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Running head: DISCUSSIONS OF TRAUMA

Pepperdine University

Graduate School of Education and Psychology

EXPLORING THE TIMING AND DEPTH OF DISCUSSIONS OF TRAUMATIC MATERIAL
AND THE STAGES OF CHANGE IN PSYCHOTHERAPY: A CASE STUDY

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

by

Lauren A. DesJardins

May, 2011

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

This clinical dissertation, written by

Lauren A. DesJardins

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

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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DEDICATION

This dissertation is dedicated to my loving family, for without their love and support I would never have survived this process. My parents, David and Cheryl, have always supported and encouraged me in every endeavor, and graduate school was no different. Without their love, support, and patience I would not have been able to accomplish my goals. Also, my little sister, Alison, has been the voice of reason when I thought I could not make it any further. Her words of encouragement have helped me to believe I can accomplish anything. Both of my grandmothers, Arlene and Celia, have provided me with the support and faith necessary to grow personally and professionally. I want to thank my loving boyfriend, Nicholas, who has supported me through the most critical part of this process. He has been my rock, studying alongside me, and pushing me to work my hardest, but also reminding me to relax.

Additionally, this dissertation is dedicated to my caring and supportive friends, both old and new. My sorority sisters, who have continued to support and encourage me, I am thankful that they always understood when I disappeared and “crawled into a hole.” Shireen (my person) and Chanel have been constant voices of warmth, kindness and encouragement throughout graduate school. This would not have been the same wonderful experience without their friendship and I am truly blessed to call them friends. Finally, my wonderful classmates, we truly have the best cohort and I am thankful to have gotten to know each and every one of you.

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I would like to acknowledge and thank all of those people who have helped contribute to the development and completion of this dissertation. First and foremost, my lab mates, Karina Campos and Whitney Dicterow. It was their constant support, encouragement and laughter that made the completion of this project possible. Without them by my side, the process would have been a lot less fun!

I especially want to say thank you to Dr. Susan Hall, my chairperson. Her brilliance and wonderful guidance have made the dissertation process manageable and exciting. She helped me take a simple idea and transform it into the wonderful project I have had the pleasure to work on. Her dedication to me and my project has been beyond words and I am truly blessed to have had the pleasure of working with her.

Additionally, I would like to thank my committee members, Drs. Bryant-Davis and Shelby. Their work and knowledge about the topic of trauma have greatly enhanced my dissertation project and the field of psychology as a whole. I am grateful that they were able to take the time and share their expertise with me.

Finally, I would like to acknowledge all of the master's students whose hard work and dedication to transcribing the numerous therapy sessions made this possible. I wish them the best of luck in their future endeavors.

VITA

Lauren A. DesJardins

Education

Pepperdine University, Graduate School of Education & Psychology, Los Angeles, CA
Doctoral Degree in Clinical Psychology (PsyD), Expected Graduation Summer 2011

- Dissertation Title: Exploring the Timing and Depth of Discussions of Traumatic Material and the Stages of Change in Psychotherapy: A Case Study
- Clinical Competency Exam: Passed September 2009

Pepperdine University, Graduate School of Education & Psychology, Irvine, CA
Master of Arts in Clinical Psychology, Emphasis Marriage and Family Therapy, June 2007

Chapman University, Orange, CA
Bachelor of Arts in Psychology, English/Literature Minor, May 2005

- Thesis Title: Media, Self-perception, and the Development of Eating Disorders in Adolescents

Clinical Experience

Metropolitan State Hospital, Norwalk, CA September 2010 – August 2011
Pre-doctoral Psychology Intern (APA Accredited)

- Rotation 1: Participate as a member of a multi-disciplinary treatment team on a co-ed forensic unit with individuals committed under penal codes 1370 and 1026. Responsible for treatment planning and WRP updates on a small caseload of individuals from the unit. Conduct short-term and long-term individual therapy with patients on the unit with a variety of diagnoses including schizophrenia, schizoaffective disorder, mood disorders, anxiety disorders, personality disorders, and substance abuse disorders. Perform psychological assessments including cognitive screenings, suicide risk assessments, diagnostic clarifications and behavioral guidelines. Co-lead/lead psychoeducational treatment groups with forensic psychiatric inpatients on a variety of topics including court competency, managing symptoms, anger management, cognitive therapy for psychotic symptoms and substance abuse. Participate in weekly individual supervision, case conference and didactic trainings.
- Rotation 2: Receive specialized clinical training in the administration, scoring and interpretation of neuropsychological batteries at an inpatient treatment facility. Perform cognitive and forensic (malingering) assessments and write integrated reports for use by multi-disciplinary treatment team. Conduct long-term individual therapy with patients diagnosed with psychotic, personality and substance abuse disorders. Co-lead/lead psychoeducational treatment groups with forensic psychiatric inpatients on a variety of topics including court competency, managing symptoms, anger management, cognitive therapy for psychotic symptoms and substance abuse. Participate in weekly individual supervision, case conference and didactic trainings.
- Rotation 3: Develop and implement a court competency program for individuals admitted to the hospital as incompetent to stand trial. Gather group therapy materials and train facilitators in leading of groups. Train multi-disciplinary team members in how to evaluate court competency of individuals for recommendation back to court. Train psychologists in

administration and interpretation of R-CAI measure to determine competency for court. Participate as a member of a multi-disciplinary treatment team on an all male forensic unit with individuals committed under penal codes 1370 and 1026. Responsible for treatment planning and WRP updates on a small caseload of individuals from the unit. Conduct long-term therapy with patients on the unit with a variety of diagnoses including schizophrenia, schizoaffective disorder, mood disorders, anxiety disorders, personality disorders, and substance abuse disorders. Perform psychological assessments including cognitive screenings, suicide risk assessments, diagnostic clarifications, behavioral guidelines and violence risk assessments. Co-lead/lead psychoeducational treatment groups with forensically and civilly committed psychiatric inpatients on a variety of topics including court competency, managing symptoms, anger management, cognitive therapy for psychotic symptoms and substance abuse. Participant in weekly individual supervision, case conference and didactic trainings.

Metropolitan State Hospital, Norwalk, CA

September 2009 – June 2010

Psychology Practicum Student

- Conduct assessments and provide short-term individual therapy for hospital patients. Co-facilitate a psychoeducational group for hospital patients. Conduct cognitive screenings for incoming patients to the hospital, neuropsychological assessments, and provide diagnostic clarifications for patients with numerous Axis I and Axis II disorders. Gain experience working with individuals who suffer from numerous severe mental illnesses including mood, psychotic, anxiety, substance abuse and personality disorders.

University of California Irvine, Department of Psychiatry & Human Behavior, School of Medicine, Irvine, CA

February 2009 – August 2009

Psychology Intern

- Participate in NIMH funded research project examining genetic, architectural, and biochemical brain abnormalities in severe mental illnesses including major depression, bipolar affective disorder, schizophrenia, and substance use disorders with a focus on suicide. Review medical records, psychiatric records, and conduct structured diagnostic interviews in order to assess and assign DSM-IV-TR diagnoses and allocate participants to appropriate research groups using forensic techniques. Gained familiarity with how individuals with severe mental illnesses interact with the criminal justice system.

University of California Irvine Medical Center, Division of Pediatric Neurology, Neurodevelopmental & Behavioral Clinic, Orange, CA

July 2008 – February 2009

Psychology Intern

- Work in weekly outpatient clinic at UCI Neuropsychiatric Center consisting of a neuropsychologist, behaviorist, pediatric neurologist and pediatric psychiatrist. Examine adults, adolescents and children diagnosed with developmental disabilities. Complete cognitive assessments and adaptive ratings with patients and share preliminary results with the treatment team. Contribute to multi-disciplinary team conference about each patient's diagnosis and treatment recommendations to be carried out by other mental health professionals.

University of California Irvine, Department of Neurobiology & Behavior, School of Biological Sciences, Autism Study, Irvine, CA

September 2008 – April 2010

Student Researcher

- Attend trainings of study procedures and assessments. Complete cognitive testing for Autism Study at initial and follow-up sessions. Administer the Leiter International Performance

Scale-Revised, the Childhood Autism Rating Scale, and the Expressive One-Word Picture Vocabulary Test to study participants. Consult with senior researchers on participant suitability for the study.

Pepperdine University Community Counseling Center, Irvine, CA September 2007 – January 2010

Pre-doctoral Practicum Therapist

- Conduct initial evaluations and intake interviews with individuals and families. Develop and implement treatment plans for clients. Provide brief and long-term therapy to individuals from diverse backgrounds dealing with a wide range of problems, Axis I, and Axis II diagnoses. Update diagnoses and treatment plans to evaluate treatment outcomes and determine need for further services.

Hope House Inc., Anaheim, CA

August 2006 – July 2007

MFT Trainee Therapist

- Conduct client intakes during initial therapeutic session. Develop and implement individual treatment plans for clients with a history of chronic drug and alcohol abuse and a variety Axis I and Axis II diagnoses. Provide individual psychotherapy and support to residents of the Hope House substance abuse program in order to increase coping skills. Support clients while formulating re-entry plans and helping with relapse prevention. Maintain client records for audits by the county, update diagnoses and treatment plans to evaluate treatment outcomes.

Other Relevant Professional Experience

Child Abuse Services Team, Orange, CA

November 2004 – August 2006

Child Advocate

- Participate in multi-disciplinary team working with child victims of sexual abuse and severe physical abuse. Observe and report any unusual behaviors in the children to team members consisting of social workers, detectives, forensic interviewers, medical examiner, assistant district attorney and therapists. Facilitate the comfort of the child by establishing rapport through child-directed games, activities, and offering of friendship. See to the child's basic needs for food and nurturing. Provide comfort and immediate support to parents and other family members. Assist with special projects for staff members.

Pepperdine University, Graduate School of Education, Irvine, CA September 2007 – August 2010

Graduate Assistant

- Create and prepare administrative documents for Administrative Director of Masters in Education program and Assistant Director of Student Teaching. Help prepare weekly lesson plans for multiple education courses. Facilitate payments for Master Teachers and University Field Supervisors. Work with local school districts to find placements for Student Teachers. Keep students informed of upcoming events necessary to attend. Manage incoming paperwork for professor to grade. Field questions from community members interested in education program.

Research Experience

Pepperdine Applied Research Center, Irvine, CA

May 2008 – July 2009

Research Assistant

- Responsible for assisting with the maintenance of a psychological research database that is part of a long-term research project conducted by the three Pepperdine GSEP clinics and counseling centers in West Los Angeles, Encino, and Irvine. Complete data entry, filing, organizing of files, scoring of completed instruments, quality control procedures and data analysis. Attend meetings and trainings with PARC faculty and other research assistants.

University of California Irvine, Department of Neurobiology & Behavior, School of Biological Sciences, Autism Study, Irvine, CA September 2008 – April 2010
Student Researcher

- Participate in research study focused on new potential therapies for children with Autistic Disorder. Complete cognitive testing for the research study at initial and follow-up sessions. Consult with senior researchers on participant suitability for the study.

University of California Irvine, Department of Psychiatry & Human Behavior, School of Medicine, Irvine, CA February 2009 – August 2009
Psychology Intern

- Participate in NIMH funded research project examining genetic, architectural, and biochemical brain abnormalities in severe mental illnesses including major depression, bipolar affective disorder, schizophrenia, and substance use disorders with a focus on suicide. Review medical records, psychiatric records, and conduct diagnostic interviews in order to assess and assign DSM-IV-TR diagnoses and allocate participants to appropriate research groups using forensic techniques.

Professional Development

Motivational Interviewing February 2011
Topic: Applying the techniques of motivational interviewing to forensic mental health

- Conference held at Metropolitan State Hospital

Forensic Mental Health Conference September 2010
Topics: Reducing Assaults at Patton State Hospital, MDO Criteria, Cognitive Therapy for Psychotic Symptoms, A Lawyer's View of MDO Criteria, CONREP Preparation, How to Prepare for Forensic Testimony

- Conference held at Patton State Hospital

Positive Psychology Symposium January 2009
Topic: Applying the Science of Positive Psychology to Improve Society

- Conference held at Claremont Graduate University in Claremont, CA

Trauma-Focused CBT September 2008
Instructor: Web-based training

- 10 hour online course on how to use Trauma-Focused Cognitive-Behavioral Therapy with children sponsored by Medical University of South Carolina.

Child Abuse Assessment & Reporting April 2006
Instructors: Pamela Harmell, PhD & Jana Martin, PhD

- 1-day intensive workshop sponsored by Pepperdine University, Graduate School of Education and Psychology

Outreach Presentations

“Pedophilia” (April, 2008). Child Abuse Services Team, Orange County Child Abuse Prevention Center, Orange, CA.

“Doctoral Roundtable” (November, 2007). Pepperdine University, Graduate School of Education & Psychology, Irvine, CA.

Awards & Recognitions

Pepperdine University, Graduate School of Education & Psychology
Recipient of Colleagues Grant 2005-2010

Chapman University
Graduate Cum Laude
Provost’s List
4-year Recipient of Presidential Scholarship
Psi Chi, National Honor Society in Psychology
Gamma Beta Phi, National Honor Society in Academics

Professional Associations

American Psychological Association, Student Affiliate
APA Division 41 – American Psychology-Law Society, Student Affiliate
Psi Chi Honor Society

ABSTRACT

Currently, there is a lack of understanding of how the stages of change (SOC) relate to discussion of interpersonal trauma in therapy. This study aimed to explore the timing and depth of trauma discussion (TD) across the course of therapy in relation to SOC. The client in this single-case study was a 28-year-old African American female who recently moved to California and reported difficulties in relationships and work problems. The course of therapy lasted 21 sessions; of the 15 videotaped sessions, 6 contained discussions of childhood sexual abuse (CSA) and workplace psychological harassment (WPH). Linguistic Inquiry and Word Count (LIWC; Pennebaker et al., 2007) was used to identify the duration and frequency of cognitive processing, insight and causation words (timing and depth of processing), and the University of Rhode Island Change Assessment (URICA; McConaughy et al., 1983) measured the client's SOC across therapy sessions. Qualitative themes were analyzed to determine SOC during sessions containing TD and other assessment measures were used to understand the context of TD, therapist techniques, and therapy course.

Findings were consistent with literature indicating no specific timing of TD across therapy (Higgins Kessler & Nelson Goff, 2006; Sano et al., 2003). Within-session TD were inconsistent with literature reporting that most intimate disclosures occur at the end of therapy sessions (Strassberg et al., 1978); however, results were consistent with expectations from each SOC. Regarding TD depth, results were consistent with findings that increased use of insight words occurs later in the therapeutic process (Hemenover, 2003); greater percentages of cognitive processing and causation words occurred towards the beginning of therapy. These findings indicated that feelings regarding the cause of trauma became less salient while gaining insight into the meaning of trauma became more salient over time. Also, trauma processing occurred more during contemplation and preparation SOC (when insight was greatest), and occurred less during the action SOC (when insight was lowest). Finally, techniques consistent with SOC theory appeared to facilitate trauma processing.

Given methodological limitations, including the lack of consistent URICA data, future research should incorporate other transtheoretical model components and client cultural factors to gain a more balanced understanding of trauma processing in therapy. Notwithstanding, this study has the potential to contribute to work with trauma survivors, as SOC appears relevant to enhancing clients' success at increasing TD depth.

Chapter I. Introduction and Literature Review

Typically, research and other clinical literature focusing on trauma and its discussion and disclosure have focused on the problems and obstacles experienced by traumatized individuals (Bonanno, Noll, Putnam, O'Neill, & Trickett, 2003; DeMarni Cromer & Freyd, 2007). Difficulties such as increased psychological dysfunction and impaired cognitive processing can affect development well into adulthood (Everill & Waller, 1995; McNulty & Wardle, 1994; Roesler, Czech, Camp, & Jenny, 1992). Within the field of Positive Psychology, some researchers have begun to focus on positive outcomes for individuals who have suffered traumatic experiences, including a more integrated sense of self, posttraumatic growth, and positive emotions (Bonanno, Colak, Keltner, Shiota, Papa, Noll, Putnam & Trickett, 2007; Hemenover, 2003; Lutgendorf & Antoni, 1999; O'Dougherty Wright, Crawford & Sebastian, 2007; Sano, Kobayashi & Nomura, 2003; Tedeschi & Calhoun, 2004), as ways to combat the possible negative effects of trauma.

Research has also shown that therapists working with clients who have suffered a traumatic event should be aware and sensitive to clients' experiences (Higgins Kessler, Nelson, Jurich, & White, 2004). As such, therapists are encouraged to have a strong working alliance with their clients as they try to help clients discuss and process trauma (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004). The difficulty for therapists is in knowing when clients are ready to discuss and process the trauma they have experienced, as there is little research that focuses on the actual timing in therapy in which discussion may occur. The use of the Transtheoretical model and the Stages of Change (Prochaska & Norcross, 2001) may be beneficial in helping therapists understand when clients are ready to discuss and how extensively they are able to process traumatic experiences.

This study used a Positive Psychology perspective in qualitatively understanding how the depth and timing of the discussion of traumatic material may be related to a client's stages of change during the course of psychotherapy. First, a review of the literature defines trauma, and

then discusses Positive Psychology perspectives on trauma and the possible outcomes that arise from experiences of trauma. Next, research findings regarding the effects of discussion of traumatic material generally, and within the therapeutic context specifically, are reviewed. Finally, this chapter will focus on the Transtheoretical model and the Stages of Change and their application to the discussion of traumatic material. This chapter concludes with a description of the purpose of the study and research questions.

Discussion of Trauma

Understanding trauma. Trauma has been defined in a variety of ways and can occur in many different contexts. It can be defined as an event, either interpersonal or non-interpersonal, or it can be defined as responses or effects on an individual (Briere & Scott, 2006; Hall & Sales, 2008). Non-interpersonal traumatic events are things such as accidental injuries (e.g., motor vehicle accidents), house or other domestic fires, chronic illnesses, or catastrophes and environmental disasters (Briere & Scott, 2006; Hall & Sales, 2008; Joseph, Williams & Yule, 1997). In contrast, interpersonal traumatic events include combat, war, mass interpersonal violence not in the context of war, physical or sexual abuse, witnessing or experiencing domestic or family violence, hate crimes, school shootings, community violence, being kidnapped, torture, and traumatic losses (Briere & Scott, 2006; Bryant-Davis, 2005; Hall & Sales, 2008; Joseph et al., 1997). These event-based definitions of trauma describe the nature of an event in a way that differentiates it from ordinary daily stressors.

Undergoing one type of trauma event does not necessarily increase the likelihood of experiencing another, especially for non-interpersonal traumas (e.g., natural disasters; fires) (Briere & Scott, 2006). However, research has begun to indicate that survivors of interpersonal trauma events are at greater risk of experiencing other interpersonal traumas (Briere & Scott, 2006), in part because such events may be seen as the cause of an individual's difficulties and problematic functioning (Hall & Sales, 2008). Research shows that rape and sexual assault are two of the most traumatic events one can experience, which produce rates of posttraumatic stress

disorder higher than those produced by other traumatic events (Briere & Scott, 2006; Frazier & Berman, 2008; Joseph et al., 1997). Additionally, those individuals who are victims/survivors of childhood sexual abuse exhibit a wide variety of short-term and long-term consequences from the abuse (Joseph et al., 1997).

Some researchers and professionals believe that trauma can be defined in relation to the responses of an individual in his or her context (Hall & Sales, 2008). Traumatizing responses or effects are those that can shatter an individual's expectations, worldviews, and even the nature of the person (Hall & Sales, 2008; Janoff-Bulman, 1992; Joseph et al., 1997). Additionally, traumatizing effects may impact individuals' information processing abilities, affect regulation abilities, and ability to socially adapt (Briere & Scott, 2006; Hall & Sales, 2008). Some negative responses that these traumatizing effects can elicit from an individual include re-experiencing the trauma, avoidance, helplessness, shame, grief, loss of connection with one's spirituality, disruption of one's ability to hope and trust (Briere & Scott, 2006; Hall & Sales, 2008; Joseph et al., 1997), and even "mental collapse" (Sano et al., 2003, p. 13). Positive responses, described in more detail in the following section, may also occur.

This definition also considers that an individual may have undergone complex trauma. Complex trauma is used to describe the problem of exposure to multiple traumatic events, usually of an interpersonal nature, and the impact this has on people's immediate and long-term outcomes (Briere & Scott, 2006; Hall & Sales, 2008). From these different definitions of trauma, one thing we can know is that it manifests itself in a variety of different ways and no one person is effected by or responds the same to a traumatic experience. For the purpose of this study a focus is placed on the interpersonal traumas experienced by this study's participant, childhood sexual abuse (CSA) and workplace psychological harassment (WPH).

Childhood sexual abuse in African American women. Research studies suggest that African Americans have a higher incidence rate of child abuse and sexual abuse in adulthood than Caucasians (Hood & Carter, 2008). Specifically, African American women are especially

vulnerable to severe forms of child abuse, such as vaginal, anal, or oral penetration (West, 2002). However, this higher rate of abuse may be influenced by outside factors, such as poverty, which may lead to heightened involvement by state authorities resulting in higher incident reports (Hood & Carter, 2008).

During childhood, acute symptoms of childhood sexual abuse may manifest across cultures as regressive behaviors, sleep and appetite disturbances, hyperactivity, fears, nightmares, withdrawn behavior, internalizing and externalizing disorders, delinquency, self-injurious behavior, general behavioral problems, school and academic problems, low self-esteem, and sexualized behaviors (Shaw, Lewis, Loeb, Rosado & Rodriguez, 2001). At the same time, differences in symptom presentation exist. For example, Hispanic girls who have suffered childhood sexual abuse were noted to be more aggressive and externalize more than African American girls, whereas African American girls were more likely to be withdrawn and have attention problems (Shaw et al., 2001).

Research shows that childhood sexual abuse in African-American women can have mental, spiritual and psychological effects on an adult woman's well-being, including impaired psychosocial functioning, depression, anxiety, dissociation, impaired sense of self, lowered self-esteem, PTSD, substance use, suicidality, distrust of others and sexual concerns (Banyard, Williams, Siegel & West, 2002; Bryant-Davis et al., 2010; Tillman, Bryant-Davis, Smith & Marks, 2010; West, 2002; Wyatt & Riederle, 1994). A study conducted by Hood and Carter (2008) looked at the relationship between symptoms of post-traumatic stress and locus of control in African American women who have experienced childhood abuse and rape/physical abuse in adulthood. Specifically, it was found that African American women may actually have lower levels of external locus of control than previously reported, and those women who experienced both childhood abuse and adult trauma had fewer and less severe symptoms of PTSD than those women who only experienced an interpersonal trauma as an adult (Hood & Carter, 2008). These findings suggest that having a history of childhood trauma may not predispose African American

women to develop more severe reactions following trauma in adulthood, but instead they may have more resiliency to serve as a buffer against later traumas in adulthood (Hood & Carter, 2008) It is this resiliency or “hardiness” of knowing the world is not fair and an uncontrollable place, also understood as a lower external locus of control, that may lead to fewer symptoms of PTSD in adult African American women who have suffered sexual abuse in childhood and adulthood (Hood & Carter, 2008).

Workplace harassment and African American women. Gender and cultural diversification continues to increase at a rapid pace in the United States (Turner & Shuter, 2004). Although there is an increase in diversity in corporate America, the experiences of African American women in the workplace differ significantly from those of Caucasian men and women (Buchanan & Fitzgerald, 2008). African American women appear to have a greater potential for experiencing racial and sexual harassment in the workplace, with approximately one half of female employees reporting at least one unwanted sex-related behavior, and 40% to 76% of ethnic minority employees reporting at least one unwanted race-related behavior within a one to two year period (Buchanan & Fitzgerald, 2008). Additionally, approximately 75% of African American women in the work force experience gender harassment, consisting of degrading or insulting comments about women as a group (West, 2002). There has been little research connecting other incidences of workplace trauma (e.g., bullying, psychological abuse) with the occupational well-being of ethnic and racial groups in the American workforce (Fox & Stallworth, 2005). One available study indicated that African Americans did not report any higher levels of general workplace bullying than Caucasians; both groups reported mean levels around 97% for general workplace bullying and 81% for bullying by a supervisor (Fox & Stallworth, 2005). Also, scant research has focused on the intersection of these multiple forms of harassment on the psychological and occupational well-being of African American women (Buchanan & Fitzgerald, 2008).

According to Buchanan and Fitzgerald (2008), sexual harassment and race harassment in the workplace can have deleterious effects on psychological well-being, as well as physical health and job satisfaction. More specifically, Buchanan and Fitzgerald noted that sexual harassment in the workplace has been linked with higher rates of work withdrawal, intentions to quit work, depression, clinical symptomatology, and decreased productivity. Additionally, race-related events have been associated with higher rates of work withdrawal, psychological and traumatic stress symptoms, chronic health conditions, and decreased life satisfaction. The study conducted by Buchanan and Fitzgerald indicated that African American women are at increased risk of multiple forms of harassment in the workplace because of their double minority status. It also supported previous research findings that experiencing multiple forms of trauma, specifically interpersonal traumas, can exacerbate the psychological distress from a single type of trauma. In their study, Buchanan and Fitzgerald found that those women who experienced racial harassment in addition to sexual harassment in their workplace experienced further harm in the areas of generalized job stress, supervisor and co-worker satisfaction, organizational tolerance of sexual harassment, and post-traumatic symptoms as compared to those who only experienced sexual harassment in the workplace.

In addition to experiencing multiple forms of harassment in the workplace more than Caucasian women, African American women also have different perceptions of conflict in the workplace. A study on perceptions of workplace conflict conducted by Turner and Shuter (2004) found that African American women were significantly more passive and less hopeful about reaching a positive outcome to conflict than European American women. Additionally, Turner and Shuter found that European American women have a more optimistic view about exercising control during conflict and finding a positive resolution for themselves. Overall, the study found that in fact African American women view conflict in the workplace from a different perspective than European American women.

Over the years, research on workplace harassment has grown to include other hostile work experiences besides sexual harassment and racial discrimination. Literature has shown that workplace harassment not only includes sexual harassment and racial discrimination, but also abusive supervision, social undermining, bullying, mobbing, harassment, petty tyranny and generalized workplace abuse (Crawshaw 2009; Keashly & Harvey, 2005). However, there has not been a consensus in terminology; often terms, such as psychological harassment, bullying and mobbing are used differently and interchangeably (Crawshaw, 2009). According to Crawshaw (2009) the term workplace abuse has been used to encompass all forms of abuse in the workplace including sexual harassment, workplace violence, unsafe working conditions, and nonphysical aggression, among other things. However, the term workplace psychological harassment (WPH) seems to identify a common denominator of all of current descriptions of a subcategory of workplace abuse which involves bullying and other hostile behaviors, including verbal abuse/aggression (Crawshaw, 2009; Fox & Stallworth, 2005; Raver & Nishii, 2010). For the purpose of this study, the term workplace psychological harassment is used to describe experiences of psychological abuse (i.e., verbal, emotional) in the workplace.

Positive psychology perspective on trauma outcomes. Since World War II, psychology has become mainly a science about healing, concentrating on repairing damage within a disease model of human function (Seligman, 2005; Seligman & Csikszentmihalyi, 2000). Although information exists regarding how people survive and endure under conditions of adversity (Lazarus, 2003; Seligman & Csikszentmihalyi, 2000), there is little understanding of what makes life worth living and how people flourish under more benign conditions (Seligman & Csikszentmihalyi, 2000).

Recently, there has been a growth in the body of evidence that supports the idea that positive psychological growth can result from people's struggles with traumatic experiences (Joseph & Linley, 2008), and within the psychology community the focus is beginning to shift from that of preoccupation with repairing the worst things in life to also building positive

qualities (Seligman, 2005; Seligman & Csikszentmihalyi, 2000). Additionally, positive psychology aims to approach traumatic experiences and posttraumatic stress from the view of adaptation and growth following the experience (Joseph & Linley, 2008), indicating that growth can spring from traumatic experiences as well as everyday life.

Pillars of positive psychology. The framework on which positive psychology rests includes three main pillars: (a) positive subjective experience, (b) positive individual traits, and (c) positive institutions (Seligman & Csikszentmihalyi, 2000). According to Seligman and Csikszentmihalyi (2000), a positive subjective experience includes a person's well-being, contentment and satisfaction with the past, hope and optimism for the future, and flow and happiness in the present. Additionally, positive individual traits include the capacity for love, courage, interpersonal skill, perseverance, forgiveness, originality, future mindedness, spirituality and wisdom. These subjective experiences and individual traits relate to the present study's focus on the ability to process and move towards change after experiencing an interpersonal trauma, such as having the courage to go into depth while discussing a traumatic experience. Finally, positive institutions are about civic virtues that move individuals towards better citizenship, responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic.

Under the guidance of these pillars, positive psychology aims to expand the knowledge within the field of psychology to understand how individuals, families and communities develop children who flourish, what work settings promote greatest work satisfaction, what policies result in the most civic engagement, and how people's lives are most worth living, among many other things (Seligman & Csikszentmihalyi, 2000). Additionally, proponents for positive psychology aim to remind the field that psychology is not only the study of weakness, pathology, and damage, but also the study of strength and virtue, and that these strengths can act as buffers against mental illness (Seligman & Csikszentmihalyi, 2000).

Critiques of positive psychology. While the concept of positive psychology is gaining momentum, there are those who criticize its claim to be a new area of psychology. For example,

some humanistic and community psychologists feel that positive psychology is not new, and ignores or does not acknowledge their work (Elkins, in press; Lazarus, 2003). Positive psychologists agree that their field is not a new phenomenon or perspective, but instead has been slowly building over the past few decades (Csikszentmihalyi, 2003; Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2005; Snyder & McCullough, 2000). Other criticisms of positive psychology involve challenges to its simplistic view of emotions, the methodological design of its research, and its lack of effort in highlighting cultural factors (Lazarus, 2003; Lopez, Prosser, Edwards, Magyar-Moe, Neufeld, & Rasmussen, 2005).

A common criticism of positive psychology is that it sees positive and negative emotions as polar opposites and that individuals can improve their well-being by simply getting rid of all negative emotions (Lazarus, 2003). Lazarus (2003) also argues that there is a fundamental problem with categorizing emotions as positive and negative as they are more likely to fall on a continuum and be experienced differently by each individual depending on the societal context. As a related point, Lazarus indicates that there is a problem with emotional valence within positive psychology. He argues that both positive and negative emotions can be brought on by both positive and negative life experiences; it is not only positive experiences that elicit positive emotions and negative experiences that elicit negative emotions. Additionally, both positive and negative emotions may co-exist within an individual at any given time (e.g., the co-existence of hope and despair in survivors/victims of abuse (Jenmorri, 2006)).

Regarding methodology, Lazarus (2003) criticizes the use of cross-sectional research as it is an undependable demonstration of antecedent-consequent contingencies and may give a false sense of causality when researching how positive emotions affect individuals. In defense of positive psychology Csikszentmihalyi (2003) points out that this criticism can be applied to most psychological studies, not just positive psychology. Additionally, it is noted that no significant longitudinal research can be expected in such a short span of time (Csikszentmihalyi, 2003). Lazarus further argues that there are problems with the measurement of emotion itself. The

problems of emotional valence and overgeneralization lead the measurement of emotion to be very complex, however often simplified check-lists and questionnaires are the only thing used to measure subjective emotion. Despite these many criticisms, Lazarus is not against the idea of exploring personality traits that could serve as valuable positive resources in an individual's life. Instead he advocates for careful measurement of the emotional state of an individual in the context within it was generated.

Finally, Lazarus (2003) believes that the experience of an emotion will differ for each individual and positive psychology tends to overgeneralize their findings to groups of people. Societal and cultural contexts often influence how individuals create identity development, life goals, and happiness (Lopez et al., 2005). Similarly, Lopez et al. (2005) argues that the scientific basis for positive psychology should include a multicultural lens through which it looks at psychological frameworks and coping. They discuss that this can be done in a multitude of ways such as:

- (a) examining the magnitude and equivalence of constructs across cultures; (b) recognizing the value of religious practices, spirituality, and diverse constructions of life meaning; (c) searching for the clues to the good life that cultural experiences might provide; (d) finding exemplars who function within a positive psychological framework and; (e) clarifying what works in the lives of people. (p. 711)

The hope for this kind of research within the field of positive psychology is that it can help those individuals pursuing their self-defined good life and provide the necessary psychological tools for that pursuit (Lopez et al., 2005).

In response to the criticisms posited by Lazarus (2003) and Lopez et al. (2005), Pedrotti, Edwards, and Lopez (2009) clarified how there appear to be two different camps with regards to culture in the field of positive psychology. Although both sides believe that all cultures have strengths, one side proposes that some strengths are universal across all cultures and the other side proposes that strengths and virtues/morals are culturally and socially determined (Pedrotti et

al., 2009). The culturally embedded perspective posits that strengths can be found in all cultures and that human behavior cannot be studied in a vacuum; as such, culture and context should be considered as part of the everyday human experience (Pedrotti et al., 2009).

The current study took the Lopez et al. (2005) recommendations and the Pedrotti et al. (2009) culturally embedded perspective into consideration by discussing how the client-participant's cultural and societal context may affect the discussion process and her progression through the stages of change. Additionally, the current study tried to understand cultural experiences of the client-participant and the researchers in hopes of better understanding the context of what therapy may look like and how this relates to the stages of change model.

Problematic trauma outcomes. Exposure to stressful and traumatic events, such as abuse and neglect, can lead to severe and chronic psychological consequences and maladaptive behaviors (Briere & Scott, 2006; Joseph & Linley, 2008; Ludy-Dobson & Perry, 2010). Failure to transform these experiences into language can also result in psychological conflict (Pennebaker & Francis, 1996). Many possible negative consequences associated with experiencing childhood sexual abuse are both interpersonal and intrapersonal. Often, loss is associated with this type of abuse; loss of one's childhood and the loss of the ability to trust others in relationships (Alaggia, 2005). Other feelings of loss may include loss of emotional and psychological well-being, loss of feeling in control over one's own body or environment, and loss of physical health (Alaggia, 2005; Hood & Carter, 2008; Pennebaker & Francis, 1996). Specifically, research shows that the reduction in feelings of control over one's life may render an individual more vulnerable to the psychological sequelae of the traumatic experience (Hood & Carter, 2008). Additionally, those individuals who use an avoidant coping pattern to deal with the stress of having been sexually abused as a child show significantly more depressive symptoms than individuals who do not use an avoidant pattern (Briere & Scott, 2006; O'Dougherty Wright et al, 2007). This strategy of avoidance may have been a strength and adaptive for the individual as a child, to prevent him or

her from being overwhelmed by the experience, but in the long-term it predicts poorer outcome (O'Dougherty Wright et al., 2007).

Research also shows that individuals with a history of childhood physical or sexual abuse may experience continuous problems in forming relationships with others and maintaining healthy intimacy in relationships (Feiring, Simon & Cleland, 2009; Sano et al., 2003). Specifically, research has shown that experiencing abuse in childhood can result in intimacy disturbances, difficulties relating to others sexually, and increased probability for violence and revictimization (DiLillo, 2001; Whisman, 2006). For example, Whisman (2006) found seven childhood traumas that were related to marital dissolution later in life. When compared with those people in the study who remained married, individuals who separated or divorced from their spouses were more like to report they had experienced rape, physical abuse, or a serious physical attack or assault during their childhood (Whisman, 2006). Furthermore, Whisman found that lower marital satisfaction was reported by those participants who had specifically experienced rape or sexual molestation in childhood. Other research has focused on what may lead to this difficulty in forming and maintaining healthy, intimate, and satisfying relationships. A study conducted by Feiring et al. (2009) looked at what specific effects of childhood sexual abuse correlated with romantic intimacy problems. It was found that abuse-specific stigmatization was more explanative of which youth were at increased risk for sexual difficulties later in life than abuse severity (Feiring et al., 2009). Feiring et al. postulated that abuse-specific stigmatization and distorted beliefs about oneself during non-consensual sex may carry over to negative views about oneself during consensual sexual relations which can, in turn, disrupt the development of a positive sexual self-schema.

In addition to having difficulty forming close intimate relationships with significant others, women survivors of childhood abuse may have difficulty forming or maintaining relationships with their mothers and other female friends (DiLillo, 2001). Research shows that surprisingly, many survivors of incest harbor feelings of anger and resentment towards other

females, not males (DiLillo, 2001). DiLillo (2001) noted that the feelings of anger and resentment are somewhat explicable as many survivors of incest and sexual abuse feel a sense of betrayal and resentment towards their mothers for not protecting them, or in some cases colluding with the perpetrator. When compared with women who were not abused during childhood, women who have experienced childhood abuse were found to have less contact with their mothers (DiLillo, 2001).

Another negative intrapersonal consequence of experiencing a trauma, such as childhood sexual abuse, is the difficulty that can result in making meaning out of the situation. Making sense or meaning from a traumatic experience involves understanding how it fits with one's view of the world (Nolen-Hoeksema & Davis, 2005). Finding meaning in why a traumatic experience occurred in one's life seems to be a difficult process; for those who do find meaning some believe that it appears to be almost always negative (O'Dougherty Wright et al., 2007). Negative meanings that may be derived as a result of an experience of abuse are shattered assumptions about the world, shattered beliefs about oneself, shattered beliefs about oneself in the world, and causal attributions (O'Dougherty Wright et al., 2007) According to O'Dougherty Wright et al. (2007), there are certain features of childhood sexual abuse trauma that seemed to make it more difficult to find any meaning in the experience such as chronic victimization at the hands of a caregiver, which can result in betrayal of trust and a lack of fault or remorse by the perpetrator of the abuse.

Positive trauma outcomes. Research has begun focusing on the possible positive outcomes that may result from the victim/survivor's response to and struggles with his/her traumatic experiences, such as the closely related constructs of benefit-finding, posttraumatic growth, resilience, positive adjustment, growth and personal change, thriving, flourishing, and self-reflection (Bryant-Davis, 2005; Fawcett, 2003; Frazier & Berman, 2008; Joseph & Linley, 2008; Morland, Butler, & Leskin, 2008; Nolen-Hoeksema & Davis, 2005; O'Dougherty Wright et

al., 2007; Sheikh, 2008; Tedeschi & Calhoun, 2004). This subsection focuses on benefit-finding and post-traumatic growth.

Different from meaning making (i.e., meaning-as-comprehensibility), benefit-finding is an individual's attempt to understand the value or worth gained from his or her struggle in the aftermath of a traumatic experience(s) (i.e., meaning-as-significance) (Nolen-Hoeksema & Davis, 2005). In regards to the traumatic experience of childhood sexual abuse, some survivors indicate that they, over time, have experienced personal growth and development as they try to rebuild their inner worlds and address issues of self-worth, make deliberate choices to be better people and parents by creating lives of value and purpose, experience spiritual growth and transcendence, and improve relationships with others (O'Dougherty Wright et al., 2007) as a result of coping with the trauma. Other perceived benefits of dealing with the trauma include higher marital satisfaction, physical health and improved parenting skills (O'Dougherty Wright et al., 2007). While finding meaning-as-significance in the experience of trauma is difficult, those who are able to do so highlight their sense of strength and coping skills for having gone through such an agonizing experience and coming through it (Lazarus, 2003; O'Dougherty Wright et al., 2007). Additionally, positive meanings that may result after experiencing a trauma are feelings of being a better person or parent, the ability to help others, strengthened faith, self-acceptance, integration and transcendence (O'Dougherty Wright et al., 2007). Specifically, for African American survivors/victims of abuse and interpersonal violence activism with others who have experienced similar situations helps to make sense of the trauma by taking a negative experience and finding a way to use it for the good of others (Bryant-Davis, 2005).

