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Exploring the therapeutic alliance and rupture repair within the context of trauma discussion: a case study

Karina G. Campos

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Pepperdine University

Graduate School of Education and Psychology

EXPLORING THE THERAPEUTIC ALLIANCE AND RUPTURE REPAIR WITHIN THE
CONTEXT OF TRAUMA DISCUSSION: A CASE STUDY

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

by

Karina G. Campos

July, 2011

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

This clinical dissertation, written by

Karina G. Campos

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

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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

Thema Bryant-Davis, Ph.D.

Janine Shelby, Ph.D.

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DEDICATION

First, and foremost, this dissertation is dedicated to my husband, Bruno. For, without his incredible support and encouragement throughout my long journey through my undergraduate, masters, and doctoral programs, I would not be here. He has been the calming voice during the many vicissitudes of this process and I am grateful for his unwavering devotion. Second, I owe a very special thank you for my loving parents, Ludmila and Anatoly, for the enthusiasm, passion, and generosity they have shared with me throughout my life. Through example, they taught me how hard work and perseverance can lead to a sense of personal self-fulfillment and pride. My dearest babushka, Vera, who is ninety as of this writing, is the true embodiment of strength and courage. I cannot adequately describe my respect and joy for her. This dissertation is also dedicated to my loving grandparents, Vera and Isaac. A special thank to you, Dedushka. I miss you and wish you were here to celebrate this milestone; I carry you with me in my spirit.

I am especially thankful for my beautiful friends, old and new, for the pleasure and humor they bring me. Mary, one of the sisters I never had, was there to provide constant cheerleading, comic relief, and distraction when it mattered most; Ilonashka, my other sister, exemplifies positivity, passion, excitement, and resilience; Rachel always exuding warmth and compassion was there to remind me to stay connected to the present; Danushka, one of my oldest and dearest friends, was also there to offer love and encouragement from several thousand miles away; and of course, I thank my very special gang-of-three: Laurie, Ani, and Kasey. Lifelong friendship comes along and hits you when you least expect it. To my New York partners-in-crime, Nikki and Heejin – without them, I would still be trying to complete this. I am so thankful for them. Finally, I thank my dear classmates and the most amazing cohort ever, who supported me along the way. All of them are so precious to me and are family.

ACKNOWLEDGMENTS

VITA

<u>EDUCATION</u>
Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
09/07-05/11
Psy.D. Candidate in Clinical Psychology
Clinical Competency Examination: *Passed*, September 2009
Dissertation: Exploring the Therapeutic Alliance and Rupture Repair within the Context of
Trauma Disclosure to Trainee Therapists: A Case Study
- Dissertation Chair: Susan R. Hall, J.D., Ph.D.
- *Passed Final Defense,* April 2011

Pepperdine University, Graduate School of Education and Psychology, Malibu, CA
08/05-05/07
M.A. in Clinical Psychology, with an emphasis in Marriage and Family Therapy

University of California at Los Angeles (UCLA), Westwood, CA
04/00-06/02
B.A. in Psychology

Santa Monica College, Santa Monica, CA
09/97-06/99
A.A. in Liberal Arts

<u>LANGUAGES</u>
Fluent in Russian

<u>CLINICAL PRE-DOCTORAL INTERNSHIP EXPERIENCE</u>
NYU School of Medicine – Bellevue Hospital/NYU Child Study Center, New York, NY
07/01/10-06/30/11
Pre-Doctoral Intern, Child and Adolescent Track
Clinical Psychology Internship Program directors: Danielle Kaplan, Ph.D. and Lori Evans, Ph.D.
Bellevue Hospital
- Provided individual, couples, group, and family inpatient and outpatient treatment for a diverse population of children, adolescents, couples, families, and adults with acute and chronic psychiatric issues
- Conducted psychological assessments with inpatient and outpatient populations
- Rotations: Adult Inpatient Rehabilitation Medicine, Child Inpatient Unit, Child/Adolescent Day Treatment/School Program, and Adult Comprehensive Psychiatric Emergency Program (CPEP)
- Conducted a STAIR group for adolescents with trauma histories and a Parent/Grandparent Skills/Support Group
- Prepared comprehensive intake reports, discharge summaries, and treatment plans
- Coordinated and attended family meetings, maintained ongoing contact with a multidisciplinary team; and provided case management for patients and their families
- Participated in weekly case conferences and didactic seminars; presented on trauma focused CBT

NYU Child Study Center
- Provided Cognitive-Behavior Therapy (CBT), Parent-Child Interaction Therapy (PICT), parent training within the Anxiety and Mood, ADHD and Disruptive Behavior Disorder, and Selective Mutism Services
- Provided Dialectical Behavior Therapy (DBT) and DBT skills training to adolescents and families
- Conducted neuropsychological assessments and diagnostic evaluations in the Institute for Learning and Achievement Service
- Treated couples and families utilizing live supervision through a one-way mirror
- Participated in weekly case conferences, didactic seminars, and grand rounds
- Presented on topics related to clinical supervision and psychological assessment

CLINICAL PRE-DOCTORAL PRACTICUM & ASSESSMENT TRAINING EXPERIENCE
Harbor-UCLA Medical Center, Department of Psychiatry, Torrance, CA
09/09-06/10
Child and Adolescent Trauma Clinic
Psychology Extern, supervised by Janine Shelby, Ph.D.
- Provided evidence-based treatment (EBT)/trauma-focused CBT and complex trauma treatment, utilizing developmentally appropriate play interventions, to children and adolescents with PTSD and complex trauma
- Provided hospital consultation and brief intervention to patients and families in the pediatric crisis unit
- Conducted thorough intake interviews and administered, scored, and interpreted trauma-specific measures to assess the frequency and severity of trauma-related symptoms
- Participated in ongoing collaboration with DCFS social workers, court appointed attorneys, psychiatrists, and forensic evaluators
- Participated in weekly individual supervision and group supervision; participated in weekly team disposition and didactic trainings focused on dyadic/family EBTs and play therapy
- Completed all paperwork in accordance with Department of Mental Health (DMH) standards; Attended a weekly EBT/CBT child/adolescent course

