated as children at times (White, 2002) Such appeared to be the case for CP1, who was concerned that her mother would be upset with her if she did not come home instead of spending time with her boyfriend. Communication based on problem-solving has been demonstrated to be effective in reducing conflict between parents and adolescents (Long & Adams, 2001). However, the therapist did not utilize this intervention, which may have been due to the emphasis the CP placed on the conflict she was having with her boyfriend, rather than the restrictions placed on her by her mother.

*Relationships with romantic partners.* Emerging adulthood has been observed to be a time of searching for the qualities one wants in a life-long romantic partner (Arnett, 2004), which is a part of the age of self-focus as when young adults decide with whom they want to be (Arnett, 2004). Similarly, Erikson saw one of the chief psychosocial crises of adulthood to be developing the capacities to form intimate relationships versus being isolated from others. Reflecting the primacy of this issue, four of the CPs in the present study discussed ongoing relationships with romantic partners. Arnett's conceptualization of emerging adults as an age of possibilities is partially influenced by the large portion of people transitioning to adulthood who believed that



they would eventually be married (Arnett, 2004). In this study, none of the CPs discussed the topic of marriage, although four were in a relationship by the first transcribed session.

While the optimism about eventually becoming married represents a common experience among emerging adults, the difficulty of finding a compatible partner could be interpreted as a part of this period being an age of instability. For emerging adults, romantic relationships are thought to be a primary source of emotional support (Meeus, Branje, van de Valk, & de Wied, 2007). At the same time, romantic relationships can be particularly unstable in emerging adulthood, as break ups and reconciliations are frequent, along with having sex with an ex-partner (Halpern-Meehin, Manning, Giordano, & Longmore, 2013). Consistent with the literature, in this study, there was a mix of romantic partners reportedly being sources of conflict and support. Communication was a particular contentious issue between three CPs and their partners, which ranged from choosing where to eat for dinner to having needs for intimacy met. Trust was another source of conflict for CPs, and they described either their own or their partner's concerns about possible attractions to past partners or current friends. These various conflicts led two CPs to question their commitment to their relationship, demonstrating that clinicians working with emerging adults can be expected to help them explore their romantic commitments, not only as a clinical issue, but as a developmental task that is part of identity exploration. Notably, CP4, a 20-year-old Caucasian male, reported that although he had a number of reasons for not wanting to stay in his romantic relationship, he was compelled to remain in his relationship because it was "stable," and he appeared concerned with the unpredictability that would come from staying with his girlfriend.

Only one CP, CP2, who was 29-years old, and the oldest person in the study, discussed her partner positively in terms of his ability to communicate and the course of his professional

development. It was this same CP who was having an open discussion about having children together. The couple made plans to have children although the partner had not completed a divorce from his marriage and there was no discussion about being married prior to having children. This would seem to reflect a growing trend in emerging adults who have uncoupled marriage from childbearing (Smock & Greenland, 2010).

*Relationships with peers/co-workers.* Peer relationships, such as friendships, have been less studied in the context of emerging adulthood compared to adolescence (Arnett, 2011), but are a continued area of interest for researchers, especially in determining how they are distinct from other developmental stages (Collins & van Dulmen, 2006). Peers are thought to be important sources of support as individuals become independent from their parents and have yet to commit to long-term romantic partners (Arnett, 2013). Similarly, Erikson theorized that peers were important for adolescents to help provide a basis for comparison to consolidate their identities (Erikson, 1968). While peer relationships are thought to be an important source of support in emerging adulthood, the period is also characterized by being an age of instability. Thus, peer relationships, including roommates and co-workers, may also be in flux. Although career exploration has been emphasized as a major developmental task during this period, little research has been done with regards to the impact of relationships with co-workers in the context of this time of life. In this study, peer and work-related relationships were the least frequently discussed interpersonal relationships.

When peers were discussed, they seemed to be a source of struggle for the CPs. Four of the CPs discussed the need for some personal boundaries from their peers, especially if they were undesirable because of their behavior or because they were concerned of being judged by them. To some extent this finding could be interpreted to be a normative manifestation of emerging

adulthood being a time of self-focus. However, CP3 appeared to be impaired and distressed by his reluctance to be vulnerable with others, suggesting that distancing oneself from one's co-workers may be maladaptive during emerging adulthood.

Negotiating personal space can be particularly difficult when sharing a residence with other emerging adults, but this study indicated that it may be a natural consequence of the frequent moves that occur during this age of instability. Living with peers was a challenge for CP1, who came into conflict with her partner's roommates for using their household goods and not taking shared responsibility of their common living space. Having a roommate is common for emerging adults who do not live with their parents (Arnett, 2004). Thus, learning how to resolve conflicts may be an important developmental task which promotes autonomy (Laursen, Finkelstein, & Townsend Betts, 2001). Research has shown that young adults use more compromise and disengagement strategies in peer conflicts compared to younger age ranges (Laursen et al., 2001). Most studies that have focused on roommate conflict in this age range have focused on college students in dormitory settings (Bahns, Crandall, Canevello, & Crocker, 2013; Bresnahan, Guan, Shearman, & Donohue, 2009; Fuller & Hall, 1996). Interventions that have focused on improving self-disclosure and empathy have shown to reduce roommate conflict (Waldo, 1989), which may be a potential treatment approach to use with noncollege emerging adults or emerging adults who are in graduate school.

Conflicts with co-workers, particularly supervisors, may require different methods for resolving conflicts than peers, but provide an opportunity for emerging adults to learn how to manage their emotions while meeting the needs of different parties (Weitzman & Weitzman, 2006). Conflict management can be challenging for those transitioning to adulthood who may take solution-oriented or avoidant strategies in the face of disagreements with fellow employees

(Taylor, 2010). In this study, CP2 briefly discussed her disapproval with her supervisor over the way the latter performed her job, but appeared to take an avoidant strategy and not confront her co-worker with her opinion. Positive relationships with co-workers may also help facilitate independence in this age range. Qualitative research comparing mentorship relationships across adolescence and emerging adulthood has found that individuals report that their mentors balanced connectedness with autonomy, as well as empowered them (Liang, Spencer, Brogan, & Corral, 2008). Thus, clinicians who work with emerging adults can anticipate that these clients may experience stress from interacting with co-workers and supervisors, and should consider interventions that focus on developing conflict resolution skills that may be particularly useful for such situations.

*Relationships with children/blended family members.* In contrast to much of the emerging adult literature that has focused on interpersonal relationships has focused on parents, peers, and romantic partners, this study showed that people within this age range also can encounter dynamic changes to their family systems as they build a family through having children, and develop close relationships with their partners and their children.

Having children is accompanied by responsibilities to others, which is at odds with emerging adulthood being a time of self-focus. Such was the case for CP3, a 23-year-old Latino male who had two daughters with whom he co-parented with their biological mother. He described being concerned that his ex-partner was neglecting his children, and that his daughters were misbehaving at school. Given these extra responsibilities, there is some question about whether this CP could be considered an emerging adult or not, despite being part of the accepted age range. While Latinos have been found to more likely support role transitions, like parenthood, as criteria for becoming an adult (Arnett, 2003), it was not known whether or not

this CP considered himself to have attained adulthood status. While having children has long been considered a marker for adulthood, and not been considered to be a part of emerging adulthood, this particular CP demonstrated that some individuals will bear this responsibility while still exploring their identity (in this case, via his education and vocation).

Even for emerging adults who do not have children, seriously considering and planning for them may occur, especially when they have entered a committed relationship. Such was the case for CP2, who, at 29-years-old, was discussing having children with her partner in the near future. She expressed a concern that having a baby would interfere with her career development. The decision to take on such multiple roles is a common concern, even among young emerging adults in college (Booth & Myers, 2011; Peake & Harris, 2002). Recent research has shown that emerging adults who perceive having greater self-efficacy with handling conflicting demands from work and romantic relationships experienced less work-partner conflicts and better health over time than those with less self-efficacy (Seiffge-Krenke & Luyckx, 2014). However, whether or not such self-efficacy would reduce conflicts between work and child demands has not been studied with this population.

Research on the emerging adulthood period has highlighted the variety of ways that individuals become parents, such as through nonmarital cohabitation (Smock & Greenland, 2010), and this study demonstrated another potential pathway toward this event. For two female CPs, being in a relationship with their partner meant having to share their time between previous significant others and children from previous relationships. Such circumstances have been observed in other research with blended families, where step-parents felt that their needs were less prioritized compared to their spouse and his/her children (Martin-Uzzi & Duval-Tsioles, 2013). Thus, although many emerging adults focus on the qualities of their romantic partner, as

was true in this study for CP1, CP2, CP4, and CP5, this research also showed that some emerging adults may also be faced with the commitment of being a parent, as well as the distress that such merging families can bring for such individuals.

**Parents themes and feeling-in-between.** While Self-Development and Interpersonal Relationships could be compared to many aspects of Arnett's theory of emerging adulthood, the two parent themes did not cover one Arnett "pillar," the age of feeling in-between. The sense that one is in-between adolescence and adulthood has been conceived to be a foundational and important phenomenological experience for emerging adults (Arnett, 2001, 2004; Arnett & Schwab, 2012). However, there did not appear to be an explicit verbalization by any of the CPs that they were between adolescence and adulthood.

For the most part, none of the participants plainly stated in any of their sessions how they perceived themselves in terms of their development stage. However, CP5, a 28-year old African-American, in one instance, referred to herself as a child for not being able to regulate her emotions better. Research has shown that emerging adults have the experience of behaving in childish ways or not being as mature as they envision typical adults, but this perception is counter-balanced by the simultaneous perspective that, despite being immature in some ways, one is also an adult in other ways (Arnett, 2004). The fact that the feeling in-between phenomenon was not observed may have been the result of the small sample of transcripts that were used in the study. It may have been the case that CP5 and other CPs did in fact feel in-between, but the therapist did not facilitate such a discussion in the sampled sessions. Thus, it remains to be seen whether or how this aspect of emerging adulthood may manifest itself in psychotherapy.