Posttraumatic growth can be defined as the positive psychological changes experienced by individuals as a result of struggles with highly challenging life circumstances that disrupt their way of understanding the world and their place in it (Tedeschi & Calhoun, 2004). Posttraumatic growth has been observed in both males and females, individuals of all ages (i.e., across the lifespan), and across cultures, including refugees, Latinas, Israelis, Germans, Americans, and

British (Sheikh, 2008). While posttraumatic growth is a positive response to the struggles of experiencing and processing a trauma, it often occurs in tandem with attempts to adapt to negative life circumstances and high levels of psychological distress (Tedeschi & Calhoun, 2004). Growth does not occur as a direct result of trauma, but instead as a result of the individual's struggle with a new reality in the aftermath of a traumatic experience; posttraumatic growth is a consequence of attempts at psychological survival (Joseph & Linley, 2008; Tedeschi & Calhoun, 2004). Discussions of trauma and survival are an important component to posttraumatic growth because the process forces survivors to confront questions of meaning and how it can be reconstructed (Tedeschi & Calhoun, 2004).

There are five domains of posttraumatic growth which a person may experience (Tedeschi & Calhoun, 2004). The first domain is a greater appreciation of life and a changed sense of priorities. In this area of growth, individuals typically report a major shift in how they approach their everyday lives and a changed sense of priorities in which the things previously taken for granted become much more important (Sheikh, 2008; Tedeschi & Calhoun, 2004). The second domain of posttraumatic growth is warmer, more intimate relationships with others (e.g., friends and family) (Sheikh, 2008; Tedeschi & Calhoun, 2004). This experience of more meaningful relationships can also occur concurrently with the loss of other relationships as individuals determine who their true friends are (Tedeschi & Calhoun, 2004) and are better able to disengage from relationships that are no longer satisfying (Sheikh, 2008). A sense of increased personal strength is characteristic of the third domain, involving identification of personal strength and decreases in a sense of being vulnerable (Tedeschi & Calhoun, 2004). As individuals begin to feel that they were able to cope with their trauma, they begin to believe that they can cope with anything which, in turn, leads to an increased sense of self-efficacy (Sheikh, 2008). The next domain of posttraumatic growth focuses on the identification of new possibilities for one's life. This can include the possibility of taking a new path in life that was not originally planned, such as a career change (Sheikh, 2008; Tedeschi & Calhoun, 2004). The

final domain of posttraumatic growth involves spiritual and existential growth in which people may experience positive change in their struggles (Sheikh, 2008; Tedeschi & Calhoun, 2004). This area of growth is not limited to only those individuals who are religious; instead it can simply be when individuals are able to connect with something greater than themselves (Sheikh, 2008).

Discussion of interpersonal abuse trauma. Studies vary in their estimation of adult victims who do not purposefully disclose childhood sexual abuse before adulthood. Some indicate that 30 to 80 percent of adult victims do not disclose and others indicate that 60 to 70 percent do not purposefully disclose (Alaggia, 2004; Alaggia, 2005; London, Bruck, Ceci & Shuman, 2007). The large variation in these statistics may be accounted for by the variety of ways data has been collected over the years and how disclosure has been differentially defined (i.e., intentional versus non-intentional first reporting or telling to another person about the abuse) (London et al., 2007). Notwithstanding, these statistics may suggest that it is a common practice not to disclose or report abuse and that a significant number of individuals may go untreated and without help or may not need help or treatment.

For the purpose of this study, the term discussion will be used to signify any disclosure and processing of a traumatic experience including the initial disclosure or first reporting of an interpersonally traumatic experience(s) to the therapist, as well as any subsequent discussions about the experience(s), whether the first telling was to the therapist or another person at a previous point in time. Additionally, the term discussion will be used to encompass any further conversations, social-sharing (i.e., re-evocation of an emotional experience in a socially shared language with some addressee present at the symbolic level; Pennebaker, Zech, & Rimé, 2001), or behavioral (e.g., showing a picture or writing sample, bringing in a journal, or gesture referring to the event) and indirect verbal attempts (e.g., discussion about subsequent life results from the traumatic experience) to discuss feelings, thoughts, and beliefs about the interpersonal trauma.

Discussion of child abuse. The process of discussion of child abuse should be seen as a dynamic rather than static event that involves many different stages and cycles (Alaggia, 2005; Lindbald, 2007). Initial disclosures can often be tentative or ambivalent, involving some telling and then recanting (Alaggia, 2005; Lindbald, 2007), and may be partial or full and occur over time (Alaggia, 2005) as a fluid process (Alaggia, 2004).

The likelihood of intentional or purposeful initial disclosures of child abuse increases with age (Alaggia, 2005; London et al., 2007). Individuals who initially try to disclose abuse in childhood often do so behaviorally rather than verbally (Alaggia, 2005). Female survivors/victims between the ages of 7 and 13 years are more likely to tell an adult of the abuse, whereas older adolescents are more likely to confide in peers (Alaggia, 2005; Hershkowitz, Lanes, & Lamb, 2007; London et al., 2007; Priebe & Goran Svedin, 2008). Purposeful disclosure has been found to be more likely when the perpetrator is a stranger rather than a family member (London et al., 2007; Priebe & Goran Svedin, 2008) as there are more likely to be social consequences for individuals if they discuss abuse by a family member, such as guilt due to changes in family composition/structure, guilt for a possible change in familial socioeconomic status, removal from the home, and fear of being not believed (Nagel, Putnam, Noll, & Trickett, 1997). Other research shows that adolescents are most likely to initially disclose sexual abuse (by both adults and peers) to their peers, as peers are not likely to seek outside professional help or notify the authorities (Stein & Nofziger, 2008). Additionally, statistics indicate that young adult survivors/victims of “simple rape” are consistently less likely to report it to the authorities than those who are survivors/victims of “aggravated rape” given the stigma attached to rapes committed by an acquaintance as opposed to a stranger (Clay-Warner & Burt, 2005, p. 157). For instance, survivors/victims may be incorrectly seen as having led on the attacker or not sufficiently resisting the attack (Pino & Meier, 1999). Therefore, disclosure to the authorities or a mental health professional may occur for the first time later in the survivors/victim’s life. While there does seem to be a difference in the pattern of initial disclosure depending on the age of the

victim at the time of abuse, there does not seem to be any pattern with relation to demographic variables of the victim (e.g., race and ethnicity) or severity of the abuse (London et al., 2007).

However, cultural factors may play a role in why discussion of abuse in childhood may be delayed. In certain cultures in which there are negative attitudes or taboos surrounding sexuality, as well as a strong value placed on family preservation, discussion of abuse may be inhibited (Alaggia, 2004). Furthermore, individuals who have been marginalized as a result of their race, religion, ethnicity, or socioeconomic status may feel too disempowered to disclose their experience, and as such do not do so (Alaggia, 2004).

There are a few theories that look at the process of discussion of trauma and offer a basis for understanding that process. Social exchange theories see discussion of trauma in the context of stopping the progression of victimization, alleviating stress and associated symptoms, preventing hypervigilance around keeping the secret, and creating opportunities to gain insight and secure necessary treatment (Alaggia, 2005). Some other models, in contrast, view the process of discussing traumatic experiences as possibly eliciting negative consequences for the individual, such as the person being blamed and/or accused of fabricating allegations, experiencing withdrawal of support and/or increases in victimization, experiencing somatic and health symptoms, and ultimately experiencing and exacerbation of symptoms related to the abuse (McNulty & Wardle, 1994; Ullman, 2007).

Negative effects of trauma discussion in adults. Trauma events can have serious effects on the psychological well-being of individuals who have experienced them (McNulty & Wardle, 1994). Some psychiatric symptoms appear to be worse among those individuals who have experienced childhood sexual or physical abuse, such as mood disorders, and, in general, adult psychiatric morbidity is higher among sexually abused populations (McNulty & Wardle, 1994; Sano et al., 2003).

With this in mind, there is discussion in the literature that the process of discussing the trauma itself may be a primary cause in the development of psychiatric symptoms. Evidence

suggests that those individuals who are vulnerable, due to childhood events may respond to negative life events or stressors with a breakdown in functioning (McNulty & Wardle, 1994). According to Sano et al. (2003), in order to move oneself away from “the brink of a serious mental collapse”, these individuals may use denial, repression and dissociation as self-defense mechanisms (p. 13). While such self-defense mechanisms may serve a function at one point in time, they may become maladaptive over time (Everill & Waller, 1995; Pennebaker, 1999). Therapists are encouraged to recognize these defense mechanisms when working with traumatized individuals in therapy since removing them may potentially cause fear and confusion in clients (Sano et al., 2003). Also, individuals who have adverse responses to discussion of abuse may have greater levels of psychological dysfunction in areas such as oral control (i.e., eating habits), self-denigration, and dissociative experiences (Everill & Waller, 1995).

Positive effects of trauma discussion in adults. Other evidence shows that short-term discussion of stressful events can be related to improved psychological adjustment, including relief from physical and emotional tension, decreased levels of distress, improved academic performance, and improved negotiation of life transitions (Farber, Berano, & Capobianco, 2004; Hemenover, 2003; Lutgendorf & Antoni, 1999). Additionally, Hemenover (2003) found that those individuals who discussed a traumatic event had increased feelings of mastery of their environment than before they discussed the trauma.

To achieve potential benefits, many theorists and researchers believe that one must integrate the traumatic event with one’s own existing mental schema; emotional evocation may be necessary for this change to become complete (Farber, Khurgin-Bott, & Feldman, 2009; Hemenover, 2003; Lutgendorf & Antoni, 1999; Sano et al., 2003; Tedeschi & Calhoun, 2004). By expressing or discussing the trauma, individuals can then interpret stressors in a personally meaningful way. This interpretation may then lead to the integration of those threatening or confusing aspects of the stressors into a coherent, non-threatening self-concept (Lepore, Fernandez-Berrocal, Ragan, & Ramos, 2004). As individuals are able to construct their

environment in new and different ways that meet their personal needs, they gain enhanced self-acceptance, a more resilient self-concept and thus, decreased psychological distress (Hemenover, 2003).

During the initial disclosure process, short-term increases of overall negative mood, shame and anticipatory anxiety may occur; however after just a few sessions, the individual's mood is returned to its previous state before disclosing the trauma and feelings of safety, pride and authenticity may be experienced (Farber et al., 2004; Lutgendorf & Antoni, 1999). In addition, research with undergraduate college students has found that levels of involvement in the discussion process increase over the number of sessions and total numbers of words used decreases (Lutgendorf & Antoni, 1999). This pattern of decreased words indicates that as people begin to process the trauma at higher levels, they emit less verbiage and may use more silent reflection on their immediate experience. Overall, Lutgendorf and Antoni (1999) found that greater involvement in the disclosure process and negative mood arousal contributed to greater insight and greater overall negative mood reduction.

Additionally, among individuals who discuss traumatic experiences, use of insight words was found to be related to increased autonomy and decreased interpersonal sensitivity (Hemenover, 2003). Use of insight words was shown to increase over the number of sessions, with the most insight occurring in the third and final session (Hemenover, 2003). These findings, that the use of insight words is associated with autonomy and interpersonal sensitivity, possibly indicate that not only is the act of discussing trauma beneficial, but the quality of that discussion can be equally beneficial.

Discussion of trauma and the therapeutic alliance. Much research has examined the alliance between therapist and client. Studies indicate that a positive therapeutic alliance is associated with a positive treatment outcome (Cloitre et al., 2004; Farber et al., 2004; Horvath, 2000). Development of a strong alliance relies on a positive, empathic disposition by the therapist as well as a collaborative partnership in which the client feels like an active and

respected participant (Horvath, 2000). This alliance may be especially important when working with adult survivors/victims of child abuse. Cloitre et al. (2004) found that a positive therapeutic relationship in the initial phase of treatment was predictive of PTSD symptom reduction at the end of treatment in a sample of adult female participants.

The therapeutic relationship between the therapist and client can be one of the therapist's greatest tools. When working with survivors/victims of childhood sexual abuse, the therapist is advised to create a therapeutic environment in which the client feels safe, does not lose the sense of security, does not feel stigmatized, and can effectively work on integrating traumatic memories (Farber et al., 2004; Sano et al., 2003). This environment is important, especially with this population of victims, because a key factor associated with sexual assaults compared with other traumas is the fact that the client may not have told anyone of the trauma before (Sano et al., 2003).

Several therapist factors within the therapeutic relationship have been shown to encourage the discussion of sexual assault and increase the likelihood that the discussion will occur in the context of psychotherapy. These often include a systematic inquiry about the client's life history throughout therapy (i.e., actively pursuing material that may be difficult to disclose); the generation of emotions inspired by adjunctive group therapy; the therapists' empathetic comments, warmth, genuineness, and compassion; making a family diagram; triggers brought on by home life; having a nonjudgmental approach; building good rapport; and being attentive (Farber et al., 2004; Higgins Kessler & Nelson Goff, 2006; Sano et al., 2003).

Therapists should also realize that there is no set amount of time that must pass before a client discusses an experience of sexual assault or childhood abuse. Some clients may discuss a trauma with the therapist after the first or second session, while others may wait months before discussing (Higgins Kessler & Nelson Goff, 2006; Sano et al., 2003). Additionally, instances of intimate disclosure may differ within the session for each client; one study found a high level of discussions by female clients in the last quarter of a session (Strassberg, Anchor, Gabel & Cohen,

1978). If a client waits to discuss a trauma until later in the psychotherapy process, it is important not to assume that the trauma then needs to become the focus of treatment. The client may not feel that the past trauma bears any weight on the current reason for seeking therapy and changing the focus may actually hurt the therapeutic relationship (Higgins Kessler & Nelson Goff, 2006). Also, the length of time that therapy continues after a discussion of trauma will vary from individual to individual (Sano et al., 2003).

No matter at what point in the therapeutic process the discussion of trauma occurs, the impact of these discussions can take many different forms. For some individuals there may be negative transference and projection of a perpetrator to the therapist on a psychotic level (Sano et al., 2003). For other individuals, feelings of anxiety can be raised and the individuals may become unsettled in the relationship (Sano et al., 2003). Still for others, the therapeutic relationship may not be disturbed at all and therapy can continue for years after the discussion (Sano et al., 2003).

Therapists' reactions to discussion of trauma. Sano et al. (2003) believe that the therapist's reactions to a discussion of trauma by a client will invariably have an impact on the relationship between the client and therapist, as well as how the discussion process continues from that point forward. Individuals will be far more likely to discuss their feelings about a trauma if they feel safe and that others won't criticize what they say (Faber et al., 2004; Pennebaker, 1990). Additionally, clients may not report events they have experienced unless specifically asked about them. As a result, clear, candid, and supportive attitude from the therapist will help encourage the client to talk, while a sympathetic relationship with the client can be meaningful in and of itself (Briere & Scott, 2006; Sano et al., 2003).

Although a strong relationship is crucial, Higgins Kessler et al. (2004) reports that there are six major issues that should always be addressed by the therapist when responding to a discussion of trauma from a client. First, a therapist should always assess for emotional problems that may affect the client and put them in danger. Secondly, one should glean the client

description of the abuse experience and determine the reason for the current discussion, especially when the presenting problem for therapy is the trauma or when it is the client's first disclosure of abuse (Agar & Read, 2002; Higgins Kessler et al., 2004). In addition, the therapist should evaluate the impact of the trauma on past functioning and current functioning. Lastly, the therapist should determine what current coping strategies the client is using and how beneficial or harmful they may be for that client (Higgins Kessler et al., 2004).

Higgins Kessler and colleagues (2004) also emphasized that competence or strengths-based perspectives should be used when working with and responding to survivors/victims of abuse or trauma. This is done by acknowledging client's courage and strengths throughout the discussion of the trauma (Higgins Kessler et al., 2004; Higgins Kessler & Nelson Goff, 2006). While this type of sympathetic and strengths-based relationship may appear to be easy to enter into with some clients, maintaining a comfortable equilibrium requires a great deal of energy (Sano et al., 2003).

Clients' experiences of trauma discussion. A client's experience of discussion of a traumatic event does not always occur within the therapeutic context; certain social conditions may also facilitate discussion of trauma or one's stressors (Palmer, Brown, Rae-Grant & Loughlin, 2001). As reported by Bottoms, Rudnicki, and Epstein (2007), survivors/victims who discuss abuse are most likely to do this with friends, followed by parents, other relatives, and significant others before discussing the trauma with therapists, teachers/clergy, or authorities. Another study notes that while current research focuses on initial disclosure of sexual assault to police or formal support systems, approximately two-thirds of African American women eventually disclose sexual assault to informal support systems such as friends, family, or romantic partners (Tillman et al., 2010).

Different social conditions (e.g., culture; gender) may facilitate discussion of trauma as well as better levels of adjustment to traumatic stressors (Bryant-Davis, 2005; Lepore et al., 2004). In a study of the social challenges that affect emotional discussions of trauma in both

American and Spanish females, Lepore et al. (2004) found that individuals who discussed their stressor with a peer and were challenged in their beliefs showed the best adjustment, whereas individuals who discussed their stressors with another and were validated showed slightly lower levels of adjustment. This finding may indicate that those who share their stressors and are challenged may go through a cognitive restructuring process in which new perspectives are explored and considered. Additionally, Lepore et al. found that discussing one's life stressors with another individual significantly increased one's level of adjustment over those who never discussed his or her stressors.

Regarding a study of African American individuals, Bryant-Davis (2005) found that both males and females often turned to the community for support in exploring themes related to their trauma; however fewer sought the support of mental health professionals. Another cultural factor which may affect the initial disclosure and discussion of sexual assault in African Americans is the amount of sexuality socialization in the cultural community (Tillman et al., 2010). Research shows that there may be inadequate or inappropriate education about sexual socialization and sexual abuse prevention in the African American communities, which may in turn affect the disclosure and discussion of sexual assault in adulthood (Tillman et al., 2010).

In addition to the different contexts in which a discussion may occur, there appear to be different psychological variables that affect clients, which may help to delay or facilitate that discussion. According to Somer and Szwarcberg (2001), accommodation, guilt and self-blame, helplessness, emotional attachment to the perpetrator, idealized self-identity, mistrust of others, and dissociation are all variables that could potentially delay an individual's discussion of abuse as a child. On the other hand, the burden of the secret and successful ego-strengthening experiences may help to facilitate a discussion (Somer & Szwarcberg, 2001).

Yet, as previously mentioned, the overall trend is towards delaying initial disclosure into adulthood (Alaggia, 2005; Lamb & Edgar-Smith, 1994; Somer & Szwarcberg, 2001), with over half of individuals doing so (Alaggia, 2005). This delay in discussion of trauma appears to differ

between genders, but for different reasons (Alaggia, 2005). These gender differences may be partially due to societal expectations regarding gender roles. Men and women differ in their willingness to discuss emotional information, with men being less willing than women (Purves & Erwin, 2004). For men, the key barrier to discussion of childhood sexual abuse was being abused by a same-sex individual and what that meant for their own sexual orientation. A precipitant of discussion of the abuse was the fear of becoming a perpetrator themselves (Alaggia, 2005). However, for women the barriers towards discussing abuse had more to do with their struggle on how the discussion would affect others and the responsibility that they felt, rather than their concern regarding sexual orientation (Alaggia, 2005). In both men and women, there was a fear of being blamed or disbelieved; however in women it was this fear that often overrode their decision to initially disclose what happened (Alaggia, 2005). Fear and lack of willingness to discuss abuse in women has often been shown to be a predictor of increased trauma symptoms (Purves & Erwin, 2004). Instead of working through the traumatic experience, women showed a tendency to focus on, and discuss, less threatening anxiety-related emotions, which allows them to be distracted from the pain of the original trauma (Purves & Erwin, 2004). This discussion of less threatening material may actually have little or no therapeutic effect for women, as their anxieties were shown to increase over time (Purves & Erwin, 2004).

Individuals may assess their situation and discuss a trauma in varied degrees based on their perceived risks and benefits; usually this is when the adult survivor/victim feels that a supportive relationship offers a safe place and opportunity to discuss their experience (Alaggia, 2005; Farber et al., 2009; McNulty & Wardle, 1994). However, a survivor/victim of childhood abuse or trauma may have some hesitations in discussing the trauma even well into adulthood for good reason. Their fears of not being believed may be well founded if there are social or cultural biases against believing childhood sexual abuse disclosures (DeMarni Cromer & Freyd, 2007; Farber et al., 2009; Somer & Szwarcberg, 2001). For instance, in the past, disclosures to professional groups, such as social workers, police, or others involved with the judicial system,

tended to leave survivors/victims with feelings of humiliation, guilt, and blame (McNulty & Wardle, 1994; Somer & Szwarcberg, 2001). For example, African American women who waited until adulthood to initially disclose their abuse have found the person they told to be unsupportive, blame the survivor, call the survivor a liar, or punish the survivor (Banyard et al., 2002). Similarly, a study of female domestic violence victims/survivors in Bangladesh showed that the women often reported to therapists feeling fears of jeopardizing family honor, tarnished reputations, repercussions from their husbands, and threats of murder (Naved, Azim, Bhuiya, & Persson, 2006). For survivors/victims of intimate partner violence these fears are very real as uncertainty surrounds how others (e.g., family members, health care providers, friends, and perpetrators) will respond to their purposeful disclosures of the violence, especially if no responses followed previous disclosures (Dienemann, Glass, & Hyman, 2005). Furthermore, feelings of embarrassment, shame, or humiliation of admitting that one is in an abusive relationship may delay purposeful discussion of the traumatic experience (Dienemann et al., 2005).

Some factors that may influence whether or not an individual's initial disclosure of a traumatic experience is believed may have to do with their gender or past trauma history. According to a study on the influences of believing child sexual abuse disclosures by DeMarni Cromer and Freyd (2007), their sample of women had a tendency to believe initial telling of abuse more than men, while men with a past trauma history (i.e., sexual abuse by someone close) had a tendency to believe initial telling of abuse more than men without past history of trauma. Additionally, DeMarni Cromer and Freyd found gender differences may be influenced by women's perceptions of vulnerability, regardless of their trauma histories. Furthermore, these perceptions may make women more likely to believe others' reports of sexual assault. In contrast, it was found that men who have suffered an interpersonal trauma may lose their feelings of invulnerability lending them to be more apt to believing other's initial telling of abuse. In addition, DeMarni Cromer and Freyd found that male survivors/victims were believed more than

female victims. This may be due to the rape myth that women lie about rape, leading others to question their motives for telling and further burdening them with feelings of guilt and fear (DeMarni Cromer & Freyd, 2007).

For others, the discussion of their traumatic experience may be more difficult on a physiological level. Research is beginning to show that traumatic memories are stored in the right hemisphere of the brain, which is a non-verbal or pre-verbal area (Harris, 2009). This knowledge may help to explain the reason traumatic memories are experienced as intrusive images rather than narratives of the experience from beginning to end (Harris, 2009).

Additionally, researchers hypothesize that at the beginning moments of terror or trauma, activity decreases in the left side of the brain, which handles language and declarative memory, undermining verbal processing of the experience (Harris, 2009). Concurrently, Broca's area, which transforms subjective experiences into speech, is largely deactivated (Harris, 2009).

Further research shows individuals who suffer an interpersonal trauma, such as abuse or neglect, may have impaired neural growth and integration (Cozolino, 2006). As such, it may be more difficult for individuals to verbally express and process their traumatic experiences in therapy. Therapists may need to explore alternatives to verbal processing in order to help some individuals work through their traumatic experiences.

Transtheoretical Model and the Stages of Change

Transtheoretical model. The transtheoretical model is an integrative and comprehensive model of behavior change (Prochaska et al., 1994). The four main components of the model are decisional balance, processes of change, self-efficacy, and the stages of change (Bulley, Donaghy, Payne, & Mutrie, 2007). According to Bulley et al. (2007), decisional balance is used to theoretically predict the behavioral decision made by an individual using perceived benefits and costs, and self-efficacy represents the degree of confidence that individual has in his/her ability to achieve the specified outcome. The specific processes and stages of change will be discussed in the following section at a later time.

The transtheoretical model has been shown to have predictive validity across variables when dynamic variables, such as the stages and processes of change, are compared to static variables, such as demographics or behaviors like termination from therapy (Brogan, Prochaska, & Prochaska, 1999; Burke, Denison, Gielen, McDonnell, & O'Campo, 2004; Prochaska et al., 1994). Furthermore, the constructs of the transtheoretical model have been found to be generalizable across a variety of populations that differ on gender, socioeconomic status, age, and minority status (Prochaska et al., 1994). The constructs of the model have also been found to be generalizable across problematic behaviors that may differ on dimensions such as acquisition and cessation of the problem, addictive and non-addictive features of the problem, frequency of the problem, legality of the problem, public and private engagement in the problem, and social acceptability of the problem (Prochaska et al., 1994). However, there have not been any studies that specifically focus on the African American population.

Stages of change. According to the transtheoretical model, behavior change is conceptualized as a six stage process. At each stage, different processes of change occur and create progress for the client (Prochaska & DiClemente, 1982; Prochaska & Norcross, 2001). Additionally, the therapist has a different role to help the client in each of the stages. The six stages of change are precontemplation, contemplation, preparation, action, maintenance and termination. Each stage represents a period of time and a set of tasks needed to move to the next stage (Prochaska & Norcross, 2001).

The first stage of change is precontemplation. In this stage the client has no intended desire to change in the foreseeable future (Bulley et al., 2002). Also, individuals in this stage are unaware, under-aware, or in denial with regards to their problems, although others in their life are well aware of the clients' problems (Frasier, Slatt, Kowlowitz, & Glowa, 2001; Prochaska & Norcross, 2001). In some cases, clients in the precontemplation stage may wish to change; however, that is a very different mindset from actually intending or considering change (Frasier et al., 2001; Prochaska & Norcross, 2001). Prochaska and Norcross (2001) analogize the role of the

therapist during this time to be that of a “nurturing parent” joining with a young person ambivalent about becoming independent (p. 444). One of the techniques often used by the therapist at this stage of change is motivational interviewing (MI). MI is thought to be most useful in the beginning phases of treatment as a way to provide the foundations for future progress to begin (Chambers, Eccleston, Day, Ward, & Howells, 2008; Miller, 1983). MI involves a series of systematic strategies that can be used by the therapist to help the client move from the precontemplation stage, through the contemplation stage, and to the action stage of change (Miller, 1983).

The second stage of change is contemplation. This stage is when clients are aware that a problem exists and are seriously thinking about overcoming it; they may even admit the problem to a close friend, family member, or coworker (Frasier et al., 2001; Prochaska & Norcross, 2001). However, they have not yet made a commitment to make a change. Contemplative behaviors may be seen as wishful thinking as the client tries to make sense of what the change may be (Frasier et al., 2001). Individuals may remain stuck in this stage for long periods of time (Prochaska & Norcross, 2001). A key component of being in the contemplation stage is that the individual is thinking of changing the problem behavior within the next 6 months (Prochaska et al., 1994). When a client is in the contemplation stage, the therapist may take the role of a “socratic teacher” who encourages their clients to reach their own insights and conclusions about their problems (Prochaska & Norcross, 2001, p. 444).

The third stage of change is the preparation stage. This stage uniquely combines both the intent to change with behavioral criteria. Individuals in this stage are consciously aware of their problem and are preparing to take action in the next month and have unsuccessfully taken action in the past year (Frasier et al., 1999; Prochaska & Norcross, 2001). Individuals in this stage may report some small behavioral changes and reductions to their problems, but they have not yet met the criteria for effective action (Prochaska & Norcross, 2001). When working with clients in the preparation stage, the therapist is likely to take the role of an “experienced coach”, helping to

provide their clients with game plans and review the clients' own plans of action (Prochaska & Norcross, 2001, p. 445).

The fourth stage is the action stage. In this stage clients are modifying their behaviors, experiences, and environments in an attempt to overcome their problems (Prochaska & Norcross, 2001). This stage involves the most overt behavioral changes and requires considerable commitment, time, and energy (Prochaska & Norcross, 2001; Prochaska et al., 1994). In the action stage the clients' work on the problematic behavior tends to be most visible to others in their lives and receives the greatest external recognition (Frasier et al., 1999; Prochaska & Norcross, 2001). To be classified in the action stage, an individual must have successfully altered their problematic behavior for a period from 1 day to 6 months (Prochaska & Norcross, 2001; Prochaska et al., 1994).

The fifth stage is the maintenance stage. During the maintenance stage individuals work to prevent relapse and consolidate the gains made during the action stage (Prochaska & Norcross, 2001). The criteria for reaching the maintenance stage is remaining free of the problematic behavior and consistently engaging in an incompatible behavior for more than 6 months (Prochaska & Norcross, 2001), which involves continued change (Prochaska et al., 1994). In both the action and maintenance stages, the therapist takes the role of a "consultant" for the client. It is the therapist's job to provide expert advice, guidance, and support for the client if things do not progress as smoothly as anticipated (Prochaska & Norcross, 2001, p. 445).

The final stage is termination. When clients have reached the termination stage they have completed the change process and no longer need to work to prevent relapse. The client is said to have total confidence and self-efficacy across all high-risk situations for the behavior and no temptation to relapse (Prochaska & Norcross, 2001).

Processes of change. There are different processes of change that are more effective within the different stages of change (Prochaska & Norcross, 2001). Although they are not the focus of this dissertation, they deserve explanation. The processes of change are generally the

ways in which an individual attempts to change with or without therapy (Petrocelli, 2002; Prochaska & DiClemente, 1982). These processes of change are usually associated with the experiential, cognitive and psychoanalytic orientations and are most useful during the early stages of change, precontemplation and contemplation (e.g., consciousness raising, self-reevaluation, self-liberation, and counterconditioning) (Burke et al., 2004; Petrocelli, 2002; Prochaska & DiClemente, 1982; Prochaska & Norcross, 2001). Those change processes commonly associated with the existential and behavioral orientations are most useful during the later stages of change, action and maintenance (e.g., stimulus control, reinforcement management, helping relationships, dramatic relief, environmental reevaluation, and social liberation) (Burke et al., 2004; Petrocelli, 2002; Prochaska & Norcross, 2001).

Stages of change and the therapeutic relationship. As a therapist learns and uses the transtheoretical model, researchers suggest some therapeutic practices to consider in order to ensure the stages of change and processes of change work in the best possible manner for the client (Norcross, Krebs & Prochaska, 2011; Prochaska & Norcross, 2001). To begin with, it is recommended that therapists assess the client's stage of change (Norcross et al., 2011; Prochaska & Norcross, 2001). This way the therapist can tailor the therapy relationships and possible interventions according to the client's readiness for change.

Another important variable noted by Prochaska and Norcross (2001) for therapists to keep in mind is not to treat each client as if he or she is in the action stage of readiness because a majority of clients who enter treatment are not yet in the action stage. Only about 10% to 20% of clients are actually ready for action when they seek therapy (Prochaska & Norcross, 2001).

The third practice to follow is to set realistic goals in which the client moves through one stage at a time (Prochaska & Norcross, 2001). There is nothing that says a client must move from precontemplation to action in a matter of weeks. Instead therapists should view any move up in stages as therapeutic progress (Norcross et al., 2011; Prochaska & Norcross, 2001).

Next, the literature recommends that therapists use stage-matched relationships and treatments of choice (Brogan et al., 1999; Norcross et al., 2011; Prochaska & DiClemente, 1982; Prochaska & Norcross, 2001). This means the therapist should use techniques and therapeutic relationships that follow along with the underlying notion of the stage of change instead of haphazardly applying techniques and relationships with the client that are too advanced or not advanced enough for the client's level of readiness to change.

The last practice that Prochaska and Norcross (2001) recommend therapists follow is avoiding mismatching stages and processes of change. Employing action-oriented processes while the client is in the precontemplation or contemplation stages may be ineffective and even detrimental to the client's progress in therapy and relationship with the therapist (Prochaska & Norcross, 2001).

Measures of the stages of change can help therapists match the interventions they use to the stage of change that their clients are currently in (Brogan et al., 1999; Norcross et al., 2011). Using measures of the stages of change has also given researchers a way to empirically predict termination and continuation status for clients, which is helpful information for therapists. A study conducted by Brogan et al. (1999) found that where a client scored on the Stages of Change measure, along with processes of change and decision-making variables, was related to whether a client was a premature terminator, an appropriate terminator, or a therapy continuer. Additionally, a benefit to using this measure as an assessment tool is that interventions can be designed to help individuals progress from one stage of change to the next.

Other studies have focused on the relationship between the stages of change and mental health in physically abused women (Burman, 2003; Burke et al., 2004; Edwards et al., 2006; Frasier et al., 2001). A woman's increased readiness to change has been associated with increased depressive and PTSD symptoms, and suicidal ideation when looking at women who are currently in abusive domestic relationships (Edwards et al., 2006). Furthermore, Burman has found different characteristics in each stage of the transtheoretical model for women who have

suffered abusive relationships, with specific treatment goals. These goals include raising doubt about maintaining the current situation through psychoeducation about the nature of the abuse, reducing ambivalence and cognitive dissonance about the abusive relationship, determining the best course of action and preparing to carry it out, carrying out strategies in place to leave the relationship, and preventing a return to the relationship (Burman, 2003; Burke et al., 2004).

Relatedly, the stages of change have been found to be helpful in indicating which types of therapy may be more effective for women in abusive relationships at different stages. For instance, those women in the early stages of behavior change, such as precontemplation, contemplation or preparation, tend to use more cognitive processes in therapy whereas women in the action or maintenance stages use more behavioral processes in therapy (Burke et al., 2004; Prochaska & Norcross, 2001)

Measuring stages of change. The stages of change are most often measured using self-report questionnaires that use a simple algorithm to place an individual into a particular stage (Sullivan & Terris, 2001). One of the first measures of the stages of change, and the most widely used, is the University of Rhode Island Change Assessment Scale (URICA; also known as the Stages-of-Change Questionnaire). McConnaughy, Prochaska, and Velicer (1983) developed it to be a brief, but highly reliable, measure of the stages of change during psychotherapy that categorized individuals into four well-defined stages: (1) precontemplation, (2) contemplation, (3) action, and (4) maintenance (McConnaughy et al., 1983). The URICA contains 32 self-report items in which clients respond about a self-determined problem using a 5-point Likert scale ranging from strongly agree to strongly disagree (Dozois, Westra, Collins, Fung & Garry, 2004; McConnaughy et al., 1983). Each of the four scales show high internal reliability (precontemplation = .88, contemplation = .88, action = .89, and maintenance = .88) in the normative sample of male and female adult outpatients at a community facility, private practice, military counseling center and university counseling center (McConnaughy et al., 1983).

Other measures of the stages of change have been based off of the URICA and adapted for specific types of behaviors (e.g., smoking cessation, drug use, and exercise) (Sullivan & Terris, 2001). The Stages of Change Scale-Substance Abuse (SCS-SA; Da Silva Cardoso, Chan, Berven, & Thomas, 2003) was developed to measure readiness to change with individuals specifically in treatment for substance abuse. The scale consists of 29-items and is rated on a 7-point Likert scale ranging from never have the feeling to always have this feeling (Da Silva Cardoso et al., 2003). Internal reliability consistency for the SCS-SA is reported to range from .84 to .93 (Da Silva Cardoso et al., 2003). The Stages of Exercise Scale (SOES; Cardinal, 1995 as cited in Landry & Solmon, 2004) measures an individual's behavior change related to his/her current degree of interest in physical activity and actual involvement in physical activity. Results are used to place each individual into one of 5 categories: precontemplation, contemplation, preparation, action and maintenance (Landry & Solmon, 2004). The SOES has a test-retest reliability range of .93 to 1.00 (Landry & Solmon, 2004). As the current study does not focus on the single specific problem of exercise or substance abuse and desires to sample from a broader range of clients who present to a university's community counseling centers, the URICA will be used as it can assess change from diverse samples of clients regarding the construct of interest, a variety of interpersonal traumas.

Purpose of the Current Study and Research Questions

Understanding the process of trauma discussion in the therapeutic context may help to facilitate interventions that encourage the processing of trauma and help mitigate the negative consequences that may be associated with it (Nagel et al., 1997). Additionally, understanding the model of change over the course of therapy is beneficial when developing effective interventions for clients (Velicer & Prochaska, 2008). However, there is a lack of research that examines processing of trauma while incorporating a model of change and its associated interventions. Furthermore, while there is increasing attention being given to the idea of posttraumatic growth, no one has taken a culturally-embedded positive psychological perspective to understand the

process of trauma discussion by using the stages of change. The current case study aimed to further understand the process of a client's trauma discussion as it related to her stages of change in psychotherapy.

The following questions guided the case study. How are the stages of change related to the timing of discussion of traumatic material within the therapeutic context across the course of psychotherapy with a client from a university's counseling centers? Additionally, how are the stages of change related to the depth of discussion (i.e., amount of processing) of traumatic material within the therapeutic context across the course of psychotherapy? Lastly, how do the techniques used by the therapist during discussion and processing of trauma during psychotherapy relate to the stages of change?

Chapter II. Method

The purpose of this chapter is to provide a description of the methods used in the current qualitative case study on the disclosure of interpersonal trauma and the stages of change in the context of psychotherapy. Included is a description of the design of the study, participant, instrumentation, analysis procedures, and human subjects/ethical considerations.

Research Design

Researchers taking a qualitative stance in psychology endeavor to make sense of actual lived experiences (Marecek, 2003). With this in mind, Morrow (2007) finds that qualitative research methods are particularly suited to use in counseling and clinical psychology as they are congruent with paradigms and methods closely related to the practice of psychotherapy. Qualitative research focuses on the questions of "How" or "What," instead of "Why," as is done in quantitative research, as these questions are the most useful in understanding the meanings people make of their experiences and understanding the process of psychotherapy in depth (Morrow, 2007). Additionally, qualitative methods can be used to explore variables that are not easily identifiable or those that have not yet been identified, as well as investigating topics for which there is little or no research (Morrow, 2007). For example, there is no current research that

focuses specifically on the disclosure of an interpersonal trauma during psychotherapy and the relationship of that disclosure to the transtheoretical model. Thus a qualitative approach to understanding this phenomenon is appropriate.

This study was a descriptive, single case study approach within a bounded system (Creswell, 1988; Yin, 2003). The study involved “a detailed, in depth data collection involving multiple sources of information (e.g., observation of sessions tapes, interviews, written materials, etc.) and reported a case description and case-based themes” (Creswell, 1988, p. 73). According to Yin, this type of design is appropriate when looking at a longitudinal case, studying a single case over multiple points in time. An embedded analysis, or analysis of themes, was utilized where a specific aspect of the case was studied. The researcher focused on the discussion of interpersonal trauma and the participant’s self-reported stages of change over time to examine any possible associations between the model and the discussion of traumatic material within the therapeutic context.

Participant

A single case study design was used for this qualitative study. Archival data of an individual adult client-participant’s written measures and video-recorded psychotherapy sessions at a southern California university’s community counseling center was used for the sample.

To determine eligibility for participation in the study, certain inclusion and exclusion criteria were used. A possible client-participant must have been an English speaking adult (i.e., age 18 or over). The possible client-participant must have completed at least 15 psychotherapy sessions in order for the researcher to assess a change in his/her written measures over time, as therapists gave some written measures after every 5 psychotherapy sessions. There must have been video or audio recordings of most psychotherapy sessions (at least 15) from which the researcher selected. Additionally, the therapist-participant in the recordings was not anyone known by the researcher to protect confidentiality of the therapist- and client-participants and because it may have introduced bias in the coding process. Finally, a possible client-participant

must have discussed some type of interpersonal trauma, as related to his/her own experiences (Lindbald, 2007), throughout the course of treatment and in the intake materials, as a goal of this study was to evaluate the depth of discussion of the trauma. There were no specifications for the client- or therapist-participants, as related to gender, socioeconomic status, race/ethnicity or religiosity; these contextual factors were considered in the case study. A possible client-participant met the exclusion criterion if he/she presented for couple or family counseling. Random selection was used to select the final client- and therapist-participants once all inclusion/exclusion criteria were met (see Sampling Procedures).