Kaiser Permanente, Medical Center, Department of Psychiatry, Los Angeles, CA
09/09-06/10
Psychology Assessment Extern, supervised by Juliet L. Warner, Ph.D., pediatric neuropsychologist
- Performed brief intake and clinical interviews with patients and families
- Conducted psycho-educational assessments, using cognitive, achievement, and emotional measures, with children and adolescents presenting to the *ADHD school clinic* and *oncology late effects clinic* with cognitive and learning difficulties, psychological, attentional, and behavioral problems
- Collaborated with patients' teachers when gathering information and/or providing recommendations
- Provided families with verbal and written report feedback regarding these assessments

UCLA Center for the Assessment and Prevention of Prodromal States (CAPPS)
07/08-07/09
Department of Psychiatry, Westwood, CA
Assessment/Case Manager/Therapist Extern, supervised by Sandra De Silva, Ph.D. and Carrie
Bearden, Ph.D.; Tyrone Cannon, Ph.D., principal investigator
- Conducted clinical assessments, including intakes and clinical-structured interviews, with culturally diverse research and treatment participants between the ages of 12-35 that were at high-risk for developing schizophrenia and other co-morbid mental disorders
- Scored, interpreted, and wrote corresponding clinical reports for these clinical assessments
- Achieved reliability in rating prodromal symptoms, depressive, and anxiety symptoms.
- Provided feedback from clinical assessments to patients and their families for diagnostic and treatment purposes
- Conducted needs assessment interviews with families and individuals to propose an individualized treatment plan
- Provided referrals, ongoing case management, and brief individual and family therapy
- Co-led a CBT Parent Skills group
- Co-led a psycho-educational workshop for families where information was provided about the prodromal state, reasons for early intervention, biological bases for mental disorders, diathesis-stress theories, psychopharmacological treatment, school interventions, and recommendations for creating a protective environment
- Participated in weekly individual and group supervision as well as monthly didactic seminars; Participated in bi-monthly multidisciplinary case conferences
- Presented potentially included cases to the NAPLS multi-site principle investigators to ensure interrater-reliability

Union Rescue Mission, Downtown Los Angeles, CA
09/07-03/09
Therapist Extern, supervised by Aaron Aviera, Ph.D. and Stephan Strack, Ph.D.
- Provided weekly brief and long-term psychotherapy from a psychodynamic and CBT theoretical orientation to a culturally diverse adult population who presented with crisis management, homelessness, chronic mental illness, substance abuse, and dual diagnoses
- Conducted intake interviews and performed thorough crisis evaluations
- Administered diagnostic and personality assessments, and wrote corresponding interpretative reports
- Provided clients with feedback from these assessments
- Maintained communication with referral sources, community resources, and psychiatrists to promote continuity of care and adherence to treatment plan
- Participated in weekly individual and group supervision; attended monthly didactic seminars
- Participated in additional weekly peer supervision with a third year doctoral student

Westwood Institute for Anxiety Disorders, Westwood, CA
01/08-06/08
Psychology Extern, supervised by Eda Gorbis, Ph.D., L.M.F.T.
- Learned to administer the Yale-Brown Obsessive Compulsive Scale to adolescent and adult patients seeking treatment for obsessive-compulsive disorder (OCD)
- Assisted the supervisor in providing CBT and Exposure and Response Prevention (ERP) treatment to patients with OCD and body dysmorphic disorder
- Observed a weekly OCD therapy group where patients and their families discussed their treatment outcomes and the personal impact of having an anxiety disorder(s)

CLINICAL MASTERS PRACTICUM EXPERIENCE
South Bay Center for Counseling, El Segundo, CA
01/06-06/07
Therapist Trainee, supervised by Susan Michael, Psy.D.
- Provided weekly psychotherapy to culturally diverse child, adolescent, family, adult clients and couples
- Conducted initial phone intake evaluations and intake interviews
- Co-developed and individually led a weekly group for siblings of a brother or sister diagnosed with autism
- Participated in weekly group supervision; attended monthly didactic seminars

CLINICAL UNDERGRADUATE VOLUNTEER EXPERIENCE
Sojourn, Domestic Violence Shelter, Santa Monica, CA
03/02-07/02
Child Counselor Volunteer
- Addressed the children's' needs for communication and emotional expression using play therapy approach
- Attended 2 months of extensive training on domestic violence and child abuse

UCLA Peer Help Line
10/00-04/01
Listener
- Conducted phone counseling with anonymous callers
- Provided crisis intervention and referrals
- Attended 2 months of training on suicide, homicide, substance abuse, depression, and domestic violence

OTHER CLINICAL TRAINING EXPERIENCE
Trauma-Focused CBT (TF-CBT)
09/08
- Sponsored by Medical University of South Carolina - Completed a 10 hour online course on TF-CBT

CLINICAL WORK EXPERIENCE
Lovaas Institute for Early Intervention, Los Angeles, CA
06/02-07/06
Behavioral Consultant [and School Aide], supervised by Dr. Scott Cross, Ph.D. and
Simone Stevens, BCBA
- Conducted applied behavioral analysis therapy (ABA) with children diagnosed with autism
- Conducted functional behavior analyses and developed data collection systems for clients' challenging behaviors
- Created and supervised the implementation of the client's individualized interventions
- Planned individualized school interventions
- Developed Individualized Education Plan (IEP) goals and presented them at annual IEP meetings to school administrators, teachers and parents; Wrote corresponding IEP reports
- *School Aide:* Accompanied clients to school and facilitated their generalization of skills acquired in the home to teachers and peer groups; Provided brief behavioral training for teachers
- Provided training for new instructors and parents