The feeling of being in-between is influenced by a person's definition of adulthood. Research on this developmental stage has demonstrated that, across many age ranges, themes related to individualism, taking care of one's family, and complying with social norms tend to be more important to people in terms of becoming an adult, as opposed to role transitions, such as being married, being a parent, or graduating college (Arnett, 1997, 2001, 2003). Variations have been observed among different ethnic minorities, along the trend of emphasizing inner-qualities over traditional markers remained the same (Silva, 2012). While CPs in this study did not necessarily share their definitions of adulthood, the themes that emerged reflected struggles toward developing many of these aspects of their identity. Several of the intermediate categories of the Self-Development Parent theme, Behavioral Regulation, Life Management Skills, Emotional Experience, and Self-Concept, reflected aspects of identity development, which is proposed to be a defining feature of emerging adulthood.

Additionally, it should be noted that while traditional markers and role transitions were not as highly ranked compared to internal changes by the aforementioned groups (Arnett, 1997, 2001, 2003; Silva, 2012), they were still considered to have some bearing on whether a person could be considered as an adult. In this study, no CP explicitly discussed a relationship between demographic markers as being part of adulthood, but such traditional markers nonetheless were discussed or framed discussions. For example, CP2, a 29-year-old Caucasian female, discussed having a child with her partner and CP3, discussed difficulties with being the parent of two daughters.

### **Parent Themes and Other Models Relevant to Emerging Adulthood**

The Parent Themes that emerged in this study reflected processes outlined not only by Arnett's model of the transition to adulthood but others as well. The following discussion

compares this study's results to Marcia's to identity status model and person-context interaction models.

**Results compared to Marcia's identity status model.** Marcia's identity status model originally emphasized the role of exploration and commitment as processes underlying identity development in adolescence, and has been expanded to apply to those transitioning to adulthood (Luyckx, Schwartz, Goossens et al., 2008; Marcia, 1966). While standardized measure of identity status are available to directly assess the extent to which an individual lie on these dimensions (Luyckx et al., 2005), they were not utilized in this study. However, results showed some indications that these processes are mentioned by emerging adults in psychotherapy.

To some extent it can be inferred that the CPs in this study were in various stages of commitment and exploration in regards to different aspects of their identity. Four CPs discussed their Professional Development and Self-Concept as part of the Self-Development Parent Theme. For example, CP1, a 23-year-old Latina female, addressed difficulties she had with completing schoolwork. From her two sessions, it was difficult to assess the extent to which she had explored her career options, but her issues with procrastination may suggest a lack of commitment to her education. Similarly, CP3, a 23-year-old Latino male, briefly discussed stopping his commitment towards his pursuit of his bachelor's degree to either continue working or getting an associate's degree instead. His indecision was in contrast to CP2, a 29-year-old Caucasian female, who appeared to be more committed to her graduate school education and future career, yet was exploring other aspects of her identity, such as her spiritual beliefs through practices like hiking and yoga. CP4, a 20-year-old Caucasian male, and the youngest of the CPs, appeared to be committed to honing his skill in his current trade as a bartender and not exploring other options for his career. While CP2 is older than the former CPs by six to nine years,



research has shown that there are diverse trajectories in terms of commitment versus exploration processes across the transition to adulthood (Meeus, 2011). Additionally, CP3's re-evaluation of his career and education options bear resemblance to other research that has shown that ethnic minorities tend to change their career goals to be more obtainable in the face of stress from finances and institutionalized discrimination (Cooper, 2011).

The Interpersonal Relationships Parent Theme also showed signs of Marcia's commitment and exploration processes with regards to significant others. Four CPs were in romantic relationships, but differed in their level of commitment. CP4, a 20-year-old Caucasian male, was questioning whether he wanted to stay in his relationship with his girlfriend, while CP2 was exploring her identity as a future mother by discussing having children with her boyfriend. While there was an age difference between the two CPs of nine years, older emerging adults are not necessarily more committed to their aspects of their identities than younger ones, and exploration does not necessarily precede commitment (Meeus, 2011).

**Results compared to person-context interaction model.** Overall, the results of the study were difficult to apply to a person-context interaction model because of the lack of longitudinal information, especially in regards to adolescent functioning. Schulenberg and Zarrett (2006) proposed several models, to explain continuities and discontinuities in psychological well-being in emerging adulthood from adolescence. Two of the models did not seem to fit the present study's themes. The *transition as catalyst* models assumes that some struggles and behaviors are a normative part of transitioning to adulthood (Schulenberg & Maggs, 2002), but this sentiment was not expressed by the client- participants in this study. Similarly, themes related to the *heightened vulnerability* model were lacking, as no individuals described experiencing chance events that were afforded by their transitioning to adulthood.

However, some emergent themes could be seen as fitting into three of the other models. First, the *overload* model posits that emerging adults experience psychological distress when faced with a new environment/context that is beyond their means to cope. CP1 described having thoughts of suicide (i.e., driving her car off the road) in response to an argument she had with her boyfriend over staying over at his house versus going home to be with her family. Her symptoms could be viewed as an interaction between having to meet her personal needs and her family obligations and her current abilities to cope with emotions and resolve conflicts.

Second, the *increased heterogeneity* model explains that of individuals entering emerging adulthood, those who are already struggling in different developmental domains will only continue to struggle in contrast to their typically developing peers. For CP1, her current difficulties with procrastinating in graduate school were likely related to her history of procrastination in high school, which would help to explain why she exhibited dysfunctional behaviors compared to her classmates, who likely did not exhibit these behaviors to the same extent of the CP.

Third, the *match-mismatch* model proposes that discontinuities and continuities in mental health stem from transitions either magnifying the fit or mismatch between developmental needs and current functioning. For CP5, her experience at being at a job that did not foster her aspirations to be a singer may have contributed to her wanting to leave her position, as well as her perception that she was not “old” like her co-workers. Taken together, these findings showed that the interaction between an emerging adult and his or her environmental context may be useful, to some extent, in understanding the presence of some issues that emerging adults discuss in therapy. While evidence to support all the different trajectory models did not emerge, this

finding should not be interpreted as a rejection of these ideas, given the small sample size of this study.

### **Parent Themes and Session Comparisons**

Session content showed both homogeneity and heterogeneity across participants. While there was some continuity in terms of Parent Themes and Subcategories, new topics often arose toward the end of treatment for many individuals. In terms of continuity, CP1 discussed having difficulty with managing her time in regards to procrastinating on her schoolwork at the beginning of her treatment, as well as near the end of her treatment. CP2's early and latter session both included content focused on her significant other, although the first session focused on his positive attributes and family planning, while the second session discussed some issues related to a lack of trust with her partner. For CP3, his earlier and latter sessions had content related to Interpersonal Relationships and Self-Development parents theme, although the specific subcategories discussed (i.e., the individuals and area of self-development) were not the same. Similar to CP3, CP4 had content related to Interpersonal Relationships and Self-Development, but the specific Subcategories in these domains varied greatly. Lastly, CP5 reported having trust issues with her significant other during the early as well as latter session.

However, for all CPs, the subcategory themes shifted between sessions. For CP1, her early session made no mention of the conflict she was having with her partner or her peers, whereas her latter session focused on disagreements between these individuals. CP2's latter session mainly discussed conflict she was having related to being in a blended family with her significant other's ex-partner, rather than her earlier discussion of wanting to have children with her partner. In her latter sessions, there was also an absence of content related to work conflict that CP2 reported in her early session. The content between CP3 early and latter session differed

greatly. While his session at the beginning of therapy focused on conflict he was having with his mother, co-workers, and his academic institution, his session toward the end of therapy focused almost entirely on conflict he was having co-parenting with his ex-partner. CP4's early sessions shifted from interpersonal relationship conflicts with his significant other his relationship with his parents, including his supportive mother and deceased father. While this CP discussed Behavioral Regulation in regards to his alcohol use in the early session, the corresponding Subcategory content changed to Diet and Exercise. New content emerged related to Life Management Skills, as the CP was experiencing a transition with regards to his housing and employment. For CP5, her early session focused on difficulty with being part of a blended family, while the latter session also included content related to her Professional Development. Taken together, these changes in the focus of therapy likely reflect the instability that is particular to this age range. Therapist that work with this population will likely have to address issues related to multiple interpersonal relationships as emerging adults gain more responsibilities and separation from their parents, while engaging in more intimate romantic relationships. Additionally, the heterogeneity in session content within participants reflected improvements that were experienced during the course of treatment. Clinicians who work this population should be prepared to discuss and reformulate treatment goals in the face of a client's changing life circumstances.

### **Limitations**

Several limitations and caveats should be acknowledged when interpreting and applying these results. This section discusses results related to sampling as well as the content of the sessions and how they were coded.

In the case of this study, selective sampling was used in order to find CPs who could be considered to be knowledgeable reporters who could increase understanding of emerging adults in therapy (Thomson, 2011). The method used was to select CPs from the generally accepted 18-29 age range, as part of the inclusion criteria in this study. Yet previous research has emphasized that the transition to adulthood has diverse trajectories and the phenomenological experience of the individual may be more essential to understanding this time, rather than objective demographic criteria. Also, because the data was gathered from an archived database, standardized measures of identity status and emerging adulthood could not be administered to CPs. Thus, it is not known whether the client participants identified as adolescents, adults, or somewhere in between. Yet, as described above, the Parent Themes that were observed replicated some observations that have been found in past research on emerging adults, suggesting that the results of this study may be representative of some emerging adults receiving psychotherapy, but obviously not to an exhaustive degree.