The client-participant in this study was a 28-year-old (at the time of intake), able-bodied, heterosexual, African-American female. The client-participant was from the southern United States and of the Christian faith. The client-participant moved to southern California from Kentucky just before she entered therapy. She reported she was single, but was in a long-distance committed relationship with her boyfriend who continued to live in her hometown. On the intake paperwork, she indicated she had no contact with her father and spoke with her mother by telephone approximately every two months. Also included in her support system were her older brother and her cousin, with whom she spoke by telephone every month.

She reported she worked as an assistant at a travel company, but continued to struggle financially. Additionally, on the intake paperwork the client-participant indicated she had experienced “sexual abuse,” “addictions” and “drug use or abuse.” She also indicated she was having difficulty at her current job as her boss made racist comments and was verbally abusive. The client-participant initially presented to therapy with issues of adjustment after her recent move and a desire to have someone with whom to talk. She endorsed items such as, “Difficulty expressing emotion,” “Lacking self-confidence,” and “Difficulty controlling your thoughts” on the intake paperwork. The client-participant also reported upon intake that she could not open up to her friends and she wanted to explore her emotions so as to not be “shut down.” The client-

participant was given an Axis I diagnosis of Partner-Relational Problem (V61.10) and a GAF of 75 upon intake by the therapist-participant.

Researchers

In the study, there was a team of four researchers coding and auditing the data (Coder 1, Coder 2, Coder 3, and Auditor 4). I (Coder 1) am a 27 year-old, able-bodied, heterosexual, female of European descent. I was raised Catholic in a family of middle socioeconomic status and identify as Italian-American and Irish-American. I am currently enrolled in a clinical psychology doctoral program. I tend to conceptualize clients from a cognitive-behavioral perspective as I find value in having structure and specific interventions when working with clients. From my experience working with clients I feel that applying some sort of structure or theoretical model to work with survivors/victims of trauma may be beneficial in helping the client through a difficult time. As often the goal of therapy is to process difficult periods in people's lives, understanding what interventions or techniques therapists can use with this specific population in helping them progress through therapy may be beneficial. Thus, in the current study I am hoping to find that when therapists use different techniques associated with the stages of change, the client will be able to successfully process part of his/her traumatic experience.

Coder 2 was an able-bodied 31 year-old, heterosexual, married, first generation Russian-American female doctoral student in clinical psychology. She generally conceptualizes clients from a psychodynamic perspective and works from an integrated therapy approach, incorporating psychodynamic, cognitive-behavioral and mindfulness techniques. Coder 2's experiences as a clinician over the past seven years, have led her to believe that therapists can benefit from becoming familiar with strategies that can be used to repair ruptures and conflict with their clients as conflict appears to be a part of every close human relationship, including therapeutic interactions. She also believes that conflict can be a healthy part of any relationship because it forces people to grow and challenge themselves in new ways, and if managed effectively, conflict

can create new opportunities for individuals and relationships to growth because it can bring about greater understanding and meaning.

Coder 3 was a 29 year-old, able-bodied, progressive, heterosexual, Caucasian, Russian-American female who was raised in a family with a middle to high socioeconomic status. She is currently a doctoral student in clinical psychology. As a clinician, Coder 3 tends to conceptualize clients and conduct psychotherapy from a cognitive-behavioral orientation, and more specifically uses dialectical behavioral therapy. Through her personal experiences, as well as training in both of these orientations, she has come to believe that the experience of positive emotion can aid in the recovery from problems rooted in negative emotions, increase overall well-being, and serve as a buffer against stressful life events.

The auditor 4 (the dissertation chairperson) was an able-bodied, 43 year-old, European-American, progressive, Christian, heterosexual, married woman of middle to high socioeconomic status. As an associate professor of psychology with degrees in clinical psychology and law, she teaches, mentors and engages in independent and collaborative research with students, including coders 1-3, and colleagues. Auditor 4 believes in the integration of diverse fields of inquiry and of research and practice. Accordingly, she generally conceptualizes clients using multiple theoretical perspectives (including behavioral, cognitive-behavioral, dialectical behavior therapy, family systems, stages of change and other strength-based and positive psychology approaches) and is supportive of evidence-based treatments. Regarding this study, she also expects that a client who has experienced trauma and discusses it in therapy with a therapist who is attuned to the client's stage of change for that issue may evidence a deepening processing of the trauma over the course of therapy.

Instrumentation

Assessment measures from the archival database in the community counseling clinics were used for this research study. The instruments provided demographic information about the client, written materials and measures completed by the client, therapist's written measures about

the client, and videotape recordings of the psychotherapy sessions. Written measures completed by the client are done at the initial intake session and at every fifth session. The following variables were looked at in the study.

Determining experience of an interpersonal trauma. In order to determine if the client-participant had experienced an interpersonal trauma, the Client Information Adult Form was used (Appendix A). In the Family Data Section, asking “Which of the following have family members including yourself struggled with?”, the client must have answered “Yes, this happened” in the Self column for at least one of the following: Physical Abuse, Sexual Abuse, Emotional Abuse, or Rape/Sexual Assault. To further support this information, the researcher also looked at the Intake Evaluation Summary (Appendix B). On this form, the therapist must have indicated that the client-participant reported an interpersonal trauma in at least one of the following sections: Presenting Problem/Current Condition, History of the Presenting Problem & History of Other Psychological Issues, or Psychosocial History. The client-participant must also have discussed the interpersonal trauma during at least one psychotherapy session that was videotaped.

Supplemental information was also considered when determining if the client-participant had experienced an interpersonal trauma. On the Telephone Intake Form (Appendix C), the participant may have indicated that some sort of interpersonal trauma was his/her reason for calling to schedule psychotherapy under the “Reason for Referral – Please tell me a bit about your reason for calling today?” Additionally, on the newest version of the University of Rhode Island Change Assessment (URICA; DiClemente & Hughes, 1990) (Appendix D), the client-participant may have indicated some form of interpersonal trauma was the problem he/she was working on at the top of the form.

Determining stages of change. The URICA (DiClemente & Hughes, 1990) (Appendix D) was also used to determine what stage of change of the transtheoretical model the client-participant was in throughout the therapy process. This particular scale has been associated with

important dimensions of outpatient psychotherapy such as duration of therapy, symptom relief and working alliance (Rochlen, Rude & Baron, 2005). This self-report measure consists of 32 items with responses given on a 5-point Likert scale. It includes four subscales (precontemplation, contemplation, action, and maintenance) that measure an individual's stage of change. Each stage provides information about the client's readiness to change during therapy. The URICA has internal consistency reliability ranging from .79-.89 (McConaughy et al., 1983). To indicate movement through the stages of change, the client-participant can either have a progression from an earlier stage of change (e.g., precontemplation) to a later stage of change (e.g., action) or movement from a later stage of change (e.g., action) to an earlier stage of change (e.g., contemplation) using the standardized scoring method at some point in time from the intake session measure to the last recorded written measure.

Determining depth of discussion of interpersonal trauma. To determine when the participant discussed an interpersonal trauma, videotapes of the psychotherapy sessions were viewed by the researchers and searched for discussion of the trauma indicated on the Client Information Adult Form and the Intake Evaluation Summary or any other interpersonal trauma which may have occurred in the client's life and discussed in therapy.

In order to determine the depth of the discussion of the interpersonal trauma, the Linguistic Inquiry and Word Count analysis program (LIWC; Pennebaker, Chung, Ireland, Gonzales, & Booth, 2007) was used. The LIWC program was created for use with written and verbal disclosures or discussions of traumatic experiences (Pennebaker et al., 2007). Pennebaker (1997) states that the disclosure paradigm analyzed with the LIWC program has been beneficial in equal rates for senior professionals with advanced degrees, maximum security prisoners with sixth grade educations, and individuals from a variety of backgrounds including French-speaking Belgians, Spanish-speaking residents of Mexico City, and English-speaking New Zealanders. These equal rates of effectiveness appear to make the program appropriate for diverse individuals.

The LIWC program allows researchers to analyze data on a more in depth and emotional level through a text analysis process counting words contained in its default dictionary (Pennebaker, 1993; Pennebaker et al., 2007). The default dictionary in the LIWC2007 program contains almost 4,500 words and word stems (Pennebaker et al., 2007). Each word entered into the program is processed and the dictionary is searched, looking for a match with the current word (Pennebaker, et al., 2007). If the entered word matches a word in the dictionary, the appropriate word category scale for that word is incremented and the analyzed text is output into a number of variable categories and subcategories. The main categories include Linguistic Processes, Psychological Processes, Personal Concerns, and Spoken Categories (Pennebaker, et al., 2007). The LIWC program counts words related to emotions and cognitive processing. Positive and negative emotion words are coded as well as the cognitive processes of insight, self-reflection and causal reasoning (Pennebaker, 1993; Pennebaker, et al., 2007). In addition to the dimensions of emotion and cognitive processes, the LIWC can assess number of words and percentage of unique words (Pennebaker, 1993). For the purpose of this study, only certain subcategories were used to determine the depth of discussion of trauma: (a) from the Linguistic Processes category, the total word count subcategory was analyzed, and (b) in the Psychological Processes category, the cognitive processes, insight, and causation subcategories were analyzed. Those instances of discussion of trauma in which one of these three subcategories (i.e., cognitive processes, insight, and causation) increased in percentage, as compared with discussions from prior therapy sessions, were considered a deeper processing of the trauma.

Pennebaker et al. (2007) calculated internal reliability and external validity for the LIWC program using the output of the program and independent judges' ratings. The external validity rating for the positive emotion subcategory was .97; the negative emotion subcategory was .97; the cognitive processes subcategory was .97; the insight subcategory was .94, and the causation subcategory was .88 (Pennebaker et al., 2007). Given the high reliability and validity of this system, it was felt to be an appropriate measure to use for the current study.

Understanding the context of therapy. In order to gain a broader understanding of the client-participant's therapeutic process the Outcome Questionnaire-45.2 (OQ-45.2; Burlingame, Lambert, Reisinger, & Neff, 1995) was used (Appendix E). The OQ-45.2 is a self-report measure consisting of 45 items which are answered on a 5-point Likert scale. This measure consists of three subscales which assess how an individual has felt on measures of Symptom Distress, Interpersonal Relations, and Social Roles over the past week. The OQ-45.2 has an internal consistency range of .70-.93 and a test-retest reliability range of .78-.84 (Burlingame et al., 1995). The researcher looked at the client-participant's Total Score on Reliable Change Index (+/-14 points) (Vermeersch, Lambert & Burlingame, 2000) from the intake session measure to the last recorded written measure to see if there was a reported improvement in subjective symptoms or not.

The researcher also used the Working Alliance Inventory – Client version (WAI-C; Tracey & Kokotovic, 1989) and Working Alliance Inventory – Therapist version (WAI-T; Tracey & Kokotovic, 1989) to better understand the therapeutic relationship between the client and the therapist (Appendix F; Appendix G). The WAI-C and WAI-T are shortened versions of the original 36-item Working Alliance Inventory (Horvath & Greenberg, 1989). These 12-item self-report measures are scored on a 7-point Likert scale that ranges from never (1) to always (7). The WAI-C and WAI-T are based on Bordin's multidimensional conceptualization of working alliance and consist of three subscales which measure agreement between the client and therapist on goals, how to achieve those goals or task agreement, and the development of a personal bond between the client and therapist (Tracey & Kokotovic, 1989). The WAI-C has an internal consistency ranging from .90 to .92 on each subscale and the WAI-T has an internal consistency ranging from .83 to .91 on each subscale (Tracey & Kokotovic, 1989).

The Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Fetzer Institute & National Institute on Aging [NIA], 1999) was used to gain an understanding of the importance of religion and spirituality in the client-participant's life (Appendix H). The BMMRS

is a 54-item scale developed to examine key dimensions of spirituality and religion and how they related to physical and mental health. It is based on a strong Judeo-Christian focus, though there are items that are relevant to different religious and spiritual beliefs. The BMMRS is divided into 12 subscales, including daily spiritual experiences, meaning, values, beliefs, forgiveness, private religious practices, religious/spiritual coping, religious support, religious/spiritual history, commitment, organizational religiousness and religious preference (Fetzer Institute & NIA, 1999). Each of the domains measured by the BMMRS are only moderately correlated, indicating they are distinct constructs (Fetzer Institute & NIA, 1999; Idler, Hudson & Leventhal, 1999). As such, the reliability coefficients of the subscales are as follows: daily spiritual experiences is .91, values/beliefs is .64, forgiveness is .66, private religious activities is .72, public religious activities/organizational religiousness is .82, religious support ranges from .64 to .86, religious and spiritual coping ranges from .54 to .81 and religious intensity is .77 (Fetzer Institute & NIA, 1999; Idler et al., 1999).

The researcher also looked at the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet & Farley, 1988) to learn how strongly the client-participant felt about potential support systems in her life (Appendix I). The MSPSS is a 12-item measure which uses a 7-point Likert scale, ranging from very strongly disagree to very strongly agree, to assess perceptions of social support adequacy. There are three different subscales (i.e., family, friends, significant other) which are each assessed with four items (Zimet et al., 1988). The higher the individual rates the subscale, the higher the perceived social support. The MSPSS has internal consistency ranging from .85 to .91, indicating good consistency for the scale as a whole and for each of the three subscales (Zimet et al., 1988). Additionally, test-retest reliability ranges from .72 to .85 indicating adequate stability over time (Zimet et al., 1988). The MSPSS has been shown to have sound psychometric properties across samples including adolescents living abroad, pediatric residents, pregnant women, psychiatric outpatients, adolescent psychiatric inpatients, urban youth, older adults, Turkish samples and adolescents in China (Canty-Mitchell & Zimet,

2000; Cecil, Stanley, Carrion, & Swann, 1995; Chou, 2000; Eker, Arkar & Yaldiz, 2001; Kazarian & McCable, 1991; Stanley, Beck & Zebb, 1998; Zimet, Powell, Farley, Werkman & Berkoff, 1990).

Additionally, the Treatment Summary (Appendix J) was considered to gain a broader understanding of the client-participant's context at the end of the therapeutic process. This measure is filled out by the therapist at the end of treatment with the client or prior to transferring the client to another therapist. The Treatment Summary was used to better understand the therapist-participant's view on the outcome of the client-participant's therapeutic process.

Procedures

Sampling procedure. This study used an archival database to obtain its participant. Each potential participant completed a written consent form to place his/her written and audio or videotaped materials in the research database. A purposive sampling procedure was used to determine which cases from the archival database fit the inclusion/exclusion criteria. Initially, a list of research record numbers was obtained. Then, English speaking adult clients over the age of 18 were purposively selected. From that list, only clients who had reportedly experienced an interpersonal trauma were selected. Next, only those clients with intake written materials and at least 2 sets of follow-up written materials were chosen. This process narrowed the list down to one possible participant who was subsequently included in this study.

Transcription. Five master's level psychology graduate students were hired to transcribe the videotaped therapy sessions of the client-participant and preliminarily note any apparent discussions of an interpersonal trauma. Each of the graduate students was trained with a training and coding manual developed by the researchers (Appendix K) in how to transcribe the therapy sessions verbatim and how to identify and note the length of time the trauma discussion lasted. This amount of time was then recorded with the transcription.

Coding. The coders were three doctoral level psychology graduate students, and their research supervisor who served as an auditor. Each of the students and the supervisor were

trained to understand the basic concepts, terminology, and issues relevant to the study (Yin, 2003) as well as the procedures to accurately code the occurrence, depth and timing of trauma discussions. Training procedures were used in which coders and the auditor practiced coding and reached 75% agreement on practice cases before coding the actual participant in the study. Once transcribed, each of the psychotherapy sessions containing a trauma discussion was coded for depth of the discussion of the interpersonal trauma using the LIWC analysis program. Each transcript was coded for use of cognitive words, insight words, and causal attributions. These words were then analyzed over the length and course of the psychotherapy sessions to determine if a change in the amount or language used in the processing of the interpersonal trauma had occurred.

Additionally, each of the psychotherapy sessions containing a discussion of interpersonal trauma were coded for themes both within and across the sessions. The three coders and auditor read through each transcript individually and looked for repetitions (i.e., topics that occurred and reoccurred) and transitions in content (i.e., naturally occurring shifts in content or pauses, changes in voice tone, presence of particular phrases that may indicate transitions e.g. so, anyway) that stood out in the client-participant's therapy process. It was important for each team member to individually review the transcripts before meeting as a team, in order to encourage diverse viewpoints and limit the biases of any one person (Hill, Thompson, & Nutt Williams, 1997). The three coders met to discuss each transcript containing a trauma discussion, line-by-line, noting recurring topics that were recorded individually by each team member. When the research team came to a line that contained an individually noted theme, each coder presented their ideas and discussed the potential theme until a consensus was reached that an overall theme indeed existed in that line of the transcript. If it was agreed that a theme category label was warranted, the coders discussed how each member had labeled the theme individually until a consensus was reached on the theme category label. For example, each coder often came up with different emotions expressed by the client. When an emotion was named as a theme, it was discussed to

see if it appeared across the course of the sessions or if it was only in that particular session. If the emotion appeared only in that particular session, it was not labeled as a theme, as the team wanted to see what emotions appeared consistently across the course of the therapy sessions for the client. However, if the emotion was apparent across the course of therapy sessions, it was labeled as a theme.

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

The fourth research team member (auditor) for the study independently reviewed the transcripts and themes key, and made suggestions based on her observations. The coders then met a final time to discuss the auditor's notes, and made changes based on consensus about theme categories that should be added, and sub-themes that would make more sense if included in different theme categories. After reviewing the team's revision of themes and subthemes, the auditor approved the final themes key. Finally, each coder individually went through each session containing a trauma discussion and found specific quotes that she felt exemplified each theme and sub-theme.

Human subjects/ethical considerations. The database materials and procedures that were used by this study were developed with Institutional Review Board (IRB) consultation. Additionally, prior to accessing the archival database and selecting the participant data, Institutional Review Board (IRB) approval for this particular research study was obtained. To be included in the archival database, the participating client and therapist consented to having their written and video recorded materials used for the purpose of research during the initial intake session (Appendix M; Appendix N). To maintain participant confidentiality, all names were

removed from written materials and audio/videotapes and replaced with research codes.

Furthermore, researchers in this study took precautions to only choose a participant whose therapist they did not previously know. Lastly, all researchers and transcribers completed Health Insurance Portability and Accountability Act (HIPAA) and IRB certification courses, signed confidentiality statements (Appendix O; Appendix P), and kept information confidential.

Data Analysis

In order to analyze the data, videotaped psychotherapy sessions were reviewed for potential trauma discussions, transcribed by trained master's level students, and then identified segments were entered into the LIWC computer program created by Pennebaker and Francis (Pennebaker et al., 2007). More specifically, prior to beginning the transcription process, all videotaped psychotherapy sessions were reviewed by the master's students and flagged if they appeared to contain a discussion of an interpersonal trauma. As part of transcription process, the transcribers were trained to note the start and stop time of the trauma discussion as they transcribe the psychotherapy sessions and flagged these portions of the transcript for the researchers.

Once the videotaped psychotherapy sessions had been transcribed, the entire transcript, as well as the sections in the transcript that were flagged with trauma discussions, were entered into the LIWC program to code for depth of the trauma discussion. The researcher looked at the percentage of insightful words and causal words to determine the depth of the disclosure. The timing of the disclosure (i.e., what session number; number of minutes into the session) and depth of the disclosure were then compared to the corresponding URICA measure for that cluster of sessions.

To further analyze the data, the researcher created an excel spread sheet to track the information (Appendix Q). The sheet contained the session ID number along the side, with the stage of change the client is in, timing of the disclosure (start and stop time), and depth of the disclosure, as evidenced by percentage of cognitive processes, insightful words, and causal words across the top of the sheet. Furthermore, another excel spread sheet was created to calculate the

averages of the client-participant's cognitive processing, insight and causation speech for each of the sessions containing trauma discussions (Appendix R).

Additionally, a separate themes tracking sheet (Appendix S) and themes occurrences sheet (Appendix T) were devised to track any themes that arose from the client and the number of occurrences of those themes. Themes were separated according to those that occurred during the discussion of an interpersonal trauma and those that occurred in the rest of the session. The themes were compared across the psychotherapy sessions for any patterns. Additionally, specific quotations made by the client-participant which best explained each theme and sub-theme were recorded on the sheet.

As this study took a single case study perspective, the researcher then analyzed the data and determined if it was consistent with, or an exception to, the current transtheoretical model and trauma discussion paradigms. This was done by exploring the non-verbal behaviors and recurrent themes brought up by the client during the trauma discussion process. The researcher was specifically mindful of any behaviors performed by the therapist which were believed to facilitate a discussion of interpersonal trauma. Additionally, the researcher noted any identifiable interventions used by the therapist to see if they corresponded with those recommended in the literature for the client's stage of change (i.e., corresponding URICA score). These behaviors and interventions performed by the therapist and client, along with other salient contextual data (e.g., symptom distress, working alliance, and treatment outcome) were qualitatively analyzed and reported (e.g., using participant quotations to illustrate themes and patterns).

Chapter III. Results

The purpose of this chapter is to present the results of the single case study. First, an overview of the course of therapy is presented. Next, the results obtained from the LIWC analysis are presented. Lastly, the researcher presents themes that were coded within each therapy session containing a trauma discussion and, more specifically, within each trauma discussion itself.

Course of Therapy

The course of therapy lasted 21 sessions, and 6 of the sessions contained discussions of an interpersonal trauma. During the phone intake, the client-participant initially reported she was “from the country” and needed some help adjusting to living in the city. She also noted she kept things in a lot and wanted someone with whom to talk. Upon the intake session with the therapist-participant, the client-participant reported her biggest problem was that she was unable to open up to her friends the way they open up to her because she had difficulty communicating her feelings. The client-participant also communicated to the therapist-participant a desire to explore her emotions because she feels she is “shut down” and wanted someone who could give her good advice about her boyfriend.

According to one of the intake measures (i.e., OQ-45.2), it appeared the client-participant was experiencing distress about social roles with regards to her work situation when she entered therapy. The therapist-participant made notes on the intake paperwork to pay specific attention to any anger management issues the client-participant may be experiencing. Additionally, the client-participant’s answers on another intake measure (i.e., MSPSS) showed she had a relatively weak support system, with her boyfriend being her strongest supporter, and her family being her weakest area of support. The therapist-participant observed that the client-participant feels like she is alone most of the time. On the URICA the client-participant indicated her level of confidence was a problem she wanted to change with therapy. Her responses showed she was in the action stage of change, indicating she was actively making changes and working on her problem.

Measures were again given at sessions 7 and 14. At the time of session seven, the client-participant appeared to no longer be distressed by social roles at work and the therapist-participant noted that the client did not feel her problems were out of control. On the URICA, the therapist-participant noted the client was working on lack of emotional expression and the client-participant reported she was working on communication. At this time, she had reverted back to

the contemplation stage of change. This indicated the client-participant was planning on making changes towards her new problem within the next six months. Despite the minor disagreement in the problem the client was working on, there was a strong working alliance between the client and therapist at this point in the therapy as evidenced by the results on the WAI-Client. At the time of session 14, the client-participant remained free from any significantly distressing symptoms as shown by her total score on the OQ-45.2, however, her score on the symptom distress scale increased slightly from the previous set of measures. On the URICA, she indicated she was working on “the voice inside of [her]” in therapy. Her measures showed she was again in the action stage of change. The strong working alliance between the client and therapist continued throughout this portion of the therapy as well.

During the course of therapy, two different interpersonal traumas were discussed and explored by the client-participant: the childhood sexual abuse she experienced at the hands of her uncle and the verbal abuse she suffered from her boss at her place of employment. The client-participant endorsed experiencing sexual abuse in the intake paperwork. These discussions appeared in at least 6 of the 21 therapy sessions, possibly more. However, since there were only video recordings of 16 of the 21 session, it is unclear how many of the sessions actually contained an interpersonal trauma discussion. The following sections provide an overview of the contents of each session containing a discussion of interpersonal trauma; these are sessions 1, 6, 7, 9, 12 and 18.

Session one. During the first session, there were 12 separate discussions of interpersonal trauma that occurred. These discussions included both the CSA the client-participant experienced as a child and the harassment she was experiencing at work. The therapist-participant started the session by bringing up the trauma discussed by the client-participant in the previous intake session. The therapist-participant expressed gratitude for the client-participant’s honesty and willingness to discuss her trauma; however, the client-participant quickly said thank you and changed the topic of discussion to a seemingly superficial discussion about a friend who was

visiting from out of town. After a while of continuing in this fashion, the therapist-participant tried to focus the therapy session back on the client-participant's original goals, learning to communicate her emotions better. The therapist-participant started out slowly by asking the client-participant to identify bodily sensations that occur when she is experiencing emotion. This led the therapy session in the direction of helping the client-participant identify if and when she experiences emotions. Most of the emotions identified by the client-participant were negative, including anger, sadness and frustration. She also made the distinction that only certain people have seen her experience these emotions.

As the therapy session progressed, the client-participant began to discuss other traumas she had experienced in her life. The second trauma discussion included an incident that occurred when she first moved to southern California. When speaking about this traumatic experience, which was never overtly stated, the only expression of emotion the client-participant attached to the incident was crying. Instead of staying with the emotional piece and what may have been causing the crying, the therapist-participant changed the topic of discussion to explore why the client-participant decided to enter therapy. In addition, throughout the therapy session, the therapist-participant appeared to demonstrate a pattern in which the client-participant would give a little bit of information about an interpersonal trauma that she experienced and the therapist-participant would let the topic quickly shift to something else. These topic changes were done by both the client and the therapist.

The last 10 discussions of interpersonal trauma that occurred during this first therapy session had to do with the client-participant's harassment at work. During each of these discussions she expressed anger. As the therapist-participant began to express feelings of job dissatisfaction and being trapped in her job, she expressed more anger towards the harassment she was experiencing. Each time these angry discussions occurred, the therapist-participant did not say too much. Instead, it appeared she waited for the client-participant to finish speaking before interjecting any questions. The client-participant often continued speaking for a several minutes

during each trauma discussion before pausing to let the therapist-participant respond. When she did ask questions, the therapist-participant often asked for clarification of content or gave problem-solving suggestions. For example, during the sixth trauma discussion in this session the client-participant was telling the therapist-participant about how much she hated her job and her boss. Instead of continuing to discuss the client-participant's feelings of anger and frustration toward her job, the therapist-participant asked how the client got the job. Each time the topic was moved from the client-participant's hatred toward her job, she eventually returned to that discussion whenever possible.

On a few occasions throughout the session the therapist-participant attempted to make interpretations about the client-participant's feelings and rationales for her behavior. For example, when discussing why the client-participant does not feel comfortable sharing her problems with her friends, the therapist-participant began explaining how the client-participant's experiences in her family of origin during childhood may have shaped her current views and behaviors in relationships. At times, these interpretations seemed well received by the client-participant as evidenced by her verbal agreement with the therapist-participant; however, at other times the interpretations were rejected by the client-participant. These misinterpretations often led the client-participant voice disagreement with therapist-participant and explain herself further to clarify her actual feelings. During each of these disagreements the tone of the session remained friendly and there did not appear to be significant rifts in the therapeutic relationship.

Toward the end of the first session, the topic of discussion moved away from the client-participant's WPH and focused on how and what she shares with her friends and boyfriend. It became apparent that the client-participant was mistrusting of others and often played games to determine a person's trustworthiness, as she stated this to the therapist-participant. At the very end of the session the therapist-participant returned to thanking the client-participant for entering therapy and being so open so quickly. The session lasted approximately 65 minutes and seemed

to end on a good note. The client-participant noted that she talked a lot, but this was validated by the therapist-participant as a positive part of therapy.

Session six. In the sixth therapy session two separate discussions of interpersonal trauma occurred. The first discussion focused on the client-participant's CSA and the other focused on her WPH.

To begin this session the therapist-participant asked the client-participant how she was doing. The response of the client-participant was one of nervous laughter, in which she stated she did not "have anything interesting to talk about." The therapist-participant encouraged the client-participant to elaborate, but she did not want to do so. Instead of allowing silence in the session until the client-participant had a topic to discuss, the therapist-participant asked the client-participant about an argument that was discussed in a previous session. The client-participant was initially unsure of what the therapist-participant was talking about, but after clarification she began openly discussing a situation with her boyfriend and how angry she was with his lack of responsibility and disrespect. This discussion lasted a few minutes before the therapist-participant asked to switch the focus of therapy to the client-participant and her ability to express and identify her emotions. The client-participant seemed hesitant to change the focus of therapy from her boyfriend's problems to her own, as she laughed and put her head in her hands at the therapist-participant's request. However, she did agree to shift the focus.

It was during this shift in focus, early in the session, that the first discussion of interpersonal trauma occurred. When prompted by the therapist-participant for any changes in her emotions over the week, the client-participant discussed her inability to identify any emotion other than anger, even though she suspected at times she was feeling sad. The client-participant indicated the CSA she experienced in the past is the one situation where she reminds herself not to turn her emotions straight to anger; she tries to remind herself that she is allowed to feel sadness about the experience. This discussion lasted for approximately one minute and throughout that time the therapist-participant listened without offering any interpretations, but sat

and nodded her head. After the discussion ended, the therapist-participant inquired about the client-participant's physiological reactions during the discussion.

After this brief discussion about her emotions, the client-participant quickly changed the topic of discussion to a less emotionally charged topic for her. She began talking about different opportunities in the entertainment industry she has been offered and her feelings about how her looks helped or hindered her. As the discussion continued it remained full of content, but not much exploration was done into the client-participant's feelings about the situation. At first, the therapist-participant listened intently to the client-participant and only asked questions for clarification. However, a few minutes into the conversation, the therapist-participant asked a question which made the client-participant evaluate her career choice. The therapist-participant questioned why the client-participant chose entertainment as her career choice if she felt uncomfortable being offered a job based off of her looks. The client-participant replied that she did not mind being offered work based on her looks, but she did not like being put in skimpy clothing and objectified to men. The client-participant continued to share her views on women in the entertainment industry and how they are sexualized. During this time, the therapist-participant attempted to clarify and reflect what the client-participant was expressing.

Such content focused conversation lasted for the rest of the session. From time to time the topic changed and focused on the client-participant's feelings of nervousness singing in front of others and what it was like for her growing up. She expressed feelings of anger towards her boyfriend for his lack of empathy and support in helping her overcome her stage fright. She also expressed anger towards her mother for her impoverished upbringing. The session lasted just over 60 minutes.

However, just as she was about to leave, the client-participant stopped the therapist-participant and wanted her to listen to a voicemail she had saved on her phone. This phone message started the second trauma discussion in the session and focused on the harassment the client-participant was experiencing at work. On the message was the client-participant's boss

being verbally abusive towards a co-worker of the client-participant. After the message ended, the session lasted approximately 10 more minutes. During this time, the client-participant discussed what she would have done if the message was left for her or done in her presence. She indicated she would not have put up with the language used and she was angry that her boss would speak to an employee the way he did. The therapist-participant listened to the client-participant's feelings and replied with a physiological explanation of the brain's chemistry as a possible reason for the client-participant's intense reaction to the trauma. The client-participant appeared satisfied with the explanation from the therapist-participant and the session ended with the client-participant continuing to discuss the experience as the two walked out of the room.

Session seven. During the seventh session there were five separate instances of interpersonal trauma discussion that occurred. Two of those discussions were about the client-participant's harassment at work and three of the discussions were about the CSA she experienced. In the beginning of the session, the therapist-participant informed the client-participant there were follow-up measures for her to complete if she felt comfortable. The client-participant agreed, but was told to wait until the end of the session. The therapist-participant then jumped into the session and asked the client-participant if she had anything she wanted to discuss that day. She noted if the client-participant had nothing of importance to discuss she had something for them to do. It seemed as if the therapist-participant barely waited for the client-participant's reply before she began explaining the game she had brought. The client-participant did not seem affected by the hastiness of the therapist-participant's game introduction and almost appeared relieved that she did not have to come up with something to discuss right away.

The next few minutes of the session were spent learning the rules of the game and what it was about. The therapist-participant explained that the game was a "feeling game" and looks at how people "work through things." The client-participant seemed excited to play the game and answered each of the questions she landed on even if she did not want to. The client-participant also appeared happy when the therapist-participant answered questions, which seemed to build

the rapport between the client-participant and therapist-participant. Throughout the game, the therapist-participant was careful not to share too much personal information and tried to keep her answers neutral.

It was during this game that the discussions of interpersonal trauma occurred. The first trauma discussion occurred about seven minutes into the session. This discussion was in response to a free question the client-participant landed on in which she could bring up anything she wanted with the therapist-participant. The client-participant very quickly stated she wanted to talk about her job. She discussed how she was challenged by her co-workers and how she sometimes would say things she shouldn't at work. After the client-participant stopped her explanation, the therapist-participant quickly moved on to the next part of the game. She did not stop to explore how the client-participant felt about her or others' actions at work, what she could do differently in those situations or any connections to workplace trauma.

The second discussion of interpersonal trauma occurred at approximately nine minutes into the session and lasted approximately 10 minutes. It was in response to another card the client-participant pulled that asked about something the client-participant would never forget. The client-participant explained the first thought that popped into her head was "the molestation." She discussed the idea that the traumatic experience may have affected her even though she did not realize it. The client-participant mentioned she felt like she was "detached" from the experience and could listen to others talk about their experiences without even realizing it had happened to her as well. During the first part of the discussion, the therapist-participant listened intently to the client-participant and let her talk. When there was a break in the conversation the therapist-participant asked the client-participant if she would be willing to talk about the experience and the client-participant agreed. The discussion continued and the client-participant explained how the molestation happened, where her family was at the time, and how she made it stop. After describing what happened, the client-participant began to discuss how the experience shaped her attitude as a person and her beliefs about others. She noted she learned not to respect

all adults and that she needed to protect herself and others around her. Throughout this discussion the therapist-participant made minimal comments, and when she did she used reflective listening to try and understand what the client-participant was saying. The therapist-participant also tried to explore the impact the sexual abuse had on the client's adult relationships and sexual encounters. The client-participant did not feel that there had been any impact in these areas as a result of the CSA; however, she did not shy away from the topic and tried to answer the therapist-participant's questions. Then, the therapist-participant attempted to give closure to the discussion by saying how "heavy" it was and then moving on in the game.

As the session and game continued, the therapist-participant asked with whom the client-participant shares information about her feelings and the events in her life. This question again led to content-focused discussions about friends, who she can talk to, and a time when she has felt sad. The conversation never explored the reason the client-participant can talk to only certain people or why a situation about being scammed by her modeling agency made her sad.

Soon after, the third discussion of trauma occurred in which the therapist-participant pulled a card that said to say something about child abuse. The therapist-participant stated that CSA was never the victim's fault. The client-participant laughed at this statement and quickly moved on in the game. The interaction lasted only a few seconds, however, a several minutes later the client-participant picked up a card which instructed her to make a comment. The client-participant stated she wanted to talk more about the therapist-participant's statement that CSA is never the victim's fault. The discussion lasted a few minutes and focused on the client-participant's question about a victim contributing to her abuse in some way. She used the example of the R. Kelly case and how some teenagers may have consensual sexual relations with older men, leading them to contribute to their abuse. During this discussion the therapist-participant did her best to explain that no one asks to be abused and even if younger individuals consent to certain situations they may not have the maturity to make those decisions and are still taken advantage of by an older person who should have the maturity to know it is wrong. It

seemed like the therapist-participant was surprised by the client-participant's questions about fault of the victim. The discussion ended when the client-participant realized that her questions came from a place of believing women could be deceitful and "gold diggers." To move away from the topic the therapist-participant asked the client-participant who came to mind when she thought of a gold digger. This led into a discussion about the client-participant's boyfriend and the mother of his child.

The game continued for the rest of the session and a few minutes before the session ended the final trauma discussion occurred. The discussion shifted focus back to the harassment the client-participant was experiencing at work. She had been discussing what her anger looks like and began to explain how she handles her anger while at work. The client-participant explained that she will often have "snappy, smart-aleck" comments to make when she first gets angry. The discussion continued on about the other "phases" of her anger. During this time, the therapist-participant did not explore any of the potential consequences or reasons for her behavior at work, but let her continue on about what happens when she gets angry. The session ended with the therapist-participant bringing out the measures for the client-participant to complete, which she had mentioned at the beginning of the session. The session ran late as the client-participant stayed in the room to complete the measures before leaving for the day.

Session nine. The ninth session contained two discussions of the trauma the client-participant experienced in her workplace. This session also began by playing the game the therapist-participant had initially brought to the seventh session. The client-participant seemed at ease and jumped right in to the game. It appeared she was able to bring up topics she wanted to discuss with the therapist-participant using this format. She started by discussing her relationship with her mother and how it has changed since she moved to California. The client-participant expressed anger towards her mother's lack of communication with her. After the short discussion, the therapist-participant kept the game moving along. Topics that were discussed varied from movies to favorite holidays to things the client-participant does when she is bored.

This discussion about being bored led into the first discussion of trauma, which lasted only a few seconds. A few minutes into the session the client-participant brought up her boss and how closely he sits next to her in their office. She described the close quarters that she works in and how boring her job is. The client-participant expressed dissatisfaction with her work environment. The therapist-participant allowed the client-participant to continue discussing her boredom at work and at home without any further exploration into reasons why and what the client-participant would want to change. However, the therapist-participant did not go back to the game right away; she allowed the client-participant to continue talking, which brought up more discussion about the client-participant looking for new jobs and trying to get a modeling agency to hire her. The client-participant used the time in the session to explore ideas about quitting her job, how to handle her money and finding a new job. When a silence occurred after the client-participant finished discussing her ideas, the therapist-participant returned the focus of the session to the game.

The next discussion concerned how the client-participant behaves when she feels angry. As in session seven, the client-participant began to talk about her varying levels of anger and how she behaves at each level. She gave an example to the therapist-participant, which marked the second discussion of interpersonal trauma at her workplace. At approximately 18 minutes into the session, the client-participant began to discuss how she handles herself when her boss makes her mad. She described how he would “get in your face and just keep on playing like a kid.” In turn, the client-participant noted she would ignore him until she could no longer take it. When she “could not take it anymore” the client-participant indicated she would do something “really rude.” Throughout this discussion, the therapist-participant listened to what the client-participant had to say and tried to explore the effectiveness of her responses to her boss’ behavior. The client-participant appeared receptive to the challenges and had a response to each of the therapist-participant’s questions. The discussion ended approximately 20 minutes into the session when

the client-participant appeared done talking and the therapist-participant turned the focus of the session back to the game.

The game continued for the rest of the session, with the client-participant and therapist-participant taking turns answering questions. The discussions that came up had to do with the client-participant's attitude towards life, which she felt was a "positive attitude, but a realistic one." The client-participant discussed how she felt she was positive and about what things in her life she was realistic. She noted how she and her boyfriend differed in this way and what things about him frustrated her. The therapist-participant used reflective listening throughout the rest of the session and tried to challenge the client-participant's beliefs about her relationship.

The game also led the therapist-participant and client-participant to discuss religion. During this discussion the client-participant talked about her childhood and attendance at Catholic school. She noted what things she learned from attending a religious school and how that has shaped her sense of responsibility in life. She also discussed her feelings of anger towards her mother for bringing up religion and praying because they were poor. The client-participant expressed that she felt like her mother should have done something more than just pray to help them survive.

The session came to a close with a discussion about the client-participant's boyfriend and the woman with whom he allegedly has a child. The client-participant was upset that her boyfriend was unable to stand up for himself to the other woman and she felt she was suffering the consequences for it. The session ran late and as the client-participant's phone began to ring. The therapist-participant noted that time was up and there was another client waiting for her outside. The client-participant apologized, but the therapist-participant reassured her that she had let it run long because she did not want the client-participant leaving the session upset. She noted that they would continue to "tackle that problem" during the next session and the client-participant stated she was "gonna cry." Again the client-participant apologized for running late and the session ended.