RESEARCH EXPERIENCE
Clinical Psychology Research Assistant – The Pepperdine Applied Research Center (PARC)
05/08-07/09
Principle Investigators, Susan Hall, J.D., Ph.D. and Kathleen Eldridge, Ph.D.
- Responsible for assisting in the maintenance of the psychological research database that is part of a long-term research project conducted at the three Pepperdine University clinics
- Duties included: data entry using SPSS, filing, maintaining quality control procedures, data analysis and assisting GA coordinators and PARC faculty with administrative tasks; Attended bi-monthly research team meetings

Educational Research Assistant — UCLA Peer Relations Project
09/01-06/02
Principle Investigators, Sandra Graham, Ph.D. and Jaana Junoven, Ph.D.
- Collected data at local elementary schools to explore peer harassment/bullying and how it affects social interactions, mental health, attitudes about school, and academic achievement
- Responsible for data entry using SPSS
- Participated in weekly meetings where the principle investigators and graduate students discussed the research topic and associated administrative issues

Social Psychology Research Assistant, UCLA
09/00-12/00
Principle Investigator, Jim Sidanius, Ph.D. and Graduate Student Lotte Thomsen, M.A.
- Research compared peoples' cultural and political attitudes towards individualism in the United States and Denmark
- Responsible for data entry using SPSS
- Participated in a focus group supervised by the graduate student that explored our views regarding individualistic and collectivistic cultures; Wrote a research paper on this topic

GRADUATE TEACHING EXPERIENCE
Clinical Management of Psychopathology, Pepperdine University, Malibu, CA
09/08-12/09
Teaching Assistant
Professor Stephanie Woo, Ph.D.
- Assisted with exam preparation and grading of midterm and final exams

Counseling Techniques in Therapy, Pepperdine University, Malibu, CA
09/07-12/07
Teaching Assistant
Professor Charlene Underhill-Miller, Ph.D.
- Reviewed students' videotaped therapy sessions and provided a written evaluation of students' clinical performance to the professor; graded students' final exams

Marriage and Family Therapy, Pepperdine University, Malibu, CA
01/07-04/07
Teaching Assistant
Professor Dennis Lowe, Ph.D.
- Graded students' midterm and final exams; met weekly with the professor to discuss class assignments and related topics

Juvenile Delinquency, Pepperdine University, Malibu, CA
08/06-12/06
Teaching Assistant
Professor Robert Scholz, M.F.T.
- Held weekly office hours; graded students' journal assignments and midterm and final exams

Introductory to Psychology, Pepperdine University, Malibu, CA
01/06-04/06
Teaching Assistant
Professor Steven Rouse, Ph.D.
- Held weekly office hours; graded students' weekly quizzes

UNDERGRADUATE TEACHING EXPERIENCE
Behavior Modification, UCLA, Westwood, CA
02/02-05/02
Teaching Assistant
Professor Ivar Lovaas, Ph.D.
- Led weekly discussion groups for the students and held weekly office hours

PROFESSIONAL PUBLICATIONS
Shelby, J. & Campos, K. G. (2010). Cognitive Behavioral Play Therapy for Traumatized Children: Narrowing the Divide Between Ideology and Evidence. In A. A. Drewes, S. C. Bratton, & C. E. Schaefer (Ed.), *Integrative Play Therapy*. Hoboken, NJ: Wiley & Sons, Inc.

Campos, K. G. (2009). Supervision ethics and the power differential: Impact on supervisors & supervisees. *CA Psychologist.*

PROFESSIONAL PRESENTATIONS
Becker-Weidman, E., Campos, K.G., Flancbaum, M., & Gunnia, K. (2011). Evidence-Based Practice: Considerations for implementation of PCIT when "one size does not fit all." NYU Child Study Center/Langone Medical Center Grand Rounds, New York, NY.

Campos, K.G. (2010). An introduction to Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Bellevue Hospital Center Child Inpatient Unit 21South, New York, NY.

Campos, K.G. (2010). Ethical adherence in clinical supervision: Power dynamics and ethical dilemmas. NYU Child Study Center Case Conference Presentation, New York, NY.

Campos, K. G. & Falender, C. (2009). Ethical compliance in supervision. International Conference on Clinical Supervision, Buffalo, NY.

Campos, K. G., Donner, M. & Fridhandler, B. (2009). Ethical dilemmas & power dynamics in supervisor-supervisee relationships. California Psychological Association Convention, Oakland, CA.

Campos, K. G., Davidoff, L., & Pezeshkian, A. (2008). Empowerment and self-esteem: Embracing our strengths. Viewpoint High School, Calabasas, CA.

Campos, K. G. (2008). Autism: Assessment, diagnosis, differential diagnosis and treatment. Pepperdine University, graduate campus, Malibu, CA.

Campos, K. G. (2007). Working with siblings affected by autism. South Bay Center for Counseling, El Segundo, CA.

Campos, K. G. (2006). Youth with Mental Health Needs in the Juvenile Justice System. Pepperdine University, undergraduate campus, Malibu, CA.

Campos, K. G. (2006). The signs of autism: Diagnosis and behavioral early intervention. Pepperdine University, undergraduate campus, Malibu, CA.