Further, while this sample of emerging adults was diverse in terms of gender, ethnicity and ages, they should not be seen as representative of all emerging adults. Instead, from a qualitative perspective, they can be regarded as offering insight into this particular population that is seeking individual mental health services. One reason is that their topics of discussion were consistent with experiences reported by emerging adults in other research literature, such as in four of the five aspects of Arnett's model of emerging adulthood: time of self-focus, identity exploration, possibilities, and instability.

Session sampling may also have limited the range of EA issues identified. While the sample of individuals that was used for this study included men and women, as well as a variety of ethnicities, little content in the sessions related explicitly to the influence of culture, gender,

other factors related to diversity. There were some notable exceptions. This included CP2, who discussed her spiritual identity going from being “Jack Mormon” during her adolescence (using substances despite the practice being against the tenants of her religion) and to identifying herself as spiritual and finding meaningful connections to nature. This same CP also described a potential gender issue that may be unique to women in emerging adulthood. She expressed that she was concerned about being in “babyland” if she were to become pregnant, which would prevent her from focusing on building her career. Yet, overall, the lack of such findings was somewhat surprising to the researchers because Emerging Adulthood is considered a cultural theory. As such, the influences of different social attitudes and beliefs on the expression and experience of emerging adulthood has been examined across several different countries and continues to gain attention from researchers.

One reason why themes did not emerge in this study that differentiated between the clients based on their differences in cultural backgrounds could be due to the limited amount of sessions which were transcribed. Another reason could be due to therapists’ training. Since, the clinicians in this study were graduate students, their level of multicultural competency and confidence with addressing issues related to diversity was likely in early development, as well as influenced by the quality of their supervision with regard to these areas (Lee & Khawaja, 2013). Additionally, a demographic and cultural match or mismatch between the CP and the therapist may have affected the quality of the relationship. Recent meta-analyses have found that individuals seeking mental health treatment tend to prefer clinicians who share their ethnic/racial background and rate them more positively than clinicians who are not similar in this respect (Cabral & Smith, 2011). While these correlations have not been shown to have a substantial effect on treatment outcomes, these relationships are stronger for African-American clients

(Cabral & Smith, 2011). For this study, it is possible that matches/mismatches in ethnic/racial backgrounds between CPs and their therapist may have affected the content of what was discussed. Unfortunately, no information regarding the therapist's racial or ethnic background was available, so it was not possible to examine this potential interaction.

The content that was discussed in therapy was also, in part, influenced by the interaction between the CPs and their therapists. Clinicians' knowledge of emerging adulthood and its implications for psychotherapy, or lack thereof, may have affected their propensity to facilitate discussion regarding the transition to adulthood. Furthermore, therapists focused and explored topics based on their level of experience and clinical orientation.

Being able to identify and reflect feelings was also a skill that was in development for these training clinicians. For example, with regards to the Emotional Experience Intermediate Category, the emotions that were reported to be experienced by the clients were, to some degree, dependent on therapists' facilitating and encouraging such reflections, as opposed to focusing on practical problem solving. An exchange between CP2 and her therapist demonstrated a typical missed opportunity to engage the emerging adult with her emotions:

C21: Yeah. I feel like I have to like hold the light [holds hand in the air as if carrying a light] in the classroom. That's the only way I can really describe it cuz she's negative and she's not real. The kids can never get any kind of human connection with her. Um...

T22: Wait, she's the teacher in a...

C22: She's my master teacher

T23: OK...

C23: At [identifying information redacted]

T24: Oh, OK, so she's the...

C24: I'm like observing under her...

T25: Oh! That must really affect the kids too, then.

C25: I mean, they're great. The kids are good. It's...it's not horrible. I've seen worse, but it could be so much better if she would just give a little [brings hands together in a gathering motion]. She doesn't have the...she doesn't think that learning is fun. I mean one of my first days student teaching she like drilled them

that you know, "We are not here to have fun."  
T26: How old are they?

In this excerpt, the therapist shifted the conversation to discuss the composition of the classroom in which the CP worked, but did not explore her thoughts and feelings regarding having to be supervised by a professional whose approach she disagreed with.

In addition to how the actual content of the sessions were influenced by the sample of CPs, the number of sessions, therapist factors, and client-therapist interactions, the subsequent categories and themes were dependent on how the data was coded. In some cases, a single talk-turn was coded for multiple categories. For example, a CP talk-turn describing a conflict with a significant other involving yelling during a conversation may have been coded as Communication Issue (and later placed under the Interpersonal Parent Theme) and as Emotional Experience (under the Self-Development Parent Theme).

Furthermore, although the investigators reviewed each others' codes to increase reliability, the overall hierarchical structure could have been organized in different ways. Studies that employ quantitative analysis, such as exploratory factor analysis, could be used in order to further assess the reliability and validity of these findings (Auer-Srnka & Koeszegi, 2007).

Finally, it should be noted that the Parent Themes, Intermediate Categories, and subcategories that emerged in this study are not considered to capture all the content related to the transition to adulthood in this population. It is expected that future research on themes with emerging adults in psychotherapy would likely yield overlapping content, but with additional themes and categories, as well as nuanced hierarchical structures.

### **Potential Contributions and Implications**

One of the main contributions of this study is that it qualitatively investigated an understudied population of emerging adults undergoing psychotherapy using in vivo therapy



sessions as a novel source of data. Much of the literature on emerging adults has focused on individuals who are attending four-year colleges and universities and there is a need for continued research on noncollege individuals (William T. Grant Foundation Commission on Work, Family, and Citizenship, 1988). This study was comprised of individuals who were mixed in regards to their educational status. At the start of therapy, two of the five CPs were earning their graduate degrees, two were earning their undergraduate degrees, and one had dropped out of college prior to earning her bachelor's degree. Additionally, the age range of this sample was broad and included CPs up to 29-years of age. While emerging adulthood was initially conceptualized as a period that took place approximately between 18 to 25, research has found that the developmental tasks of this age, such as identity exploration, can continue well into a person's late twenties and early thirties (Arnett, 2001; Clark, 2007). This study contributes to this literature by demonstrating emerging adults in their late twenties in various stages of their career development and relationship development, which suggests that this expanded age range is appropriate for this period.

Regarding methodology, investigators in the emerging adulthood field have recognized a need for qualitative research on this developmental period (Arnett, 2006; Van Dulmen, 2013). This study adds to the small but growing literature using such approaches to examine mental health issues in emerging adults. Previous qualitative research has used semi-structured interviews to shed light on emerging adults' dissatisfaction with treatment while being in a restricted care setting and the stigmatizing effects of mental illness (Polvere, 2011), as well as how poor mental health can impede identity development (Kuwabara et al., 2007). Personal blogs of emerging adults have also been shown that individuals in this age range can feel isolated from mental health clinicians (Marcus et al., 2012). In contrast to these other studies, this

research was the first to examine the content of actual therapy sessions. It used an archived set of therapy sessions with emerging adults in an outpatient community care setting located at a university setting. The results demonstrated that themes related to self-development and interpersonal relationships naturally occurred in therapy with a diverse but small sample of emerging adults.

The themes that were found in this study related to Arnett's conceptualization of emerging adulthood. These findings do not support or reject the concept of emerging adulthood as a distinct developmental stage, but they do provide further evidence for the phenomenological experiences that have been observed among this population. Arnett has characterized emerging adulthood as an age of self-focus, identity exploration, instability, possibilities, and feeling in-between (Arnett, 2001, 2004). Aspects of each of these different "pillars," save feeling in-between, related to many themes that were observed in this study. The lack of the latter does not necessarily invalidate its current inclusion in Arnett's model, but does suggest the need for further investigation of its relevance in therapy settings.

The identification of emerging adulthood themes in these therapy sessions has implications for clinical practice. Clinicians who work with these populations would do well to be aware of the kinds of developmental tasks and processes that are common for this age range when conceptualizing their clients' issues as well as when collaborating with clients on treatment modality and goals. For example, being a time of self-focus allows emerging adults to evolve various capacities that they will need as independent and functioning adults. In terms of gathering information to inform conceptualizations, the typical intake for therapists in this study described development in regards to peri-natal/post-natal development and childhood learning disabilities. In addition to this history, additional information could have been collected

regarding clients' adolescence and transition to adulthood. Such assessments could include self-reports on autonomy and/or interdependence (e.g., degree of financial independence, independence with activities of daily living) and identity exploration (e.g., degree of exploration/commitment to career).

Whether or not it is directly inquired about during the intake, the self-focused nature of emerging adulthood may present itself during the course of therapy, as it did in this study when clients discussed concerns related to behavioral regulation, emotional regulation, and practical life management skills. With regards to behavioral regulation, therapists should pay particular attention to substance use as normative but potentially impairing in this population. In terms of emotional regulation, emerging adults may struggle with understanding and coping with their feelings, despite increasing neurological maturation. Clinicians should be aware that suicidal ideation is common among this population (as it was for one CP; American College Health Association, 2008), and that risk assessment should be an ongoing process in therapy. Regarding practical skills, such as budgeting money and managing one's time that were sources of distress among several CPs, clinicians should consider including teaching such skills in treatment plans as they may wish to function autonomously outside of therapy.

Other relevant domains of discussion that therapists should attend to include identity development and interpersonal issues. In terms of identity exploration, several of the CPs discussed their educational and professional development. Therapists who work with emerging adults should be prepared to offer or have referrals for career counseling services. The instability that appears to be inherent with this time of life may cause more stress than an individual can handle. Clinicians who work with emerging adults can anticipate that situational stressors may be

related to presenting concerns, as well as anticipate that they will likely arise through the course of therapy.