Throughout the session, the client-participant seemed more open to answering the questions in the game with less superficial responses than in the previous session. The therapist-participant tried to explore issues with the client-participant, but stopped when the client-participant did not want to go any further. She did not push the client-participant too far until the end of the session when the therapist-participant noted that the topic of the boyfriend's relationship with the supposed mother of his child was a recurring theme the client-participant would bring up, and that it appeared bothersome to her. This seemed to really affect the client-participant, but then the session was ended even though it again ran long.

Session twelve. During the twelfth session two discussions of interpersonal trauma occurred. The first one revolved around the client-participant's WPH and the second one revolved around the CSA she experienced. At the beginning of the session the client-participant returned the follow-up clinic measures she had taken home after the seventh therapy session. The first few minutes of the session were spent on questions the client-participant had about the measures. The client-participant was unsure of what she had written down on the previous URICA as the problem she wanted to focus on changing. The therapist-participant responded by saying "it [didn't] matter" what she wrote down and to put what she was feeling right now. The client-participant remained somewhat confused by the answer but agreed to finish the measures at the end of the session.

Instead of processing the assessment measures, the therapist-participant asked the client-participant what had been going on with her since the last session. This time, the client-participant had something to discuss immediately. She noted she had tried something the therapist-participant had suggested in a previous session. When the therapist-participant asked for clarification as to what suggestion the client-participant was talking about, the client-participant had difficulty explaining what she did. Eventually she was able to piece together that she had spoken up to her boyfriend about how she was feeling and the fact that they need to communicate better. The therapist-participant listened and questioned her about the response she

got from her boyfriend and how she felt about the whole situation. Then, the client-participant mentioned she had guessed the mother of the boyfriend's child's e-mail password and read her e-mails. A small rift in the therapeutic relationship occurred at this time as the therapist-participant reminded the client-participant that her actions were illegal. The client-participant responded by saying she did not care. The therapist-participant attempted to repair the rupture in the relationship by explaining that she would not report the client-participant because of confidentiality. This discussion did not appear to bother the client-participant and she just continued with her story.

The session continued with discussions about the client-participant's boyfriend and how she felt about the relationship. She discussed her ambivalence towards breaking up with him, and her concern for how she wanted to be treated in a relationship.

The discussion of how she broke in to the other woman's e-mail led to the first trauma discussion about her work. It occurred approximately 12 minutes 30 seconds into the session and lasted only a few seconds. The client-participant again described the close working quarters she is in and how her boss, "the evil man who's never there" sits next to her. The therapist-participant allowed the client-participant to continue with her discussion about how she was ashamed for breaking in to the e-mail while at work, because her co-workers are so close to her. The client-participant's feelings or reasoning for calling her boss an evil man were never discussed.

The majority of the session continues with discussions about the mother of the boyfriend's child and how the client-participant feels about the whole situation. She shares the information she learned from the e-mails with the therapist-participant who continues to listen and ask for clarification from time to time. The conversation remains on a relatively superficial level throughout most of the rest of the session. The client mostly expresses feelings of anger towards the mother of her boyfriend's child and feelings of disrespect and frustration with her boyfriend's lack of dealing with the issues. Towards the middle of the session, the therapist-

participant began to help the client-participant identify what issues she wanted to talk about with her boyfriend and how she might approach those issues. The client-participant was receptive to alternate ways of talking with her boyfriend and practicing those skills in therapy. After she was done discussing her anger with her boyfriend and the mother of the boyfriend's child, the client-participant began talking about "the voice inside" of her that makes it difficult for her to sing in public and move forward with her career. The client-participant continued to talk about her feelings of insecurity and how she always has an excuse for not promoting her career. During this discussion, the therapist-participant asked the client-participant for more details about "the voice" (i.e., how often she hears it, how it has helped or hindered her). Specifically, the therapist-participant asked "who does it sound like, if you could identify a person that sounds most like this voice." This led the client-participant back into a discussion about her frustrations with her boyfriend and her anger towards her mother.

Approximately 47 minutes into the session, the second discussion of trauma occurred. At this point in the session, the discussion had returned to "the voice" the client-participant experienced as negative and judgmental. The therapist-participant offered an interpretation of the function of "the voice" in the client-participant's life. She noted it could be the client-participant's way of protecting herself, like she protected herself as a child from her uncle, by having a "parent voice" telling her what to do. The client-participant agreed with therapist-participant's interpretation and seemed angry by the idea that she had to protect herself because no one was there to protect her. This part of the discussion lasted only a few seconds before it returned to how "the voice" was affecting her in her current life situation.

The session ended at approximately 60 minutes. Towards the end, the therapist-participant and client-participant were brainstorming different ways the client-participant could overcome her fear of singing in public. The therapist-participant provided psychoeducation about phobias and panic attacks and how people deal with them. The session ended with the client-participant and therapist-participant agreeing to find ways to control or manage "the voice" and

its impact on the client-participant. Overall, the client-participant appeared excited at the potential to work on fixing the problem that is hindering her singing career.

Session eighteen. The 18th session was the last recorded session to contain discussions of interpersonal trauma. During this session there were two separate discussions of harassment the client-participant was experiencing at her job.

The session began with the client-participant expressing her attempts at following through with one of the interventions the therapist-participant explained to her during a previous session. The discussion continued to surround the topic of the client-participant's self-critical "voice" that makes it difficult for her to follow through with her singing career. The therapist-continued to explore with the client-participant the difficulty she had with the intervention and how she could best modify it or break it down into smaller steps. During this part of the session, the therapist-participant was attentive to the client-participant and kept the session going by systematically questioning the client-participant about her fears of being heard singing and why they might be hindering her. The therapist-participant attempted to help the client-participant see how unreasonable some of her fears are by having her take the perspective of an outsider and say how she would react from the other point of view. This technique seemed to help the client-participant see how some of her fears were irrational; however, she continued to give more reasons for her behavior.

The session continued with discussions about stress levels and feeling in control. The therapist-participant used different scenarios to try and allow the client-participant to see situations from a new perspective. At first the scenarios seemed to be helpful to the client-participant; however, at one point the client-participant started to become confused by what the therapist-participant was describing. Eventually, the therapist-participant was able to clarify her analogy, which appeared helpful for the client-participant, and made an interpretation that seemed to resonate with the client-participant. She began to explore a view of herself that she had not known before, that she is "hard on herself."

Approximately half way through the session, the topic changed to the client-participant's frustration with her boyfriend and her job. This topic is where the first trauma discussion occurred. The client-participant was talking about needing a computer and how she had to delay leaving her job in order to save enough money to buy one. She was frustrated as she counted the number of months it would mean she would have to stay in a place that she "can't stand." At this time the therapist-participant just listened intently to the client-participant. The discussion lasted for only a few seconds before the client-participant switched back to talking about her boyfriend and the problems she was having with his behaviors. The conversation then moved on to money problems and how the client-participant had to be financially responsible for her boyfriend too, which led to the second discussion about her job. The client-participant expressed how much she hates her job and the people she works with, especially her boss. She also expressed how she felt about her day-to-day routine and that she felt her job was making her seem old. The discussion lasted just over one minute, and the therapist-participant did not interrupt the client-participant. Instead, when the client-participant quickly switched the topic back to her anger towards her boyfriend, the therapist-participant continued to take the rest of the session in that direction. There were no follow-up questions to the client-participant's discussion of her workplace trauma.

Most of the rest of the session consisted of talks about the client-participant's various issues with her boyfriend. She noted his jealousy towards her meeting new people when he is so far away and her furthering her career. The therapist-participant pointed out to the client-participant that she was beginning to look out for herself and what she wanted for her future. This observation seemed to resonate with the client-participant because she began to discuss different ways she was going to start looking out for herself. The therapist-participant continued to offer different suggestions and interventions for how the client-participant could attempt to help her boyfriend be more realistic in their relationship. Although the client-participant was eager to hear and accepting of the therapist-participant's suggestions, she began to express more anger towards her boyfriend for putting unrealistic expectations on her.

The session ended after approximately 60 minutes with the therapist-participant giving the client-participant some homework. The client-participant was willing to try the homework, which consisted of her sharing her feelings with her boyfriend, and thanked the therapist-participant for some of her insights during the session, specifically that the client-participant was being hard on herself. The final seconds were spent on housekeeping items, such as setting up the next session because of a holiday. Overall, the client-participant seemed very satisfied with how the session had gone and what she had learned and explored with the therapist-participant. Also, during this session it appeared the therapist-participant took a more active role in the overall discussion with the client. Little focus was placed on the traumas discussed by the client or their impact on other areas of her life; instead the session seemed to focus on her difficulty with her boyfriend.

LIWC Analysis

The Linguistic Inquiry and Word Count computer program, created by Pennebaker and Francis (Pennebaker et al., 2007) was used to determine the depth of the discussion of interpersonal traumas in each of the six therapy sessions described above. Each discussion of CSA and WPH by therapist and client was entered into the LIWC and the percentage of cognitive processing words, insight words and causation words were recorded on the data tracking sheet (see Appendix Q). Additionally, the average percentage of cognitive processing, insight and causation words spoken by the client-participant was calculated for each session and recorded (see Appendix R). The average cognitive processing, insight and causation words spoken by the therapist was not recorded as this study is focused on the amount and depth of processing undergone by the client-participant specifically.

Childhood sexual abuse. Throughout the course of therapy there were seven separate discussions of the client-participant's childhood sexual trauma and her feelings about the trauma. Two discussions occurred in the first session, one in the sixth session, three in the seventh session and one in the twelfth session. Over the course of the trauma discussions in these sessions, the

client-participant's speech contained an average of 10.09% cognitive processing words, 2.46% insight words and 1.61% causation words. The results of each individual session are discussed below.

Discussions of the client-participant's sexual trauma occurred at approximately 3 minutes and 18 minutes into session one. During the first discussion in that session 4.55% of the words spoken by the client-participant were cognitive processing words as defined by the LIWC dictionary. Of that percentage zero words fell into the insight or causation subcategories of the LIWC. In contrast, 22.03% of words spoken by the therapist-participant were cognitive processing words. Specifically, 5.08% of the words were insight words and zero words were causation words. The client-participant's speech during the second discussion of CSA contained 13.01% cognitive processing words, 2.44% insight words and 4.07% causation words. The therapist-participant's speech during the second discussion decreased to zero cognitive processing, insight or causation words. Examples of cognitive processing words included cause and know, insight words were think and know, and causation words included because and effect.

The only discussion of sexual trauma in the sixth session occurred approximately five minutes into the session and lasted just over one minute. During this discussion, 17.41% of the client-participant's speech was cognitive processing words, 5.46% was insight words and 3.41% was causation words. The therapist-participant's speech during this discussion contained zero cognitive processing, insight or causation words.

There were three separate discussions of CSA during the seventh session. The first occurred approximately 9 minutes into the session, the second at approximately 23 minutes into the session and the third occurred approximately 32 minutes into the session. During the first discussion of sexual trauma, which lasted approximately 10 minutes, the client-participant's speech contained 17.35% cognitive processing words, 3.00% insight words and 1.77% causation words. The therapist-participant's speech during the first sexual trauma discussion in the session contained 11.55% cognitive processing words, 3.22% insight words and 2.27% causation words.

During the second discussion of sexual trauma in the session, lasting approximately 30 seconds, the client-participant's speech contained zero cognitive processing, insight or causation words. The therapist-participant's speech contained 18.60% cognitive processing words during this discussion and zero insight or causation words. The third discussion of sexual trauma during this session lasted approximately six minutes. The client-participant's speech contained 18.28% cognitive processing words. More specifically, 6.30% were insight words and 2.00% were causation words. The therapist-participant's speech contained 21.03% cognitive processing words, 5.46% insight words and 1.32% causation words during the third discussion.

The 12th session was the final recorded session to contain a discussion of the client-participant's sexual trauma. This discussion occurred approximately 47 minutes into the session and lasted about 30 seconds. The client-participant's speech contained zero cognitive processing, insight or causation words during this discussion. However, the therapist-participant's speech contained 18.87% cognitive processing words, 0.94% insight words and 0.94% causation words.

The average percentage of cognitive processing words, insight words and causation words of the client-participant's speech was calculated for each session containing a discussion of sexual trauma. In session one the average percentage of cognitive processing words spoken by the client-participant was 8.78. Her speech during the discussions contained 1.22% insight words and 2.04% causation words. In the sixth session the client-participant's speech contained an average of 17.41% cognitive processing words, 5.46% insight words and 3.41% causation words. The client-participant's speech in the seventh session contained an average of 11.88% cognitive processing words, 3.10% insight words and 11.26% causation words. Her speech in the 12th session contained an average of zero cognitive processing, insight or causation words.

Workplace psychological harassment. Throughout the course of therapy there were 18 individual discussions of the WPH the client-participant was experiencing at her job. These discussions also included the client-participant's feelings about her boss, her co-workers and the verbal abuse she was experiencing. Of these discussions, 10 occurred in the first session, one in

the sixth session, two in the seventh session, two in the ninth session, one in the 12th session and two in the 18th session. Across the sessions, the client-participant's speech contained 17.29% cognitive processing words, 1.75% insight words and 2.92% causation words. The results of each individual discussion of WPH are discussed below.

In the first session, the first discussion of the client-participant's workplace trauma occurred approximately 21 minutes into the session and lasted about 15 seconds. During this time, the client-participant's speech contained 8.89% cognitive processing words, zero insight words, and 2.22% causation words. The therapist-participant's speech contained 6.67% cognitive processing words, zero insight words and 4.35% causation words. The second discussion of WPH occurred approximately 22 minutes into the session and lasted 2 ½ minutes. The client-participant's speech contained 17.32% cognitive processing words, 3.75% insight words and 2.32% causation words. The therapist-participant's speech contained 11.94% cognitive processing words and zero insight or causation words. Approximately 25 minutes 30 seconds into the session, the third discussion of WPH occurred and lasted only about 30 seconds. During this discussion, the client-participant used 23.13% cognitive processing words, zero insight words and 2.99% causation words. The therapist-participant's speech contained zero cognitive processing, insight or causation words. The fourth WPH discussion was equally as short as the third, beginning approximately 26 minutes into the session and lasting about 30 seconds. The client-participant's speech contained 11.32% cognitive processing words, 0.94% insight words and 1.89% causation words. Again, during this discussion the therapist-participant's speech contained zero cognitive processing, insight or causation words. The fifth discussion of trauma experienced by the client-participant at work occurred approximately 27 minutes 30 seconds into the session and lasted about 2 minutes. During this discussion the client-participant's speech contained 19.03% cognitive processing words, 2.27% insight words and 3.69% causation words. The therapist-participant's speech contained 10% cognitive processing words, 2% insight words and zero causation words. During the sixth discussion of her WPH, which occurred

approximately 29 minutes 40 seconds into the session, the client-participant's speech contained 13.13% cognitive processing words, 1.01% insight words, and 4.04% causation words. The therapist-participant's speech contained 11.11% cognitive processing words and zero insight or causation words. The seventh discussion of workplace trauma contained only speech by the client-participant; there was no response from the therapist-participant. The discussion began about 32 minutes into the session and lasted approximately three seconds. During this short discussion, the client-participant's speech contained 20.91% cognitive processing words, 2.79% insight words and 3.83% causation words. Approximately 35 minutes into the first session the eighth discussion of workplace trauma occurred; it lasted just over one minute. During this particular discussion, the client-participant's speech contained 18.75% cognitive processing words, 1.79% insight words and 3.57% causation words. The therapist-participant's speech contained 24% cognitive processing words, 8% insight words and 12% causation words; an increase from the previous discussion.

After a shift in the topic of conversation for a short while, the ninth discussion of WPH between the client-participant and therapist-participant occurred. This occurrence was almost 45 minutes into the session and lasted approximately 3 minutes 20 seconds. The client-participant's speech during this discussion contained 17.93% cognitive processing words, 1.54% insight words and 1.82% causation words. The therapist-participant's speech contained 18.33% cognitive processing, 1.67% insight words and 0.83% causation words. The 10th and final discussion of WPH occurred about 49 minutes into the session and lasted approximately 20 seconds. This discussion contained speech from the client-participant only. Her speech contained 21.69% cognitive processing words, 2.41% insight words and 3.61% causation words.

The sixth session contained one discussion of the client-participant's experiences of workplace trauma. This discussion occurred approximately 60 minutes into the session and lasted about 8 minutes, 30 seconds. During this discussion, the client-participant's speech contained 16.81% cognitive processing words, 2.37 insight words and 2.53% causation words. The

therapist-participant's speech during this discussion contained 14.95% cognitive processing words, 2.14% insight words and 3.56% causation words.

During the seventh therapy session there were two separate discussions of workplace trauma. The first occurred approximately 7 minutes into the session and lasted about 30 seconds. The client-participant's speech contained 20.17% cognitive processing words, zero insight words and 2.52% causation words. The therapist-participant used zero cognitive processing, insight or causation words. The second discussion of WPH in this session occurred approximately 52 minutes into the session and lasted about 30 seconds. The client-participant's speech contained 14.29% cognitive processing words, 1.79% insight words and 3.57% causation words. The therapist-participant's speech again contained zero cognitive processing, insight or causation words.

In the ninth session there were two instances of trauma discussions about the client-participant's workplace psychological harassment. The first discussion took place approximately 9 minutes 30 seconds into the session and lasted about 15 seconds. During this discussion only the client-participant spoke. Her speech contained 26.15% cognitive processing words, zero insight words and 1.54% causation words. During the second discussion, which occurred about 18 minutes 30 seconds into the session and lasted approximately 1 minute 30 seconds, the client-participant's speech contained 20.78% cognitive processing words, 2.71% insight words and 3.92% causation words. The therapist-participant spoke during this discussion and her speech contained 8.06% cognitive processing words and zero insight or causation words.

In the 12th therapy session, only the client spoke during one discussion of WPH. It started approximately 12 minutes 30 seconds into the session and lasted about 3 seconds. During this discussion the client-participant's speech contained 13.64% cognitive processing words, zero insight words and 4.55% causation words.

The 18th session contained two separate discussions of WPH. The first discussion took place approximately 28 minutes into the session and lasted about 15 seconds. During this

discussion, the client-participant's speech contained 12.66% cognitive processing words, 3.80% insight words and 2.53% causation words. The therapist-participant's speech contained zero cognitive processing, insight or causation words. In the second discussion, which occurred about 32 minutes 30 seconds into the session and lasted approximately 30 seconds, the client-participant's speech contained 14.63% cognitive processing words, 4.39% insight words and 1.46% causation words. Again, the therapist-participant's speech contained zero cognitive processing, insight or causation words.

The average percentage of cognitive processing, insight and causation words in the client-participant's speech was calculated for each recorded session that contained a discussion of WPH. In the first session, which contained the most discussions of workplace psychological harassment, the average cognitive processing words spoken by the client-participant were 17.21%. Specifically, an average of 1.65% insight words was spoken and an average of 3% causation words was spoken. During the sixth session, the client-participant's speech contained an average of 16.81% cognitive processing words, 2.37% insight words and 2.53% causation words. The client-participant's speech during session seven contained an average of 17.23% cognitive processing words, 0.9% insight words and 3.05% causation words. In session nine, the client-participant's speech contained an average of 23.47% cognitive processing words, 1.36% insight words and 2.73% causation words. The depth of processing of the WPH decreased in session 12 with the client-participant's speech containing an average of 13.64% cognitive processing words, zero insight words, and 4.55% causation words. In the final recorded session containing a discussion of workplace trauma, session 18, the client-participant's speech contained an average of 13.65% cognitive processing words, 4.10% insight words and 2% causation words.

Themes Analysis

Over the course of therapy, 6 themes and 28 subthemes emerged from the data, which seemed to capture the experiences of the client-participant. Each theme and subtheme was defined and specific quotations representing the subthemes were recorded for each session

containing a trauma discussion on a theme tracking sheet (see Appendix L; see Appendix S). Furthermore, the number of occurrences of each theme and subtheme within each session containing a trauma discussion was calculated and recorded (see Appendix T). Below are descriptions of each theme category, including subthemes, and client-participant's quotes, that appeared across the course of therapy and within the context of each trauma discussion.

Self-protection. Throughout the course of therapy, it appeared the client-participant had a vested interest in maintaining physical and psychological safety, as she tried to avoid experiencing negative events in her life. The theme of self-protection appeared 131 times across the sessions containing a trauma discussion with 25 occurrences in sessions one and six, 31 occurrences in session seven, 10 occurrences in session nine, 19 occurrences in session twelve and 22 occurrences in session eighteen. The subthemes of self-protection represented the client-participant's numerous ways of protecting herself, including avoidance of trauma discussion, avoidance of emotions, mistrust of others, distancing from others, respect for others, financial security, and a sense of responsibility. Each of these subthemes occurred at different points throughout the therapeutic process, and each subtheme was not present in every session containing a discussion of trauma.

The first subtheme, avoidance of emotion, was developed as the client-participant showed reluctance to discuss feelings other than anger and sadness during therapy and to other in her life (i.e., friends and family). Also, this subtheme captured the use of humor to mask deeper feelings experienced by the client-participant. Avoidance of emotion occurred 11 times during the sessions containing a trauma discussion and 11 times during specific discussions of sexual trauma. Although avoidance of emotion was noted in sessions containing discussions of CSA, it did not appear during any specific discussion of WPH. For example, during the second discussion of the client-participant's CSA in the first session, the client-participant stated, "Ok, so then I cried and it's like it's ok. As long as I don't do it every day. I'd get sick of it." Another instance of this subtheme occurred during the discussion of the client-participant's CSA during the first

discussion of CSA in session seven. The client-participant noted, “You know, so all that hugging and stuff I don’t understand.”

Another subtheme, avoidance of trauma discussion was noted during two sessions over the course of therapy. This subtheme related to the client-participant’s reluctance to discuss the sexual trauma she experienced as a child and the related emotions during psychotherapy; it did not appear during the client-participant’s specific discussions of her WPH. Avoidance of trauma discussion occurred three times in sessions containing trauma discussions and six times during discussions of CSA. Specifically this subtheme appeared five times during session one and four times during session seven. During the first discussion of CSA in session one the client-participant stated, “About what?” when the therapist-participant brought up the incident with the client-participant’s uncle that had been discussed in the previous session. Additionally, during the first discussion of the client-participant’s CSA in session seven the client-participant noted, “...it’s like I’ve been so detached from it, like I could listen to other people talk about them being molested and I don’t even think that I have anything to do with that.”

Mistrust of others was the third self-protection subtheme. This subtheme included the client-participant’s reluctance to confide in others with her feelings and secrets, and her disbelief that others would want to help her without wanting something in return. Mistrust of others came up 25 times during sessions 1 (six times), 7 (seven times), 12 (nine times) and 18 (one time). For example, during session one, the client-participant stated, “...I may as well just tell the wall, because I’m going to get the same response” when talking about opening up to her friends. During session 12, she stated, “No, no. I don’t even give nobody a chance to say nothin’.” The only examples of the client-participant’s mistrust of others that happened during a discussion of trauma occurred during the first discussion of CSA in session seven. The client-participant stated, “...it took a long time for me for me accept help or to accept something.” The subtheme mistrust of others did not appear during any of the discussions of WPH.

The sense of responsibility subtheme included the client-participant's strong feelings of obligation to care for herself and others in her life (i.e., boyfriend, family). It occurred 23 times: three times during the 1st session, one time in the 6th, one time in the 9th, nine times in the 12th and one time in the 18th session. For example, during the first session the client-participant stated, "How do I fix it if I'm still having to be responsible?" During the 12th session she noted, "It's always somethin' bad, even when it's my part, usually I can blame him and I can say well because he did that and he got caught, so we talked about it, but this time it was me." Specifically, this subtheme included the client-participant's strong feelings of responsibility to take care of her boyfriend, "I feel like because, ok this is wrong, but I feel like he's a responsibility of mine right now. I feel like I have a kid." The subtheme sense of responsibility did not appear during any specific discussion of WPH or CSA between the client-participant and therapist-participant.

Financial security was the fifth subtheme that developed under the theme of self-protection. The client-participant expressed strong feelings and actions related to money, specifically the importance of having money to prevent her from have to rely on others for support. The subtheme also included the client-participant's feelings about the ability of her boyfriend to gain financial security and her lack of monetary support in childhood. Financial security appeared a total of 36 times in sessions 6 (14 times), 7 (8 times), 9 (6 times), 12 (5 times) and 18 (3 times). For example, during session seven, the client-participant reported, "I don't like taking off work...I'm kind of in debt and, I mean, I don't like that." She also stated during session 18, "You not, you have not made it yet, you cannot take care of me, therefore I can take care of myself. What else do you want me to do?" None of the examples of the subtheme of financial security occurred during either type of trauma discussion, childhood sexual abuse or workplace psychological harassment.

The sixth subtheme that occurred within the overall theme of self-protection was distancing from others. This subtheme included the client-participant's avoidance of forming and

maintaining close relationships with others in her life to prevent herself from being emotionally hurt. It differed from the mistrust of others subtheme in that the client-participant already had a relationship with some people (e.g., her boyfriend, her cousin) and would choose to create space in the relationship to avoid being let down. Distancing from others occurred 10 times throughout the course of therapy with one occurrence in session seven during the first CSA trauma discussion and nine occurrences during session 18; it did not occur during any discussions of WPH. The client-participant stated, “It makes me hard, it makes me a little bit rougher with me because, well I’m getting better now.” She also noted, “I’m sure they don’t care but, you know, how like just rather stay under the radar just because I don’t even want you to know me,” during session 18.

The final subtheme in the self-protection category was respect for others. The client-participant made it clear throughout the course of therapy that she had strong feelings of consideration and courtesy for others especially people who treated her with respect. She stated in session one, “It’s just not respectful,” when her boss threw a piece of paper on the ground and expected an elderly employee to bend down and pick it up. The subtheme also included the client-participant’s beliefs about how people should treat each other in the workplace and in life in general. The subtheme of respect for others appeared seven times throughout the course of therapy including during discussions of the client-participant’s childhood sexual abuse and workplace psychological harassment. It occurred in session one (one time), specifically during the third (two times) and ninth (one time) discussions of her workplace trauma, session seven during the first discussion of her CSA (two times), and session nine (one time). The client-participant reported, “...where I grew up, dudes don’t really deserve respect,” during session seven. She also noted during session nine, “He don’t see how that’s disrespectful—that’s disrespectful to you. You don’t do that.”

Power and control. In each session containing a discussion of trauma, the theme of power and control appeared. This theme included the ways the client-participant felt competent

and gained command over her environment and her life experiences. This theme occurred 133 times over the course of therapy; 12 times in session 1, 27 times in session 6, 35 times in session 7, 16 times in session 9, 13 times in session 12, and 30 times in session 18. There were a variety of subthemes that best captured the client-participant's varying feelings and ways of gaining power and control including assertiveness, aggression, the desire/attempt to control self, the desire/attempt to control environment/others, and independence.

The first subtheme that appeared in power and control was assertiveness. Assertiveness included the use or desired use of determination and decidedness during important life events. Assertiveness appeared a total of nine times in all aspects of the course of therapy, including during discussions of the client-participant's CSA and workplace trauma. It occurred during the second, seventh and ninth discussions of workplace trauma in the 1st session (one time each), during the 7th session (five times), and specifically during the first discussion of CSA in the 7th session (three times), and the 12th session (three times). For example, the client-participant noted during the first session, "I just started talking back. I don't care, like you're not going to talk to me like that," with regards to how her boss speaks to her. She also stated, "I'm like say something. Like no, I'm not doing this," during the seventh session. The subtheme of assertiveness also applied in the context of the client-participant's relationship with her boyfriend as she reported in the 12th session, "If I don't have facts, I need to find out. If you don't want to tell me, I'm not gonna harass you, but when you leave I'm gonna find the f*** out."

Aggression was the second subtheme that appeared under the theme of power and control. It included the client-participant's hostile feelings and attitudes expressed during psychotherapy. The subtheme of aggression was apparent 15 times in both the discussions of WPH and CSA. Specifically, it occurred during fifth discussion of work trauma in session one (one time), the discussion of WPH in sixth session (one time), session seven (five times) including the first discussion of CSA (three times) and the last discussion of WPH (two times), and session nine (one time) including the last discussion of work trauma (two times). The client

stated during session six, "I'm glad he didn't say that in my face because I woulda had to talk to him, be like don't be talking about burning in hell, f*** you." During session seven she noted, "...usually I just get up and walk off, you know, I haven't really hit in a long ass time, so I don't do that anymore," when discussing how she handles feelings of anger, frustration and annoyance.

The third subtheme that appeared in power and control was the desire/attempt to control self. This subtheme encompassed the client-participant's wishes and trials to gain and maintain mastery over her reactions to her environment and life experiences. It occurred a total of 14 times in the 1st session (one time), 6th session (one time), 7th session (six times), 9th session (two times) and 18th session (four times). None of the instances of the client-participant's desire/attempt to control herself occurred during any specific discussion of CSA or WPH. In the first session the client-participant stated, "This is what he did, this is what I did. I can control me, I can't control him. So what part did I play?" Additionally, the client-participant noted, "I have to keep constantly telling myself calm down, calm down, just wait, just wait," during the seventh session.

The fourth subtheme of desire/attempt to control environment/others also came up frequently for the client-participant. This subtheme included her wishes and trials at gaining command of the reactions of others and the responses of the environment to her life experiences. Overall, desire/attempt to control environment/others occurred 50 times in sessions containing trauma discussions and 4 times during discussions of CSA. Specifically, the subtheme appeared 3 times in session 1, 11 times in session 6, six times in session 7, four times specifically during the first discussion of CSA, 11 times in session 9, 8 times in session 12, and 11 times in session 18. For example, during the first discussion of CSA in session seven the client-participant stated, "But of course you don't tell your momma something like that because you need your parents to be here. Her boyfriend would have beat his ass and they would be in jail and who's gonna watch me now?" Also, during the 18th session the client-participant stated, "I knew I didn't want a roommate that was anything like me, 'cause I didn't want to be friends." It was apparent

throughout the sessions that the client-participant wanted to be in control of all aspects of her environment.

The final subtheme in the power and control category was independence. Throughout the sessions the client-participant desired ability to reach and maintain autonomy from others. The theme of independence appeared 41 times throughout the course of therapy including four times during discussions of CSA; however, it did not appear during discussions of her WPH. This subtheme occurred 4 times in session 1, 14 times in session 6, 2 times in session 7, 4 times specifically during discussion of CSA, 2 times in session 12, and 15 times in session 18. During the first session she noted, “Well I had to think, ok I have these skills, how can I make money? I just try to use my brain. How can I get what I need? Because if I don’t, nobody is.” The client-participant discussed her independence from her family during the 12th session when she stated, “So it’s like I gotta take care of myself. And that’s the attitude I have with my mom...” Additionally, during the 9th session the subtheme of independence appeared with regards to client-participant’s desire to maintain her independence as she reported, “I mean, I just feel like I’ll do anything that I can—that I’m able to do.”

Sense of self. Sense of self was the third theme that appeared throughout the therapy sessions containing discussions of trauma. This theme was developed to capture the client-participant’s feelings about self-efficacy and her place in the world. It was apparent that the client-participant had varying levels of her self-efficacy which were captured in a variety of subthemes including fear of judgment, insecurity, being self-critical and respect for self/pride. The overall theme of sense of self occurred 73 times across each session containing a trauma discussion with 3 occurrences in session 1, 10 occurrences in session 6, 1 occurrence in session 7, 4 occurrences in session 9, 30 occurrences in session 12 and 25 occurrences in session 18. However, each individual subtheme did not occur in every session.

The first subtheme, fear of judgment, was created to encompass the client-participant’s distress at being thought of negatively by others, including strangers and her therapist. This

subtheme seemed quite prominent and appeared 22 times. Specifically, it occurred during the first discussion of WPH (1 time) in session 1 (1 time), as well as during session 6 (2 times), session 7 (1 time), session 9 (1 time), session 12 (4 times) and session 18 (12 times). Fear of judgment did not occur during any discussions of CSA. For example, during a discussion of WPH in session one the client-participant stated, “I don’t want to start, you’re going to get mad at me,” when the therapist-participant asked her what she wanted to talk about during the session. During session six the client-participant also reported, “I cannot do that, totally not on camera, looking like an idiot.” Throughout the rest of the sessions the client-participant continued to be fearful of being judged negatively by others as she stated, “I was like somebody may hear me,” when explaining why she does not practice her singing during session 18.

The second subtheme that appeared in sense of self was insecurity. This subtheme encompassed the client-participant’s feelings of doubt and hesitancy in her abilities, knowledge and life decisions. The subtheme of insecurity appeared 40 times, but it did not appear in each session, it only occurred during session 6 (5 times), session 9 (3 times), session 12 (25 times) and session 18 (7 times). Additionally, the subtheme of insecurity did not appear during any discussion of childhood sexual abuse or workplace psychological harassment. An example of the client-participant’s feelings of insecurity occurred during session 18 in which she stated, “Like, it just makes me have a lack of confidence. Like stuff that I know I can do...” Another instance of insecurity apparent during that session was when the client reported, “I know exactly what to do, but this voice is telling me I ain’t good enough.”

Being self-critical was a third subtheme that came up throughout the course of therapy for the client-participant. This subtheme included disparaging and belittling beliefs the client-participant expressed about the ways she navigated her life experiences. Self-critical occurred less frequently than the other subthemes in the sense of self category, as it only occurred during session 18 (two times). The client-participant reported to the therapist-participant that “I guess

it's because to me, my mistakes are so horrible." Another example of her self-criticism was apparent when she stated,

"So and really, me being like, that it's kind of getting, meeting, it's bleeding over into the rest of my life. It's like f***ing 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."

This subtheme did not appear during either discussion of workplace trauma that took place during session 18.

The final subtheme in sense of self was respect for self/pride. This subtheme was created to encompass the client-participant's feelings of positive self-esteem and dignity towards herself for how she handled both positive and negative life experiences. There were 9 instances of respect for self/pride which appeared during the ninth discussion of workplace trauma in session 1 (one time), in session 6 (three times), session 12 (one time) and session 18 (four times). This subtheme did not appear during any of the discussions of CSA. During the discussion of WPH in session one the client-participant stated, "I try to be respectful, but at the same time I can't let him verbally abuse me," when talking about how she was being treated by her boss at work. In session six the client also stated, "I feel disrespected..." when talking about her relationship with her boyfriend. Her feelings of self-respect and pride were also apparent in what she was willing to do to promote her music career. The client-participant stated, "...like advertising a big butt and bending over and showing your breasts you know, I don't want to do that."

Gender role struggles. Throughout the course of therapy the recurrent theme of gender roles appeared. The client-participant struggled with her ideas about the jobs and capacities of men and women in society and how they interact with one another. As such, the theme gender role struggles was created to capture the client-participant's experiences. This theme appeared 29 times across each session containing a trauma discussion, though it only occurred during discussions of CSA, not workplace trauma. To better understand the client-participant's

experiences of gender role struggles, the subthemes stereotypes of men, stereotypes of women and role reversals emerged.

The subtheme stereotypes of men encompassed the beliefs the client-participant held about the conventional roles of males in society, specifically how she felt her boyfriend should behave. This subtheme came up four times across the sessions with one instance in session 1 during the second discussion of CSA, one instance in session 7, one instance in session 12 and one instance in session 18. Although this subtheme appeared during only one discussion of trauma, it was apparent throughout the discussions the client-participant had regarding her relationship with her boyfriend. During the first session she stated, "...he's not gonna cry because he's a man, especially not in front of me." The client-participant often placed generalized stereotypes of men's behavior on how she thought her boyfriend would react to her. In session seven the client-participant noted, "He became a little more weak to me," after her boyfriend behaved in a way she did not feel was consistent with the conventional societal roles of how men should behave. Additionally, in session 12 the client-participant reported, "He didn't act up, act crazy. He didn't cry and stuff, so that was good."

In addition to stereotypes about men, the client-participant also expressed stereotypes about women. As such, a subtheme of stereotypes of women was created to capture the client-participant's ideas about the standard roles of females in society, including her own role. Stereotypes of women were found a total of 21 times in session 6 (three times), session 7 (two times), specifically during the first (one time) and third (two times) discussions of CSA, session 9 (three times), session 12 (eight times) and session 18 (two times). This subtheme appeared when the client-participant was talking about her efforts to break into the entertainment and music industries. For example, during session six the client-participant stated, "I don't mind getting paid for how I look, it's just I don't like the sluts. I don't like—like a whole bunch of dudes right here and I'm up here just dancing around shaking my ass, like heck no..." Additionally, stereotypes of women came up when the client-participant discussed her feelings about the

mother of her boyfriend's child. During session nine she reported, "...But it's just—a I don't know how—just a—the whole baby mamma shit that baby mammas do." Another stereotype of women that was of importance to the client-participant came out during the first discussion of childhood sexual abuse in session seven. She stated, "So, plus I mean, it's just that, and a whole lot of you know, you know a black, a beggin' black woman. You know what I'm saying? It's like I don't want to be one of those, I'm not." Also during session seven a general discussion about childhood sexual abuse occurred in which the client-participant expressed general stereotypes about women that she holds. For example, she reported "...women are deceitful like that, you know what I'm saying?" and "...they like to seduce men, and then get them in trouble...like a gold digger." This subtheme was most apparent when the client-participant discussed general stereotypes of women that she wanted to avoid becoming a part of.

The final subtheme in the gender role struggles category was role reversals. This subtheme encompassed the struggle the client-participant had with deviation from the societal standards of male and female duties and reactions, specifically the reversal of duties and reactions between herself and her boyfriend. The role reversal subtheme came up four times across sessions 1 (one time), 6 (one time), 12 (one time) and 18 (one time). This subtheme did not appear during any of the discussions of CSA or WPH. For instance, during the first session the client-participant reported, "Because I have a tendency to be the male and it's like, ok, I let him take care of it though I know we're gonna fail. Just let him be a man. I have to tell myself to let him be a man." This same type of thought process continued for the client-participant throughout the sessions. In session 18 she stated, "Like how many plane tickets have I bought for your ass to come out here?" and "Just make him feel like less of a man," when discussing the numerous things she has done for her boyfriend.

Emotional difficulties. The fifth theme that appeared recurrently throughout the course of therapy was emotional difficulties. This theme was created to encompass the complications the client-participant had experiencing, expressing and sharing her feelings about her life

experiences with others. This theme was apparent 54 times across every session containing a trauma discussion, as well as during specific discussions of WPH and CSA. Specific feelings came up for the client-participant within the context of therapy, which were categorized into subthemes including anger towards her boss, anger towards her mother, difficulty identifying and expressing emotion, frustration with her boyfriend's lack of responsibility and jealousy.

Although the theme of emotional difficulties was present in each session containing a trauma discussion, each subtheme was not present in each session.

The subtheme anger towards boss was developed to encompass the client-participant's feelings of animosity, annoyance and hatred experienced when discussing or working with her boss. This subtheme was apparent in six times session one, specifically during most discussions of WPH, as well as two times in session six, one time in session seven and two times in session nine. Each of the 11 instances of anger towards her boss occurred during a discussion of WPH. The client-participant expressed what things she would like to say or do to her boss, but could not. For example, during the first session the client-participant stated, "But my boss is an absolute jackass. I cannot stand him and I can't wait to say, you know what, f*** you , I quit." She also reported, "...I swear I'm gonna hit this fat man in his eye," during the sixth session. Additionally, the client-participant expressed her anger towards her boss for how he treated her and her co-workers. During session nine she stated,

"Then I'll just ignore him. Then he—because he ain't getting no reaction he want to keep saying stuff, then I'm like, alright whatever, I'm not even listening. Then finally when he's made me too mad I'm like, if you don't stop I'm going to do something really f***ing rude."