OTHER PROFESSIONAL, LEADERSHIP AND VOLUNTEER EXPERIENCE
The California Psychological Association Ethics Committee
03/08-05/10
Graduate Student Member
- First student member elected to the ethics committee
- Participated in bimonthly ethics' committee meetings with expert psychologists in law and ethics
- Contributed to the ethics' committee ListServ
- Participated in the interviewing of new ethics committee members
- Presented on the ethics panel at the *April 2009 CPA convention* and published an article in the *CA Psychologist*

Peer Supervisor
09/09-06/10
- Supervised two first-year doctoral students on a weekly basis; provided feedback regarding supervisees' clinical skills, including case conceptualization, diagnosis, treatment planning, and personal and professional development
- Attended supervisees' weekly case conference meetings in order to provide further feedback; Led case conference
- Participated in weekly supervision of peer supervision with supervisor, Aaron Aviera, Ph.D.
- In collaboration with supervisor, participated in providing formal verbal and written mid-year and final-year evaluation feedback to the students

California Psychological Association Annual Convention
Division II Presentation: "Best Practices in Clinical Supervision: Are We Ready?"
04/07/10
Presentation Panelist
- Invited by Drs. Edward Shafranske and Tamara Anderson to participate as a panelist to share student perspective regarding supervision competencies in light of the benchmarks document (Fouad et al., 2009)

Member of Pepperdine University's Student Government Association (SGA)
06/09-06/10
Vice-President and Steering Committee
- Elected by peers; Participated in SGA and steering committee meetings with professors

SGA Pepperdine University
09/08-06/09
2nd year Class Student Representative
- Elected by peers; participated in student government meetings

Multicultural Research and Training Lab, Pepperdine University, Los Angeles, CA
09/08-01/09
Member
- Participated in monthly meetings with fellows members including professors and doctoral students interested in building a multicultural competent professional community
- Co-coordinated the annual MRTL conference

L.I.F.E. Conference – Greenleaf Institute for Servant Leadership, Downtown Los Angeles, CA
11/06/09 *Presenter*
- Invited by Dean Margaret Weber to present on service and leadership in psychology

California Governor and First Lady's Women's Conference, Long Beach, CA
10/27/09
- Personally invited by Dean Margaret Weber to attend this conference for demonstrating professional leadership in psychology; Speakers included Madeleine Albright, Katie Couric, Caroline Kennedy, and Maria Shriver

Clinical Supervision: Best Practices to Address Impasses in the Alliance
02/23/09
Student/Supervisee Representative
- Invited by Drs. Carol Falender and Edward Shafranske to represent a supervisee's perspectives on issues related to the supervisory relationship at the Annual Supervision Invitational Conference for Program and Training Directors

Lobby Day, California Psychological Association, Leadership & Advocacy Conference, Sacramento, CA
03/24/09
Student Representative
- Participated as a student representative of CPA and LACPA in Lobby Day at the State Capital

CURRENT PROFESSIONAL ASSOCIATIONS
American Psychological Association, Graduate Student Affiliate
APA - Division 37 Society for Child and Family Policy and Practice/Child Maltreatment
APA – Division 56 Trauma Psychology
NYC CBT Association

FORMER PROFESSIONAL ASSOCIATIONS
Los Angeles California Psychological Association, Graduate Student Affiliate
California Psychological Association, Graduate Student Affiliate
California Psychological Association Graduate Student Ethics Committee Member
California Association of Marriage and Family Therapists

<u>HONORS AND AWARDS</u>
Member of PsiChi, National Honor Society in Psychology
UCLA Peer Help Line Listener of the Month Award
Varsity Volleyball Captain at Beverly Hills High School—Voted MVP
South Bay Volleyball Club—Voted MVP of the San Diego Volleyball Tournament

ABSTRACT

At present, there is a lack of research on how the rupture and repair process transpires within the context of interpersonal trauma discussion in psychotherapy. Therefore, this study employed a case study approach to qualitatively understand Safran and Muran's (1996; 2000) model of rupture and repair with a 28 year-old African-American, Christian female client who discussed her interpersonal traumatic experiences in individual psychotherapy at a community counseling clinic. The treatment lasted 21 sessions and of the 15 videotaped sessions, six contained discussions of childhood sexual abuse and workplace psychological harassment. Safran and Muran's (1996; 2000) model of rupture and repair and select Inventory of Countertransference Behavior (Friedman & Gelso, 2000) items were used to develop a coding system to identify the occurrence of ruptures and repairs in those sessions and examine their relationship with the client's and therapist's Working Alliance Inventory (Horvath & Greenberg, 1989) ratings. Other assessment measures and qualitative themes and subthemes, were analyzed to further understand the context of interpersonal trauma discussion as it related to the dynamics between the client and therapist, and overall treatment.

Consistent with rupture and repair research, this study found a sizable amount of ruptures occurring within the context of trauma discussions, with high rates of the therapist-participant imposing too much structure, not providing validation, and being critical of the client-participant. Although there is a lack of research on the comparison between ruptures and repairs, this study found that the majority of ruptures were not repaired; 33 ruptures and only three repairs were identified over the course of therapy. The therapist-participant did not follow the repair model, and instead appeared to notice certain ruptures by laughing, changing topics, or taking back her statements or intentionally apologizing. Given data limitations, associations between ruptures and repairs and WAI ratings could not be identified. However, both participants rated their therapeutic alliance as strong. Future studies should develop a rupture and repair model more suitable to working with clients presenting with trauma histories, specifically focusing on how

cultural factors enhance or hamper therapists' and clients' abilities to successfully engage in

repairs. Such studies could use procedures created in this dissertation, including its operational

definitions of ruptures, which may make their identification and repair easier. Results can also be

used to inform therapists working with trauma survivors that ruptures and therapists' ability to

successfully repair them can be opportunities for meaningful dialogue, and growth (Joseph &

Linley, 2008) within an interpersonal context (Seligman, 2005; Seligman, Rashid, & Parks, 2006;

Seligman & Csikszentmihalyi, 2000).