This study also showed that interpersonal conflict with parents, partners, and peers may be a source of clinical concern for emerging adults. Consistent with past research (e.g., Fingerman, et al., 2009; Padilla-Walker et al., 2012), mothers were discussed as sources of support as well as being sources of distress. Fathers were not mentioned in the context of emerging adulthood among the study CPs, but one individual discussed the mixed emotions he had about his father's passing prior to this period. Clinicians will have to be judicious when considering parents as potential sources of support for clients, and family therapy may be a potentially helpful intervention to resolve discord between emerging adults and their parents, with a focus on facilitating culturally appropriate transitions to adulthood (Sachs, 2013). In addition, this study showed that romantic relationships can be challenging for emerging adults, especially in regards to communication, sharing financial resources, and if there are children from a previous relationship. In such cases, clinicians should be prepared to have referrals for couples therapy and family therapy if they do not have a background in such interventions. With regards to peers, social isolation appeared to be problematic for some individuals in this study, which suggests that clinicians may want to help emerging adults make more intimate social connections with peers as part of their development to adulthood. The results of the study also showed that conflict with a supervisor may be a concern for emerging adults, and that clinicians may need to help these clients learn effective problem-solving skills in the workplace.

Thus, given the unique demands and clinical concerns of emerging adulthood, the concept of this developmental stage could be helpful to incorporate into interventions with this population. One intervention could include providing psychoeducation to clients about the

different tasks that have been conceptualized as relating to transitioning to adulthood in order to normalize presenting problems. Sharing these models would allow clients to discuss how relevant the theory was to them, as well as open a dialogue about personal and cultural nuances that were pertinent to the individual. In addition, emerging adulthood theory could be used to help frame goals for treatment (e.g., become more independent by managing own finances, volunteer in order to explore possible future career).

Finally, clinicians may also increase their understanding of emerging adulthood clients by having discussions on how they define adulthood and where they currently see themselves in terms of achieving this status. Such clinician self-work is recommended given the interactions involving clinician self-disclosure were that observed in this study. For example, when CP1 was discussing about her drinking, her therapist briefly mentioned her own alcohol use:

T15: I think it's hard to keep up with doing it every night, for it and kinda continue this...

C15: Well that and money, man. [Therapist laughs] It's expensive!

T16: It, those are expensive habits.

C16: [Unintelligible] expensive...

T17: I had a cocktail the other night and it was eleven dollars for one drink, so...

C17: That's crazy. See that's what, if I'm going to buy something from a bar I gotta make sure its like a heavy, hard drink cuz thats when it's worth it. You know, thirteen dollars for an AMF or something, [shrugs] it's worth it.

T18: Yes.

C18: It's good, so, you know.

T19: I think the prices around here in general are just crazy on alcohol [Client agrees], unless you're buying a beer and drinking it at home, it's hard to justify spending that much and not being able to buy groceries, you know?

In this example, both the CP and the therapist happened to be in graduate school and likely could identify with some of each other's experiences. Although therapists typically refrain from self-disclosures in therapy for ethical and theoretical concerns (Peterson, 2002; Ziv-Beiman, 2013), emerging adult clinicians who are experiencing the same challenges with transitioning to adulthood may be more likely to self-disclose. Given the research is mixed on the effectiveness

or harm that can come with self-disclosure (Ziv-Beiman, 2013), programs and supervisors should monitor trainees for such behaviors and help them to be aware of the ethical and clinical impact they may have in therapy.

### **Future Directions**

The present study highlighted additional areas that are needed for research on emerging adults receiving psychotherapy. This population is diverse, not only in terms of demographics, but also in terms of trajectories. Future investigations should focus on selective sampling of understudied populations, interpersonal relationships, incorporating developmentally appropriate measures of emerging adulthood, and further investigations on how emerging adulthood is related to mental health. Specific suggestions are delineated below.

**Selective sampling.** While the sample used in this study was diverse in terms of gender and ethnic identification, no conclusions could be drawn between CPs based on such demographic differences. There is a need to understand how culture can impact clinical presentations as well as how it can serve as a supportive resource for emerging adults. Studies that selectively sample from emerging adults of specific minority/underserved groups, and that use qualitative methods, such as case studies and semi-structured interviews, can help provide rich information to improve understanding of the experiences of those from diverse backgrounds. While emerging adults overall tend to seek treatment at rates compared to the general population (Kessler, Demler, Frank et al., 2005; Wang et al., 2005), this line of research is particularly important in the context of mental health, as minority populations utilize mental health services at different rates (Cheung & Snowden, 1990) and LGBT populations report services not meeting their mental health needs (Burgess et al., 2008).

**Interpersonal relationships.** Along with targeting emerging adults of diverse backgrounds, research should also focus on determining how interpersonal relationships manifest and influence development during this time. Based on the findings in this study, additional investigations on relationships with parents, co-workers, children, and blended families would aid in the understanding of the transition to adulthood period.

*Parents.* With regards to parents, the CPs in this study did not discuss their ongoing relationships with their fathers. There is growing research on the influence of parenting styles in adolescence (McKinney & Renk, 2008) and emerging adulthood (Nelson et al., 2011) in relation to wellness outcomes. Future investigations should examine whether fathers of emerging adults who are in psychotherapy give differential support or have different conflicts with them compared to their mothers, and if there are any interactions based on the emerging adult's gender. This information could be gathered via through self-report measures of relationship quality for each parent or semi-structured interviews asking individuals to describe and differentiate their relationships with their parents. Additionally, in vivo interactions could be observed in which emerging adults, who received psychotherapy in the past year, discuss how to address actual/hypothetical developmental stressors (e.g., housing transitions, choosing a career/major) with each of their parent.

*Co-workers.* The CPs in this study discussed relationships with their co-workers briefly, but they appeared to be sources of distress. Additional research is needed on how co-workers support or impede development during this stage, such as identity exploration and identity commitment. Semi-structured interviews could be used with emerging adults to ask about positive and negative experiences they had with co-workers and explore whether they related to their career and educational goals. These same kinds of questions could be asked retrospectively

of adults who believed that they had completed exploring their career options and were committed to their professions.

*Children and blended family members.* Parenthood has been considered a hallmark of adulthood, and not of emerging adulthood; however, this study showed that individuals who are within this age range have children themselves or take on co-parenting responsibilities when dating a partner with children from a previous relationship. Future research should examine how individuals who are responsible for children in these situations differ from peers who do not. Specifically, longitudinal studies may be useful to compare emerging adults with and without children in terms of different areas of development and functioning (e.g., independence, emotional/behavioral regulation, identity exploration/commitment, instability). Semi-structured interviews could also be conducted between emerging adults with and without children to gain a better understanding of how their experiences are similar or different during this developmental period (e.g., whether this period is experienced as a time of self-focus, identity exploration, feeling in-between, possibilities, and instability to the same degree). Quantitative research methods such as self-report inventories on quality of life may also help measure there are significant differences in well-being.

Additionally, more investigation is required regarding the prevalence of emerging adults entering into blended families, especially how a partner's former significant other may affect an individual's development and functioning. Specifically, studies interviewing emerging adults in romantic relationships with and without involvement with a partner's former significant other could provide insight into how these relationships impact identity exploration and commitment. In this study, only females discussed being in such relationships, and future investigations should incorporate and compare males in similar relationships. The findings highlighted the discord that



can occur between emerging adults, partners, and partners' former significant others.

Quantitative research could compare whether emerging adults and older adults endorse the same kinds and number of conflicts. Additionally research should also consider mixed-method approaches such as using both semi-structured interviews and family communication inventories to investigate how emerging adults resolve these conflicts among blended family members.

**Developmentally appropriate measures.** While inventories have been developed to measure to what extent individuals endorsed experiencing aspects of emerging adulthood, these have been used for research and not clinical purposes (Arias & Hernandez, 2007; Facio et al., 2007; Negru, 2012; Reifman et al., 2007; Sirsch et al., 2009). Given that there does not appear to be literature describing whether such measures are valid in emerging adults who receive psychotherapy, future research should examine the utility of these measures

Moreover, the findings from the current study suggest there is a need to incorporate evaluations of functioning that are developmentally appropriate in this population while they are receiving psychotherapy, namely the domains in which emerging adults are maturing as they transition to an adulthood role, including self-identity exploration, developing competency in behavioral/emotional regulation and practical skills, and exploring intimacy with romantic partners/peers. Research assessing self-perceived competency with work and romance in emerging adults has shown that such beliefs relate to better functioning in young adulthood (Roisman, Masten, Coatsworth, & Tellegen, 2004). Validated instruments such as the Outcome Questionnaire (Lambert, Kahler, Harmon, Burlingame, & Shimokawa, 2011) could be used to assess functioning across several domains relevant to emerging adults, including symptoms distress, substance use, interpersonal conflict, and social roles (Lambert et al., 2011). Other instruments that were not designed as clinical measures may still be relevant for use in

psychotherapy with this population, such as those measuring identity status (Luyckx et al., 2005) or how much an individual identifies with the emerging adulthood stage (IDEA; Reifman et al., 2007). Longitudinal studies that incorporate measures of emerging adulthood progress, including identity development, along with clinical measures would help clinicians assess for functioning on a broader scale than sole reliance on symptom checklists, as well as evaluate how psychotherapy can facilitate change across different domains of development.