It was apparent throughout the discussions of her experience of workplace trauma that the client-participant felt strong anger towards her boss.

The second subtheme in emotional difficulties was anger towards mother. This subtheme was developed to capture the client-participant's feelings of agitation and impatience expressed

when discussion her past and current relationship with her mother. Anger towards her mother occurred 15 times. Specifically, it appeared 11 times during session six and 4 times during session nine. No occurrences of the anger towards mother subtheme occurred during a discussion of trauma. During session six the client-participant stated, "I've always had a snotty attitude towards her. I used to make her cry when I was little, I didn't even know it 'til I got older..." During session nine, the client-participant discussed her current relationship with her mother. She noted, "Same thing she always says first, why didn't you call me? Like you know, her phone doesn't work. She doesn't have fingers."

Difficulty identifying and expressing emotion was the third subtheme that appeared in the emotional difficulties theme. This subtheme captured the problems labeling and discussing feelings other than anger about her life experiences to others and during psychotherapy. Her difficulty in the area was apparent six times during session 1 (one time), session 6 (one time), specifically during the discussion of CSA (two times), session 9 (one time) and session 12 (one time). An example of the client-participant's difficulty identifying and expressing emotion that occurred in the first session was, "...I think mine, like it comes out as anger. Because I can express anger..." During session six she recalled, "...my first instinct is sad but it turns to anger. I'm so used to being not sad, but angry." Furthermore, the client-participant noted,

"Well I was freezing cold, crying and scared. Because I felt like a lot of stuff at once. I felt like a psychopath. I felt like, you know what I mean, I'm sitting there, not that I got the stuff out, I printed that shit out,"

during session 12. This subtheme was used to help understand the client-participant's experiences of emotions other than anger and sadness.

The fourth subtheme was frustration with her boyfriend's lack of responsibility. This subtheme encompassed the feelings of disappointment, annoyance and irritation the client-participant expressed towards her boyfriend's behaviors and participation in their relationship. Examples of this subtheme were apparent 18 times in sessions 6 (five times), 7 (two times), 9

(four times), 12 (three times) and 18 (four times). The only occurrences of the client-participant's frustration with her boyfriend's lack of responsibility that occurred during a discussion of workplace trauma was in session nine; there were no instances during discussions of CSA. Many of the instances in which the client-participant expressed her frustration about her boyfriend had to do with the way he handled the situation with the mother of his child. For example, in session six she stated, "I feel like you're not handling your business, you ain't gonna interfere and you and that child, and that baby mamma, whatever y'all ain't interfering with me..." She also reported in session seven, "He's a f***ing welcome mat and just lets her in as long as she ain't doing nothing outrageous. It's just annoying." In session nine, the client-participant noted, "And it's just like, first of all stand up to this broad because she's gonna snowball into a point where it's—you know how it's like if you keep—if you keep doin' stuff—" The client-participant continued to make similar statements in sessions 12 and 18 when discussing her boyfriend and how he handles the business in his life.

The final subtheme in the emotional difficulties category was jealousy. Throughout the course of therapy the client-participant seemed to express feelings of resentment and spite towards other women involved in her boyfriend's life. Specifically this jealousy seemed directed at the mother of her boyfriend's child, as well as the child itself. Instances of jealousy occurred four times: one time in sessions six, two times in session seven and one time in session nine. None of the occurrences of jealousy occurred during any discussions of CSA or WPH. In session six the client-participant stated, "...the only people who know what's going on is me and her. She ain't gonna tell you the truth because why would she go and tell me she had to get me drunk for me to sleep with her." In session seven the client-participant noted, "...disgust, jealousy. Jealousy with a five year old...Like what do you think that's gonna do? Competing with a five year old." This subtheme also included the client-participant's feelings about people being jealous of her. For instance, in session nine she stated, "I don't want her jealousy to get in my way. And it's goin' to. Because he's already done babied her. I'm talkin' about the mom."

Job dissatisfaction. The final theme that appeared throughout the course of therapy for the client-participant was job dissatisfaction. Many of the discussions of trauma that took place focused on the client-participant's experiences of WPH. As such, there was a great deal of discontent and unhappiness about the client-participant's place of employment that was discussed in each session. There appeared to be a variety of types of dissatisfaction with her job experienced by the client-participant which were broken down into subthemes including disengagement from job, hatred toward job, frustration with job responsibility and feeling trapped in job. There were 22 occurrences of the overall theme of job dissatisfaction in sessions 1, 7, 9 and 18 though not all of them occurred within the context of a specific trauma discussion.

Disengagement from job was the first subtheme noted in the job dissatisfaction category. It was developed to capture the client-participant's feelings of detachment, disconnection and indifference with her work and job duties. Disengagement from job appeared three times and only during discussions of WPH. It appeared during the ninth discussion of workplace trauma in session one (one time) and during session nine (one time), specifically during the first discussion of workplace trauma (one time). During the discussion in session one the client-participant stated, "...and I don't care and I hope I get fired." When discussing how she gets through her time at work she reported, "Just sit there and be ok. In two weeks we get paid."

The second subtheme in job dissatisfaction was hatred toward job. This subtheme was created to include the expressed feelings of anger, disgust and contempt the client-participant expressed toward her work and the need to go to work. Hatred toward job occurred 10 times across the course of therapy. It appeared in session 1 (three times), specifically during the first (one time), third (one time), fourth (one time) and eighth (one time) discussions of WPH, session seven during the first discussion of workplace trauma (one time) and session 18 (one time), specifically during the second discussion of trauma in the workplace (one time). During the first session the client-participant told the therapist-participant, "I can't stand my job, but that's a whole 'nother session." She also stated, "I hate it—I hate waking up in the morning. I hate

going. I cannot stand it. I cannot stand it—,” during the fifth discussion of trauma in the first session. Over the course of therapy, the client-participant continued to express hatred towards her job as she reported, “I hate this f***ing job. I hate, hate, hate,” during the 18th session.

Frustration with job responsibility also came up as the third subtheme. This subtheme encompassed the client-participant’s expressed feelings of dissatisfaction, annoyance and irritation with her required duties at work, specifically those duties she felt were not part of her job description. Session one contained three occurrences of the subtheme frustration with job responsibility. The client-participant stated, “The simple—I told him, I said—and I told him, but it’s my responsibility...Do you want to know how big—inventory is a job in itself. Accounting and bookkeeping is a job in itself.” She also noted, “And not only do I do that, I have to, um—I mean everyone now and then they ask me questions because it’s not their responsibility to know when checks come in.” Most of the occurrences of this subtheme had to do with co-workers, particularly her boss, asking extra things of the client-participant.

The last subtheme in job dissatisfaction was feeling trapped in her job. This subtheme was intended to capture the client-participant’s expressed emotions of being stuck and obligated at work despite her strong desire to leave. The client-participant often discussed what she wanted to do instead of her current job and her plans for leaving the job, but had many reasons why she could not follow through on her other plans yet. The client-participant’s feelings of being trapped and stuck occurred throughout the sessions containing trauma discussions, as well as during specific discussions about her workplace trauma. Feeling trapped in job appeared a total of seven times in the 1st session (two times), specifically during the second (one time) and sixth (one time) discussions of workplace trauma, during the first discussion of workplace psychological harassment in the 9th session (one time) and in the second discussion of work trauma in the 18th session (two times). An example occurred in the first session when the client-participant stated, “I feel trapped because I can’t do what I want.” She also noted, “Yeah, because I sit in a box at

work,” in the ninth session. During session 18, the client-participant finally stated, “I feel like I’m their age. I feel like I may as well be 50.”

Overall, there were six different themes and 28 different subthemes that appeared throughout the course of therapy for the client-participant, which provided a better understanding and context of the client-participant’s problems and desires and willingness to make changes towards those problems. Each theme and subtheme recurred a number of times (themes ranged from 23 to 133 times; subthemes ranged from 3 to 54 times), indicating a level of importance to the client-participant. Some of those themes occurred solely within the context of trauma discussions (e.g., anger towards boss) and others never occurred during any specific discussion of CSA or WPH (e.g., sense of responsibility and desire/attempt to control self).

Chapter IV. Discussion

The current case study retrospectively investigated the timing and depth of trauma discussion across the course of therapy in an adult client at a university community counseling center, as related to stages of change theory. Although researchers have measured the amount of trauma processing through clients’ writings and narratives, little research has looked at the depth and timing of processing of trauma and change within the context of actual psychotherapy sessions. A qualitative analysis of the written and videotaped psychotherapy data allowed for examination of what actually occurred within the context of therapy, what types of traumas were processed, the challenges encountered during trauma discussion, the involvement of the therapist in the trauma processing, and the appearance of change related themes. A summary of this information is included in the Stages of Change diagram (see Appendix U).

This chapter first describes the current case and identifies trauma processing patterns (regarding trauma experiences and the discussion of those experiences with the therapist) over the client-participant’s course of therapy. Then, the client-participant’s URICA results are discussed, and the research questions relating stages of change theory to the URICA and Linguistic Inquiry and Word Count (LIWC; Pennebaker, et al., 2007) results, themes and other relevant information

observed across the course of therapy are addressed. Next, methodological limitations are discussed. Lastly, implications and future directions for research are proposed.

Processing of Trauma

This case involved a 28-year-old (at the time of intake) single, Christian, African American female who moved to southern California from Kentucky shortly before she entered therapy. She reported she was in a long-distance, committed relationship with a man from her hometown and was having difficulties with him. The client-participant worked at a travel company as a bookkeeper, but struggled financially and experienced WPH. Her OQ-45 results showed she was above the clinical cutoff in the domain of social roles as she reported difficulty at work and fear that she might do something she might regret out of anger. She presented to therapy with problems adjusting to her recent move and a need to have someone to talk to, as she felt she lacked social support. The course of therapy lasted 21 sessions, with videotapes of 15 sessions. Content of the videotaped sessions contained discussions of the client-participant's relationship with her mother, boyfriend and friends, as well as problems at her current job and problems beginning a new career in the entertainment industry. Six of those videotaped sessions contained discussions of trauma (i.e., sessions 1, 6, 7, 9, 12, 18) including sexual abuse as a child at the hands of her uncle and WPH from her boss. According to the treatment summary, therapy ended after 21 sessions as the therapist-participant was no longer going to be working at the clinic and the client-participant did not want to transfer to another therapist. She chose to discontinue treatment.

Trauma experiences. From the initial paperwork, and throughout the course of therapy, it was evident that the client-participant experienced at least two forms of trauma in her life. Specifically, she reported she was sexually abused by her uncle as a child. The client-participant told the therapist-participant her uncle tried to molest her on two separate occasions, however, she did not let it go any farther than that. She also stated she never told her mother or her mother's

boyfriend of the abuse because she was afraid of what her mother might do to her uncle. The client-participant noted she was afraid of losing her mother if she disclosed the abuse, as she thought her mother would end up in jail for hurting her uncle.

Additionally, throughout the course of therapy the client-participant indicated she experienced workplace psychological harassment from her boss. She presented incidences in which her boss would call her and her co-workers derogatory names. She even had a phone message left by her boss containing verbal harassment that she played in therapy for the therapist-participant. Additionally, the client-participant described how her boss would put her and other co-workers down, making her workplace an uncomfortable environment whenever he was around. She often discussed what she would like to say to her boss, though she never said it to him directly, and her strong desire to quit.

Research shows that once individuals have experienced one form of interpersonal trauma, they may be at an increased likelihood to experience additional forms of interpersonal trauma (Briere & Scott, 2006). Additionally, exposure to multiple forms of trauma is associated with increased distress as compared to experiencing a single type of trauma, and experiencing multiple interpersonal traumas creates the greatest distress (Buchanan & Fitzgerald, 2008). Although the client-participant's CSA occurred many years ago, her distress at work may have been exacerbated by the fact that she experienced prior interpersonal distress, making it more difficult for her to manage her difficult work environment. Specifically, throughout the course of therapy it became evident that the client-participant experienced some negative responses as a result of experiencing multiple traumas including those found in the literature, such as avoidance of emotions, loss of connection with her spirituality, and disruption of her ability to trust (Briere & Scott, 2006; Hall & Sales, 2008; Joseph et al., 1997). Also, the client-participant expressed feelings of anger and a potential for acting out at work both to the therapist-participant and on her OQ 45.2 ratings, which is consistent with findings that experiencing childhood abuse may increase the probability for violence (Whisman, 2006). Additionally, the client-participant

struggled with maintaining a healthy relationship with her boyfriend; relationship problems have also been noted in the literature (Feiring et al., 2009; Sano et al., 2003). These negative responses appeared to impact her ability to cope with her current trauma and life experiences.

Also, the client-participant's experiences of specific types of trauma appear to be somewhat consistent with current literature. Specifically, research has shown repeated sexual victimization may be common among African American women (Campbell, Greeson, Bybee & Raja, 2008; Wyatt & Riederle, 1994). Community studies have indicated that over half of African American women reported more than one incidence of sexual victimization in childhood, and research suggests that though both African American women and Caucasian women are likely to experience repeated sexual victimization in adulthood if they reported at least one sexual abuse incidence in childhood (i.e., before age 18) (Bryant-Davis, Chung & Tillman, 2009; Campbell et al., 2008; Wyatt & Riederle, 1994). Although the client-participant reported two instances of sexual abuse as a child, she did not indicate that she had experienced any sexual victimization in adulthood.

Furthermore, research indicates that approximately 25.6% of African American women are living in poverty, and that women whose income is at or below the poverty line are at increased risk for sexual victimization (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010). Throughout the course of therapy, the client-participant expressed anger at her mother for growing up poor and not having enough resources (e.g., electricity). Additionally, she often discussed her current concerns about not having enough money. She expressed feelings of anger and disappointment at having to take care of her boyfriend financially and the struggles she had to make ends meet.

The client-participant also discussed her strained relationship with her mother during therapy, which is consistent with research that has shown women survivors of CSA may harbor feelings of anger and resentment towards other females, and specifically have difficulty maintaining a relationship with their mothers (DiLillo, 2001). The theme of anger towards her

mother appeared across two of the sessions containing trauma discussions. Although the client-participant made the choice in childhood not to tell her mother about the CSA, her relationship with her mother continued to be strained into adulthood. She reported she rarely felt supported by her mother and only spoke to her mother on the phone if she made the first contact, consistent with research that women who were abused during childhood have less contact with their mothers than women who were not abused in childhood (DiLillo, 2001). If the client-participant's mother did call, she only called to ask for money from the client-participant.

Themes throughout the therapeutic process suggested that the client-participant did not fully process her traumatic experience, as avoidance of emotion and avoidance of trauma discussion repeatedly appeared. Her avoidance of emotions and trauma discussion appeared to be adaptive for the client-participant as it was a form of self-protection; however, while such a mechanism of self-protection may serve a function at one point in time, it may become maladaptive over time (Everill & Waller, 1995; Pennebaker, 1999). Some research suggests that to fully achieve the potential benefits of trauma discussion and processing, one must integrate the traumatic event with one's existing mental schema, and evocation of emotions and vulnerabilities may be necessary for this process to happen (Farber et al., 2009; Hemenover, 2003; Lutgendorf & Antoni, 1999; Sano et al., 2003; Tedeschi & Calhoun, 2004). The themes of self-protection observed in the current study may have allowed the client-participant to not be perceived as weak by the therapist-participant, and thus hindered her from fully processing her trauma. Specifically, these themes are consistent with research on African American women as they may show an understanding that the world is not fair, which may protect them from developing symptoms of PTSD (Hood & Carter, 2008). However, this understanding may also allow them to avoid fully processing their traumatic experiences.

Yet, her experiences were also consistent with some of the literature on positive outcomes after trauma experiences. Specifically, the client-participant noted she learned not to blindly trust and follow all adults. She discussed how she learned to stand up for herself and

considers other's intentions before going along with what they say. She also told the therapist-participant she learned how to say no especially when she is unsure of the intentions of others. Her interpretation of her traumatic experience, that she learned to say no to others, helped the client-participant to create a non-threatening self-concept (Lepore et al., 2004). This increased sense of personal strength and empowerment helped to decrease the client-participant's feelings of vulnerability, which is consistent with the third domain of posttraumatic growth (Tedeschi & Calhoun, 2004). The client-participant also expressed to the therapist-participant that she had recently become a more spiritual person. This report is consistent with the fifth domain of posttraumatic growth, in which a person experiences spiritual and existential growth as a positive change as a result of his or her struggles (Sheikh, 2008; Tedeschi & Calhoun, 2004). The client-participant did not appear to experience any of the other domains of posttraumatic growth.

The client-participant's experiences of workplace abuse are also partially consistent with literature on African American women's harassment in the workplace. Specifically, African American women who are young, single and work in low status jobs often report the greatest frequency of sexual harassment (West, 2002). Furthermore, increased distress, which results from the experience of multiple forms of interpersonal trauma, has been shown to specifically affect generalized job stress and supervisor and co-worker satisfaction with an individual (Buchanan & Fitzgerald, 2008). The client-participant's perceptions of how to resolve the workplace psychological harassment she was encountering was also congruent with literature, which shows African American women are more passive and less hopeful about reaching a positive outcome of conflict (Turner & Shuter, 2004). She often kept quiet and did not stand up to her boss, though she wanted to, for fear of the confrontation not going as she would have planned.

Trauma discussion. Across the 15 videotaped sessions of therapy, the client-participant discussed her experiences of CSA and WPH during six of the sessions. Additionally, the client-participant disclosed her CSA trauma on the written materials completed during the intake

session. From the written and videotaped materials, it is unclear if the client-participant has ever previously disclosed or discussed her experiences of CSA or workplace trauma with others, as she reported she did not discuss her experiences of CSA with her mother. However, it appears she had problems with her social support system and opening up to friends, indicating this may be her first disclosure/discussion of the trauma.

Some aspects of the client-participant's discussions of trauma are consistent with the current literature. Research has shown that children who try to initially disclose CSA in childhood often do so behaviorally as opposed to verbally explaining their experience (Alaggia, 2005). This appears to be how the client-participant initially handled her traumatic experience as she stated she "developed an attitude" and her mother did not understand why. Additionally, the fact that the client-participant was abused by a family member may have contributed to her fear of discussing the trauma with her mother. She told the therapist-participant that she purposely did not tell her mother about the molestation by her uncle, even though her mother always told her to, because she was afraid her mother would do something to the uncle and end up in jail. She noted she was concerned about who would take care of her and her brother if her mother was in jail. This is consistent with research noting people are less likely to initially disclose CSA when the perpetrator is a family member, as there are more social consequences such as guilt over changes in the family structure, guilt for possible change in familial socioeconomic status, and fear of being removed from the home (Nagel et al., 1997).

Moreover, the client-participant's process of discussion of CSA was a fluid process (Alaggia, 2004), in which she briefly expressed her trauma to the therapist-participant on a few occasions across therapy (Alaggia, 2005) before actually beginning to process aspects of that trauma. A more in depth discussion of her trauma processing is included in following section. The client-participant's decision to discuss her CSA to a mental health professional later in life is also consistent with research (Pino & Meier, 1999).

Throughout the course of therapy, the client-participant also began to discuss experiences of verbal abuse she was encountering at her place of employment. These discussions were more frequent than her discussions of CSA, and they appeared to come more easily to her, as she provided more detail about her experiences. Additionally, it was easier for her to express her emotions (e.g. anger) towards her experience of WHP and towards her boss. The traumatic experiences at work described by the client-participant appeared to be less discriminatory than the workplace racial and sexual harassment covered by previous literature. According to Deitch, Barsky, Butz, Chan, Brief, and Bradley (2003), racism in the workplace is not disappearing but is being replaced by less overt forms. Although the client-participant did not report experiencing any sexual harassment or racial discrimination at work, she did report verbal abuse from her boss.

Her description of her work environment is consistent with literature on workplace psychological harassment. WPH involves repeated or persistent hostility over an extended period of time, which undermines the person's sense of competence as an employee and a person (Keashly & Harvey, 2005). The client-participant described her work experiences with her boss as verbal abuse, which would fall into the category of WPH as it includes experiences of abusive supervision, bullying and generalized workplace abuse (Crawshaw, 2009; Keashly & Harvey, 2005). According to Keashly and Harvey (2005), research on emotional abuse and aggression at work has noted numerous psychological, behavioral and emotional effects on an individual, including negative mood, cognitive distraction, lowered self-esteem, decreased job satisfaction and greater turnover at work. In addition, research has shown that experiences of verbal abuse in the workplace are positively associated with confusion in women, and suggest a passive coping style (Brotheridge & Lee, 2010). Throughout therapy, it became clear that the client-participant experienced some of the negative factors associated with chronic workplace abuse (e.g., decreased job satisfaction) as evidenced by themes that emerged across her therapy. Additionally, the client-participant described having a passive coping style as she did not confront

her boss about the verbal abuse, although she was angry with him, but instead discussed it in therapy.

Stages of Change

Discussion of URICA results. Over the course of therapy, the client-participant completed the URICA on three occasions to assess her stage of change. However, there were limitations with the use of these measures, as the problems reported by the client-participant on each measure were not specific to her trauma discussions or experiences of CSA and WPH. Instead of discarding the URICAs, the researcher took an inclusive approach to the case study and used them to inform her about what the client-participant expressed as what she wanted to work on in therapy and how her stages of change looked in relation to those particular problems. To identify the client-participant's stage of change in relation to her trauma discussions, the researcher examined the themes and subthemes that generally emerged during trauma discussions across the course of therapy and attempted to determine whether they applied to the stages of change theory. This allowed the researcher to better identify the stage of change the client was in regarding discussions of CSA and WPH. It was beyond the scope of this dissertation to develop a coding system to specifically identify the client-participant's stages of change during trauma discussions, which would have been the most accurate method.

The first URICA measure was given during intake (session zero). There was no videotape of this session, so it is unclear if any discussions of CSA or WPH trauma were discussed. On the URICA measure, the client-participant indicated "confidence" was the problem/issue she was working on; the therapist did not provide any details about this issue on the Score Summary Sheet. According to the measure she had a readiness for change score of 12.0, placing her in the action stage. The therapist-participant noted the client-participant was "very interested in changing" on the score summary sheet. According to the stages of change theory, action is the fourth stage of change in which individuals are modifying their experiences and environments as a way to overcome their problems (Prochaska & Norcross, 2001). As there

is no videotape of this session, this researcher is unable to determine if the client-participant's speech and behaviors were consistent with this stage of change in regards to her issue of confidence. However, the act of seeking therapy may indicate that she was making overt behavioral changes that required considerable commitment, time and energy (Prochaska & Norcross, 2001; Prochaska et al., 1994).

Additionally, some of the themes from session one (the following week) appeared consistent with the action stage of change. The client-participant showed themes of independence and a desire/attempt to actively control herself and the environment around her. Specifically, she discussed making her own decisions and taking the time to look at what role she played in the problems in her relationship with her boyfriend. According to Prochaska and Norcross (2001), during the action stage of change, individuals modify their behaviors and environments to overcome their problems. Themes of having a sense of self, in particular respect for oneself/pride, also appeared in the first session. During this session the client-participant discussed with the therapist-participant her struggle with continuing to be respectful to her boss at work, without letting him continue to be verbally abusive. She described different techniques she had tried and whether they were successful or not, which is consistent with the action stage of change. However, regarding her discussions of CSA, the client-participant's stage of change seemed more consistent with the contemplation stage of change as themes of avoidance of emotion, avoidance of trauma discussion, as well as difficulty identifying and expressing emotion, appeared during discussions of CSA.

The second URICA measure was given to the client-participant during session 7, which was a videotaped session including three discussions of CSA and two discussions of WPH; however, the URICA measure was not returned to the therapist-participant until session 12. During session 12, the client-participant reported to the therapist-participant that she could not recall her problem from the previous URICA measure given at intake. The therapist-participant told the client-participant that it did not matter what her previous problem was, but to instead

write in what she wanted to work on now. The client-participant indicated “communication” was the problem/issue on which she was working. Yet, as the problematic behavior changed from session to session, and it is unclear which session the client-participant was referring to when she wrote in her new problem, the researcher cannot accurately determine if the second URICA measure corresponds with session 7, session 12, or any of the sessions in between. She received a readiness for change score of 11.57, which placed her in the contemplation stage of change. According to Prochaska and Norcross (2001), the contemplation stage is the second stage of change in which a client is aware that a problem exists and is seriously considering overcoming the problematic behavior, but no commitment to change has been made yet.

The client-participant’s URICA ratings were consistent with the therapist-participant’s comment on the score summary sheet that the client-participant liked to come to therapy, but was “not ready to face some of the more difficult emotional issues.” With regards to the client-participant’s reported problematic behavior, communication, themes from sessions 7 and 9 indicated she appeared to know that she was unhappy with her lack of communication with her boyfriend and how their relationship was going, and she was thinking about how to make changes to the relationship; however she had not yet committed to making changes in the relationship. Additionally, themes of self-protection, specifically sense of responsibility and financial security, appeared in which the client-participant’s ambivalence over quitting her job was evident during discussions of WPH. She had not yet committed to leaving her abusive work environment, but was considering doing so, which is consistent with the contemplation stage of change. Furthermore, subthemes of avoidance of emotion and avoidance of trauma discussion appeared during discussions of CSA, in which the client-participant indicated she thought her past traumatic experiences may have impacted her current functioning, but was not ready to discuss them fully. Again, these themes noted during CSA were consistent with the contemplation stage of change as the client-participant was willing to admit that she had experienced a trauma, but was not ready to begin processing it.

The third and final URICA measure completed during the course of therapy was given to the client-participant during session 14, however it is unclear when the measure was actually completed and returned to the therapist-participant as the date on the measure does not correspond with any of the therapy session dates. There was a videotape of session 14, but because there were no discussions of CSA or WPH during the session, it was not coded. Instead, the researcher reviewed the transcript from the session and as further discussed below, it seemed to focus on the client-participant's relationship with her boyfriend and the problems she had trusting him, communicating with him, and being affectionate towards him. On this URICA, the client-participant indicated "the voice inside of me" was the problem/issue she was working on. Her readiness for change score was 12.14, indicating that she was in the action stage of change. Yet, the client-participant did not seem to address this problem in session 14, instead "the voice inside" was specifically addressed using that phrase in sessions 12, 16, and 18. This could indicate that she was not consistently in the action stage of change, as her focus of treatment did not remain on the same problematic behavior from session to session; she more likely was in the preparation stage of change during session 14.

Also supporting this idea, the therapist-participant indicated on the score summary sheet that the client-participant was "still contemplating" making changes, which is inconsistent with the scores and proposed behaviors involved in the action stage of change. To be classified in the action stage of change, an individual must have successfully changed his or her problematic behavior for at least one day up to six months (Prochaska & Norcross, 2001; Prochaska et al., 1994).

Additionally, according to the researcher's review of the videotape of session 14, it appeared that the client-participant wanted to communicate with her boyfriend in a new way and had practiced what to say to him in session, although she did appear worried about the possible outcomes of changing her behaviors. This therapy discussion is more consistent with the preparation stage of change, in which a person is preparing to take action within the next month,

and has unsuccessfully taken action in the past year (Frasier et al., 1999; Prochaska & Norcross, 2001). Additionally, individuals in the preparation stage have made some small behavioral changes to reduce their problem, but they have not yet successfully changed their behavior (Prochaska & Norcross, 2001). For example, when the session ended, the client-participant stated she was planning to talk with her boyfriend before he left to go back to Kentucky in a few days.

Furthermore, themes of emotional difficulties, specifically frustration with the lack of responsibility of the client-participant's boyfriend, and sense of self, including insecurity and fear of judgment, which were apparent throughout session 18, appeared consistent with the preparation stage of change. During this session, the client-participant continued to struggle with her level of confidence and "the voice inside" that often was critical of her and her abilities. In parts of sessions 12, 16 (not coded as it did not contain a trauma discussion), and 18, the client-participant continued to discuss the different things she was thinking of trying and had tried in the past to help her work through her lack of confidence and fears about her music career. Again, these results were consistent with the preparation stage of change as she had not yet successfully made the changes she wanted to (Frasier et al., 1999; Prochaska & Norcross, 2001). Thus, the session review, the therapist-participant's description of the client-participant's stage of change, and themes and subthemes observed are more consistent with the preparation stage of change than the action stage of change regarding the issue of "the voice inside me." Regarding her discussions of trauma, the client-participant also appeared to be in the preparation stage of change as the themes of hatred toward job and feeling trapped in job appeared, indicating the client was able to acknowledge her problem, as well as express what she had tried that was not working for her.

Across the course of therapy, the client-participant fluctuated between stages of change moving from action to contemplation and back to action on the URICA measures, though analysis of the themes and transcripts indicates the client-participant seemed to remain in the contemplation stage of change during discussions of CSA across the course of therapy, and fluctuated between the action, contemplation and preparation stages of change during discussions

of WPH. This fluctuation seems to indicate that the stages of change for this client-participant are a more cyclical and dynamic process, rather than linear, which is consistent with the literature (DiClemente & Hughes, 1990). According to Prochaska and Norcross (2001), each stage of change represents a particular period of time and a set of tasks that must be completed to move to the next stage of change; however the length of time needed in each stage of change varies by individual. The client-participant's experiences of the stages of change also appear to be consistent with this research.

Research on the transtheoretical model and stages of change has been based on changing one problematic behavior at a time (e.g., smoking, exercise, eating habits, domestic violence); although there is some evidence that individuals in the later stages of change have modified several health behaviors simultaneously (Unger, 1996). But, this did not appear to be the case for the client-participant who appeared to report a new problem/issue on each of the URICA measures, as opposed to focusing on one specific problem. As a result, the researcher was not able to determine how she viewed her stage of change for each problem over time. However, the client-participant's different issues all appeared to be related to a similar theme of lacking confidence, as she appeared to lack confidence overall, lack confidence in effectively communicating with others in a calm and assertive manner, and lack confidence in herself due to her inner voice that told her not to trust herself. If all issues were connected, then the client-participant's issues appear to fit with the transtheoretical model and the stages of change, as she moved back and forth through the stages across the course of therapy in a cyclical and recursive way, as many individuals require up to seven cycles before succeeding in long-term maintenance of change (Begun, Shelly, Strodthoff & Short, 2001).

Additionally, the client-participant discussed and processed two different types of trauma (CSA and WPH) over the course of therapy. It appeared that each type of trauma had its own specific stages of change associated with it, as the client-participant did not appear to equally process her traumas. As mentioned above, during discussions of WPH the client-participant

progressed through the stages of change in a dynamic manner (DiClemente & Hughes, 1990). However, she appeared to remain in the contemplation stage of change during discussion of CSA. This too is consistent with the stages of change theory which notes that there is no specific time frame to progress from one stage to another, but instead a set of tasks must be met before the client can move to the next stage (Prochaska & Norcross, 2001). It appeared that when discussing her experiences of CSA, the client-participant had not yet completed the tasks necessary to move to the next stage of change.

Timing of trauma discussion. The first research question in the current case study aimed to investigate the association, if any, between the stages of change theory and the timing of trauma discussions during the course of therapy. There has been no research that specifically addresses timing of trauma discussions across the course of therapy or within a therapy session, in relation to particular stages of change. According to the available research from Higgins Kessler and Nelson Goff (2006), Sano et al. (2003), and Strassberg et al. (1978), the researcher expected that when the client-participant was in the preparation and action stages of change discussions of trauma would occur at any point in time across-therapy, and that within-therapy discussions would occur more frequently during preparation and action than during the other stages of change. The researcher also expected that trauma discussions would occur during other stages of change, specifically contemplation and maintenance. It was expected that in the contemplation and preparation stages discussions of trauma would have a longer duration than discussions during the action and maintenance stages of change. This expectation was based off of the research stating the contemplation and preparation stages of change correspond with the cognitive and psychoanalytic processes of change, while the action and maintenance stages of change correspond with the experiential and behavioral processes of change (Burke et al., 2004; Petrocelli, 2002; Prochaska & DiClemente, 1982; Prochaska & Norcross, 2001). Furthermore, the researcher expected that any discussions of trauma that occurred in the pre-contemplation stage would be brought up by the therapist-participant and not the client-participant.

Research on discussion/disclosure of sexual trauma has addressed timing across therapy. Essentially, across the course of therapy there is no set amount of time that must pass before a client discusses CSA or sexual assault. For instance, some clients may discuss their trauma during the first or second session, others may wait months before approaching the subject (Higgins Kessler & Nelson Goff, 2006; Sano et al., 2003), and some may never bring up the trauma during therapy.

In the current study, the client-participant indicated she had experienced “sexual abuse” on the Client Information Adult Form in the intake paperwork and during the intake session (session zero) as the therapist-participant included information about the abuse in the Intake Report. However, as there is no videotape of the intake session, it is not known how much detail was given about the trauma or if it was merely mentioned and who initiated the discussion. Additionally, of the 15 videotaped sessions, the client-participant discussed her experience of CSA during session 1, session 6, session 7, and session 12, which is consistent with literature indicating trauma discussions can occur at any point in time across the course of therapy.

However, the client-participant’s discussions of CSA did not appear to be her focus as she did not readily bring this topic up for discussion during therapy. In the current case study, the client-participant presented to therapy with issues adjusting to her recent move and problems with her boyfriend. When the client-participant discussed her experiences of CSA, the topic was usually brought up by the therapist-participant, as expected by the researcher, but quickly dropped when the client-participant was done with the discussion. Research shows that if a client waits to discuss a trauma until later in the therapy process, the therapist should not assume that the trauma should be the new focus of therapy (Higgins Kessler & Nelson Goff, 2006). If the therapist-participant had changed the focus of therapy to processing the experiences of CSA, it may have hurt the therapeutic relationship and pushed the client-participant away from therapy, as themes of avoidance of trauma discussion and avoidance of emotion were apparent throughout the course of therapy.

Additionally, there does not appear to be a specific time frame in which clients typically disclose/discuss experiences of WPH. Instead, research indicates that individuals may struggle to gain recognition from others of WPH experiences, and that denial of WPH at the organizational level reduces the availability of support and impedes the process of discussion of the trauma (Lewis & Orford, 2005). The client-participant did not report her experiences of WPH on any of the intake paperwork; however, it was mentioned by the therapist-participant in the intake summary, indicating it may have been discussed during the intake session. Other discussions of WPH occurred during session 1, session 6, session 7, session 9, session 12 and session 18. The client-participant's experiences of discussing her experiences of WPH trauma across the course of therapy are consistent with research as she felt she could not bring up the abuse at work with other coworkers because they would not support her blaming the boss for the abuse. Research shows that blaming the other is an effective form of support which enables the person to externalize problems more effectively and resist self-blame (Lewis & Orford, 2005).

The researcher's expectation that across-therapy discussions of trauma, both CSA and WPH, would occur at any point in time when the client was in the preparation or action stages of change was found to be partially true as many of the trauma discussions occurred in sessions close to when the URICA scores and observation of themes placed the client-participant in the action stage of change regarding her discussions of WPH (sessions 1 and 6), and only a few trauma discussion occurred when the observation of themes placed the client-participant in the preparation stage of change regarding discussions of WPH (session 18). Also, nine discussions of CSA and WPH occurred during sessions 7, 9 and 12, which corresponded with the client-participant's URICA score, as well as observed themes, placing her in the contemplation stage of change regarding her reported problem and her discussion of CSA and WPH. This finding was consistent with the researcher's expectation that discussions of trauma in the preparation

and action stages of change would occur more frequently than during the contemplation stage of change as the client-participant would be discussing and working on her trauma during these stages and beginning to make successful and unsuccessful changes.

Furthermore, the researcher's findings were consistent with the expectation that longer discussions would occur during the contemplation and preparation stages.

Regarding within-session discussions of trauma, one study, conducted by Strassberg et al. (1978), indicates that instances of trauma disclosure may differ within each session. Specifically, it was found that a high level of intimate self-disclosures, described as a willingness to share material of a personal and intimate nature, by female clients occurred in the last quarter of therapy sessions (Strassberg et al., 1978). This finding is inconsistent with the client-participant's trauma discussions and self-disclosures. Within each session containing discussions of CSA and WPH, the client-participant's timing of trauma discussions varied.

More specifically, during the first session in which she was in the action stage of change on the URICA, the client-participant's experiences of CSA were discussed during the first quarter of the session. Discussions of WPH occurred during a majority of the second, third and fourth quarters of the session. One might expect that a majority of the session would be spent discussing experiences of trauma seeing as the client-participant was in the action stage of change if she had noted working through her trauma was the problem she wanted to focus on in therapy during intake, including on the URICA. The client-participant did not fill out the URICA measure in terms of working through her trauma; instead she wanted to work on her confidence. Based off of the themes present during the discussions of CSA and WPH in the first session, the researcher was able to ascertain that the client-participant was not ready to discuss her experiences of CSA as avoidance of trauma discussion and avoidance of emotion were present (appeared to be in the contemplation stage), but was able to discuss her experiences of WPH as themes of anger towards boss, respect for others and assertiveness were present (appeared to be in the action stage).

Seeing as most of the discussions of WPH occurred during the second, third and fourth quarters of the session, this finding is partially consistent with the findings of Strassberg et al. (1978) that discussions of intimate material would be more likely to occur at the end of the therapy session, but more consistent with being in the action stage of change.

During the sixth session, which did not have a corresponding URICA stage of change, the client-participant seemed to remain in the same stages of change as the previous session (contemplation stage for CSA and action stage for WPH) based off of the observed themes. During this session she discussed her experiences of CSA in the first quarter of the session and her experiences of WPH during the last quarter of the session. These results are also somewhat consistent with the findings of Strassberg et al. (1978). Specifically, during the discussion of CSA in the beginning of the session the themes of avoidance of emotion and difficulty identifying and expressing emotion were present, indicating the client-participant was not ready to discuss this particular trauma. However, during the discussion of WPH in the fourth quarter of the session, the themes of anger towards boss and aggression were apparent. Additionally, the discussion of WPH lasted longer than the discussion of CSA earlier in the session. These results indicate that the client-participant was able to spend more time discussing an intimate topic during the final part of the session.

In the seventh session, in which the client's URICA reflected the contemplation stage of change regarding communication, and observed themes of trauma discussion also reflected the contemplation stage of change, discussions of WPH occurred in the first quarter and last quarters of the session, while discussions of CSA occurred in the second and third quarters of the session. The client-participant's discussions of trauma across each quarter of this session appears consistent with the contemplation stage of change in which an individual is exploring the problem and deciding on whether or not to make a change, but not consistent with Strassberg et al. (1978).

Similarly, the client-participant's timing of trauma discussion in session nine was also inconsistent with Strassberg et al. (1978), as discussions of WPH occurred during the first and

second quarters of the session. Additionally, her discussions of WPH in session 12 occurred during the first quarter of the session. But a discussion of CSA occurred during the last quarter of the therapy session. There were no corresponding URICAs for sessions 9 and 12 though it is unclear if the score from the URICA given in session 7 actually corresponds with one of these sessions. Based off of the general themes observed during sessions 9 and 12, the client-participant appeared to continue to be in the contemplation stage of change for both discussions of CSA and WPH.

However, in session 14, which did not contain a discussion of trauma, the client-participant's URICA score was again in the action stage of change. Discussions of WPH during session 18 were also inconsistent with the Strassberg et al. (1978) study as they occurred in the second and third quarters of the session, though they more were consistent with being in the preparation stage of change.