Chapter 1

Introduction and Literature Review

Among the most consistent findings from psychotherapy research is that the quality of the therapeutic alliance is, across various treatment modalities, one of the most valuable predictors of outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The therapeutic alliance may be particularly important to establish with those clients who have experienced interpersonal trauma because of their essential need for safety and trust. During sensitive conversations in which clients discuss their traumatic experiences, which will be defined as discussion in this dissertation, therapeutic ruptures can occur and may negatively impact the alliance. However, ruptures may also be meaningful opportunities for the strengthening of the alliance, if the therapist can successfully engage the client in a repair exchange. Through a positive psychology lens, the repair exchange can be seen as balancing the negative and positive processes/effects/issues that can arise from therapeutic ruptures. Repairing ruptures might be particularly important when working with individuals who have taken the courageous step to discuss their experiences of interpersonal trauma to the therapist because they can be an opportunity to work through the trauma and rebuild shattered relationships.

Taking a positive psychology perspective, this study seeks to qualitatively understand Safran and Muran's model of the repair process with a client who discussed her interpersonal traumatic experiences within the context of psychotherapy. First, to contextualize this study, this chapter defines and discusses interpersonal trauma from a positive psychology perspective and describe its discussion as it relates to psychotherapy. Second, a review of the literature defines therapeutic alliance, therapeutic ruptures and repairs to that alliance, and explores various factors that contribute to therapeutic ruptures and affect the repair process. This chapter concludes with a description of the purpose of the study and its research questions.

Trauma and Its Discussion in Psychotherapy

  Understanding Trauma. Trauma is defined in the literature in various ways. Hall and Sales' (2008) definition of trauma includes a variety of components, such as an event (noninterpersonal and interpersonal), and responses to the event or its effects (e.g., symptoms, emotions, disorders, syndromes), including the Diagnostic and Statistical Manual of Mental Disorder, 4th edition, Text Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000) definition of trauma and Posttraumatic Stress Disorder (PTSD), and complex trauma.

  Most other definitions of trauma include only the event and response components. First, the DSM-IV-TR defines trauma as the:

> direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involve death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior; Criterion A2). (APA, 2000, p. 463)

The DSM-IV-TR's list of traumatic events includes combat, sexual and physical assault, being kidnapped or taken hostage, robbery, terrorist attacks, torture, natural disasters, serious automobile accidents, life-threatening illnesses, child abuse and witnessing death or grave injury by violent assault, war, accidents or natural disaster (APA, 2000).

  Second, Herman (1992) defines trauma as ranging from a single to multiple overwhelming events to more complex effects of long-term and repeated abuse. In addition, she states that trauma is "an affliction of the powerless" and "traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection and meaning" (p. 33). Third, Sheikh (2008) defines trauma as "an event that profoundly challenges an individual's fundamental schemas, beliefs, goals, as well as the ability to manage emotional distress, and

profoundly affects the individuals' life narrative" (p. 87). Furthermore, Briere and Scott (2006)

suggest that trauma is a term that "should be reserved for major events that are psychologically

overwhelming for an individual" (p. 3).

The two categories (i.e., noninterpersonal and interpersonal) of trauma events highlight

the context in which the trauma occurs. Noninterpersonal trauma encompasses some of the

following situations: accidental injuries, chronic or severe illnesses and natural disasters while the

interpersonal trauma category includes some of these following events: sexual and physical

maltreatment, hate crimes, loss, witnessing partner violence, war, kidnapping and school shooting

(Hall & Sales, 2008). According to Herman (1992), when traumatic events are of the

noninterpersonal nature, people (i.e., witnesses and bystanders) tend to sympathize more easily

with the victim, but when traumatic events are caused directly by human beings, people are less

sympathetic with the victim and more likely to blame the victim and feel forced to takes sides

between the victim and perpetrator. Briere and Scott (2006) states that individuals seeking

mental health services usually have experienced both types of trauma: a) noninterpersonal, which

consists of natural disasters, large-scale transportation accidents, house or other domestic fires,

motor vehicle accidents and emergency worker exposure to trauma, and b) interpersonal, which

includes interpersonal violence, rape and sexual assault, stranger physical assault, partner battery,

torture, war and child abuse. For the purposes of the present study, our focus will be on

interpersonal trauma.

Additionally, as the DSM-IV TR diagnosis of PTSD has been based primarily on the

experiences of combat war veterans and not on individuals who have experienced prolonged and

repeated interpersonal trauma (Courtois, 2008; Perry, 2009), this study also extends its definition

of interpersonal trauma to include a definition of complex trauma. Complex trauma is "a type of

trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific

relationships and contexts, including domestic violence and attachment trauma" (Courtois, 2008,

p. 86). According to Courtois (2004; 2008), individuals exposed to trauma over various time

spans and developmental periods suffer from an assortment of psychological problems not

included in the current diagnosis of PTSD, including depression, anxiety, self-hatred,

dissociation, substance abuse, self-destructive and risk-taking behaviors, re-victimization,

problems with interpersonal and intimate relationships (including parenting), medical and somatic

concerns, and despair. In addition, adult survivors of childhood abuse demonstrate complex

symptom presentations and show evidence of impairment in their ability to regulate emotion,

avoid further retraumatization, and to stay connected in relationships, including therapeutic ones

(Briere & Scott, 2006; Courtois, 2004; 2008). The focus of this dissertation was on the

interpersonal traumas of childhood sexual abuse (CSA) and workplace psychological harassment,

experienced by this study's participant, an African American woman; these contexts are

described next.

> ***Childhood Sexual Abuse and African American Women.*** Several research studies have

documented the negative impact CSA can have on ethnic minority women and indicate that

African American women in particular are more vulnerable to sexual assault (Banyard, Williams,

Siegel, & West, 2002; Kallstrom-Fuqua, Weston, & Marshall, 2004; West, 2002). African

American women are also particularly prone to more severe forms of child abuse, such as

vaginal, anal, or oral penetration (West, 2002). Bryant-Davis, Chung, and Tillan (2009) pointed

out that sexual assault of ethnic minority women cannot be studied in isolation as it transpires

within the context of intergenerational trauma, history of oppression, sexism, poverty, and racism.