**Relationship between emerging adulthood and mental health.** As demonstrated by the study's results, content pertaining to the transition to adulthood does appear in psychotherapy sessions with individuals from 18 to 29 years of age. One notable finding was the lack of themes related to "feeling in-between," which is considered to be one of the defining features of emerging adulthood (Arnett, 2004) and has been observed in other qualitative literature with emerging adults experiencing depressive symptoms (Kuwabara et al., 2007). Despite the plethora of content related to the transition to adulthood that was found in this study, none of the sessions that were reviewed contained any explicit discussions about feeling in-between adolescence and adulthood. More qualitative studies, using methods such as session observations and semi-structured interviews, with emerging adults receiving mental health treatment would illuminate how/whether feeling in-between relates to clinical presentations in this population. With regards to semi-structured interviews, individuals in psychotherapy could be asked how they define adulthood, where they see themselves in terms of attaining this status, and how their psychotherapy relates to their developmental status and progression. These interviews could be implemented at different intervals during the course of an emerging adult's therapy in order to observe any changes

In addition, research is needed on how the transition process to adulthood impacts mental health in emerging adults. One study found that experiences related to the instability of this period were accompanied by reports depressive symptoms (Luyckx et al., 2011). While the themes that emerged in this study did not necessarily parallel these findings, CP3, a 23-year-old Latino male, was diagnosed with an adjustment disorder with depressed mood, which was related to his recent break up with a romantic partner. Future studies should examine whether certain transitions are more stressful than others and explore their diagnostic impact, which may inform preventive interventions when working this population. Qualitative research could lay the foundation for future qualitative studies. For example, semi-structured interviews could be used to ask emerging adults, including those who received psychotherapy during this period, what events or experiences were particularly challenging in transitioning to an adult role. Additionally, those in later developmental stages, such as adults and older adults could be asked these same questions. Individuals could also be queried about how therapy or other protective factors helped or did not help through the transition to adulthood. Sampling different age ranges, in conjunction with measures such as the IDEA (Reifman et al., 2007) to confirm self-identification with the emerging adulthood or other developmental stages, would allow interesting comparisons between cohorts regarding whether similar difficult transitions/experiences were endorsed across generations. Then, quantitative research could, for example, follow-up this research by determining whether certain transitions/experiences are correlated with greater impairment.

In sum, while the sample in this qualitative study was small and the review of therapy sessions did not include the whole course of treatment, the results showed a great diversity of developmental topics and clinical issues related to the transition to adulthood. Future research, taking the aforementioned directions and using the suggested methodology, will help further our

understanding of the experiences of emerging adults in psychotherapy, and inform clinicians so they may be better able to meet their needs. While this research is underway, it would behoove therapists who work with individuals in this age range to familiarize themselves with emerging adulthood theory and the corresponding processes related to self-development and interpersonal relationships in order to understand and facilitate the developmental growth that is likely taking place for their clients.

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APPENDIX A

Institutional Review Board Approval



# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

May 12, 2014

Brian Louie  
[REDACTED]

**Protocol #:** P0214D03

**Project Title:** Themes in Therapy with Emerging Adults

Dear Mr. Louie:

Thank you for submitting your application, *Themes in Therapy with Emerging Adults*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Hall, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Full Approval**. The IRB approval begins today, **May 12, 2014** and terminates on **May 12, 2015**.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For **any** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **[DATE]**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

6100 Center Drive, Los Angeles, California 90045 • 310-568-5600

Sincerely,



Thema Bryant-Davis, Ph.D.  
Chair, Graduate and Professional Schools IRB  
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives  
Mr. Brett Leach, Compliance Attorney  
Dr. Susan Hall, Faculty Advisor



APPENDIX B

Pepperdine Applied Research Center Co-Directors Letter of Permission

# PEPPERDINE

GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY  
December 20, 2013

Brian Louie  
Pepperdine Psy.D. student

RE: Request for Permission to Access PARC database

Dear Brian Louie:

We appreciate your application for accessing the Pepperdine Applied Research Center (PARC) research database for your dissertation, **Themes in therapy with emerging adults**. We are pleased to inform you that we have approved your use of our database for this purpose under the supervision of Dr. Hall.

You can begin using the PARC database once you submit your IRB approval letter to us. Please follow carefully the Confidentiality Agreement you've signed for access to the PARC database located in our GSEP Clinics and Counseling Centers. If any questions or concerns emerge during your research process, please contact us immediately.

Thank you for your contributions to PARC. We look forward to learning about the results of your research, and to assisting you in sharing your findings with the community. When you present your findings in professional settings, please acknowledge PARC as appropriate.

Sincerely,

Digitally signed by Kathleen Eldridge  
Date: 2013.12.21 12:54:34 -08'00'

Kathleen Eldridge, Ph.D.

Co-Directors, Pepperdine Applied Research Center  
Associate Professors of Psychology, Pepperdine University, GSEP

Susan R.  
Hall

Susan R. Hall, J.D., Ph.D.

Digitally signed by Susan R. Hall  
DN: cn=Susan R. Hall, o=Pepperdine  
University, ou=GSEP,  
email=srh@pepperdine.edu, c=US  
Date: 2013.12.20 22:59:28 -08'00'

PEPPERDINE UNIVERSITY • GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY  
24255 Pacific Coast Highway • Malibu, CA 90263-4608 • Phone 310-506-8356 • Fax 310-506-8561

APPENDIX C

Client Consent Form

**Pepperdine University  
Counseling and Educational Clinics  
Consent for Services**

**INITIALS**

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; Appendix I), be sure to review the Privacy Rights pamphlet that was also given to you today. It is important that you understand the information presented in this form. If you have any questions, our staff will be happy to discuss them with you.

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

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

I understand and agree with the above three statements.

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

*Psychotherapy:* The first few sessions of therapy involve an evaluation of your needs. At the end of the evaluation phase, a determination will be made regarding whether our services appropriately match your mental health needs. A determination will also be made regarding whether to continue with services at our clinic, or to provide you with a referral to another treatment facility more appropriate to your needs. As part of your services, you will be asked to complete questionnaires during your intake session, at periodic intervals (e.g., every fifth session), and after you have completed treatment. Psychotherapy has both benefits and risks. Risks sometimes include being asked to discuss unpleasant aspects of your life and experiencing uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.

Sometimes decisions are made in therapy that are positive for one family member and can be viewed negatively by another family member. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience. In order for therapy to be effective, a commitment to regular attendance is necessary. Frequent cancellations or missed therapy appointments may result in termination of services or a referral to an alternative treatment setting. Unless otherwise arranged, therapy sessions are scheduled once a week for 50 minutes. Educational Therapy is also offered in some of our clinics. This is an intervention that focuses on learning difficulties by addressing how circumstances in a person's life contribute to these difficulties. Educational therapy combines tutoring as well as attention to socio-emotional issues that affect learning.

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

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

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

I understand and agree to \_\_\_\_\_

\_\_\_\_\_ Video/audiotaping

\_\_\_\_\_ Direct Observation

Psychological Research: As a university based clinic, we engage in research activities in order to determine the effectiveness of our services, including client satisfaction, as well as to better understand assessment and therapy practices. Participation in research is totally voluntary and means that the forms you complete as a part of your treatment will be placed in a secure research database. Clinic staff will remove any of your identifying information (e.g., name, address, date of birth) from the written materials before they are placed in the database. You may also consent

to have your taped sessions included in the research database, and if so these tapes will be used and stored in a confidential manner. Only those professors and graduate students who have received approval from the Clinic Research Committee, and who have signed confidentiality agreements, will be granted access to the database in order to conduct scholarly research. If any information from the database is involved in a published study, results will be discussed in reference to participant groups only, with no personally identifying information released. Your services do not depend on your willingness to have your written and/or taped materials included in our research database. You may also change your mind about participation in the research database at any time. While there is no direct benefit to you to have your materials placed in the database, your participation may provide valuable information to the field of psychology and psychotherapy.

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

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

\_\_\_\_\_ Written Data  
\_\_\_\_\_ Videotaped Data  
\_\_\_\_\_ Audiotaped Data

OR

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

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

OR

- I do not wish to be contacted in the future about the opportunity to participate in other specific research programs. \_\_\_\_\_

Fees: The fee for the initial intake is nonrefundable.

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

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



and interpretation, oral feedback of test results, and a written test report. Any additional services requested will be billed separately.

---

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

---

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

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

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

---

Your Records: The clinic keeps your Protected Health Information in your clinical records. You may examine and/or receive a copy of your records, if you request it in writing, except when: (1) the disclosure would physically or psychologically endanger you and/or others who

may or may not be referenced in the records, and/or (2) the disclosure includes confidential information supplied to the clinic by others.

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

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

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

Treatment & Evaluation of Minors:

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

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

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

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

and/or

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_

Relationship to client

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

\_\_\_\_\_  
Clinic/Counseling Center  
Representative/Witness

\_\_\_\_\_  
Translator

\_\_\_\_\_  
Date of signing

APPENDIX D

Therapist Consent Form

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

1. I, \_\_\_\_\_, agree to participate in the research database project being conducted under the direction of Drs. Eldridge, Ellis, and Hall, in collaboration with the clinic directors. I understand that while the study will be under the supervision of these Pepperdine GSEP faculty members, other personnel who work with them may be designated to assist or act in their behalf. I understand that my participation in this research database is strictly voluntary.
  
2. One purpose of research at the Pepperdine University GSEP Clinics and Counseling Centers is to examine the effectiveness of new clinic policies and procedures that are being implemented. This is being done through standard internal clinic practices (headed by the clinic directors and the Clinic Advancement and Research Committee) as well as through the construction of a separate research database (headed by Drs. Eldridge, Ellis, and Hall). Another purpose of this research project is to create a secure database from which to conduct research projects by the faculty members and their students on other topics relevant to clinical practice.
  
3. I have been asked to participate in the research database project because I am a student therapist or intern at a GSEP Clinic or Counseling Center. Because I will be implementing the new clinic policies and procedures with my clients, my input (or participation) will provide valuable data for the research database.

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

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

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

- \_\_\_\_\_ I understand and agree that the following information will be included in the Research Database (check all that apply).

\_\_\_\_\_ Written questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures

Written Data about My Clients (e.g., Therapist Working Alliance Form) \_\_\_\_\_

Video Data of sessions with my clients (i.e., DVD of sessions) \_\_\_\_\_

Audio Data of sessions with my clients (i.e., CD or cassette tapes of sessions) \_\_\_\_\_

OR

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

\_\_\_\_\_

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

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

OR

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

4. My participation in the study will last until I leave my position at the GSEP Clinic or Counseling Center.

5. I understand that there is no direct benefit from participation in this project, however, the benefits to the profession of psychology and marriage and family therapy may include improving knowledge about effective ways of training therapists and implementing policies and procedures as well as informing the field about how therapy and assessments are conducted in university training clinics.