Overall, the client-participant's experiences of the timing of trauma discussion were somewhat consistent with the trauma literature and the stages of change. Specifically, her experiences of CSA and WPH discussions across therapy sessions was consistent with literature reporting that there is no specific time to discuss trauma over the course of therapy (Higgins Kessler & Nelson Goff, 2006; Sano et al., 2003). However, the client-participant's experiences of trauma discussion within each therapy session are inconsistent with literature stating that most intimate disclosures occur in the last quarter of the therapy session (Strassberg et al., 1978). Additionally, the client-participant's trauma discussions of WPH appear to be consistent with the stage of change she was reported to be in on the URICA during the corresponding sessions, however, her discussions of CSA do not appear to be consistent with the stages of change reported on the URICA. Although, it is hard to know if this is true for each session containing a trauma discussion as there were not URICA measures for each session. Therefore, the researcher relied on general themes observed during each session containing a trauma discussion and the client-participant's behaviors regarding trauma discussion to determine if they were consistent

with the stage reported on the URICA, and if not, what stage of change she was in for each type of trauma.

Depth of trauma discussion. The second research question in the current case study aimed to investigate how the stages of change were related to the depth of trauma discussion, or the amount of processing of the trauma, across the course of therapy. To determine the depth of trauma discussions, the current study used the LIWC program (Pennebaker et al., 2007) to analyze the number of words spoken and percentage of cognitive processing words, including insight and causation words, used by the client-participant and therapist-participant during each trauma discussion, and across sessions (LIWC results are summarized in Appendix Q and Appendix R). The researcher considered there to be an increase in depth of trauma processing in the instances of trauma discussion in which one of the three LIWC subcategories (i.e., cognitive processes, insight, and causation) increased in percentage, as compared with discussions that occurred earlier in the session and from prior therapy sessions.

Research shows that as involvement in trauma discussion (as measured by the Experiencing Scale) increases across sessions, the number of words spoken decreases (Lutgendorf & Antoni, 1999). Additionally, research shows that greater involvement in trauma discussion contributes to greater insight and overall negative mood reduction across the course of therapy (Lutgendorf & Antoni, 1999). Use of insight words has also been shown to increase across the course of therapy and with higher levels of autonomy (Hemenover, 2003). Also relevant to across-session and within-session results from this study is the work of Burke and Bradley (2006) who found that the act of writing an imagined dialogue, rather than a written narrative of the trauma, led to language use that suggested greater cognitive and emotional processing. Specifically, Burke and Bradley found that written dialogues of traumatic experiences exhibited higher levels of cognitive word use and a more present-oriented affective style than written narratives of trauma experiences. According to the study by Burke and Bradley, individuals who completed a written dialogue of their traumatic experiences had a mean

percentage of 8.70% cognitive processing words, with a mean of 2.80% insight words and 1.30% causation words.

Based off of the current literature, the researcher expected that there would be a greater percentage of cognitive processing words, specifically insight and causation words, in the sessions at the end of the course of therapy. Additionally, the researcher expected that there would be fewer words spoken during therapy sessions containing trauma discussions at the end of the course of therapy, as it was believed with more cognitive processing words being used, the client-participant would not be discussing the content of the trauma, but her feelings about it.

It was also expected that within each session occurring in the contemplation and preparation stages of change, trauma discussions occurring at the end of the therapy session would have greater depth of processing (i.e., higher percentage of cognitive processing, insight and causation words) than those trauma discussions occurring at the beginning of the therapy session, as greater involvement in trauma discussion is related to increased insight (Lutgendorf & Antoni, 1999). Furthermore, the researcher expected that trauma discussions taking place during the contemplation and preparation stages of change would contain a greater number of cognitive processing words, including insight and causation words, than other stages. It was believed that trauma discussions occurring in the pre-contemplation, action and maintenance stages of change would be shorter in duration and contain less cognitive processing words, specifically insight and causation words, as the client-participant would be in denial of the problem during the beginning stage and the focus of therapy would be on more behavioral changes in the later stages. Lastly, the researcher expected that the themes of avoidance of emotion and avoidance of trauma discussion would be observed more during the pre-contemplation, contemplation stages of change, while the themes of independence, assertiveness, and respect for self/pride would be observed more during the preparation, action and maintenance stages of change.

Across the course of therapy, the client-participant's overall number of words and percentages of cognitive processing, insight and causation words in her speech varied. There

were slight increases and decreases in the totals of number of words and LIWC subcategories (i.e., cognitive process, insight, causation) from the beginning to the end of therapy. The specific results will be discussed later in this section. Overall, the findings were somewhat consistent with researcher's expectations and research stating that use of insight words increases over the number of sessions (Hemenover, 2003) and overall number of words would decrease across the course of therapy (Lutgendorf & Antoni, 1999).

The client-participant had the greatest percentage of cognitive processing words (18.79%), including the greatest percentage of causation words (2.61%), during the first session, when the client-participant was in the action stage of change on the URICA and with regards to discussions of WPH. However, the greatest percentage of insight words (3.89%) occurred during session 18, when she was observed to be in the preparation stage of change regarding discussions of WPH. The results of percentage of insight words are consistent with the literature that the most insight words would occur towards the end of the course of therapy (Hemenover, 2003), as well as the researcher's expectation that they would occur most in the preparation stage of change (session 18).

When compared with the results of the Burke and Bradley (2006) study (8.70%), the client-participant's mean percentage of cognitive processing words during discussions of CSA in session 1 (8.78%), session 6 (17.41%) and session 7 (11.88%) were above the mean; however, her mean percentage of cognitive processing words during discussions of CSA in session 12 (0.00%) was below the mean. These findings indicate the client-participant had greater overall cognitive processing of CSA at the beginning and middle of therapy than at the end of the course of therapy. Her mean percentage of cognitive processing words during discussions of WPH in session 1 (17.21%), session 6 (16.81%), session 7 (17.23%), session 9 (23.47%), session 12 (13.64%) and session 18 (13.65%) were all above the mean found by Burke and Bradley. These findings were consistent with the literature and indicated that the client-participant continued to show higher levels of cognitive processing of WPH throughout the course of therapy.

However, the mean percentages of specific insight and causation words spoken by the client-participant varied in comparison from the averages found by Burke and Bradley (2006). Specifically, Burke and Bradley found a mean average of 2.80% of insight words spoken by participants in the trauma dialogue group of their study. The client-participant's mean percentage of insight words during discussions of CSA were above this mean in session 6 (5.46%) and session 12 (3.10%), and below this mean in session 1 (1.22%), indicating a greater depth of insight processing of CSA during sessions in the middle and at the end of the course of therapy. Moreover, her mean percentage of insight words during discussions of WPH in session 18 (4.10%) was above the mean; however, during session 1 (1.65%), session 6 (2.37%), session 7 (0.90%), session 9 (1.36%) and session 12 (0.00%) the client-participants mean averages fell below that of Burke and Bradley. These results suggest that the client-participant showed a greater depth of insight processing of WPH at the end of therapy than at the beginning of therapy. However, due to the limitations of the LIWC program, the researcher was not able to determine the nature of the insight words expressed by the client-participant.

With regards to percentages of causation words used during trauma dialogues, Burke and Bradley found a mean percentage of 1.30%. During discussions of CSA, the client-participant had means above the average in session 1 (2.04%) and session 6 (3.41%), and she had means below the average in session 7 (1.26%) and session 12 (0.00%), indicating she experienced greater depth of processing of causation of CSA at the beginning of therapy than at the end of the course of therapy. Her mean percentage of causation words spoken during discussions WPH was above the average found by Burke and Bradley in sessions 1 (3.00%), 6 (2.53%), 7 (3.05%), 9 (1.36%), 12 (4.55%) and 18 (2.00%). These findings show the client-participant had a greater depth of processing of causation of WPH throughout the course of therapy. As noted above, the limitations of the LIWC did not allow the researcher the ability to examine the nature of the causation words used by the client-participant.

The pattern for percentage of insight words appeared to differ from that of the percentage of cognitive processing and causation words, which appeared to show a similar pattern. The difference in these patterns appears consistent with previous literature. According to Hemenover (2003), when writing about trauma experiences, an increase in percentage of insight words used was related to higher levels of autonomy and a more resilient self-concept, while an increase in percentage of causation words was not. In the current study, increase in percentage of insight words coincided with the themes observed when the researcher believed the client-participant to be in the preparation and action stages of change regarding discussions of WPH, such as independence, respect for self/pride and a desire/attempt to control self. These stages can be related to feelings of autonomy and resilience as the client-participant was making decisions and taking action on changes she wanted to make in her life. However, the client-participant appeared to remain in the contemplation stage of change throughout the course of therapy regarding her discussions of CSA. Themes of independence and respect for self/pride were not observed during these discussions.

In relation to the overall number of words spoken across sessions, the results are inconsistent with the researcher's expectations. Specifically, during discussions of CSA, the client-participant's average number of words increased across sessions 1, 6 and 7, but decreased in session 12. This is inconsistent with what the researcher expected to find in relation to the stages of change. During sessions 1, 6, 7 and 12 the client-participant was believed to be in the contemplation stage of change regarding her discussions of CSA, which was thought to be associated with more trauma discussions and greater depth of processing. However, the client-participant's number of words dropped toward the end of the course of therapy, even though she was still in the contemplation stage of change. The number of words spoken during discussions of WPH varied and did not show a consistent pattern. This may indicate that she was having more difficulty processing her experiences of WPH than her experiences of CSA.

Furthermore, the findings across the course of therapy, in relation to the stages of change and occurrence of themes, are somewhat consistent with the researcher's expectations. The researcher expected that there would be a higher percentage of cognitive processing, insight and causation words during the contemplation and preparation stages of change. The findings showed that there were a higher percentage of insight words during the preparation stage of change and the lowest percentage of insight words during the action stage of change. However, the researcher's expectations were incorrect with regards to the percentage of cognitive processing and causation words; there were higher levels of those words during the first session, when the client-participant was in the action stage of change on the URICA and regarding WPH, than in any of the other sessions. Additionally, the themes of avoidance of trauma discussion and avoidance of emotion occurred more during the sessions which the client-participant was thought to be in the contemplation stage of change regarding CSA (session 1, 6, 7, and 12). The themes of independence and respect for self/pride occurred more often during sessions in which the client-participant was in the action and preparation stages of change regarding WPH (sessions 6 and 18).

Findings from within each session varied in their consistency with the literature and the researcher's expectations. During session one, when the client-participant was in the action stage of change on the URICA regarding confidence and the contemplation stage of change regarding CSA, there were two discussions of CSA that occurred in the beginning of the session. A greater percentage of insight words were spoken by the client-participant during the second discussion (2.44%) than during the first discussion (0.00%). Additionally, there was a greater percentage of cognitive processing words, specifically causation words, spoken during the second discussion (13.01%; 4.07%) than during the first discussion (4.55%; 0.00%). This finding is consistent with the researcher's expectations that trauma discussions later in the therapy session would contain greater depth of processing, and shows an increase in depth of CSA discussion during the session, and is consistent with the researcher's belief that this would occur only during the contemplation

and preparation stages of change. Additionally, these findings appear consistent with the themes observed by the researcher and the client-participant's stage of change regarding CSA. Both themes avoidance of trauma discussion and avoidance of emotion were present during the CSA discussions while the client-participant was in the contemplation stage of change. It was expected that these themes would appear during trauma discussions in the pre-contemplation and contemplation stages of change.

There were 10 discussions of WPH over the course of the first session. The first discussion contained the lowest percentage of cognitive processing words (8.89%), specifically insight words (0.00%), which is consistent with the researcher's expectations. However, the rest of the discussions of WPH in session one varied in the percentage of cognitive processing, insight and causation words, with the greatest percentage of cognitive processing words (23.13%) occurring in third discussion of WPH, the greatest percentage of insight words (3.75%) occurring in the second discussion of WPH, and the greatest percentage of causation words (4.04%) occurring in the sixth discussion of WPH. These results are consistent with the researcher's expectations that there would not necessarily be an increase in depth of trauma processing from the beginning of the session to the end of the session during the action stage of change. Furthermore, the themes that were observed during the discussions of WPH were consistent with the researcher's expectations of themes that would appear in the action stage of change. During the second discussion of WPH, which also contained the greatest percentage of insight words, the theme of assertiveness was observed. Additionally, during the ninth discussion of WPH the theme of respect for self/pride was observed.

As there was only one discussion of CSA and one discussion of WPH during session six, the researcher was not able to determine the depth of trauma discussion within the session. However, when compared with the last discussions of CSA and WPH from the previous session

there appeared to be an increase in depth of processing of CSA and a slight decrease in depth of processing of WPH. Specifically, there was an increase of 4.40% in percentage of cognitive processing words, 3.02% in percentage of insight words, and a decrease of 0.67% in percentage of causation words spoken during the discussion of CSA from the previous session. Additionally, there was a decrease of 4.88% of percentage of cognitive processing words, 0.04% of percentage of insight words, and 1.08% of percentage of causation words during discussion of WPH from session 1 to session 6. Although there is no way to determine within session depth of processing for session six, the themes observed during the discussions of CSA and WPH were consistent with the researcher's expectations. Avoidance of emotion was observed during the discussion of CSA in session six, which corresponded with the contemplation stage of change. Again, it was expected that this theme would appear during the pre-contemplation and contemplation stages of change.

During session 7 the client-participant was reported to be in the contemplation stage of change on the URICA, but, as mentioned before it is unclear if this measure corresponds to session 7, 9 or 12 as it was returned to the therapist-participant during session 12. However, it is assumed that this session relates to the contemplation stage of change as themes observed during this session appeared most consistent with this stage for both discussions of CSA and WPH. There were two discussions of WPH and three discussions of CSA during session seven. Consistent with the researcher's expectations, the client-participant had the greatest percentage of cognitive processing words (18.28%), and specifically insight (6.30%) and causation (2.00) words during the third discussion of CSA. Additionally, this is consistent with the researcher's belief that this pattern of processing would occur specifically during the contemplation stage of change. During the second discussion of CSA none of the expected themes appeared; however,

during the first discussion of CSA avoidance of trauma discussion and avoidance of emotion were both observed. This is consistent with the researcher's expectations that during the contemplation stage of change these specific themes would occur, and furthermore they occurred during the discussion in the session with the lowest amount of trauma processing. This indicates that as the client began to increase her depth of trauma processing (as observed by greater percentages of cognitive processing, insight and causation words), she was less avoidant to discuss the trauma and her related emotions.

Regarding the discussions of WPH during session seven the depth of processing varied. During the second discussion of WPH there was actually a decrease in overall cognitive processing words. The client-participant's speech contained 14.29% cognitive processing words during the second discussion of WPH and 20.17% cognitive processing words during the first discussion of WPH. This was inconsistent with the literature and the researcher's expectations. However, there was an increase in both the percentage of insight and causation words in the second discussion of WPH from the first discussion. Specifically, the percentage of insight words in the second session increased by 1.79% and the percentage of causation words increased by 1.05%. This finding is consistent with expectations and is also consistent with the client-participant's stage of change. The difference in the pattern of percentage of cognitive processing words and insight and causation words may have been affected by other words included under the overall cognitive processing category in the LIWC. Specifically, there may have been fewer words from other subcategories spoken by the client-participant, decreasing the overall percentage of cognitive processing words, yet more words specific to the insight and causation subcategories, increasing the percentages of those words. The themes observed during the discussions of WPH in session seven that were consistent with the researcher's expectations and the contemplation stage of change were those of self-protection.

The findings for depth of processing of WPH in session nine were again partially consistent with the researcher's expectations. During this session, the first discussion of WPH

contained a greater percentage of overall cognitive processing words (26.15%) than the second discussion of WPH (20.78%). However, during the second discussion of WPH there was a greater percentage of insight and causation words, with increases of 2.71% and 2.38% respectively. This indicates an increase in the depth of processing of the trauma from the beginning of the session to the end of the session. Again, these findings were consistent with the researcher's expectation that more insight and causation words would be found during the contemplation stage of change. However, they were inconsistent with the themes observed as avoidance of emotion and avoidance of trauma discussion were not observed during session nine, when the client was observed to be in the contemplation stage of change.

Again, in session 12, there was only one discussion of CSA and one discussion of WPH, and as such, the researcher was not able to determine the depth of trauma discussion within the session. Although a discussion of CSA occurred in this session, there did not appear to be any processing of the trauma as the percentage of cognitive processing words, including insight and causation, were 0.00%. Additionally, there appeared to be slight decrease in percentage of cognitive processing and insight words from the last discussion of WPH in the previous session, and an increase in the percentage of causation words. Specifically, the percentage of overall cognitive processing words decreased by 7.14%, the percentage of insight words decreased by 2.71%, and the percentage of causation words increased by 0.98%. Although, these findings appear inconsistent with the researcher's expectations and the contemplation stage of change, one cannot make a determination as the changes were across sessions and not within the session. Additionally, there was a lack of themes observed during both the discussion of CSA and WPH, which is again inconsistent with the belief that the themes of avoidance of trauma discussion and avoidance of emotion would occur during trauma discussions in the contemplation stage of change.

At session 14, the URICA measure placed the client-participant in the action stage of change, though through review of the transcripts and themes for sessions 14, 16 and 18 it appears that the client-participant was most likely in the preparation stage of change. Although there were no trauma discussions in sessions 14 and 16, there were two discussions of WPH during session 18. During session 18, it was assumed the client-participant was likely in the preparation stage of change. Again, the results were somewhat consistent with the literature and the researcher's expectations as there was an increase in overall cognitive processing words, and specifically insight words, from the first discussion of WPH to the second discussion of WPH. Specifically, during the first discussion the client used 12.66% cognitive processing words and 3.80% insight words, while she used 14.63% cognitive processing words and 4.39% insight words during the second discussion. However, there was a lower percentage of causation words spoken during the second trauma discussion (1.46%) than during the first discussion of WPH (2.53%). These results appear somewhat consistent with the researcher's expectation of depth of trauma processing during the preparation stage of change. Additionally, the results suggest that the client-participant engaged in greater depth of processing, specifically gaining more insight, later in the therapy session than earlier. However, the themes observed were not consistent with expectations or the literature as there were no occurrences of independence, assertiveness, or respect for self/pride during this stage of change.

Overall, it appears that the client-participant's depth of processing CSA and WPH within each session, in relation to the stages of change and observed themes, is somewhat consistent with the literature and the researcher's expectations. Specifically, there appeared to be greater depth of trauma processing (i.e., higher percentage of cognitive processing, insight and causation words) within each session in the contemplation and preparation stages of change. However, it also appeared that at times, there was also greater depth of trauma processing later in the session during the action stage of change as well. This might have occurred if the client-participant was discussing actions specifically related to her WPH during that stage of change. Furthermore, the

themes observed within each trauma discussion were inconsistent with the researcher's expectations as many of the specific trauma discussions did not contain the expected themes for that particular stage of change.

Therapist techniques. The third and final research question in the current case study aimed to investigate how the techniques used by the therapist during trauma discussion and processing of trauma related to the stages of change. To determine techniques used by the therapist, the researcher reviewed the therapist-participant's speech and non-verbal behaviors during the discussions of CSA and WPH across the course of therapy and reviewed the treatment summary. The behaviors were then considered in relation to the recommended roles of the therapist for each stage of change. The literature notes specific therapeutic practices that can be used by the therapist, across diverse forms of treatment, to facilitate and ensure that the stages of change work best for the client (Prochaska & Norcross, 2001). The researcher expected that the therapist-participant would have followed a few of those recommended techniques, but not all of them as she was a trainee therapist.

According to the therapeutic practices recommended by Prochaska and Norcross (2001), the therapist should first assess the client's stage of change. In the current case study, the therapist-participant assessed for the client-participant's stage of change during the intake (session zero) and at two other points across the course of therapy. However, the measures were not filled out and turned in during the same session (i.e., given at session 7 and returned at session 12); they were not filled out on time (i.e., every fifth session); and they were not discussed with the client-participant after review of the results. Still, the measures provided the therapist-participant with an ongoing idea of the client-participant's progression through the stages of change, but not for the same issue.

Next, Prochaska and Norcross (2001) recommended that the therapist not treat each client as if he or she is in the action stage of change when they enter therapy; however, in the current study the client-participant was in the action stage of change when she entered therapy. It was

important for the therapist-participant to realize that this did not mean the client-participant was ready to process her trauma, as she stated she wanted to work on her confidence on the first URICA measure. Upon reviewing the transcripts of the first discussion of CSA in the first session, the therapist-participant thanked the client-participant for sharing her trauma experiences, but did not force her to continue discussing the trauma when the client-participant changed the topic. Additionally, she addressed the client-participant's confidence in opening up to her friends and expressing her emotions, by gathering more information about the client-participant's reported problem and trying to gain a better understanding of how long this has been a problem and what from the client-participant's past may be contributing to the problem.

Prochaska and Norcross (2001) also recommend that the therapist set realistic goals to aid the client to move through one stage at a time. Upon reviewing the entire course of therapy, the therapist-participant did not appear to set any specific goals with the client-participant. Instead, the therapist-participant let the client-participant discuss whatever she wanted in the sessions.

Additionally, it is recommended that the therapist used techniques and relationships that are matched to the client's current stage of change (Prochaska & Norcross, 2001). It appeared that the therapist-participant attempted to do this; however, it is not known whether she used the stages of change to inform her treatment approach. When the themes of avoidance of emotion and avoidance of trauma discussion were present, the therapist-participant did not pressure the client-participant to continue with the discussions of CSA or WPH; instead she attempted to provide empathy and validation by nodding or verbally agreeing with the client-participant. Once again, it is not known if she used this approach because of the client-participant's current stage of change, but it is consistent with research that establishing a positive therapeutic relationship leads to a safe therapeutic environment in which the client can effectively work on processing trauma (Farber et al., 2004; Sano et al., 2003). Furthermore, this is consistent with the role of the therapist to be a "nurturing parent" (Prochaska & Norcross, 2001; p. 444) during the pre-contemplation stage of change, which is the stage the client-participant appeared to be in with

regards to her CSA. However, there were instances during discussions of WPH, specifically in session one, when the therapist-participant tried to provide the client-participant with suggestions of new behaviors she could try. In these instances, the client-participant came up with reasons why each of the therapist-participant's suggestions would not work, indicating she did not find this technique helpful. This could also mean that the client-participant was not in the action stage of change regarding WPH either; and as such, techniques matched to that stage of change would not have been helpful for the client-participant.

The final practice recommended by Prochaska and Norcross (2001) was to have the therapist avoid mismatching stages of change with the processes of change and the techniques that work best. Specifically, research notes that action-oriented process of change (i.e., stimulus control, reinforcement management and environmental reevaluation) and techniques work best during the action and maintenance stages of change (Burke et al., 2004; Petrocelli, 2002; Prochaska & Norcross, 2001). Additionally, cognitive and psychoanalytic oriented processes of change (i.e., consciousness raising, self-reevaluation and self-liberation) work best during pre-contemplation, contemplation and preparation stages of change (Burke et al., 2004; Petrocelli, 2002; Prochaska & Norcross, 2001).

According to the treatment summary, the therapist-participant reported she took a psychodynamic approach to “assist the client to explore her childhood trauma” and later took a cognitive behavioral approach to “help her communicate her emotion.” Additionally, the therapist-participant reported she “established a good, trusting relationship” with the client-participant, and her WAI scores reflected a strong therapeutic alliance with the therapist-participant. Research has shown that the therapeutic relationship and safe environment of therapy is especially important with victims of sexual assaults as they may have not told anyone of the trauma before (Sano et al., 2003), as well as with individuals in the pre-contemplation stage of change as they may show more ambivalence towards working on their problem and be more likely to prematurely terminate from therapy (Rochlen et al., 2005).

The techniques and theoretical orientations employed by the therapist-participant are consistent with the literature. Specifically, during discussions of CSA and WPH when the client-participant was in the contemplation stage of change, the therapist-participant would verbally and non-verbally agree with the client-participant, increasing the rapport and showing support for the client-participant. She also asked the client-participant if she wanted to discuss her experiences of CSA and went along with the client-participant's response each time. Furthermore, when the client-participant was in the action and contemplation stages of change, the therapist-participant used a psychological board game to aid the client-participant in her ability discuss her experiences and problems. During this game, the therapist-participant again followed the client-participant's lead. However, when the client-participant was willing to discuss her experiences of CSA and WPH, the therapist-participant asked questions about the client-participant's feelings on the situations and how the experiences in her past might be affecting her current situations.

Overall, the techniques observed to be used by the therapist-participant were consistent with the literature and with the researcher's expectations. Although she did not follow all of the recommendations suggested by Prochaska and Norcross (2001), with the ones she did follow, the therapist-participant was able to help the client-participant move through the stages of change and appeared to create a space for her to begin to process her trauma. However, as there is no cultural critique of the techniques recommended by Prochaska and Norcross (2001) to be used with the stages of change, or studies employing such techniques with African American clients, the researcher cannot be sure if these techniques were appropriate for the client-participant in this study.

Methodological Limitations

Throughout the process of the current study, multiple concerns about the limitations of case study research arose, as well as concerns about the specifics of the current study. One of the limitations of conducting a case study research design is that one cannot make statistical generalizations across the findings as sampling units are not used to measure the data (Yin, 2003).

Yet, generalizability of results is not as much of a concern in qualitative research as it is in quantitative studies, as the experience of each participant is considered to be unique (Merriam, 2002). Still, an analytical generalization can be made in which a previously developed theory is used as a template with which to compare the empirical results of the case study (Yin, 2003). In the current case study, the researcher aimed to explore the relationship between timing and depth of trauma discussion and the stages of change from the transtheoretical model. In and of itself, the transtheoretical model has been extensively researched as to the generalizability of its components across problem behaviors (Prochaska et al., 1994). As such, the researcher compared the findings on timing of trauma discussion and depth of trauma discussion to the client-participant's recorded stage of change. However, the researcher had some difficulty with this process as the URICA measures were not administered according to the clinic's protocol (not on time, at every 5th session, and different problems were staged at different administrations), not returned during the same session they were given, and results were not discussed during sessions. Therefore, the researcher had difficulty knowing which specific sessions the URICA measures, and the reported stages of change, corresponded with. These points are discussed in more detail below. But, to increase the transferability of the findings and aid others in determining if and how the results can be applied to their situations, the researcher provided detailed descriptions of observations and processes used during the study.

Another limitation of this study is that it is a single case study design. Single case study designs can be vulnerable because the researcher has put "all their eggs in one basket" (Yin, 2003, p. 53). The analytic benefits may not be as strong as they would if there were even a two-case study design (Yin, 2003). To combat this limitation, the current study used a longitudinal approach in which the participant was studied over multiple points in time; specifically 6 of the 21 therapy sessions were coded and analyzed. That way the researcher had more confidence in her findings (Yin, 2003). Furthermore, multiple sources of evidence were used, as they were necessary to provide reliability for the study (Yin, 2003). The need to gather multiple sources of

evidence can be time-consuming, making the process challenging for researchers (Yin, 2003). In this study, an archival database of multiple sources of evidence was used to lessen the time needed to gather information. The database included demographic information, written measures (e.g., symptom distress, stages of change and therapeutic alliance), and videotapes of psychotherapy sessions. However, using an archival database also had limitations: the researcher only had the information already in the database; there was no ability to check in with the client-participant; written measures could not be added; and check-ins with the therapist-participant were not possible.

Finally, the analysis of case study evidence is one of the least developed and most difficult aspects of this design (Yin, 2003). The researcher in this study prepared a clear data analysis plan for the data to make the analysis process more concrete. The researcher created a training and coding manual (see Appendix K) that documented each step of the coding and data analysis process. Specifically, the procedures for training members of the research team to transcribe videotaped sessions and code for discussions of trauma, code for timing and depth of trauma processing, and identify and label themes and subthemes, were outlined. In addition, tables and tracking sheets were created to organize LIWC findings, timing of trauma discussions, and themes and subthemes observed across the course of therapy. However, the coders in this study were not experts in working with ethnic minorities in therapy, and as such may have failed to include all potential variables, themes and subthemes in the coding manual, process, results and discussion. For example, the coders may not have understood the context of the client-participant's speech when she spoke using slang or Ebonics. As such, it is possible that the coders interpreted the client-participant's language incorrectly from their own cultural biases and not hers.

In addition to concerns with using a case study approach, there were specific limitations of the current study. First, because the URICA was only given at intake and at five session intervals, discussions of trauma occurring in a session in which the URICA was not given were

not able to be accurately related to the client-participant's current stage of change. By using the stage of change the client reported the last time the measure was given, the researcher could only assume that the client-participant was in the same stage of change. Additionally, the researcher had to rely on the therapist-participant to administer the measures at the appropriate times indicated by the clinic where the therapy was conducted. This was not the case. Instead of administering the URICA every five sessions, they were given sporadically, on three separate occasions, throughout the course of therapy. This made it difficult for the researcher to determine what sessions, and subsequent trauma discussions, corresponded with each URICA measure.

Second, on the follow-up URICA, there is a place for the therapist-participant to write in what the client-participant's previously reported problem; however, in the current case, the therapist-participant did not fill this out and actually told the client-participant that it did not matter what her previous problem was. As such, the client-participant's problem she was working on was different on each URICA measure. Also, the client-participant did not refer to the traumatic experience as the problem being measured with the URICA on any of the measures, which made it difficult for the researcher to accurately determine if her reported stage of change had any influence on her trauma discussions.

To address these URICA limitations, the researcher observed general themes and subthemes that emerged during discussions of trauma across the course of therapy which appeared to be related to depth of trauma discussion and the stages of change. These themes and subthemes were then compared to the client-participant's URICA measures and used to determine the client-participant's stage of change specifically regarding her discussions of CSA and WPH. The most accurate method of determining the client-participant's stage of change would have been to develop a coding system; however, it was beyond the scope of this dissertation to do so.

Third, there were limitations with the use of the LIWC text analysis computer program. Although, the LIWC dictionary itself contained over 4,500 words and word stems (Pennebaker et al., 2007), it may not have accounted for all of the words related to the processing of trauma in

the client-participant's speech. The LIWC program only examines word usage, and does not provide information about the context of the narrative in which the words are embedded (Hirsh & Peterson, 2009). Seeing as narratives operate at many levels simultaneously (e.g., word, sentence, paragraph and page), the meaning of written narratives can be lost in a simple word count (Hirsh & Peterson, 2009). Furthermore, seeing as the writings entered into the LIWC program were actually written transcriptions of a dialogue between two people, even more of the context (including non-verbal communication) was lost. Additionally, examining the types of cognitive processing words, including insight and causation, was made difficult as the LIWC did not specifically indicate which words in the transcript it categorized, nor did it provide a dictionary of words in each category and subcategory for the researcher to review. Therefore, the researcher was not able to determine the nature of the client-participant's insight, nor was the researcher able to connect the cognitive processing, insight and causation words to the themes. It was beyond the scope of this study to further analyze the tapes and transcripts to determine what words constituted improved cognitive processing, insight and causation.

Fourth, there were cultural limitations to both the stages of change theory and the LIWC text analysis program. Specifically, regarding the stages of change theory, literature has included African American in research on a variety of health and addictive studies; however there have not been any studies that focus on working specifically with African American women or survivors of trauma. As such, the current study was unable to address if the stages and techniques recommend in the theory were culturally appropriate for the client-participant. Furthermore, although studies of the LIWC program have also included a variety of populations including African Americans (Pennebaker, 1997), there are no studies specific to the validity of its use with African American women. Therefore, the specific cultural language and slang used by the client-participant may have been analyzed out of context and therefore inaccurately reported.

Fifth, limitations in relation to identifying the techniques used by the therapist-participant also occurred. Specifically, the poor quality of the video-recordings made it difficult for the

researcher to see or hear the responses of the therapist-participant at times. Additionally, it was difficult to determine when the therapist-participant was employing a technique or intervention other than rapport building, as she did not have an identified theoretical orientation (the treatment summary reported she used multiple theoretical orientations) and did not appear to be using techniques consistent with those orientations throughout the course of therapy. To address these limitations, the researcher reviewed the therapist-participant's speech and non-verbal behaviors during trauma discussions in each therapy session. Furthermore, the treatment provided by the therapist-participant did not appear to be trauma-focused therapy or informed by the stages of change theory. As such, the researcher must consider that if such techniques had been employed by the therapist-participant, there may have been a different outcome to therapy.

Additionally, the current study did not focus on the therapist-participant's reactions to the client-participant, or the process between the client-participant and the therapist-participant. This may have led to oversights by the researcher in the processing of the trauma, such as the therapist-participant avoiding trauma discussions in addition to the client-participant's avoidance. For example, it is possible that the therapist-participant's attempts to change the topic of discussion when the client-participant did not want to discuss her trauma were avoidance of confrontation with the client-participant on the part of the therapist-participant. Additionally, the therapist-participant's topic changes could have been related to therapist wanting to avoid the stereotype of the angry black woman.

To identify the client-participant's stage of change in relation to her trauma discussions, the researcher examined the themes and subthemes that generally emerged during trauma discussions across the course of therapy and attempted to determine whether they applied to the stages of change theory. This allowed the researcher to better identify the stage of change the client was in regarding discussions of CSA and WPH. It was beyond the scope of this dissertation to develop a coding system to specifically identify the client-participant's stages of change during trauma discussions, which would have been the most accurate method.

Another limitation of the current study involved the positive psychology perspective taken by the researcher. The researcher focused on creating a balanced view of the client, including both challenges and strengths. As such, the development of the themes and subthemes was done by objectively observing videotapes and transcripts of the course of therapy to determine what themes emerged, as opposed to being informed from a purely strengths-based approach. Additionally, this method did not include the researcher observing themes specifically related to the stages of change theory, but instead involving the researcher maintaining an objective or more inclusive viewpoint.

Lastly, the inclusion criterion that a traumatic experience must have been indicated on the intake measures may have skewed the sample towards including a client-participant who had already made an initial disclosure of the traumatic experience and/or was ready to discuss and process the experience. A client in the pre-contemplation stage who may not have discussed the trauma with anyone before may have been less likely to put it on the intake forms or mention it during the initial session with the therapist-participant.

Future Directions

Future research should continue studying the timing and depth of trauma discussion as related to the stages of change. Prior to the current study, there was no available literature that specifically focused on how these aspects of therapy interacted. It would be important to address the limitations regarding case studies and archival database presented above to ensure that future studies gather more accurate data.

In order to continue to understand the relationship of the stages of change to depth and timing of trauma discussion, the researcher suggests future studies focus on more than one client's experiences of trauma discussion. It is recommended that multiple clients from different populations be studied in a longitudinal fashion. This would allow for more generalizability of the results across populations. Additionally, future studies should be done with available participants instead of using an archival database to allow for access to clients' and therapists'

reactions to the process, and the ability to ensure that written materials are completed according to protocol. Researchers should continue to accurately assess clients' stages of change when they present for therapy, as well as their progression through the stages across the course of therapy. One suggestion for future research is to assess clients when they present for therapy (Prochaska & Norcross, 2001), as was done in the current study, and continue to assess the client at each session thereafter. This would ensure that the therapist is aware of clients' progression and cycles through the stages across the course of therapy. Accurately identified stages would allow the therapist to know what relationship stance to take and therapeutic interventions to use to facilitate progression through the stages (Prochaska & Norcross, 2001). It would also be important for the researcher to ensure that clients intend on working on the same problem over the course of therapy, or begin a new set of stage of change measures for each newly identified problem. To do this across the course of therapy, the therapist should discuss the reasons for measuring stages of change with clients, as well as, the results of each measure, to ensure that there is communication with clients about their intended focus of therapy.

Furthermore, previous research has not focused on the specific types of trauma studied in the current study (i.e., CSA and WPH). Future studies could continue to focus on these types of trauma and expand to other types of traumas, including non-interpersonal traumas.

The methods used in the current case could be replicated and expanded upon. Specifically, the measures and analysis program used (i.e., LIWC, OQ-45.2, URICA, WAI) should continue to be used and additional measures focusing on other aspects of the transtheoretical model (i.e., decisional balance and processes of change) could be added to provide further information aid in understanding the process of trauma discussion during psychotherapy. Additionally, continuing to use videotaped therapy sessions will provide researchers with access to both verbal and nonverbal aspects of trauma discussion and techniques used by the therapist during sessions. Furthermore, it would be beneficial to administer written measures more frequently than was done in the current study. By administering written measures

(e.g., URICA) at every session or every other session, researchers would have a more accurate understanding of what stage of change clients are in during each therapy session.

Once methodological limitations from the current study have been addressed, future research could focus on specific social or sociocultural contexts which may also influence clients to change their behaviors (e.g., peer group influences, media images, economic stressors, family norms and values) (Begun et al., 2001). Looking at what societal factors may inhibit or encourage behavioral or cognitive changes, in this case processing of traumatic experiences, may give the therapist further information as to what interventions may be helpful to aid clients' progress through the stages of change. Additionally, including an understanding of cultural factors which may hinder or promote behavior change and progression through the stages should be included in future research (Begun et al., 2001), as it may change how the therapist helps clients progress. Specifically, learning if clients have discussed their traumatic experiences with others in the past and how they felt about those discussions would help therapists tailor treatment to what clients find helpful for them. In the current study, considering research and literature on cultural factors such as race, ethnicity, gender, and geographic location of the client-participant was helpful in determining any patterns of trauma discussion that were specific to the client-participant's specific life experiences. Yet, future research is needed to focus on critiquing and potentially expanding the model of behavior change to particular ethnic populations to determine its usefulness with each specific population. Understanding societal and cultural factors would provide a more balanced approach to examining the theory and how it can best be employed in psychotherapy practice (Seligman & Csikszentmihalyi, 2000).

Yet another direction for future research would be to examine how other aspects of the transtheoretical model (i.e., decisional balance, self-efficacy and processes of change) affect the timing and depth of processing of trauma discussions. Understanding the relationship of decisional balance (e.g., cognitive and motivational aspects of decision making) and self-efficacy (e.g., how confident people are that they can maintain the change in their behavior) (Prochaska,

Wright & Velicer, 2008) may provide necessary information to how well clients will fit with the stages of change. For example, researchers could develop a measure of decisional balance that would help clients weigh the pros and cons of processing their traumatic experiences. Research on the benefits (e.g., meaning-making and posttraumatic growth) and disadvantages (e.g., psychological discomfort) of trauma discussion could be used in this tool. Additionally, understanding the processes of change (e.g., specific strategies for behavior change) (Prochaska et al., 2008) and which ones correlate with each specific stage of change would aid the therapist in creating stage-matched interventions (Prochaska & Norcross, 2001) to be used specifically for clients who have experienced trauma, and thus enhance clients' success at increasing depth of trauma discussion. The Processes of Change Questionnaire developed by Prochaska, Velicer, DiClemente and Fava (1988) could be used to assess what processes of change clients are using and see if they match with the stages of change clients are reported to be in.

Finally, future research could examine the psychological and physiological effects of trauma discussion (Burke & Bradley, 2006) during each stage of change, as the current study was not able to link the linguistic characteristics of trauma discussion (LIWC cognitive processing words related to insight and causation) during each stage of change to outcomes of therapy. Future studies could include therapy outcome measures, looking at overall physical health, overall psychological health, or improvement of interpersonal relationships, in addition to linguistic analysis. This would allow for observation of outcome differences between clients in addition to their progression through the stages of change.

Potential Contributions

Research and literature on the stages of change have typically focused on creating and maintaining change in health behaviors such as smoking cessation, alcohol use, weight control, exercise, and safe sex. More recently, research has begun to focus on the application of stages of change to domestic violence survivors and perpetrators; however, this theory has not been applied to other experiences of trauma. The current case study aimed to investigate the relationship

between the timing and depth of trauma discussions, specifically CSA and WPH, during psychotherapy and the stages of change, in an effort to gain an understanding of how the stages of change can be used to facilitate processing of trauma.

The findings of the current study contributed to the knowledge of the discussion of traumatic material within the therapeutic context. Previous literature has not focused on when discussions of trauma occur both within therapy sessions and across therapy sessions. Findings from the current study are consistent with literature that trauma discussions can occur at any point across the course of therapy (Higgins Kessler & Nelson Goff, 2006; Sano et al., 2003). Furthermore, it adds to the knowledge of the field that trauma discussions can occur at any point in time during a therapy session, and are not more likely to occur in the final quarter of the session as previously reported (Strassberg et al., 1978).