Therefore, when researching and working clinically with the experiences of ethnic minority

women, it is imperative to also understand the potential barriers that exist in these women

attaining security and support (Bryant-Davis et al., 2009). In a study comparing adult survivors

of CSA to a non-abused control group, it was found that survivors of CSA reported higher levels

of clinical symptoms, which are often seen in traumatized individuals, including anxiety,

depression, dissociation, intrusive reexperiencing, sexual concerns, and an impaired self-esteem

(Banyard et al., 2002). Research on sexual abuse and retraumatization in African American

women has additionally shown that these traumatic experiences can have deleterious effects on a variety of relational processes, including the ability to trust and form healthy bonds in relationships (Banyard et al., 2002). Furthermore, survivors of CSA, including African American women, likely experience a sense of powerless and loss of control given their experience of being interpersonally violated and feeling like they do not have influence on what is happening to them (Kallstrom-Fuqua et al., 2004). This powerlessness and loss of control in interpersonal relationships can further lead to withdrawal from social engagement, the development of negative beliefs and feelings about women and men, an apprehension towards seeking out and depending on others, a fear of being negatively evaluated by others, and a sense of detachment (DiLillo, 2001). Similarly, another study found that African American women with a history of CSA reported a larger discrepancy in their beliefs about feminine standards. Specifically, a greater difference was found between a woman's perceived self and her notions of what a woman ought to be or ideally should be. Furthermore, they also indicated identifying more with masculine traits rather than feminine traits and endorsed more negative and stereotypical beliefs about women as compared to the control group (Krause & Roth, 2010).

Workplace harassment and African American women. Research has shown that there continues to be a rapid increase in the cultural and gender diversification of the United States workplace (Turner & Shuter, 2004). African American women in particular have historically been found to play an important role in the labor market, as they have higher rates of labor force participation as compared to white women (Hatchett, Cochran, & Jackson, 1991). Although African American women may a stronger presence in terms of the amount of participation in the workplace, the quality of their experiences often differ considerably from those of Caucasian men and women (Buchanan & Fitzgerald, 2008; Hughes & Dodge, 1997). A study conducted by Mays, Coleman, and Jackson (1996) found that Black women's perceptions of discrimination in the workplace, specifically related to race and gender, was significantly associated with job stress and a decrease in overall, psychological well-being. Similarly, a study conducted by Buchanan

and Fitzgerald (2008), with 91 African American women involved in a sexual harassment lawsuit, found that sexual harassment as well as race-related harassment in the workplace had harmful effects on the physical and psychological health of the participants as well a negative impact on their job satisfaction. More specifically, Buchanan and Fitzgerald (2008) discovered that sexual and race-related harassment in the workplace was correlated with higher rates of general work-related stress, dissatisfaction with supervisors and co-workers, increased negative affect, including depression, and decreased productivity. Sexual harassment on its own was associated with more reported rates of organizational (work) withdrawal and life dissatisfaction while the experience of race-related discrimination alone was correlated with chronic health conditions and trauma-related symptomatology.

There has been a lack of research however investigating other forms of workplace trauma, including psychological abuse, and their impact on the daily occupational experiences and well-being of various ethnic/racial groups, including Asians, African-Americans, Hispanics/Latinos, and Caucasians, in the U.S. labor force (Fox & Stallworth, 2005). Over the years, various terms (e.g., workplace bullying, mobbing, psychological abuse, and gender harassment) have been used to describe the phenomenon of psychological pain experienced in the workplace (Crawshaw, 2009; Duffy, 2009; Keashly & Harvey, 2005; Raver & Nishii, 2010). According to Crawshaw (2009), this propagation of definitions makes it harder to conceptualize workplace difficulties in understandable and consistent terms and complicates researchers and clinicians' abilities to collaborate effectively to further investigate this problem. In order to ameliorate this confusion and inconsistency over terminology, she proposes that the term psychological harassment be used as a universal nomenclature to capture all of the varied experiences of workplace aggression, including emotional abuse, workplace bullying, and hostile workplace behavior. Therefore, this current study used the term workplace psychological harassment (WPH) to encompass the diverse experiences of psychological abuse (i.e., verbal, emotional) experienced by the study's participant.

There is not any research that specifically uses the term WPH to describe the experiences of African Americans given that this is a newer term proposed by Crawshaw (2009) to encompass all experience of workplace abuse. But, there are studies that look at this concept using other words. For example, the terms WPH and bullying tend to be used interchangeably; the research on bullying and African Americans shows that the experience of perceived violence and overt hostility disrupts psychological well being and contributes to increased levels of distress (Raver & Nishii, 2010). Also, research on sexual and race-related harassment of African American women generally report higher rates of work-related stress, including discontentment with supervisors and co-workers, depressive symptoms, and decreased productivity (Buchanan & Fitzgerald, 2008).

In order to better manage these inequalities and feel more successful at work, African American women have had to find ways to cope with these stressors. Specifically, Jones and Shorter-Gooden (2003) found that most African American women have to go through a process of "shifting" between different identities in order to feel successful within their work environment. They further define this process of shifting for African American women by explaining that:

> Shifting is what she does when she speaks one way in the office, another way to her girlfriends, and still another way to her elderly relatives. It is what may be going on when she enters the beauty parlor with dreadlocks and leaves with straightened hair, or when she tries on five outfits every morning looking for the best camouflage for her ample derriere. (Shorter-Gooden, 2003, p. 7)

In a study conducted with 400 African American women, Jones and Shorter-Gooden (2003) found that most of the women reported that they "shifted" their behavior in order to put others at ease. Specifically, more than half of the participants in this study indicated that at times, they changed the way they spoke, toned down their mannerisms, avoided controversial topics, and conversed in ways they felt would be acceptable by White people. While shifting appears to be

both an internal and hidden process to the outsider and serves as an adaptive coping skill in being

able to succeed in the workplace, shifting can also be damaging to one's self-esteem and sense of

belonging. This concept of shifting is reminiscent of Dubois' (2003) writings of African

American's experiences of oppression and overall disempowerment. Specifically, Dubois points

out that Black Americans as a result of years of oppression and degradation have developed what

he called a double consciousness where their strivings for true self-consciousness have been

limited and instead are often made up of two identities; one directly informed by larger White

American expectations and pressures and another informed by African American cultural values.