6. I understand that there are certain risks and discomforts that might be associated with this research. These risks include potential embarrassment or discomfort at having faculty review materials about my clinic practices, which may be similar to feelings about supervisors reviewing my work ; however this risk is unlikely to occur since the written materials will be coded to protect your identity. Sensitive video data will be also coded to protect confidentiality, tightly secured (as explained below), and reviewed only by those researchers who sign strict confidentiality agreements.

7. I understand that I may choose not to participate in the research database project.

8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also understand that there might be times that the investigators may find it necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).

9. I understand that the investigators will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project.

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

11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access.

In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.

12. I understand I will receive no compensation, financial or otherwise, for participating in study.

13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at [REDACTED], Dr. Mesha Ellis at [REDACTED], or Dr. Susan Hall at [REDACTED] 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 [REDACTED].

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 E

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Therapy              | <input type="checkbox"/> Child                | <input type="checkbox"/> Individual   |
| <input type="checkbox"/> Assessment           | <input type="checkbox"/> Adolescent           | <input type="checkbox"/> Couple (Ask if there has been any domestic violence) |
| <input type="checkbox"/> Don't know or unsure | <input type="checkbox"/> Adult                | <input type="checkbox"/> Family   |
|   | <input type="checkbox"/> Don't know or unsure | <input type="checkbox"/> Group  |
|   |   | <input type="checkbox"/> Don't know or unsure                                 |

8/7/08 1

ID# \_\_\_\_\_

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

**Reason for Referral**

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

sample

ARE THERE ANY PAST OR CURRENT LEGAL PROBLEMS?:  Y  N \_\_\_\_\_  
IS THERE A COURT ORDER THAT REQUIRES TREATMENT?  Y  N \_\_\_\_\_  
FOR WHAT REASON? \_\_\_\_\_  
CLIENT TOLD LIMITS REGARDING COURT ORDERS?  Y  N \_\_\_\_\_  
ARE THERE ANY PAST OR CURRENT DRUG AND/OR ALCOHOL PROBLEMS?:  Y  N \_\_\_\_\_  
\_\_\_\_\_  
ANY CURRENT THOUGHTS OF HURTING YOURSELF?:  Y  N \_\_\_\_\_  
ANY PREVIOUS THOUGHTS OR ATTEMPTS AT HURTING YOURSELF?:  Y  N \_\_\_\_\_  
IF SO, WHEN WAS THE LAST TIME YOU *THOUGHT* ABOUT HURTING YOURSELF?: \_\_\_\_\_  
WHEN WAS THE LAST TIME YOU *ATTEMPTED* TO HURT YOURSELF?: \_\_\_\_\_  
DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOU HAVE A "BAD TEMPER" OR THAT YOU GET MAD EASILY?:  Y  N \_\_\_\_\_  
IF SO, PLEASE PROVIDE EXAMPLES: \_\_\_\_\_  
ANY PAST VIOLENCE TOWARDS OTHERS?:  Y  N \_\_\_\_\_

ID# \_\_\_\_\_

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

IF SO, LIST: \_\_\_\_\_

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

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

WHO IS THE CHILD'S PRIMARY CAREGIVER? \_\_\_\_\_

WHO HAS LEGAL CUSTODY OF THE CHILD? \_\_\_\_\_

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

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

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

WHO WILL BE BRINGING THE CHILD TO THE CLINIC? \_\_\_\_\_

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

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY?  Y  N

### Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL?  Y  N

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

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

WHAT IS (CLIENT'S) OCCUPATION?: \_\_\_\_\_

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

### Intake Interviewer Checklist

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

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

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

ID# \_\_\_\_\_

- I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT VIDEO (AND SOME TIMES AUDIO) TAPES/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 F

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: \_\_\_\_\_

## 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:<br>_____ |  |

CURRENT AND PREVIOUS JOBS:

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

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 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**

WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, <i>INCLUDING YOURSELF</i> , STRUGGLED WITH:	SELF			FAMILY			PLEASE INDICATE WHICH FAMILY MEMBER(S)
	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	
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"/>	_____

---

---

## 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 G

### Client Intake Evaluation Summary

Client Intake Evaluation Summary  
Pepperdine Psychological and Educational Clinic

Client: \_\_\_\_\_ Intake Therapist: \_\_\_\_\_

Intake Date(s): \_\_\_\_\_ Date of Report: \_\_\_\_\_

I      Identifying Information

(Name, age/D.O.B., gender, marital status, # of 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)

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

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

IV      Psychosocial History

A      Family History

(Family constellation, family of origin and current family, family dynamics, domestic violence/abuse; Include family psychiatric, medical and substance abuse history)

B      Developmental History

(Note progression of development milestones, as well as particular strengths or areas of difficulty)

C     Educational/Vocational History

(Highest grade completed, strengths/weaknesses, learning issues/interventions; Work history, including any work related difficulties)

D     Social Support/Relationships

(Current social support network; Intimate relationships and their history, especially as related to presenting problem)

E     Medical History

(When was client last seen by a doctor? Describe current/past medical conditions, injuries, medications, procedures/surgeries)

F     Cultural Factors and Role of Religion in the Client's Life

(Cultural group identification/identity, acculturation issues relevant to presenting problems/therapy) (Religious affiliations, strength of commitment to and/or 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, education/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 diagnosis given):

## VIII DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: Global Assessment of Functioning (GAF) Scale:

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 problem and diagnoses.

\_\_\_\_\_  
Intake Therapist

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date

## APPENDIX H

### Treatment Summary





## APPENDIX I

### Research Project Transcription and Coding Manual

# **RESEARCH PROJECT TRANSCRIPTION AND 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. Lauren Ford and Brian Louie will be using this for their respective dissertations to gain a more in-depth understanding of psychotherapy with emerging adults.

## **I. TRANSCRIPTION INSTRUCTIONS** **(adapted from Baylor University's Institute for Oral History -** **[http://www3.baylor.edu/Oral\\_History/Styleguiderev.htm](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 two question marks in parentheses.

Example: I went to school in Maryville (??) or Maryfield (??).

If you and those you consult (i.e., other RA's) cannot make a guess as to what is said, leave a blank line and two question marks in parentheses.

Example: We'd take our cotton to Mr. \_\_\_\_\_ (??)'s gin in Cameron.

If a speaker lowers his/her voice, turns away from the microphone, or speaks over another person, it may be necessary to declare that portion of tape unintelligible.

Example: When he'd say that, we'd— [unintelligible].

While there is some merit in having an absolutely verbatim tape, which includes all the feedbacks (such as Um-hm and Yeah), too many interruptions in the flow of the therapist's remarks make for tedious transcribing now and exhaustive reading later. Knowing when to include feedback sounds and when to omit them calls for very careful judgment. Usually the therapist's noises are intended to encourage the client to keep talking. Look at your transcript. If every other line or so is a therapist's feedback, go back and carefully evaluate the merit of each feedback. 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 two crutch words per occurrence. Crutch words are words, syllables, or phrases of interjection designating hesitation and characteristically used instead of pauses to allow thinking time from the speaker. They also may be used to elicit supportive feedback or simple response from the listener, such as: you know?, see?, or understand?

Use of *Uh*: The most common word used as a crutch word is *uh*. When *uh* is used by the narrator as a stalling device or a significant pause, then type *uh*. But sometimes a person will repeatedly enunciate words ending with the hard consonants with an added "uh," as in and-uh, at-uh, did-uh, that-uh, in-uh. Other examples are to-uh, of-uh, they-uh. In these instances, do **not** type *uh*.

Guggles are words or syllables used to interrupt, foreshorten, or end responses, and also as sounds of encouragement. Guggles are short sounds, often staccato, uttered by the therapist to signal his/her desire to communicate. They may be initial syllables of words or merely *oh*, *uh*, *ah*, or *er*. Spelling of specific guggles: Agreement or affirmation: uh-huh, um-hm; Disagreement: unh-uh.

For consistency, use **only** the following for exclamations:

- Uh
- Um
- Uh-huh

- Mm-hmm
- Unh-uh

Do **not** use ah, oh, er, and so forth. Pick from the list above and use what seems closest to what is being uttered.

Incomplete sentences are familiar occurrences in oral history because of its conversational nature. They are best ended with an em dash (—). Use one dash (-) for an incomplete word that is then continued (e.g., mo- mother). Interruptions should be indicated using an ellipsis (...). Similarly, an ellipsis should be used when the person who was interrupted continues their sentence after the interruption.

Example: Interruption

T1: Do you feel like he was ignoring you or...

C2: No, I just felt like he wasn't understanding what I was saying.

Interruption and continuation

T1: He was coming toward me and I felt, I felt... C2: Scared? T2: ...scared and confused.

Quotation Marks:

1. When a direct expression is spoken by one person (I, he, she), set apart the expression with commas, use opening and closing quotation marks, and capitalize the first letter of the first word quoted.

Example: She said, "I am going to graduate in May."

2. When a direct expression is spoken by more than one person (we, they), do not use quotation marks, but do set apart the expression with commas and do capitalize the first letter of the first word quoted.

Example: They said, What are you doing here?

3. When a thought is quoted, do not use quotation marks, but do set the thought apart by commas and capitalize the first letter of the first word quoted.

Example: I thought, Where am I?

When you have completed the transcription, please go through the session one time to make sure you have captured all the spoken data, and an additional time to ensure you have noted all the significant non-verbal behaviors.