Findings on the timing of trauma discussion in the current study also showed consistency with the stages of change theory (not previously examined in research), indicating that clients may be more willing to discuss traumatic experiences when they are in the contemplation or preparation stages of change. Understanding the timing of when discussions of interpersonal trauma may occur in the therapeutic process, and how they are associated with the stages of change, is likely to be beneficial to therapists. With this knowledge and future research expanding on the results of the present study, therapists may have a better understanding of the appropriate time and interventions/methods for encouraging their clients during the disclosure process. Therapists should consider and understand such factors when working with clients who have experienced a traumatic event to facilitate growth and avoid re-traumatization.

Additionally, the current study contributed to knowledge on the depth of trauma discussions, specifically amounts of cognitive processing words, including insight and causation, across the course of therapy and within each therapy session, and how they appeared to relate to the stages of change. The researcher's results were consistent with literature that greater percentages of insight would occur in a client's speech at the end of the course of therapy

(Hemenover, 2003). Moreover, the current study found that greater percentages of cognitive processing and causation words occurred towards the beginning of the course of therapy, indicating that as a client continues processing trauma throughout the course of therapy, his or her feelings of the cause of the trauma may become less important and gaining insight into the meaning of the trauma may become more important. Previous research has shown that struggles with processing traumatic experiences may lead to benefit-finding, posttraumatic growth, positive adjustment, thriving, flourishing and self-reflection (Bryant-Davis, 2005; Fawcett, 2003; Frazier & Berman, 2008; Joseph & Linley, 2008; Morland et al., 2008; Nolen-Hoeksema & Davis, 2005; O'Dougherty Wright et al., 2007; Sheikh, 2008; Tedeschi & Calhoun, 2004). In the current case study, it appeared that this may have been the process the client-participant was beginning.

Furthermore, the findings of the current study showed that the processing of trauma was more likely to occur during the contemplation and preparation stages of change (when insight was greatest), and less likely to occur during the action stage of change (when insight was lowest). This finding seemed contradictory to what most therapists might expect. If clients were actively making successful changes to their behaviors, one might expect they would be in the action stage of change. However, results of the current study provide information that the contemplation and preparation stages of change, which are often associated with cognitive changes as opposed to behavioral changes (Burke et al., 2004; Petrocelli, 2002; Prochaska & Norcross, 2001), were more likely to contain processing of trauma and increased insight into traumatic experiences.

Finally, the current study aimed to contribute to the knowledge on what techniques could be used by therapists in order to help facilitate the processing of trauma. Specifically, it was found that building rapport and providing validation during the contemplation and preparation stages of change was helpful in facilitating discussion of trauma. Additionally, when techniques were used that did not match the client's stage of change (i.e., advice giving in the contemplation stage of change) it was not found to be helpful for the client, and she dismissed what the therapist said. By gaining a better understanding of what stage of change a client is in during trauma

processing, future clinicians are encouraged to develop and use the best stage-matched interventions (Prochaska & Norcross, 2001) that encourage increased processing of trauma and promote the strengths the client already possesses. This approach is consistent with the positive psychology framework that aims to build on the positive qualities of an individual, does not just focus on repairing the negative experiences in life (Seligman, 2005; Seligman & Csikszentmihalyi, 2000), and believes that growth and adaptation can follow traumatic experiences (Joseph & Linley, 2008).

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APPENDIX A
Client Information Adult Form

CLIENT INFORMATION **ADULT FORM

ID# _____

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

TODAY'S DATE _____

FULL NAME _____

HOW WOULD YOU PREFER TO BE ADDRESSED? _____

REFERRED BY: _____

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

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

Personal Data

ADDRESS: _____

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

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

LIST BELOW THE PEOPLE LIVING WITH YOU:

Table with 4 columns: NAME, RELATIONSHIP, AGE, OCCUPATION

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

ID# _____

CLIENT INFORMATION **ADULT FORM

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

MEDICATIONS BEING TAKEN: _____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

OTHER SERIOUS ILLNESSES

DATE

sample

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHOLOGISTS, PSYCHIATRISTS, MARITALS, COUNSELING, GROUP THERAPY, ETC.)

DATE

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

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

CURRENT AND PREVIOUS JOBS:

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

ID# _____

CLIENT INFORMATION **ADULT FORM

HOUSEHOLD INCOME:

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

OCCUPATION: _____

Family Data

IS FATHER LIVING?

Yes IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

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

CAUSE OF DEATH: _____

IS MOTHER LIVING?

Yes IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

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

CAUSE OF DEATH: _____

BROTHERS AND SISTERS

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

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

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

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

ID# _____

CLIENT INFORMATION **ADULT FORM

Current Difficulties

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

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

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

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

Social/Cultural (Optional)

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

APPENDIX B

Intake Evaluation Summary

Pepperdine Community Counseling Center
Intake Evaluation Summary

Client:
Intake Date(s):

Intake Therapist:
Date of Report:

I. Identifying Information

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

II. Presenting Problem/Current Condition

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

Sample

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

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

IV. Psychosocial History

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

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

V. Mental Status Evaluation

Hygiene & grooming:

Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

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

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

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

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

Thought Content (appropriate; delusions, odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

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

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

VII. Summary and Conceptualization

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

VIII. DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

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

IX. Client Goals

X. Treatment Recommendations

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

Therapist Date

Supervisor Date

APPENDIX C

Telephone Intake Form

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

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

sample

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 SOMETIMES AUDIO) TAPE 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 D

University of Rhode Island Change Assessment (URICA) Scale

ID # _____

Name _____ Date _____ Session # INTAKE _____

SCS

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

Please write that problem or issue here: _____

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

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

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

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

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

Date: _____ Session #: INTAKE ID # _____

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

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

APPENDIX E

Outcome Questionnaire (OQ-45.2)

Outcome Questionnaire (OQ-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name: _____ Age: _____ yrs. Sex M F ID# _____

Session # _____ Date ____/____/____

Table with 5 columns: Never, Rarely, Sometimes, Frequently, Almost Always. Rows 1-45 with various statements like 'I get along well with others', 'I feel stressed at work/school', etc.

SD IR SR DO NOT MARK BELOW. Total = _____

sample

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APPENDIX F

Working Alliance Inventory – Client

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

WORKING ALLIANCE INVENTORY SHORT FORM - CLIENT

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

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

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

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

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

3. I believe my therapist likes me.

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

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

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

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

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

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

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

7. I feel that my therapist appreciates me.

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

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

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

sample

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

9. My therapist and I trust one another.

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

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

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

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

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

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

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

CLIENT EXPERIENCES SCALE

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

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

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

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

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

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

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

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

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

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

APPENDIX G

Working Alliance Inventory – Therapist

Client Name: _____ Therapist Name: _____

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

**WORKING ALLIANCE INVENTORY SHORT FORM - THERAPIST**

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

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

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

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

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

3. I believe my client likes me.

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

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

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

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

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

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

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

7. I feel that my client appreciates me.

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

Client Name: _____ Therapist Name: _____

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

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

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

9. My client and I trust one another.

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

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

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

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

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

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

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

APPENDIX H

Brief Multidimensional Measure of Religiousness/Spirituality

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

A note to our clients

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

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

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

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

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

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

Thank you!

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

10. I have forgiven those who hurt me.

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

11. I know that God forgives me.

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

Private Religious Practices

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

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

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

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

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

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

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

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

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

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

Religious and Spiritual Coping

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

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

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

18. I work together with God as partners.

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

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

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

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

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

Brief Multidimensional Measurement of Religiosity/Spirituality for Use in Health Research # _____

21. I wonder whether God has abandoned me.
 1-A great deal
 2-Quite a bit
 3-Somewhat
 4-Not at all
22. I try to make sense of the situation and decide what to do without relying on God.
 1-A great deal
 2-Quite a bit
 3-Somewhat
 4-Not at all
23. To what extent is your religion involved in understanding or dealing with stressful situations in any way?
 1-Very involved
 2-Somewhat involved
 3-Not very involved
 4-Not involved at all

Religious Support

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

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

Sometimes the contact we have with others is not always pleasant

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

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

Religious/Spiritual History

28. Did you ever have a religious or spiritual experience that changed your life?
 No
 Yes
- IF YES: How old were you when this experience occurred?
29. Have you ever had a significant gain in your faith?
 No
 Yes

IF YES: How old were you when this occurred?

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

IF YES: How old were you when this occurred?

Commitment

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

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

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

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

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

Organizational Religiousness

34. How often do you go to religious services?

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

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

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

Religious Preference

36. What is your religious preference?

IF PROTESTANT
Which specific denomination is that?

Overall Self-Ranking

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

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

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

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

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

APPENDIX I

Multidimensional Scale of Perceived Social Support

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

Circle the "1" if you **Very Strongly Disagree**

Circle the "2" if you **Strongly Disagree**

Circle the "3" if you **Mildly Disagree**

Circle the "4" if you are **Neutral**

Circle the "5" if you **Mildly Agree**

Circle the "6" if you **Strongly Agree**

Circle the "7" if you **Very Strongly Agree**

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

APPENDIX J
Treatment Summary

TREATMENT SUMMARY**Identifying Information:**

Treatment Information (*date of initial evaluation, number of sessions, treatment modality [e.g., individual or conjoint], date of termination*):

Course of Treatment (*conceptualization of client's difficulties, therapy orientation, client's response to treatment, emergency/crisis issues. Be sure to connect this with the client's presenting problem, nature of therapeutic relationship, etc*):

sample

Diagnosis at Termination:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

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

sample

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

Student Therapist

Supervisor

Date

Date

APPENDIX K

**DISCUSSION OF INTERPERSONAL TRAUMA IN PSYCHOTHERAPY TRAINING
AND CODING MANUAL**

This training and coding manual is intended to help orient you to the methods of transcription and coding that will be utilized for this research project. The specific therapy tapes will be clients and therapists at the Pepperdine University clinics that have been selected by the researcher based on inclusion/exclusion criteria (e.g., individual adult clients representing diverse ethnicities, gender, religions, and presenting issues). Karina G. Campos, M.A., Lauren DesJardins, M.A., and Whitney Dicterow, M.A., will be utilizing this criteria for their respective dissertations to gain a more in-depth understanding of how clients disclose and process trauma in relation to ruptures and repair of the therapeutic alliance, the stages of change theory, and the expression of positive emotion, within the context of individual psychotherapy (across the course of treatment). Your role as research assistants will be to transcribe the sessions in great detail and help with the preliminary coding phase for each discussion of an interpersonal trauma (see below).

I. TRANSCRIPTION INSTRUCTIONS

(Adapted from Baylor University's Institute for Oral History -
http://www3.baylor.edu/Oral_History/Styleguiderev.htm)

The first step will be to transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of client statements to then be coded using the Verbal Response Mode (VRM) codes for form and intent of disclosures of interpersonal trauma. Attached at the end of this section is a template that you will use for your transcriptions. After reading this manual and discussing questions during training, you will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the practice, we will review with you a completed transcript to check your work and address any questions.

A good transcription should reflect as closely as possible the actual words, speech patterns, and thought patterns of the speakers. The speakers' word choice, including his/her grammar, nonverbal gesture, including sighs, yawning, body movement (e.g., adjusting positions, posture etc), and speech patterns should be accurately represented. The transcriber's most important task is to render as close a replica to the actual event as possible. Accuracy, not speed, is the transcriber's goal.

When identifying who is speaking, 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. Do not include every feedback, especially if it interrupts the client's comments in midstream. Only if the feedback is a definite response to a point being made by the client should you include it. When in doubt, please ask the research team.

Type no more than two crutch words per occurrence. Crutch words are words, syllables, or phrases of interjection designating hesitation and characteristically used instead of pauses to allow thinking time from the speaker. They also may be used to elicit supportive feedback or simple response from the listener, such as: you know? see?, or understand?

Use of *Uh*: The most common word used as a crutch word is *uh*. When *uh* is used by the narrator as a stalling device or a significant pause, then type *uh*. But sometimes a person will repeatedly enunciate words ending with the hard consonants with an added "uh," as in and-uh, at-uh, did-uh, that-uh, in-uh. Other examples are to-uh, of-uh, they-uh. In these instances, do **not** type *uh*.

Guggles are words or syllables used to interrupt, foreshorten, or end responses, and also as sounds of encouragement. Guggles are short sounds, often staccato, uttered by the therapist to signal his/her desire to communicate. They may be initial syllables of words or merely *oh*, *uh*, *ah*, or *er*. Spelling of specific guggles: Agreement or affirmation: uh-huh, um-hm; Disagreement: unh-uh.

For consistency, use **only** the following for exclamations:

- Uh
- Um
- Uh-huh
- Mm-hmm
- Unh-uh

Do **not** use ah, oh, er, and so forth. Pick from the list above and use what seems closest to what is being uttered.

Incomplete sentences are familiar occurrences in oral history because of its conversational nature. They are best ended with an em dash (—). Use one dash (-) for an incomplete word that is then continued (e.g., mo- mother). Interruptions should be indicated using an ellipsis (...).

Similarly, an ellipsis should be used when the person who was interrupted continues their sentence after the interruption.

Example: Interruption

T1: Do you feel like he was ignoring you or...

C2: No, I just felt like he wasn't understanding what I was saying.

Interruption and continuation

T1: He was coming toward me and I felt, I felt...

C2: Scared?

T2: ...scared and confused.

Quotation Marks:

1. When a direct expression is spoken by one person (I, he, she), set apart the expression with commas, use opening and closing quotation marks, and capitalize the first letter of the first word quoted.

Example: She said, "I am going to graduate in May."

2. When a direct expression is spoken by more than one person (we, they), do not use quotation marks, but do set apart the expression with commas and do capitalize the first letter of the first word quoted.

Example: They said, what are you doing here?

3. When a thought is quoted, do not use quotation marks, but do set the thought apart by commas and capitalize the first letter of the first word quoted.

Example: I thought, where am I?

When you have completed the transcription, please go through the session one time to make sure you have captured all the spoken data, and an additional time to ensure you have noted all the significant non-verbal behaviors.

TRANSCRIPTION TEMPLATE**CONFIDENTIAL VERBATIM TRANSCRIPT**

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Session Number:

Coder:

Client #:

Date of Session:

C = Client

T = Therapist

Verbatim Transcript of Session	Initial Coding Impressions
T1:	
C1:	
T2 :	
C2:	
T3:	
C3:	
T4:	
C4:	
T5:	
C5:	

VERBATIM TRANSCRIPT FOR CODING TRAINING**William Miller Therapy Session from APA Series III-Behavioral Health and Counseling**

Therapist: Dr. William Richard Miller

Session Number: 1

Client: Ms. S

Date of Session: xx/xx/xxxx

Introduction: This session was included in a training video for APA, entitled, “Behavioral Health and Health Counseling: William Richard Miller, PhD, Drug and Alcohol Abuse,” and was hosted by Jon Carlson, PsyD, EdD. The session that follows was transcribed verbatim, for the purposes of coder training for Pepperdine University as a part of the Positive Psychology PARC Lab supervised by Susan Hall, JD, PhD. This format will be followed for future transcribed sessions to be utilized in the actual research.

T = Therapist; C = Client

Verbatim Transcript of Session	
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,</p>	

<p>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>	
<p>T3: Yeah, you get thrown along with the lifestyle</p>	
<p>C3: Exactly, and that was also a problem because I have an addictive personality and it's, I believe it's hereditary and it's part of other problems that I have.</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 freebasing. You buy the, buy it in the rock form or in the powdered form, and I spent, I spend \$7000 in 3 months on that.</p>	
<p>T4: So you're very efficient about the drug use, packing it into a short period of time.</p>	
<p>C4: Well I packed it in, unfortunately, I don't know if it's good or it's bad, I went from buying it from people I didn't really, trying to get what I could from wherever, to climbing up the ladder to finding the main source, so to speak.</p> <p>C4.1: And I was one of those people, who I'm always proud to say, I never did any sex or anything for drugs or anything like that. Now, I didn't do any, anything... prostitution, or there was a lot of girls that would, a lot of women that would do that.</p>	
<p>T5: [Head nodding] So it was very common.</p>	
<p>C5: And, I was the kind of person, I got my nose broken because I wouldn't sleep with somebody's; this one fella wanted me to sleep with him when his girlfriend was at work and I wouldn't do it so he busted my nose. That's the kind of person I am. I don't believe in, that the two have to meet. My love was drugs. I didn't need a man, I didn't need relationships. If I had the money, if I didn't have the money, I had a way to get, you know, get it through people. I had, I didn't just party you know. I partied with uh--</p>	
<p>T6: Contacts.</p>	

<p>C6: Yeah, people who used to be in the show business industry, so to speak. You know, or who were related, A girl that was related to a guitarist in a famous rock star's band, and I'm not gonna name names, and she unfortunately—she died of AIDS but she had the money and she had, always, there was always partying going on with her. We'd go to the hotel and party, party, party.</p>	
<p>T7: And you got caught up in that very quickly.</p>	
<p>C7: Oh, very quickly, and it's easy to I guess, if you have the personality for it, you know. And I didn't have any, and I was at a point in my life where I didn't really care about anything. And I wasn't young either. I was 32.</p>	
<p>T8: So it sort of felt natural to you.</p>	
<p>C8: It felt fun, it felt, actually, it felt good, you know. I was trying to, as they say, chase that next high. It got fun, but when I started running out of the money and I don't know how I had the stamina for it because I actually still worked, paid rent, kept a job, I did everything, well, which a lot of people can do, but for the amount of drugs and drinking I did--</p>	
<p>T9: Pretty remarkable--</p>	
<p>C9: Some people would probably not even be able to get out of bed. I'm not bragging about it. C9.1: Now, ten years later, I feel like I'm physically, I'm just kind of burnt out, you know, C9.2: I stopped doing cocaine in '95, and then I admitted myself into rehab in California that same year, and I've done it still on occasion, but I'm on medication which, thank goodness, doesn't make it where the drug has addictive properties.</p>	
<p>T10: Really?</p>	
<p>C10: Ya, I found it very interesting. I could do cocaine and put it down and not go back to it.</p>	
<p>T11: Which was new?</p>	
<p>C11: Which is something new to me, I mean, this is as recent as moving back to Chicago. [Therapist's head nodding] You know, I haven't been able, I've struggled in and out of sobriety, you know, I feel like Robert Downey, Jr. sometimes. [Therapist</p>	

<p>laughs]</p> <p>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?</p> <p>C11.2: One time I had drank and drove, and that was because I was at my boyfriend's, we were out, I had an argument, and we both went our separate ways. So, I ended up having to go home inebriated. And, um, fortunately nothing happened so I was pretty lucky.</p> <p>C11.3: And um, I've been in and out of recovery with AA and NA and, although I love the program and I espouse to do it, they say anonymity in AA, but I think that the condition in a situation like this, it's...well, it's part of talking about recovery and addiction. And, I've worked in and out of the program, I was clean, and sober for 3 years until I moved back to Chicago. Because I had gotten myself surrounded by people in recovery. Yet, when I moved back here, I was not surrounded by people in recovery and I discovered that I was staying clean and sober for the wrong reasons. I was doing it for other people, not for myself. I was doing it to help my mother, because my mother was dying of cancer, so I tried to, I wanted to...</p>	
<p>T12: So the change again of, of moving--</p>	
<p>C12: Right, they say geographics; you are running away from yourself. But I left California for many reasons. And uh.</p>	
<p>T13: And coming back here in a way set off--</p>	
<p>C13: It set off, right. It set off everything because I felt like I had the freedom. There was nobody there, I had no sponsor, no clean and sober neighbor, nobody checking up on me so to speak to make sure I was still, I was still smoking pot. I hadn't quit marijuana and, but the alcohol was the one that really got to me. I had been, I had quit marijuana for about a 7-8 months after I got out of recovery, but ended up getting back into that situation when I moved in, uh, out of sober living</p>	

<p>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 different colors. I've noticed it's not that big here in Illinois, in Chicago.</p>	
<p>T14: So when you say you're in and out of recovery now, its alcohol and marijuana you're talking about—and every now and then cocaine.</p>	
<p>C14: Right, ya, well the cocaine, basically I've stopped, ah, pretty much avoided that because the individual who introduced me to that again, I avoid seeing him at all costs...which I do for my own well being. I don't want to ride the dragon again. I don't want to go there, even though I know that if I do, I'm not going to be going there again every day. I won't be getting loaded every day because of the medication I take. But, and, he was paying for it, but I realized it was just something that I wasn't even enjoying.</p>	
<p>T15: So why do it?</p>	
<p>C15: Right, you know, to me, everybody, I believe has an addiction. We all have addictions be it food, sex, drugs, alcohol, gambling, family life, work. You know, whatever it may be, I think everybody has one, one thing at least that they crave and that in the back of their mind that they focus on and they really desire.</p>	
<p>T16: And you said you think you have an addictive personality--someone who easily gets drawn into things</p>	
<p>C16: Yeah, well right, I have been. I'm an artist, freelance artist as well, and my addiction used to just be drawing. As a child, I would just come home and draw, you know.</p>	
<p>T17: So whatever you do like that you do it intensely</p>	

<p>C17: Yeah, I wish I could do it to make money and do it, you know. [Therapist laughs] Get a money making idea and do like that, I'd probably be rich, it's just um, but not able to find a proper substitute, you know. At this time, I'm trying to get back into drawing and being more creative, and my personal life, though I feel so mentally, emotionally, and physically exhausted after all I've been through in my life, that all I want to do is almost not do anything. I'm trying not to focus on any addictions. I'm at the point where I'm getting tired. You almost get tired of it physically. Like, if I drink I feel, I don't get the hangovers cuz I won't even allow myself to drink enough, but physically the next day, I feel, I ache, you know I feel the hangover with the headache would manifest itself with my body aches, and I don't want to, want to get up on the...you feel as vital and I've just done so much that I'm burning out.</p>	
<p>T18: And you've used up your chances, huh?</p>	
<p>C18: Yeah, pretty much. And being single all my, which, since 1990 and not having...being blessed without having children, which I never wanted, thank God, I'm not a kid lover. I chose not to have kids also because of my husband and that was one of the reasons we also parted ways. I was happy. I'm lucky enough to where I've had my own life and I've not had to drag anybody, drag anybody down with me, you know. It did affect family members. Anytime you're, you have an addiction, people who care about you, it will, but eventually they turn you away too.</p>	
<p>T19: Now what is recovery for you besides not using alcohol or marijuana?</p>	
<p>C19: To me recovery would be going to meetings, having a sponsor, working a twelve step program, um, I still try to incorporate 12 step beliefs and behaviors in my life as far as, "Let go, Let God," the use the steps, resentment, a lot of people say if you're drinking and using you cannot work the steps, but I think you can use them in a behavior, method of behavior modification if you're, instead of turning to getting loaded or anger or what have you, when you have a problem in life, try to do something positive, call somebody, read if you have an AA Big Book or an NA Big Book, pick something up in there and try to read it. Try to keep</p>	

<p>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 to where I'll say drink more, or just stop totally leaving in that whole lifestyle or that whole belief process.</p>	
<p>T20: There's a piece here which were missing before we go, which is what are you wanting to move toward? What do you--</p>	
<p>C20: What I want to move toward is to just be able to totally not have to drink or use. And at this point--</p>	
<p>T21: Which is doing nothing.</p>	
<p>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.</p>	

II. CODING TIMING OF INTERPERSONAL TRAUMA DISCUSSION INSTRUCTIONS

The second step involves noting when interpersonal trauma discussions take place during the therapy session. This involves understanding our definitions of trauma as well as discussions about it

Definition of Interpersonal Trauma:

Interpersonal trauma includes the following events or experiences: combat, war, mass interpersonal violence not in the context of war, physical or sexual abuse, witnessing or experiencing domestic or family violence, emotional abuse, invalidation, neglect, hate crimes, school shootings, community violence, being kidnapped, torture, and traumatic losses (sudden or violent death of a loved one). These event-based definitions of trauma describe the nature of an event in a way that differentiates it from ordinary daily stressors.

Definition of Trauma Discussion:

The term discussion will be used to signify any disclosure of a traumatic experience including the initial disclosure or reporting of an interpersonal traumatic experience(s) to the therapist as well as any subsequent discussions about the experience(s). Additionally, the term discussion will be used to encompass any further conversations, social-sharing (i.e., re-evocation of an emotional experience in a socially shared language with some addressee present at the symbolic level), or behavioral (e.g., showing a picture or writing sample, bringing in a journal, or gesture referring to the event) and indirect verbal attempts (e.g., discussion about subsequent life results from the traumatic experience) to discuss feelings, thoughts, and beliefs about the interpersonal trauma.

When you observe an interpersonal trauma discussion, you should note the time in which the disclosure/discussion/sharing began and ended. As you are transcribing, please pause the video and make a note of the start time by writing the word Start and then the time in bold, highlighted (in green) brackets. When the discussion changes to a topic other than an interpersonal trauma disclosure/discussion/sharing, again pause the video and write the word Stop and then the time in bold, highlighted (in red) brackets. If you have a question about what constitutes the beginning or end of an interpersonal trauma discussion, please ask the research team.

Example: I have had a difficult marriage **Start [1:14]**. Most of the time my husband hits me. Sometimes he even throws things at me... **Stop [1:45]**

MASTER TRAUMA TRANSCRIPTION

Laura S. Brown Therapy Session from APA Series III-Specific Treatments for Specific Populations – Working with Women Survivors of Trauma and Abuse

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Therapist:	Dr. Laura Brown	Session Number:	1
Client:	Ms. M	Date of Session:	xx/xx/xxxx

Introduction: This session was included in a training video for APA, entitled, “Series II-Specific Treatments for Specific Populations,” 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

CONFIDENTIAL VERBATIM TRANSCRIPT

Verbatim Transcript of Session	Initial Coding Impressions
<p>T1: Ms. M, I want to start by thanking you for being here this afternoon. And we talked a little bit before the cameras came on about what you want to talk about with me today. So, why don't you tell me about that, let's start from there [therapist used open hand gesture inviting client to share].</p>	
<p>C1: Well, um, [client scratching under nose as talking], I have, um [client looking down], I have dealt with a lot of issues in therapy, um, but one of the issues that I really haven't talked about or really dealt with in therapy [client briefly looking off] is my relationship with my sister. She's my younger sister, um; she's three years younger than me. Um, we really are not talking. We haven't been talking [client briefly looking up] since, I think, the year 2000, since my mother passed away. We haven't, we haven't really spoken. We talk but it's very business-related when things have to get done but I really don't talk to her and I [client looking down], um, I really don't have any desire to have a relationship with her. I liked to, a part of me wants to but a part of me, um, doesn't want to because she is, um, she gets really angry, and I sense that I</p>	

<p>really can't be myself around her, um, that she, for some reason, I don't know, it might be the past that she's angry and I have no idea because I don't know [client clearing throat] and I have a sense that she doesn't know either why she's angry with me. But, um [client looking down and taking a deep sigh], she was, um, we never really got along when we were growing up. Start [1:42] We fought a lot [client looking away and down]. I spent a lot of time with her. I grew up in a family of seven. And, um, she was very, she was always fighting with with all of us. She was very angry.</p>	
<p>T2: [therapist nodding] Fighting physically or verbally or both?</p>	
<p>C2: sometimes it was physical with my brothers, and, but it was verbal with me because I wouldn't I wouldn't get into fights with her because I was afraid of her because I watched how angry she would get with my brothers and my brothers were (2) they were pretty, violent too, and, um, one of my brothers, one of my younger brothers was in a gang, was a gang member, and she would fight with him. [therapist nodding] She, I saw her one time, um, put an iron right to his chest and when I saw these things happening, I just I grew really afraid of her. And so when we would argue I knew what she was capable of so, I I would stay clear of any like physical, anything physical with her. I would try to talk my talk my way out of it.</p>	
<p>T3: [therapist nodding] Mm-hmm. Were there ever times where she was physically violent with you?</p>	
<p>C3: Well, there was one time when we got into it and my mom was there and my father was there. Um [client sighs deeply], my mother immediately got between us [therapist nodding] and she just got us both together and said she was going to hit both of us. Um [client pressed lips], that was the only time that we were rolling on the floor and really nothing happened.</p>	
<p>T4: Mm-hmm [therapist nodding]</p>	
<p>C4: She just was, we were pulling each other's hair, and actually I was mo—I was mostly like trying to get her away from me, trying to get her off of me.</p>	

T5: Mm-hmm [therapist nodding]	
C5: Um, but that was the only time that we got into it. I never, after that, wanted to get into any physical. I don't, I don't know why I just- she really scared me.	
T6: Yeah I kind of get a sense, and tell me if I'm reading this accurately, that it's like you saw her as having no fear...	
C6: Right [client slowly nods]	
T7: ...as having no limits [slowly nodding] to what she would be willing to do.	
C7: Right [Client nods]. And that scared me.	
T8: Mm-hmm [therapist nodding]	
C8: And the verbal things that she would say to me were really scary. Like, "I'm gonna stab you, I'm gonna—" she would tell me all these things that she was gonna do to me.	
T9: Mm-hmm [therapist nodding]	
C9: And they were very detailed.	
T10: Mm-hmm [therapist nodding]	
C10: And that scared me. And the things that I saw I mean I saw her doing [client takes a deep breath in and out] being a, not being afraid of my brothers who were violent themselves. Um who were gang members who fought with weapons and that didn't scare her [client swallows]. They didn't scare her. So to me I thought she would, she would, there would be no limits to what she would do. That she...	
T11: So it sounds like [therapist scrunches up her face and squints] she feels dangerous to you [therapist nodding].	
C11: Yeah [client nods]. To this day she feels dangerous to me. And [licks lips] I had— I would go back and forth with having relationship with her. My sister has a really sweet personality. And then on the other hand, when you say something, and she interprets it as being, like she has to get on the defense...	

T12: Mm-hmm [therapist nodding]	
C12: ...she, she can get really violent. And it happened more with me [client scrunches up face inquisitively] I sensed, than with more-- I, I she was real sensitive with me. Um, well that's what my nieces say that it was something historically with us.	
T13: Mm-hmm [therapist nodding]	
C13: [Client looks down] Um, but she recently had an altercation with my [client points to the side] my niece. And my niece confirmed to me that [client looks up at therapist] it wasn't me that it was my sister. And my sister has had a past with [client scratches chin] violence, like she has had a past with her husband with, with um, hitting her husband [client nods]. And I've seen her doing it.	
T14: So you know she's capable of being physically violent.	
C14: Mm-hmm	
T15: You know she has these really violent fantasies about what [client nods] she might do to you. She's had them over the years...	
C15: Mm-hmm [client nodding]	
T16: ...and you experience her as not having any internal limits [therapist's hands gesture toward middle of her body], no sense of [therapist nodding] something that will stop her even when she might actually be in danger.	
C16: Mm-hmm [client nods] that's right, that's correct.	
T17: So it does sound like she's a pretty scary person.	
C17: [client nodding] Yeah, although, um, for a lot, [client looks up at ceiling] for a long time and still [client looks down at floor], other family members, um, that were close to her [client looks back up at therapist] didn't want to believe that about her. And so I always thought that it was me. I always felt that it was me because I, we were really close [client looks down at ground], um,	

T18: Thought that it was you like [therapist scrunches up face, squints, and puts hand up in the air] you were overreacting or—	
C18: Yeah that I was overreacting or that my sister just didn't like me for whatever reason...	
T19: Mm-hmm [therapist nodding]	
C19: ...and it was— but I also sensed that they kind of protected her too. Um, (3) the, she can be really sweet she has a nice she has a really good disposition. Um, but once you get to know her she gets pretty scary and (3) [client gazes up in the air] we don't— she doesn't have a relationship really with any of my brothers [client gazes towards the floor] and my sister- my older sister who passed away they didn't get along either (3) so—	
T20: So it's not as if she really relates to anybody in the family [therapist gestures at middle of body with both hands as speaks]	
C20: [client nodding] Right, right now she does, she's not— [client gestures with both hands as speaks] she's kind of isolated, um, each family member throughout the years and for me it happened very early because I grew up with her and I had experience with her.	
T21: So, it seems like what you're saying is [therapist gestures with both hands as speaks] so here you are now today an adult and this person is still being really scary for you. [therapist nodding]	
C21: [client nods head in agreement] Yeah, she is and that bothers me. [both therapist and client nod heads in agreement]	
T22: It bothers you because—	
C22: It bothers me because [client gazes down toward the floor away from the therapist] uh, she can't hurt me. [client looks directly at therapist] I mean, she can't do anything to me now. I mean, if she laid a hand on me, [client looks around the room] I know that I'd be able to call the co- call the police or— [therapist nodding] um, there'd be somebody there to defend me or I could defend myself. Stop [7:52]	

MASTER RUPTURE AND REPAIR TRANSCRIPTION**Safran & Muran Therapy Vignette 1 from Resolving Therapeutic Impasses****Disk 1 - Metacommunication**

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Therapist: Dr. Jeremy Safran

Session Number: 1

Client: X

Date of Session: xx/xx/xxxx

C = Client; T = Therapist

Verbatim Transcript of Session	Initial Coding Impressions
T1: Ok, so why don't you tell me a little bit about what brings you here today?	Segment #1
C1: Well I was hoping that that you [client gestures with both hands towards therapist] might be able to help me with, um, some, some [therapist nodding] behaviors that I have that seem to be causing me some problems. [therapist nodding] Uh, it's, it's mostly with, with relationships and I've, I've noticed that, uh, a lot of times I [client gestures with both hands while speaking] I seem to keep people at, at an arm's length [client extends one arm forward with palm open indicating an arm's distance] in, in a relationships. I seem to have what's, um, what's called a problem with intimacy, [client gestures with both hands facing one another towards the therapist] [therapist nods] uh, and I don't know if there's, um, if there's a, a better psychological [client motions with hands in a circle in front of middle of body] description of, of what the cause is, of, of that problem might be, [therapist nods head] um, whether I have some kind of a fear [client motions towards self with hand] of intimacy [therapist nods] uh, or if I had— if I had, uh, some	

<p>sort of traumatic experience [client shakes head side to side] um either with my parents [client gestures to side with one hand and then the other side with the other hand] or with with any of my siblings or or perhaps even in an early [client gestures with both hands facing one another toward therapist] relationship and that, uh, that that baggage [client motions with one hand in front of chest toward therapist] from that has has now developed to the point where, um, how I interact with people [client gestures with both hands at sides towards therapist] is is really in in some way affected by this, um, by this this [client gestures towards self with both hands] fear of intimacy. [therapist nods] Um,</p>	
<p>T2: Can can, you, um, I mean you're getting a good [therapist gestures with both hands towards client and leans forward in chair] gen- general description of the problem. I'm wondering if you can give me any, any examples [therapist sits back in chair] and you know in some ways the fresher the better.</p>	
<p>C2: [client gestures with both hands as speaks] The main way that that I've been trying to deal with this in, in the relationship with, with my girlfriend is that she's very affectionate [therapist nodding] and she has this— she has this desire to be more physically affectionate with me [therapist nods] and, and that's something that I, I don't really seem able to [client shakes head and gestures with hands] respond to, and I think it probably, [client gestures with one hand toward client and scrunches face] I think it has to do with, um, problems I had with intimacy early on even as even as a little boy [client gestures with both hands towards client] in, in trying to um, uh return the affection uh of my parents. I mean I don't [client purses finger tips together on each hand together in front of middle of body] I really don't remember any kind of traumatic experience that, uh, I had growing up that would have that would have affected me this way but [client swallows and continues talking with hands] if I think about, uh, the, the, uh, the whole uh, uh, feelings that I have uh toward my parents and how that might be now affecting [client gestures with hands as if to indicated over a period</p>	

<p>of time] this problem with intimacy that I have today it, it seems— it really does seem to me that there, there are some unresolved things, uh, with my parents that are that are preventing me from really expressing [client gestures with one hand in a circular motion towards self in front of body] the kind of physical affection, uh that um, that my that my girlfriend is looking for and I'm not, um, I'm not sure exactly how [client nods head and gestures with hands towards therapist] how a psychologist [client motions with one hand towards therapist in repetitive motion] would describe that but [client motions towards self with one hand] the way that I've been thinking about it though is that, um, I I I often try to seek my parents approval [client gestures towards therapist with both hands] and I really never— I don't feel that I ever really got the kind of approval that I needed from my parents. You know the kind [client gestures with both hands in front of body and palms facing out as if to block self] recognition that I needed from them and maybe, um, maybe in some way [client nods head] that that fear of rejection that I that I experienced early on with my parents is now creating, uh, this wall [client gestures with both hands in front of body as if to simulate a wall] between, uh, between me and relationships that I, uh, that I'm trying to have with other people and uh, you know that that I think is probably [client nods] uh, yeah I think that's I think that's a pretty good way to describe it is that there's this there's this fundamental [client gestures towards self with both hands] fear of rejection that probably stems from the way I was brought up and now that's really, um, having this uh [client shakes head from side to side] this this affect on relationships for me now [client nods head].</p>	
<p>T3: [therapist nods head] Ok. Um, I mean [therapist leans forward in chair, re-positions self, sits back, and gestures with one hand in a circular motion towards client] as as I'm listening to you talk, I'm sort of sitting here struggling [therapist gestures with one hand towards client] um, to come up with [therapist nods head] something to say and for some reason, you know I'm I'm having difficulty thinking of [therapist places elbow on arm of chair and leans head on hand] a meaningful response. And I'm trying to figure out why that is, and and I</p>	

<p>think part of it is that it it— (3) You know on one hand [therapist gestures in a downward motion with both hands] you're sort of laying out what the problem is in in you know in a really sort of good clear terms, but there's also way in which it sort of feels almost as if [therapist motions with one wrist in circular motion in front of body] you already know the the answer. It's it's like you're sort of— [therapist nodding]</p>	
<p>C3: Well, well I've thought a lot about this uh, [client looks directly at therapist and gestures with both hands] and I, you know I I certainly before before it ever occurred to me that I [client gestures with hands when speaking] that I should seek any you know kind of professional help, um uh, and I know I tend to think about things a lot [client leans forward in chair, nods head towards therapist and gestures with open hands towards therapist] I mean I do I do this a lot, you know, try to figure out what's you know what my problems are [client gestures with arms in a circular motion towards self] and see if I can come up with um, with uh, with some kind of solution, some some way of dealing with um, but um, I mean I don't know maybe I'm just not giving you [client gestures with both hands towards therapist] enough information that you can, you know uh, see this as clearly as I now can just from thinking about it from my from my life experiences.</p>	
<p>T4: Well no it doesn't feel like you're not giving me enough information, um, but I I'm wondering do you have any memory of how it felt [therapist gestures with one hand towards client] when I when I said that to you a minute ago that it feels like you've already got the answers? Do you have any memory of what that— if you don't that's [therapist puts hand out in front of body as if to stop something and shakes head from side to side one time] that's fine, but do you have any memory of what that what that felt like?</p>	
<p>C4: Um, well I feel like I feel like [client gestures with both hands towards therapist] you're you're trying to help help draw out my [client gestures in circular motion with one hand in front of body and nods head] thought process in all of this. That that,</p>	

<p>you know, I might I might have come to some conclusions about what the problem is and and you're trying to help me do that, but at the same time [client gestures towards self with both hands] I mean I have to tell you what I think the answers are. I mean I have to give you some sense of of where my head is in all of this [client continues to speak with hands] and then you know maybe, you know, I don't know, your, maybe you can help me, maybe you can't.</p>	
<p>T5: Mm-hmm [therapist nodding]. Right, so so it it's important for you [therapist gestures with one hand in circular motion towards the client] you have thought about it a lot and it's important for you to, you know, at least start by letting me know your, what your understanding of it is or what your analysis of the situation is...</p>	
<p>C5: Right, well I mean I have I have to start [client gestures with both hands palms up towards the therapist] somewhere...</p>	
<p>T6: Right</p>	
<p>C6: ...you know and I, you know I have certainly I have read a few books in psychology and I've [client gestures with hands as speaks] thought about, you know, how how, um, my young situation, you know, might might be described based on different theories in psychology and stuff like that. But I mean, don't don't get me wrong [client gestures with both hands palms facing toward therapist] I mean I'm I'm really hoping that that you will be able to help me, uh, you know and gi- and give me a different, I guess a different perspective in all of this, but, um, uh, but I want I want to participate in all that. [client gestures with both hands as speaks] I want I want you to value my insights about where things are, [therapist nods head] where my head is in all this. [client nods head]</p>	
<p>T7: Ok, so tha- that's important right [therapist leans forward in chair] that you, you know, that you have thought about it, [therapist adjusts self in chair] that you have some understanding [therapist gestures with one hand as speaks] of what's going</p>	

on...	
C7: Right [client nods head]	
T8: ...and it's important for me to to recognize [therapist gestures with hands as speaks] that and and value it. [client and therapist nodding in agreement]	Segment #2 begins
C8: Right, and the same thing happens, you know in the relationship. I'm mean, if my girlfriend wants me to behave in a certain way and that's just not how I feel [client using hands to gesture], I mean, I want to be able to tell her, what my real feelings are, and, and, if you have thoughts about what's going on with me, I would want to be able to express my, my feelings to you [client gesturing with open hands towards therapist]. You know, know, the same way. I mean I'm the one here who's looking for help	
T9: I mean, I'm wondering, uh, are you feeling, um, so far that I am hearing and valuing, the, the sorts of things you're saying [therapist gesturing with hands], sort of valuing your understanding?	
C9: yeah, yeah, for the most part, and I mean, you know, I want to be able to share, um, my, my feelings and thoughts about this as much as I can. And of course, have you take all of that into consideration. But, if I, I come to the conclusion that, because of my whole life experience, here's where I am, here's my interpretation of this, this is what I think is the problem. I mean, that's something that you [therapist changes position in chair as client is gesturing hand towards therapist in a pointing fashion] are going to have to figure out how, how we deal with it. I mean, uh, how, how, how, we can deal with it together.	
T: 10: Mm-hmm, alright, so that it's important that it's kind of a mutual process is what you're saying.	
C:10: Well, I hoping we get to that point [client is nodding head up and down]	
T11: Uh-huh [therapist is shaking head up and down], okay, okay [therapist shakes head up and down] (2), um, you're hoping we get to that point. So I mean, how would you describe, you know, the point we're at right now?	