In response to the increasing levels of emotional distress within the workforce reported

by Black women, Mays (1995) conducted a study exploring the effectiveness of a cost effective

community-based intervention designed to decrease self-reported stress and increase supportive

relationships among working Black women. She found that small group discussions focusing on

the topic of work-related racism and sexism emerged as the most useful interventions in reducing

job stress and increasing feelings of support. These discussions not only helped reduce stress and

increase support but also raised awareness of the dilemmas African American women often face

in the labor market and provided participants with examples of valuable coping strategies to

manage such stressors (Mays, 1995).

In terms of other forms of coping, spirituality and religion appears to be a great source of

strength and resilience in African American men and women (Newlin, Knafl, & Melkus, 2002).

African American men and women's participation in religion has demonstrated to have positive

influences on health and life satisfaction, as well as protect against the negative impact of chronic

illness and trauma (Ellison, 1993; Ellison & Gay, 1990). It may also have protective effects on

family members, as one study focusing on children of low-income African American women

involved in a violent romantic relationship, found that the mothers who experienced

religious/spiritual well-being also had children who exhibited less internalizing and externalizing

psychological symptoms (Kaslow et al., 2003).

However, not all trauma survivors have a positive association between their experience of trauma and religion. Specifically, one study using a sample of African American women with a history of trauma, including CSA, found that positive religious coping did not protect against or help reduce PTSD symptoms (Bradley, Schwartz, & Kaslow, 2005). The researchers made sense of this finding by explaining that traumatic experiences and PTSD symptoms may actually contribute to a disturbance in one's previously held positive religious beliefs and beliefs about the self, the world, and others as being safe. For example, the experience of trauma and subsequent PTSD may lead to questioning the existence of God or the sense of feeling abandoned by God. Although this is the experience of some trauma survivors, others have reported that struggling with trauma, besides its capability to produce negative symptomology, can possibly also lead to transformative religious experiences whereby one finds solace in his/her faith and feels closer to God (Bridges, 2005).

Positive Psychology Approach to Trauma. According to Seligman and Csikszentmihalyi (2000), since World War II, positive psychology has become a science that is dedicated to healing and examining conditions that contribute and/or lead to people flourishing, being fulfilled and living a life that is worth living. Positive psychology also focuses on "repairing damage within a disease model of human functioning" (Seligman & Csikszentmihalyi, 2000, p. 5). Moreover, positive psychology's purpose is to create a balance between repairing negative life events and at the same time building upon and strengthening peoples' positive qualities (Seligman & Csikszentmihalyi, 2000). Seligman et al. (2006) argue that balance is needed because psychology has performed well in alleviating certain disorders but has neglected enhancing human positive experiences. For this reason, positive psychology is interested in learning about "what works?" "what is going right?" and "what is improving?" rather than focusing solely on "what is wrong?" or "what doesn't work?" (Linley, Joseph, Harrington, & Wood, 2006). Therefore, the present study's focus on examining therapeutic ruptures within the therapeutic alliance and their repair relates well to positive psychology's framework and aims.

Pillars of Positive Psychology. The foundation of positive psychology is based on three pillars: (a) positive subjective experiences, (b) positive individual traits, and (c) positive institutions (Seligman & Csikszentmihalyi, 2000). Positive subjective experiences occur at the subjective level and include some of the following experiences: well-being, contentment and satisfaction with the past, flow and happiness in the present, and hope and optimism for the future (Seligman & Csikszentmihalyi, 2000). Positive individual traits refer to individual attributes that are characterized by courage, interpersonal skills, capacity for love and vocation, forgiveness, perseverance, spirituality and wisdom (Seligman & Csikszentmihalyi, 2000). Positive institutions, which function at the group level, are meant to inspire individuals toward civic duty, responsibility, altruism, tolerance, nurturance and work ethic (Seligman & Csikszentmihalyi, 2000). The current study's focus on repairing ruptures in the therapeutic alliance within the context of trauma discussion is associated with positive experiences and individual traits such as interpersonal skills, forgiveness, and courage. It is hypothesized that the repair process involves honesty, authenticity and taking responsibility for one's feelings and actions in relationship to another, as well as the exercise of will to accomplish goals in the face of adversity or opposition.

Critiques of Positive Psychology. Although positive psychology is considered an emerging valuable science, there are those who question whether it is a new area. For instance, some humanistic and community psychologists purport that positive psychology as a field is ignoring their existing contributions by misrepresenting itself as a new phenomenon and approach (Elkins, 2009; Lazarus, 2003). They cite, for example, Abraham Maslow as the first to use the term, "positive psychology" and Carl Rogers whose positive view of human potential led to the development of his client-centered approach to psychotherapy that focuses on nondirective interventions that support clients' natural proclivities towards growth and positive change (Mollen, Ethington & Ridley, 2006; Rogers, 1951).