## TRANSCRIPTION TEMPLATE

### CONFIDENTIAL VERBATIM TRANSCRIPT

**Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by**

**individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.**

Session Number:  
Client #:

Coder:  
Date of Session:

C = Client  
T = Therapist

<b>Verbatim Transcript of Session</b>	<b>Initial Coding Impressions</b>
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

<b>Verbatim Transcript of Session</b>	
T1: Ok, Well now that we're settled in just a little bit, um, I understand that what you wanted to talk about was alcohol and perhaps some other drugs and how that fits into some of the other things that you are dealing with in your life, so fill me in a little, what's happening?	
C1: Well, as far as the alcohol and drugs I've been in and out of recovery since 1995. I used to be basically a social drinker. I lived in Chicago 32 years and moved to California and that's when the heavy use started.	
T2: Uh-huh. [Head nodding]	
<p>C2: A lot of that had to do with, I think, the change in lifestyle. Out there, especially where I lived, it was the Palm Springs area. A lot of people, a lot of partying, a lot of drugs. And I just kind of got into it because the people were in the environment where I was living, it—um, that's what everybody did.</p> <p>C2.1: I actually started cuz I was going to college, and I wanted, a girl who I was a neighbor suggested I try speed to keep me awake. She used it as a waitress and it helped her and I thought, well, and that's how I got started into that part of it.</p> <p>C2.2: I had been smoking marijuana for the longest time, since the eighties, but I had done nothing else. And then when I moved to California, I started drinking because I hung out with younger people, and we would drink, I don't mean just beers, we'd drink hard liquor.</p>	
T3: Yeah, you get thrown along with the lifestyle	
<p>C3: Exactly, and that was also a problem because I have an addictive personality and it's, I believe it's hereditary and it's part of other problems that I have.</p> <p>C3.1: It just manifested itself very quickly. I did in perhaps one year, what some people would do 3, 4, 5 years. I just crammed it all together. I got started with the speed, and then I switched to cocaine. Now, people call it crack or rock, whatever you want to call it. Free, the</p>	

freebasing. You buy the, buy it in the rock form or in the powdered form, and I spent, I spend \$7000 in 3 months on that.	
T4: So you're very efficient about the drug use, packing it into a short period of time.	
C4: Well I packed it in, unfortunately, I don't know if it's good or it's bad, I went from buying it from people I didn't really, trying to get what I could from wherever, to climbing up the ladder to finding the main source, so to speak. C4.1: And I was one of those people, who I'm always proud to say, I never did any sex or anything for drugs or anything like that. Now, I didn't do any, anything... prostitution, or there was a lot of girls that would, a lot of women that would do that.	
T5: [Head nodding] So it was very common.	
C5: And, I was the kind of person, I got my nose broken because I wouldn't sleep with somebody's; this one fella wanted me to sleep with him when his girlfriend was at work and I wouldn't do it so he busted my nose. That's the kind of person I am. I don't believe in, that the two have to meet. My love was drugs. I didn't need a man, I didn't need relationships. If I had the money, if I didn't have the money, I had a way to get, you know, get it through people. I had, I didn't just party you know. I partied with uh—	
T6: Contacts.	
C6: Yeah, people who used to be in the show business industry, so to speak. You know, or who were related, A girl that was related to a guitarist in a famous rock star's band, and I'm not gonna name names, and she unfortunately—she died of AIDS but she had the money and she had, always, there was always partying going on with her. We'd go to the hotel and party, party, party.	
T7: And you got caught up in that very quickly.	
C7: Oh, very quickly, and it's easy to I guess, if you have the personality for it, you know. And I didn't have any, and I was at a point in my life where I didn't really care about	



anything. And I wasn't young either. I was 32.	
T8: So it sort of felt natural to you.	
C8: It felt fun, it felt, actually, it felt good, you know. I was trying to, as they say, chase that next high. It got fun, but when I started running out of the money and I don't know how I had the stamina for it because I actually still worked, paid rent, kept a job, I did everything, well, which a lot of people can do, but for the amount of drugs and drinking I did—	
T9: Pretty remarkable—	
C9: Some people would probably not even be able to get out of bed. I'm not bragging about it. C9.1: Now, ten years later, I feel like I'm physically, I'm just kind of burnt out, you know, C9.2: I stopped doing cocaine in '95, and then I admitted myself into rehab in California that same year, and I've done it still on occasion, but I'm on medication which, thank goodness, doesn't make it where the drug has addictive properties.	
T10: Really?	
C10: Ya, I found it very interesting. I could do cocaine and put it down and not go back to it.	
T11: Which was new?	
C11: Which is something new to me, I mean, this is as recent as moving back to Chicago. [Therapist's head nodding] You know, I haven't been able, I've struggled in and out of sobriety, you know, I feel like Robert Downey, Jr. sometimes. [Therapist laughs] C11.1: It's like okay, but I've not, I've never gotten arrested for drugs, or for selling, you know, one of those people who was too smart to keep it in the house and you know, I even though I never had money I had the common sense of well, you don't keep it in the house, don't drive around with it, you don't drink and drive, you don't drink and use. You know, why ask yourself for trouble? C11.2: One time I had drank and drove, and that was because I was at my boyfriend's, we were out, I had an argument, and we both went our separate ways. So, I ended up having to go	

<p>home inebriated. And, um, fortunately nothing happened so I was pretty lucky.</p> <p>C11.3: And um, I've been in and out of recovery with AA and NA and, although I love the program and I espouse to do it, they say anonymity in AA, but I think that the condition in a situation like this, it's...well, it's part of talking about recovery and addiction. And, I've worked in and out of the program, I was clean, and sober for 3 years until I moved back to Chicago. Because I had gotten myself surrounded by people in recovery. Yet, when I moved back here, I was not surrounded by people in recovery and I discovered that I was staying clean and sober for the wrong reasons. I was doing it for other people, not for myself. I was doing it to help my mother, because my mother was dying of cancer, so I tried to, I wanted to...</p>	
<p>T12: So the change again of, of moving—</p>	
<p>C12: Right, they say geographics, you are running away from yourself. But I left California for many reasons. And uh.</p>	
<p>T13: And coming back here in a way set off—</p>	
<p>C13: It set off, right. It set off everything because I felt like I had the freedom. There was nobody there, I had no sponsor, no clean and sober neighbor, nobody checking up on me so to speak to make sure I was still, I was still smoking pot. I hadn't quit marijuana and, but the alcohol was the one that really got to me. I had been, I had quit marijuana for about a 7-8 months after I got out of recovery, but ended up getting back into that situation when I moved in, uh, out of sober living and I ended up eventually moving in keeping a roommate who was a friend of mine from my drinking and using days who was dying of AIDS. But he needed someone to take care of him. And I was going back to school at night plus working, so basically, my drug use was limited to marijuana and alcohol, sometimes doing coke or whatever. I never liked speed really because I saw people, the more they did that their teeth would rot out and, you know, it's Drain-o or rat poison, it comes in so many</p>	

different colors. I've noticed it's not that big here in Illinois, in Chicago.	
T14: So when you say your in and out of recovery now, its alcohol and marijuana your talking about—and every now and then cocaine.	
C14: Right, ya, well the cocaine, basically I've stopped, ah, pretty much avoided that because the individual who introduced me to that again, I avoid seeing him at all costs...which I do for my own well being. I don't want to ride the dragon again. I don't want to go there, even though I know that if I do, I'm not going to be going there again every day. I won't be getting loaded every day because of the medication I take. But, and, he was paying for it, but I realized it was just something that I wasn't even enjoying.	
T15: So why do it?	
C15: Right, you know, to me, everybody, I believe has an addiction. We all have addictions be it food, sex, drugs, alcohol, gambling, family life, work. You know, whatever it may be, I think everybody has one, one thing at least that they crave and that in the back of their mind that they focus on and they really desire.	
T16: And you said you think you have an addictive personality—someone who easily gets drawn into things	
C16: Yeah, well right, I have been. I'm an artist, freelance artist as well, and my addiction used to just be drawing. As a child, I would just come home and draw, you know.	
T17: So whatever you do like that you do it intensely	
C17: Yeah, I wish I could do it to make money and do it, you know. [Therapist laughs] Get a money making idea and do like that, I'd probably be rich, it's just um, but not able to find a proper substitute, you know. At this time, I'm trying to get back into drawing and being more creative, and my personal life, though I feel so mentally, emotionally, and physically exhausted after all I've been through in my life, that all I want to do is almost not do	

<p>anything. I'm trying not to focus on any addictions. I'm at the point where I'm getting tired. You almost get tired of it physically. Like, if I drink I feel, I don't get the hangovers cuz I won't even allow myself to drink enough, but physically the next day, I feel, I ache, you know I feel the hangover with the headache would manifest itself with my body aches, and I don't want to, want to get up on the...you feel as vital and I've just done so much that I'm burning out.</p>	
<p>T18: And you've used up your chances, huh?</p>	
<p>C18: Yeah, pretty much. And being single all my, which, since 1990 and not having...being blessed without having children, which I never wanted, thank God, I'm not a kid lover. I chose not to have kids also because of my husband and that was one of the reasons we also parted ways. I was happy. I'm lucky enough to where I've had my own life and I've not had to drag anybody, drag anybody down with me, you know. It did affect family members. Anytime you're, you have an addiction, people who care about you, it will, but eventually they turn you away too.</p>	
<p>T19: Now what is recovery for you besides not using alcohol or marijuana?</p>	
<p>C19: To me recovery would be going to meetings, having a sponsor, working a twelve step program, um, I still try to incorporate 12 step beliefs and behaviors in my life as far as, "Let go, Let God," the use the steps, resentment, a lot of people say if you're drinking and using you cannot work the steps, but I think you can use them in a behavior, method of behavior modification if you're, instead of turning to getting loaded or anger or what have you, when you have a problem in life, try to do something positive, call somebody, read if you have an AA Big Book or an NA Big Book, pick something up in there and try to read it. Try to keep yourself as close to the, that behavior as you can because it helps you to get...the closer I try to stay to meetings, even if I'm drinking, if I go to meetings it helps me from not wandering too far off track</p>	

to where I'll say drink more, or just stop totally leaving in that whole lifestyle or that whole belief process.	
T20: There's a piece here which were missing before we go, which is what are you wanting to move toward? What do you—	
C20: What I want to move toward is to just be able to totally not have to drink or use. And at this point—	
T21: Which is doing nothing.	
C21: Right. Well, at this point I still enjoy my pot. I'll be the old person sitting out there smoking a joint on the steps with all my cats around me, you know, and that's okay with me, but I don't want to drink. That's what I'm trying to avoid, and I'll be, I'll go a couple weeks without drinking and then maybe I'll drink again. But it's getting to where I want it less and less again.	