<p>C11: Well, well, I think right now you're probably trying to figure out what's going on with, with me and, and, I'm doing the best I can to describe that, you know, whether I just talk about how a certain situation makes me feel or whether I talk about a specific examples, and you know, what my interpretations are of those examples, I'm trying to be as straight forward as I can with you [client gestures hand towards therapist] about how I think about those examples and I'm hoping that maybe, um, you have a special perspective that you can use to, to improve my understanding, and, and then I get to a point, we, we together [client gesturing hands signifying a "we" collaborative motion] get to a point where, um, I'm able to somehow, get over those problems.</p>	
<p>T12: Mm-hmm, mm-hmm [therapist shaking head up and down]. I mean, there's a couple of things going on in my mind [therapist changes position in chair]. One is that, I mean, you're saying that you hope I have a special perspective...</p>	
<p>C12: different from mine...</p>	
<p>T13: different from yours, uh-huh, (2), I mean part of me sort of whether you really, you really want to hear my perspective and part of me, ah, is uncertain as to whether I'm up to the challenge when you say special perspective (2). I have some anxiety that whatever I'm going to say is not going to feel, sort of, special enough, to be compelling to you.</p>	
	<p>STOPPED transcription at 31:50 (end of segment 2)</p>

Safran & Muran Therapy Vignette 2 from Resolving Therapeutic Impasses

Disk 2 – Repairing Ruptures

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Therapist: Drs. Saffron and Muran

Session Number: 2

Client: Ms. X

Date of Session: xx/xx/xxxx

T = Therapist; C = Client

CONFIDENTIAL VERBATIM TRANSCRIPT

Verbatim Transcript of Session	Initial Coding Impressions
<p>T1: So um (2) this our second session together and I'm wondering, you know, how you're feeling and whether you have any any thoughts or questions after our um our last session, first session.</p>	
<p>C1: [shifts gaze to floor and gaze stays on floor throughout monologue] Yeah I'm not very happy. [shifts rear forward in chair and sits back more] I'm very frustrated with you (1) actually. Last time I came in here, I just sat here, and I talked [gestures with hands] and I talked and I talked and I talked and I talked and I talked (laughs) and nothing, absolutely nothing. You sat there [gestures toward chair] kind of the way you're sitting there now (laughs), and you didn't really say much of anything I, and ugh [guttural sound] it's angering me because it's- it's [sighs breath out], if I'm supposed to come, if I'm going to therapy if I'm going here and I'm doing this, I- I want an answer. I can't just talk and talk and talk and have you just say things that lead me in an abstract way. How is this going to work? I need to know from you [shifts gaze back to floor] how is this thing going to work</p>	

<p>[makes eye contact with therapist]? I need a concrete answer. How do I get from where I am now [indicates point A with hand] to somewhere else [indicates point B with other hand]? I need a [positions hands to signify path] way to go I [grazes one hand by the other signify a path] don't know how to go and I've been in therapy for two years and nothing seems to be helping. And [throws hands up in dismay and they fall in her lap] you're not helping either so, what do I do [let's hands fall loudly back on chair and continues to gaze at floor, then looks up]?</p>	
<p>T2 : Oh Okay, so you know I I'm hearing that you're not [leans forward in chair and then sits back again] very happy about our last session and you're feeling frustrated and also if I understand correctly that you'd like to hear more from me as as to what as to how the therapy works or</p>	
<p>C2: [gazing at floor] How do you work? How do you do what you do? How does this, how is this supposed to help me [looks at therapist]? How do I fix what's going on?</p>	DT2
<p>T3: Okay I'll- I'll try to answer that I I mean even before I say anything I I want to say that I'm I have some concern about whether or not whatever I'm gonna say is gonna give you what you're really wanting but I'll- I'll do my best, okay? [client moves head back and grimaces] You have a funny look on your face...</p>	1TM
<p>C3: [looking at floor] I'm not sure why you're concerned about that, isn't that you're job [looks up at therapist]? To tell me how things [looks down at floor] are supposed to go? I'm confused then [looks up at therapist].</p>	DT2
<p>T4: Yeah I mean is my job to do my best to help you and to try to answer your questions [client</p>	1TM

<p>nodding], yeah, there's just something about the, um, it's a bit [therapist grins] difficult for me to put it into words but something about the sort of intensity [pumps fists forward] with which your asking for things [client nodding] that makes me, um, sort of a little bit [therapist grins], um, sort of question my ability to give you the- the answer you're wanting but I'll- I'll try [therapist nods].</p>	
<p>C4: Okay [client nods].</p>	
<p>T5: As I see it the way in which therapy works, is that, uh, the two of us [therapist grins], we'll we'll work together to, um explore things that you may be doing in relationships with other people that may be self defeating [client starts to speak then stops], that you may not be completely aware of, um, ways that you may see things that are self-defeating or ways in which you're dealing with your own feelings that are self-defeating, or ways in which you're- [client shaking head] you're shaking your...</p>	
<p>C5: [Client shaking head and looking at floor] I'm not defeating myself. I don't defeat myself. I don't understand how coming in here and working on it together [client pushes hands together] is gonna help. Aren't I— isn't - isn't it supposed to be that I say what's going on and then you tell me an answer [client looks up at therapist]? Give me an answer? Isn't that the way it usually works? You ask a question, you get an answer? I'm— [client looks down at floor] I don't understand what [client gestures in a circular motion pointing to herself and therapist], trying to do that would help. I, I don't think I'm defeating myself [client frowns]. I don't think I'm defeating myself at all [client frowning]. I think I come in here for answers and you're not giving them to me [client looks up at therapist].</p>	<p>CR (2); DT2</p>
<p>T6: [Therapist nods and leans chin on hand] Mm-hmm. [Therapist exhales]. I mean I'll certainly give you answers, um, to the extent that I have them. Um, but also some of it will have to come out of the two of us really exploring things together.</p>	<p>2TM</p>

C6: [Client looks down at floor] See that's too abstract for me [client shaking head]. I, I need [client laughs] something in the concrete. [Client grinning] I need to know how to get from point A [indicates point A with left hand] to point B [indicates point B with right hand].	DT2
T7: Mm-hmm.	4T
C7: And if I'm just gonna sit here and get this abstract then I'm— it's kind of wasting my time, isn't it [client grins and looks up at therapist]? It's kind of, a waste of my time. That's what the two years [client laughs] have been with other people. It's just a waste of my time if I just, sit and get things in the abstract [client scrunches face, looks down at floor, and then looks up at therapist].	2CD
T8: Uh-huh. Yeah, um [therapist grinning], I— you know I'm trying to think if there's any way I can be more concrete [therapist stops grinning] than I am right now, um, [client nodding] I mean let me- let me give you an example, okay?	1TM
C8: Okay. That's concrete.	
T9: Even right now let's try to take a look at what's going on between the two of us. You obviously— you- you want something, okay? [Client nodding] You- you know, you want an answer, right? And I understand that you want an answer [client nods]. And, [therapist grins] I want to be able to give you what you need, okay?	2TM
C9: [Client nods] Okay.	
T10: But I think there's something about—you know, just to try to give you a sense of what's going on for me, there's something about the sort of the intensity [therapist motioning quickly with hand and grins slightly] with which your asking [client furrows brow], the—this sort of pressure that I need to produce something, that makes it difficult for me to...	1TM
C10: But isn't that your job? [Therapist nods] To produce something? To give me an answer? Isn't that your job?	DT2
T11: [Therapist shifts forward in seat] Well my job is to help you [client continues to furrow brow]. But there's something about, um, [exhales] what's	2TM

going on between the two of us right now, [client nods] which is making it difficult for me to really, give you what you want and you're needing.	
C11: So aren't you asking me to perform too? Aren't you asking me to, give you stuff too?	2CD
T12: What— tell me more about that. Does it feel like I'm ...	2TM
C12: [Client looks down at floor] Aren't you asking me to give you, give you what's going on with me and articulate what's going on with me? So I'm being asked to perform too. Aren't I? [Client looks up at therapist, then throws hands up in air and lets them fall in her lap. She then looks down at her hands].	2CD
T13: I'm wondering if you felt criticized [client looks up at therapist] by what I said just now.	2TR
C13: [Client looks down at floor] Well of course I did. I—it felt like you were blaming me. Like I came in here and I was trying to say how I felt and trying to just be who I am and say what I wanted from you and needed from you and it's like you, put right back on me [client shakes head].	2CC
T14: [Therapist nods] Okay. Um, I need to think about that a little bit. I mean I don't think it was my intention to blame you. But maybe there was a way in which I was responding [client nods] out of feeling pressured and, you know maybe feeling-feeling a little bit blamed for, you know not giving you what you want [client nods], so that in- in turn I was kind of, um, you know sort of blaming you [client nods], where you know it's kind of like [client nodding] passing a hot potato back and forth you know, like you're saying I'm not doing my job, I'm saying you're not doing your job. [Client nods]. Does that make any sense to you?	2TR; 2TM
C14: [Client nodding and looking at floor] Yeah. Yeah a little. Yeah. Yeah. [Client looks up at therapist].	2CC
T15: Okay so, um, you know if that is what's going on between the two of us [client nods], then [therapist grins], you know what- what we're going to do, you know, I- I'm not sure exactly how we're going to get past this, [client nods] but I think, you know the two of us being able to, to agree that	2TM

maybe some of what's going on is [client nods]- is a start, right? And I'm willing to work with you [client nods] in order to help the two of us find a way of getting past this point [client nods], right? And and my sense is that that would be an important first step for us. [Client nods] Okay?	
C15: [Client nodding] Okay. Yeah, okay.	2CC

Coding System for Ruptures and Repair:

Definition of Ruptures: deteriorations in the relationship between therapist and client or a mismatch between clients' and therapists' treatment goals, tasks and personal bond. Accordingly, these deteriorations may result in negative affect and/or behaviors and appear during a therapy session in two alternative ways: *confrontational ruptures* and *withdrawal ruptures*. Ruptures can be a combination of both confrontation and withdrawal.

*Underlined codes = Inventory of Countertransference Behavior (ICB) items

Identifying a Rupture(s)

Rupture Codes	Examples	Comments
<p>Confrontational Rupture (CR)</p> <p><i>Def:</i> client explicitly reveals his/her dissatisfaction with the therapist or with some aspect of the therapy</p>	<ul style="list-style-type: none"> - "I am so mad at you right now." - "You don't know what you are talking about." - "I don't think you understand me at all." - Client's fists clench up - Client moves head back and grimaces 	<p>For CR and WR, you will be looking at the client's verbal and non-verbal behavior to determine a rupture(s).</p>
<p>Withdrawal Rupture (WR)</p> <p><i>Def:</i> client emotionally or cognitively withdraws from the therapeutic relationship</p>	<ul style="list-style-type: none"> - Changes topic - Avoids eye contact - Looks withdrawn - Affect change (e.g., client becomes sad, happy, laughs, etc) 	

	<ul style="list-style-type: none"> - Posture changes - Deep sigh(s) 	
Disagreement on goals (DG)	<p>Client:</p> <ul style="list-style-type: none"> - “What are our goals?” - “I’m confused about what - I am supposed to be working on___.” - “This is not what I expected therapy to be.” - “I thought I came in to talk about X and now, we’re talking about Y.” <p>Therapist:</p> <ul style="list-style-type: none"> - “I understand that you are really coming to talk about X, but it seems that Y is the real issue.” 	For these subsequent codes, you will be looking at the therapist and client to determine whether a rupture has occurred.
Disagreement on tasks (DT)	Anything other than DT1-DT5	
<u>DT1: Therapist Provided too much structure</u>	<ul style="list-style-type: none"> - Sticking to an agenda too rigidly - little flexibility in addressing other issues that arise in therapy - Therapist pushes client to disclose/discuss too much without picking up on client’s cues - Therapist does not follow up with appropriate questions regarding client’s disclosure/discussion 	

<p>DT2: Therapist Provided too little structure</p>	<ul style="list-style-type: none"> - Not setting any limits - Allowing time to pass by without discussing things related to treatment goals - “You’re not telling me what to do.” - “You really didn’t say much of anything.” 	
<p>DT3: Therapist changed the topic at any point</p>	<ul style="list-style-type: none"> - Changing the topic and/or Client responds negatively - “You never let me say anything.” - “I feel you never let me get in a word.” “ 	
<p>DT4: <u>Client indicated that Therapist talked too much in the session</u></p>	<ul style="list-style-type: none"> - I feel like I never get a chance to speak.” - Therapist interrupts client - Discussing personal material that is not related to the client or treatment 	

DT5: Therapist Engaged in unhelpful self-disclosure		
<p>Misalignment in bond (MB)</p> <p>MB1: <u>Therapist Critical of the client</u></p> <p>MB2: <u>Therapist Behaved as if he or she were “somewhere else”</u></p> <p>MB3: Therapist does not provide validation</p>	<p>MB – any misalignment in bond not falling into MB1-MB3</p> <ul style="list-style-type: none"> - Asking “why questions?” - Using “should” statements with judgmental quality - Blaming statements implying client is at fault - Not present - Looking at clock or watch - Yawning a lot - Not making eye contact - Leaves the room - Leaving too much silence and not responding, - Looking away - Not mirroring client’s mood, affect, and tone, - Laughing - Making an in appropriate joke 	

Repairing Ruptures

Repair Codes	Examples	Comments
<p>Stage 1 – attending to the rupture</p> <p>1TM: Therapist focuses client on immediate experience using metacommunication (M) and self-disclosure through the use of I statements</p>	<p>“I am feeling confused about our communication right now”</p> <p>“I noticed that you changed position when I said X.”</p> <p>“I have a sense that I am potentially being critical, rather than allowing you to really explore and express your concerns more fully.”</p>	<p>For the repair process, you will be coding both the client’s and therapist’s verbal and nonverbal behavior.</p>
<p>Stage 2 – Exploration of Rupture Experience</p> <p>2C: Client expresses negative feelings mixed with rupture</p> <ul style="list-style-type: none"> ○ 2CC: Constructive ○ 2CD: Destructive <p>2T: Therapist facilitates self-assertion in 3 different ways:</p> <ul style="list-style-type: none"> ▪ 2TR: Therapist takes responsibility for interaction ▪ 2TM: By refocusing on the “here and now” of the rupture occurring in the therapeutic relationship ▪ 2TE: Use of an awareness experiment 	<p><i>*2C not a code – only 2CC & 2CD</i></p> <p>2CC: “I am feeling angry about what you just said.”</p> <p>2CD: Client expresses feelings (verbally or nonverbally) in a blaming or belittling way.</p> <p><i>*2T: Not a code, just a category</i></p> <p>“I apologize for saying X.”</p> <p>“I have a feeling that you may be upset with me.”</p> <p>“Can you experiment with telling me directly how you</p>	

	are feeling right now.”	
<p>Stage 3 – Exploration of Avoidance (<i>this stage is necessary only if client is displaying avoidance</i>)</p> <p>3Ca: Client displays block</p>	<p>Changing the topic</p> <p>Speaking in a flat voice tone</p> <p>Speaking in general terms rather than the here-and-now specifics</p> <p>“Everything is fine.”</p>	
<p>3T: Therapist probes block</p>	<p><i>*3T is not a code, only a category</i></p> <p><i>*Need a 3Ca to occur for a 3TS to happen</i></p>	
<ul style="list-style-type: none"> ▪ 3TS: Therapist probes block on surface level 	<p>“It feels to me like you attack and then soften the blow. Do you have any awareness of doing this?”</p>	
<ul style="list-style-type: none"> ▪ 3TD: Deeper level of connecting to client’s interpersonal relationship style 	<p>“I noticed that you changed the subject.”</p> <p>“I wonder if this relates to your style of relating in other relationships?”</p> <p>“Do you notice yourself reacting in this way in other relationships?”</p>	
<p>3Cb: Client explores block</p>	<p>“Has managing conflict always been difficult for you?”</p> <p>“I guess I do feel kinda of hurt and confused right now.”</p>	

<p>Stage 4 – Self-Assertion</p> <p>4C: Client self-asserts (expressing a wish or need) spontaneously without therapist’s help</p> <p>4T: Therapist validates assertion directly in response to Client’s assertion (4C)</p>	<p>“I am noticing that I tend to get angry and lash out when I don’t know how to express that anger.”</p> <p>“I think I need (X).”</p> <p>“I really want X in my relationships.”</p> <p>“I need X but I feel I am not getting it.”</p> <p>“I see.” or “I hear you.”</p> <p>“I’m so glad you have shared your feelings with me.”</p> <p>guggles, reflecting back what client has just said, head nodding, eye contact, leaning forward</p>	
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III. CODING OVERVIEW

The third step of the process involves the coding of timing and depth of disclosure, ruptures and repairs, use of positive emotion, and general themes during the context of a trauma discussion.

- A. **Linguistic Inquiry and Word Count:** The Linguistic Inquiry and Word Count (LIWC) will be used to code for depth of discussion of trauma and the use of positive emotion. The LIWC is a text analysis program which looks at the various emotional, cognitive, and structural components present in written and speech samples from individuals. This system has five main categories with numerous subcategories.
- B. **Coding System for Ruptures and Repair:** Codes and definitions of ruptures and repair were developed by one of the researchers (Karina Campos) with input from the research team and based on her review of the literature and existing coding systems (see above). It was used to code for ruptures and repairs during psychotherapy sessions in which a trauma discussion occurred.
- C. **Positive Affect Coding System:** Codes and definitions of positive affect were developed by one of the researchers (Whitney Dicterow) from her review of the literature (Keltner & Bonano, 1997) and from information taken from the EMFACS, a method for using the Facial Action Coding System (FACS, Ekman & Friesen, 1976, 1978) focusing only on the facial actions that might be relevant to detecting emotion. Specifically, the literature and information from the EMFACS were used to operationally define smiles and laughter (see below) to code for positive affect during psychotherapy sessions in which a trauma discussion occurred.

Positive Affect Codes	Definition
Smile (S)	- A facial action characterized by the raising of the lip corners towards the cheekbones and showing of teeth.
Laughter (L)	-A smile accompanied by audible laughter-related vocalization (i.e. “he he” and/or “ha ha” and an open mouth.

D. General Themes: Each of the psychotherapy sessions containing a discussion of interpersonal trauma were coded for themes both within and across the sessions. The research team worked independently to determine larger general themes and sub-themes based on the themes that were created as a team. This process involved re-reading the transcripts and grouping together specific themes that appeared to be related or to serve a similar function for the client (Ryan & Bernard, 2003). Once all of the specific themes were grouped together, each team member then created general, overarching theme labels that best categorized/described the more specific sub-themes.

Coding Steps

1. Read this manual to learn and understand the definition of interpersonal trauma and discussion of trauma. Familiarize selves with coding steps for each topic (rupture and repair definitions, depth of discussion change talk, positive emotion non-verbals).
2. Watch the video tape of a session and read the transcript all of the way through, take notes in the right hand column of the transcript to get a general gist of when a discussion of interpersonal trauma occurs, impressions of the therapeutic relationship and working alliance (non-verbals, language, tone, affect) and general themes present. Begin the preliminary coding process.
 - 2a. To code for general themes we will read through each transcript again individually and look for repetitions (i.e., topics that occur and reoccur) and transitions in content (i.e., naturally occurring shifts in content or pauses, changes in voice tone, presence of particular phrase that may indicate transitions e.g. so, anyway). Examine the content of each repetition and transition and extract themes. Then, categorize dialogue into themes and subthemes.
 - 2b. Run the full verbatim transcript through the LIWC computer program for results on depth of discussion of trauma and positive emotion. Run the verbatim transcript of the client’s speech during the trauma discussion through the LIWC computer program and collect results. Run the verbatim transcript of the therapist’s speech during the trauma discussion through the LIWC computer program and collect results. Run each individual line of verbatim transcription through the LIWC computer program as needed. Record data on LIWC tracking sheet.

For the purposes of this study the following main categories and subcategories of the LIWC will be analyzed:

1. Linguistic Processes Category

- a. Total Word Count
2. Psychological Processes Category
 - a. Cognitive Processes
 - i. Insight
 - ii. Causation
 - b. Affective Processes
 - i. Positive Emotion
3. Individually, read the transcript again in detail by looking at each statement (C1, C2, etc.) and write your rupture and repair coding impressions on the code sheet including possible themes.
4. Review your code sheet and give your final ratings
5. Individually watch each recorded psychotherapy session while following along with the transcript, and note in the transcript when the client-participant smiles or laughs. Meet with research team to compare notes on when the client-participant smiled and/or laughed throughout the recorded psychotherapy sessions. Come to a consensus on noted smiles and laughs, returning to the recorded sessions if there is any discrepancy in observations between coders.

When coding, you want to try to balance attention to details with an ability to think abstractly and see the bigger picture. It is also important to maintain focus by pacing yourself carefully. It is difficult to code accurately when you are rushed or code in binges. In the discussion meetings, it helps to present your questions and confusions and to agree with others only when the consensus makes sense. Coding requires an openness and flexibility but not acquiescence.

Record each instance in the transcript that you believe a code is present on the code sheet (record "C1," "C2" etc. and the phrase you believe matches the code). Then, tally the frequency count on the code sheet. This will help to verify your overall score and will be used during group meetings to discuss and compare scores for the sessions. Refer to training materials when guidance is needed.

APPENDIX L

Themes Key

- I. **Self-protection – Avoidance of experiencing negative life events and maintenance of physical and psychological safety**
 - a. Avoidance of trauma discussion
 - i. Reluctance to discuss experience of CSA and related emotions
 - b. Avoidance of emotion
 - i. Reluctance to discuss feelings other than anger and sadness during psychotherapy and to others in her life; Use of humor to mask deeper feelings
 - c. Mistrust of others
 - i. Reluctance to confide in others with emotions and secrets; Disbelief that others would offer help without expecting something in return
 - d. Sense of responsibility
 - i. Strong feelings of obligation to take care of self and others involved in her life
 - e. Financial Security
 - i. Strong feelings and actions related to money and the importance of having enough money
 - f. Distancing from others
 - i. Avoid forming and maintaining close relationships with others in life to avoid being emotionally hurt
 - g. Respect for others
 - i. Strong feelings of consideration and courtesy for others, especially those who have treated her with respect

- II. **Power and Control – Ways to feel competent and gain command over environment and life experiences**
 - a. Assertiveness
 - i. Use/desired use of determination and decidedness during important life experiences
 - b. Aggression
 - i. Hostile feelings and attitudes expressed during psychotherapy
 - c. Desire/Attempt to control self
 - i. Wishes and trials at gaining and maintaining mastery over reactions to environment and life experiences
 - d. Desire/Attempt to control environment/others
 - i. Wishes and trials at gaining command of the reactions of others and the responses from the environment to life experiences
 - e. Independence
 - i. Desired ability to reach and maintain autonomy from others

- III. **Sense of Self – Feelings about self-efficacy and place in the world**
 - a. Fear of Judgment
 - i. Distress at being thought of negatively by others, including strangers
 - b. Insecurity
 - i. Feelings of doubt and hesitancy in abilities, knowledge and decisions
 - c. Self-critical
 - i. Disparaging and belittling beliefs about ways of navigating life experiences
 - d. Respect for Self/Pride

- i. Positive self-esteem and feelings of dignity towards self for how handling positive and negative life experiences

IV. Gender Role Struggles – Ideas about the jobs and capacities of men and women in society

- a. Stereotypes of men
 - i. Beliefs about conventional roles of males in society
- b. Stereotypes of women
 - i. Ideas about standard roles of females in society
- c. Role reversals
 - i. Struggles with deviation from societal standards of male and female duties and reactions, specifically reversal of duties and reactions

V. Emotional Difficulties – Complications experiencing, expressing and sharing feelings about life experiences with others

- a. Anger toward boss
 - i. Feelings of animosity, annoyance and hatred experienced when discussing or working with her boss
- b. Anger toward mother
 - i. Feelings of agitation and impatience expressed when discussing her current and past relationship with her mother
- c. Difficulty identifying and expressing emotion
 - i. Problems labeling and discussing feelings other than anger about life experiences during psychotherapy and to others
- d. Frustration with boyfriend's lack of responsibility
 - i. Expressed feelings of disappointment, annoyance and irritation with her boyfriend's behaviors and his participation in their relationship
- e. Jealousy
 - i. Feelings of resentment and spite expressed towards other women involved in her boyfriend's life

VI. Job Dissatisfaction – Discontent and unhappiness with place of employment

- a. Disengagement from job
 - i. Feelings of detachment, disconnection and indifference with her work and job duties
- b. Hatred toward job
 - i. Expressed feelings of anger, disgust and contempt with her work and the need to go to work
- c. Frustration with job responsibility
 - i. Expressed feelings of dissatisfaction, annoyance and irritation with required duties at work, specifically those not related to her job description
- d. Feeling trapped in job
 - i. Expressed emotions of being stuck and obligated at work despite a strong desire to leave

APPENDIX M

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

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

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

I understand and agree with the above three statements.

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

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

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

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

- For Teaching/Training purposes, check all that apply:
I understand and agree to

_____ Video/audiotaping

_____ Direct Observation

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

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

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

_____ Written Data

_____ Videotaped Data

_____ Audiotaped Data

OR

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

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

OR

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

Fees: The fee for the initial intake is nonrefundable.

Payment for services is due at the time the services are rendered. You're on

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

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

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

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

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

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

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

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

- You can request to amend your records.
- You can request to restrict from your clinical records the information that we can disclose to others.

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

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

Treatment & Evaluation of Minors:

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

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

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

_____ and/or _____

Signature of client, 18 or older

Signature of parent or guardian

(Or name of client, if a minor)

Relationship to client

Signature of parent or guardian

Relationship to client

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

Clinic/Counseling Center

Representative/Witness

Date of signing

Translator

APPENDIX N

Therapist Consent Form

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

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

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

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

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

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

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

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

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

OR

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

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

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

OR

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

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

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

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

11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access. In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.

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

13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at (310) 506-8559, Dr. Meshia Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.

14. I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness to continue in the study.

15. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

Participant's signature

Date

Participant's name (printed)

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

Researcher/Assistant signature

Date

Researcher/Assistant name (printed)

APPENDIX O

Researcher Confidentiality Statement - Coder

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

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

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

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

Coder Signature: _____

Date: _____

Witness Signature: _____

Date: _____

APPENDIX P

Research Assistant Confidentiality Agreement - Transcriber

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

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

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

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

Printed Transcriber Name: _____

Transcriber Signature: _____

Date: _____

Witness Signature: _____

Date: _____

APPENDIX Q

Data Tracking Sheet

x.x = Session #.Trauma Discussion #

Th-C = Therapist and Client Speech for Whole Session

TD-Th = Therapist Speech during Trauma Discussion

TD-C = Client Speech during Trauma Discussion

LIWC Results

Session ID #	Stage of Change	Time of disclosure (in minutes)	Word Count	% Cognitive Process Words	% Insight Words	% Causation Words	Type of Trauma
0	Action (12.0)	No Video					
1 Th-C			14014	18.35	3.14	2.61	CSA/ WPH
1 C			10902	18.79	3.10	2.90	CSA/ WPH
1.1 TD-Th		3:07-3:28	59	22.03	5.08	0	CSA
1.1 TD-C		3:07-3:28	22	4.55	0	0	CSA
1.2 TD-Th		18:21-18:54	21	0	0	0	CSA
1.2 TD-C		18:21-18:54	123	13.01	2.44	4.07	CSA
1.3 TD-Th		20:56-21:08	15	6.67	0	4.35	WPH
1.3 TD-C		20:56-21:08	64	8.89	0	2.22	WPH
1.4 TD-Th		22:43-25:07	67	11.94	0	0	WPH
1.4 TD-C		22:43-25:07	560	17.32	3.75	2.32	WPH
1.5 TD-Th		25:36-26:01	6	0	0	0	WPH
1.5 TD-C		25:36-26:01	134	23.13	0	2.99	WPH
1.6 TD-Th		26:09-26:40	15	0	0	0	WPH
1.6 TD-C		26:09-26:40	106	11.32	0.94	1.89	WPH
1.7 TD-Th		27:47-29:35	50	10.00	2.00	0	WPH
1.7 TD-C		27:47-29:35	352	19.03	2.27	3.69	WPH
1.8 TD-Th		29:40-30:01	9	11.11	0	0	WPH
1.8 TD-C		29:40-30:01	99	13.13	1.01	4.04	WPH
1.9 TD-C		32:17-33:21	287	20.91	2.79	3.83	WPH
1.10 TD-Th		34:49-35:53	25	24.00	8.00	12.00	WPH
1.10 TD-C		34:49-35:53	224	18.75	1.79	3.57	WPH
1.11 TD-Th		44:52-48:17	120	18.33	1.67	0.83	WPH
1.11 TD-C		44:52-48:17	714	17.93	1.54	1.82	WPH

1.12 TD-C		49:08-49:26	166	21.69	2.41	3.61	WPH
5		No Trauma					
6 Th-C			16318	17.81	3.25	2.18	CSA/ WPH
6 C			13365	18.30	3.40	2.29	CSA/ WPH
6.1 TD-C		5:13-6:24	293	17.41	5.46	3.41	CSA
6.1 TD-Th		5:13-6:24	36	0	0	0	CSA
6.2 TD-C		59:55-68:23	1267	16.81	2.37	2.53	WPH
6.2 TD-Th		59:55-68:23	281	14.95	2.14	3.56	WPH
7 Th-C	Contemplation (11.57)		13560	16.78	3.29	1.86	CSA/ WPH
7 C			9739	17.62	3.33	1.98	CSA/ WPH
7.1 TD-C		7:18-7:47	119	20.17	0	2.52	WPH
7.1 TD-Th		7:18-7:47	9	0	0	0	WPH
7.2 TD-C		8:58-18:18	2202	17.35	3.00	1.77	CSA
7.2 TD-Th		8:58-18:18	528	11.55	3.22	2.27	CSA
7.3 TD-C		23:08-23:32	7	0	0	0	CSA
7.3 TD-Th		23:08-23:32	43	18.60	0	0	CSA
7.4 TD-C		31:42-37:55	651	18.28	6.30	2.00	CSA
7.4 TD-Th		31:42-37:55	604	21.03	5.46	1.32	CSA
7.5 TD-C		52:08-52:29	56	14.29	1.79	3.57	WPH
7.5 TD-Th		52:08-52:29	4	0	0	0	WPH
9 Th-C			14022	16.45	3.38	2.32	WPH
9 C			11076	17.55	3.58	2.57	WPH
9.1 TD-C		9:29-9:47	65	26.15	0	1.54	WPH
9.2 TD-C		18:30-19:57	332	20.78	2.71	3.92	WPH
9.2 TD-Th		18:30-19:57	62	8.06	0	0	WPH
10		No Trauma					
11		No Trauma					
12 Th-C			13385	17.33	3.36	2.05	CSA/ WPH
12 C			9999	18.53	3.86	2.35	CSA/ WPH

12.1 TD-C		12:24-12:27	22	13.64	0	4.55	WPH
12.2 TD-C		47:12-47:39	11	0	0	0	CSA
12.2 TD-Th		47:12-47:39	106	18.87	0.94	0.94	CSA
13		No Trauma					
14	Action (12.14)	No Trauma					
16		No Trauma					
18 Th-C			12213	16.99	3.72	1.88	WPH
18 C			8119	17.71	3.89	2.25	WPH
18.1 TD-C		27:59-28:16	79	12.66	3.80	2.53	WPH
18.1 TD-Th		27:59-28:16	4	0	0	0	WPH
18.2 TD-C		32:30-33:00	205	14.63	4.39	1.46	WPH
18.2 TD-Th		32:30-33:00	8	0	0	0	WPH
19		No Trauma					
Unknown Session 1		No Trauma					
Unknown Session 2		No Trauma					

APPENDIX R

LIWC Averages

Sexual Trauma Averages of Client Speech

Session #	Average Word Count	Average % Cognitive Process Words	Average % Insight Words	Average % Causation Words
1	72.5	8.78	1.22	2.04
6	293	17.41	5.46	3.41
7	953.33	11.88	3.10	1.26
12	11	0	0	0
All Sessions	472.71	10.09	2.46	1.61

Workplace Psychological Harassment Averages of Client Speech

Session #	Average Word Count	Average % Cognitive Process Words	Average % Insight Words	Average % Causation Words
1	270.6	17.21	1.65	3.00
6	1267	16.81	2.37	2.53
7	87.5	17.23	0.90	3.05
9	198.5	23.47	1.36	2.73
12	22	13.64	0	4.55
18	142	13.65	4.10	2.00
All Sessions	269.5	17.29	1.75	2.92

APPENDIX T

Themes Occurrences Sheet

x.x = Session #.Trauma Discussion #

(x)= # of occurrences

s = Discussion of Sexual Trauma

w = Discussion of Workplace Trauma

o= Discussion in which a theme occurred outside of a trauma discussion

	Occurrences Per Session							Total [by sub-theme]
	Session 1	Session 6	Session 7	Session 9	Session 12	Session 18		
Self-Protection	25	25	31	10	19	22	132	
Avoidance of trauma discussion	1(3)o 1.1(1)s 1.2(1)s	None	7.2(4)s	None	None	None	3 o 6 s 9 Total	
Avoidance of Emotion	1(1)o 1.2(6)s	6.1(2)s	7(6)o 7.2(3)s	9(1)o	12(1)o	18(2)o	11 o 11s 22 Total	
Mistrust of others	1(5)o 1.2(1)s	6(1)o	7(4)o 7.2(3)s	9(1)o	12(9)o	18(1)o	21 o 4 s 25 Total	
Sense of responsibility	1(3)o	6(8)o	None	9(1)o	12(4)o	18(7)o	23 Total	
Financial security	None	6(14)o	7(8)o	9(6)o	12(5)o	18(3)o	36 Total	
Distancing from others	None	None	7.2(1)s	None	None	18(9)o	9o 1s 10 Total	
Respect for others	1(1)o 1.5(2)w 1.11(1)w	None	7.2(2)s	9(1)o	None	None	2 o 3 w 2 s 7 Total	
Power and Control	12	27	35	16	13	30	133	
Assertiveness	1.4(1)w 1.9(1)w 1.11(1)w	None	7.2(3)s	None	12(3)o	None	3 o 3 w 3 s 9 Total	
Aggression	1.7(1)w	6.2(1)w	7(5)o 7.2(3)s 7.5(2)w	9(1)o 9.2(2)w	None	None	6 o 6 w 3 s 15 Total	
Desire/Attempt to control self	1(1)o	6(1)o	7(6)o	9(2)o	None	18(4)o	14 Total	
Desire/Attempt to control others/ environment	1(3)o	6(11)o	7(6)o 7/2(4)s	9(11)o	12(8)o	18(11)o	50 o 4 s 54 Total	
Independence	1(4)o	6(14)o	7(2)o 7.2(4)s	None	12(2)o	18(15)o	37 o 4 s 41 Total	
Sense of Self	3	10	1	4	30	25	73	

Fear of judgment	1(1)o 1.3(1)w	6(2)o	7(1)o	9(1)o	12(4)o	18(12)o	21o 1w 22 Total
Insecurity	None	6(5)o	None	9(3)o	12(25)o	18(7)o	40 Total
Self-critical	None	None	None	None	None	18(2)o	2 Total
Respect for self/Pride	1.11(1) w	6(3)o	None	None	12(1)o	18(4)o	8o 1w 9 Total
Gender Role Struggles	2	4	6	3	10	4	29
Stereotypes of men	1.2(1)s	None	7(1)o	None	12(1)o	18(1)o	3 o 1 s 4 Total
Stereotypes of women	None	6(3)o	7(2)o 7.2(1)s 7.4(2)s	9(3)o	12(8)o	18(2)o	18 o 3 s 21 Total
Role reversals	1(1)o	6(1)o	None	None	12(1)o	18(1)o	4 Total
Emotional Difficulties	7	22	5	12	4	4	54
Anger toward boss	1.4(2)w 1.6(1)w 1.7(1)w 1.11(2)w	6.2(2)w	7.5(1)w	9.2(2)w	None	None	11 Total
Anger toward mother	None	6(11)o	None	9(4)o	None	None	15 Total
Difficulty identifying/ expressing emotions	1(1)o	6(1)o 6.1(2)s	None	9(1)o	12(1)o	None	4 o 2 s 6 Total
Frustration with boyfriend's lack of responsibility	None	6(5)o	7(2)o	9(4)w	12(3)o	18(4)o	14 o 4 w 18 Total
Jealousy	None	6(1)o	7(2)o	9(1)o	None	None	4 Total
Job Dissatisfaction	15	0	1	3	0	4	23
Disengagement from job	1.11(1)w	None	None	9(1)o 9.1(1)w	None	None	1 o 2 w 3 Total
Hatred toward job	1(3)o 1.3(1)w 1.5(1)w 1.6(1)w 1.10(1)w	None	7.1(1)w	None	None	18(1)o 18.2(1) w	4 o 6 w 10 Total
Frustration with job responsibilities	1(3)o	None	None	None	None	None	3 Total
Feeling trapped in job	1(2)o 1.4(1)w 1.8(1)w	None	None	9.1(1)w	None	18.2(2) w	2 o 5 w 7 Total
TOTAL (per session)	32 o 22 w 10 s 64 Total	81 o 3 w 4 s 88 Total	45 o 4 w 30 s 79 Total	38 o 10 w 48 Total	77o 77 Total	86o 3w 89 Total	359 o 42 w 44 s 445 Total

APPENDIX U

Stages of Change Diagram