## **II. CODING OVERVIEW**

The second step of the process involves the researcher-participants engaging in three distinct coding processes to be completed in the following order: open coding for themes related to emerging adults and acceptance.

### 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.

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.

### **Coding Steps for Researcher-Participants**

1. Watch the videotape 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. 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.
5. 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.
6. 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.
7. Final codes will be entered into the Excel data-tracking sheet for further analysis.

APPENDIX J

Institutional Review Board Certificate





APPENDIX K

Health Insurance Portability and Accountability Act Certificate

**UCLA** Health System

## *Certificate of Completion*

*This is to certify that*

*Brian Louie*

---

*has completed the  
HIPAA Training  
on*

*Saturday, September 17, 2011*

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Reference No: 125180

APPENDIX L  
Coding Hierarchy

Parent Theme	CPs	Intermediate Category	CPs	Subcategories	CPs	Total Freq.	Freq. by CP (# talk turns)
Self-Development	5	Behavioral Regulation	3	Substance Use	3	13	CP2 (7) CP3 (3) CP4 (3)
Self-Development	5	Behavioral Regulation	3	Impulse Control	1	4	CP2
Self-Development	5	Behavioral Regulation	3	Diet and Exercise	2	12	CP3 (5) CP4 (7)
<b>Total</b>						29	
Self-Development	5	Life Management Skills	3	Money Management	3	12	CP1 (3) CP4 (7) CP5 (2)
Self-Development	5	Life Management Skills	3	Time management difficulties	1	38	CP1
Self-Development	5	Life Management Skills	3	Time management interventions	1	5	CP1
Self-Development	5	Life Management Skills	3	Study Environment	1	5	CP1
Self-Development	5	Life Management Skills	3	Housing Transition	1	5	CP4
<b>Total</b>						65	
Self-Development	5	Emotional Experience	3	Anger	2	5	CP2 (3) CP3 (2)
Self-Development	5	Emotional Experience	3	Suicide	1	6	CP1
Self-Development	5	Emotional Experience	3	Not understanding source of emotions	1	3	CP2
Self-Development	5	Emotional Experience	3	Improvements in emotional regulation	2	7	CP1 (2) CP2 (5)
Self-Development	5	Emotional Experience	3	Anxiety	1	7	CP5
<b>Total</b>						28	
Self-Development	5	Professional Development	4	Dissatisfaction with Work and School	2	11	CP3 (7) CP5(4)
Self-Development	5	Professional Development	4	Education and Career Goals	3	9	CP2 (2) CP3 (2) CP5 (5)
Self-Development	5	Professional Development	4	Confidence in job skills	1	8	CP4
<b>Total</b>						28	
Self-Development	5	Self-Concept	3	Self-Examination	1	6	CP2

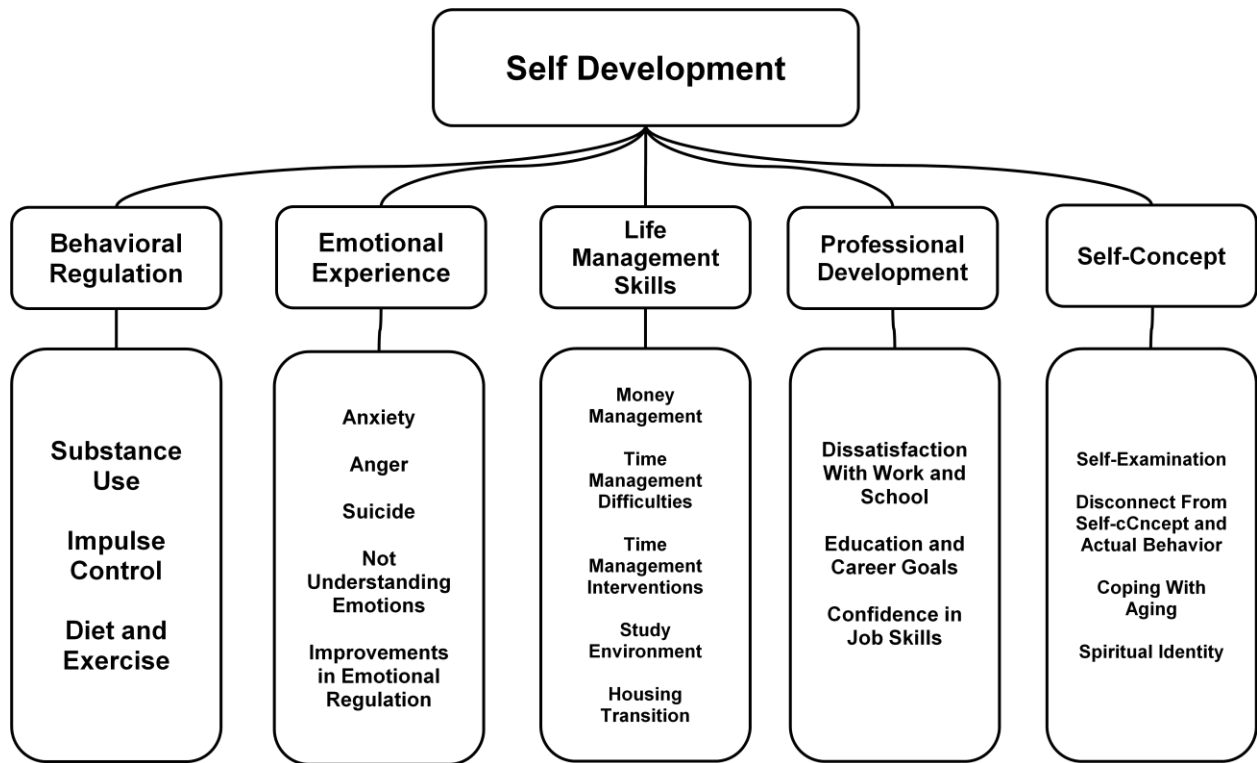
Self-Development	5	Self-Concept	3	Disconnect from self-concept and actual behavior	1	6	CP5
Self-Development	5	Self-Concept	3	Coping with Aging	1	9	CP4
Self-Development	5	Self-Concept	3	Spiritual Identity	1	12	CP2
<b>Total</b>						33	
<b>Self-Development Response Total</b>						183	
Interpersonal Relationships	5	Peer/Work Relationship	5	Meeting classmates expectations	1	4	CP1
Interpersonal Relationships	5	Peer/Work Relationship	5	Difficulties sharing chores/resources	1	11	CP1
Interpersonal Relationships	5	Peer/Work Relationship	5	Personal boundaries	4	45	CP2(2) CP3 (35) CP4 (3) CP5 (5)
Interpersonal Relationships	5	Peer/Work Relationship	5	Moving away from friends	1	2	CP4
Interpersonal Relationships	5	Peer/Work Relationship	5	Unhappy with supervisor	1	7	CP2
<b>Total</b>						69	
Interpersonal Relationships	5	Partner Relationship	4	Partner not tending to client	2	11	CP1 (2) CP5 (9)
Interpersonal Relationships	5	Partner Relationship	4	Communication Issue	3	56	CP1 (12) CP4 (42) CP5 (2)
Interpersonal Relationships	5	Partner Relationship	4	Money Management	1	7	CP1
Interpersonal Relationships	5	Partner Relationship	4	Ambivalence/Questioning Commitment	2	25	CP1 (2) CP4 (23)
Interpersonal Relationships	5	Partner Relationship	4	Trust Issues	3	55	CP2 (5) CP4 (7) CP5 (43)
Interpersonal Relationships	5	Partner Relationship	4	Open Facilitative Communication	1	2	CP2
Interpersonal Relationships	5	Partner Relationship	4	Partner's Professional Progression	3	9	CP1 (2) CP2 (5) CP5 (2)
Interpersonal Relationships	5	Partner Relationship	4	Family Planning	1	36	CP2
<b>Total</b>						201	
Interpersonal Relationships	5	Family Relationship	5	Challenges with blending families	2	59	CP2 (23) CP5 (36)
Interpersonal Relationships	5	Family Relationship	5	Challenges with co-parenting	1	72	CP3 (72)
Interpersonal Relationships	5	Family Relationship	5	Communication Issue	1	15	CP3 (15)

Interpersonal Relationships	5	Family Relationship	5	Trust Issues	2	4	CP3 (4)
Interpersonal Relationships	5	Family Relationship	5	Family Support	2	14	CP1 (11) CP4 (3)
Interpersonal Relationships	5	Family Relationship	5	Family of Origin	3	9	CP2 (4) CP4 (2) CP5 (3)
Interpersonal Relationships	5	Family Relationship	5	Grief over parental death	1	15	CP4
Interpersonal Relationships	5	Family Relationship	5	Family Boundaries	1	2	CP1
<b>Total</b>						190	
<b>Interpersonal Relationship Response Total</b>						460	

Notes. There were a total of five CPs in this study.

## APPENDIX M

### Self-Development Parent Theme Diagram





## APPENDIX N

### Interpersonal Relationship Parent Theme Diagram