Others wonder if positive psychology is at a crossroads. Linley et al. (2006) suggest that there are three possible routes for the future direction of positive psychology. First, they feel that

it could become irrelevant as a separate construct if all psychology disciplines come to completely appreciate and utilize the full range of human functioning and potential. Second, positive psychology could allow researchers and clinicians to understand both the negative and positive but also continue to mainly emphasize emotions, including topics such as happiness and strengths (Linley et al., 2006). Similarly, Lazarus (2003) believes that it has a narrow view of human experience because it focuses more on positive experiences and leaves out the full range of human functioning, which also includes negative experiences. He argues that positive and negative emotions cannot be separated as they represent "two sides of the same coin of life" and an individual needs both emotions to experience life to its' fullest degree (p. 167). Lazarus elaborates by saying that "we need the bad, which is part of life, to fully appreciate the good" and "anytime you narrow the focus of attention too much to one side or the other, you are in danger of losing needed perspective" (p. 94). Third, it could continue as a specialty area and as a result, become marginalized and eventually prevented from being a major part of psychological discourse (Lazarus, 2003).

Additionally, Lazarus (2003) argues that positive psychology utilizes research methods that have inherent problems. For example, he states that cross-sectional research, which is usually used in emotional research, is not able to demonstrate cause-effect relationships and therefore, provides a pseudo-sense of causality on how positive emotions impact individuals.

Finally, although positive psychology understands the importance of examining protective factors, resources, and strengths that help guide people towards optimal functioning, the field has been also criticized for not placing enough focus on cultural factors that may also affect well-being and the meaning of living a good life (Lopez et al., 2005). Some suggest that positive psychology needs to continue to understand how culture relates to health and also create novel conceptual frameworks that identify and build upon individual and group resources and strengths and can be easily incorporated into culturally and developmentally appropriate psychotherapy assessment and treatment (Lopez et al., 2005; Maddi, 2006).

Responses to Critiques of Positive Psychology. Csikszentmihalyi (2003) responded to the criticism that positive psychology is branding itself as a new phenomenon by stating that positive psychology does not falsely advertise itself nor claim to be a new psychological phenomenon but is rather aware that its traditions are build upon the theories of Maslow and humanistic psychology. He further added that positive psychology's relevance within the psychology field rests on the notion that even the most obvious insights or truths in psychology are likely reconsidered every few generations given the constant flux of knowledge. With this in mind however, he also explained that positive psychology's aim to contribute to contemporary science goes slightly beyond what humanistic psychology encompasses and therefore, to a certain extent does bring a certain amount of novelty to the current psychological discourse. Yet, he does not take into account the contributions of community psychologists who have also added to the psychological discourse on positivity, empowerment, and the use of strength-based approaches when working with diverse populations (Perkins & Zimmerman, 1995; Speer et al., 1992).

In response to the other criticisms brought forth by Lazarus (2003) and others, positive psychologists have responded in different ways. First, Csikszentmihalyi (2003) challenges Lazarus' (2003) view that positive psychology is only restricted to the study of emotions by arguing that positive psychologists study not only emotions but also larger systems, including various social environments, including schools, youth groups, religions, and various cultural groups, in order to understand how external factors not only impact subjective well-being but also academic performance, family unity, job satisfaction, and so forth.

Second, some positive psychologists (Campos, 2003; Lyubomirsky & Abbe, 2003) feel that Lazarus inadvertently dichotomizes the experience of negative and positive emotions by suggesting that positive psychology solely focuses on the positive aspects of human emotions, such as happiness. Although King (2003) agrees with Lazarus' (2003) point that psychology in general should take into account both the positive and negative affective experiences of human beings, she argues that because researchers tend to frame their research questions from a more

problem focused perspective, the existing body of literature is left unbalanced; thus, positive

psychologists tend to focus more on the positive aspects of human experience as a way to

compensate for this disequilibrium.

In addressing Lazarus' third point that one needs both the negative and positive aspects of

emotion to fully experience life, King (2003) notes that although at first glance this may be true,

research has not really supported this idea. Furthermore, she argues that to some extent research

has demonstrated that a positively biased individual may actually fair better in a variety of ways

in comparison to a person who is more balanced or negatively slanted (Taylor, Kemeny, Reed,

Bower, & Gruenewald, 2000).

Fourth, in response to Lazarus (2003) criticism of positive psychology's methodological

approach, Csikszentmihalyi (2003) and Diener (2003) agree with Lazarus (2003) that no

meaningful longitudinal research can be produced in short periods. Yet, they also point out that it

is unfair of Lazarus (2003) to single out positive psychology in this way, as most of psychology,

not just positive or any other, has to deal with similar research methodological limitations.

Lastly, Pedrotti, Edwards, and Lopez (2009) responded to the criticisms posited by

Lazarus (2003) and Lopez et al. (2005) specifically on culture by highlighting the difference

between two groups studying culture within the field of positive psychology. Although both

groups believe all cultures have strengths, one group suggests that most strengths are universal

across all cultures while the other proposes that strengths and virtues/morals are more culturally

and socially created (Pedrotti et al., 2009). The group in support of the notion that culture is

embedded in all human experience suggests that because strengths are found in all cultures,

human behavior cannot be studied in isolation (Pedrotti et al., 2009). Dahlsgaard, Peterson, and

Seligman (2005) further supports this view based on their investigation of moral behavior and

what it means to live a good life in the philosophical and religious traditions of China, South

Asia, and the west. For example, the writings of these traditions all reflect these six core virtues:

courage, justice, humanity, temperance, wisdom, and transcendence, suggesting that they are

universal to most cultures rather than being more socially created and specific to certain cultures (Dahlsgaard et al., 2005, p. 203). Although it may be that there are universal strengths found across cultures, Diener (2003), supporting the other group's view, points out that there are also values and strengths that may in fact vary by culture. He goes on to say that even if all virtues and strengths are inherent to every culture, it is likely that they way these virtues and strengths manifest behaviorally will be quite dissimilar across cultures as well as across individuals within a culture (Diener, 2003).

      Effects of Interpersonal Trauma. Consistent with positive psychology's aim to balance the negative and positive aspects of experience, this section identifies both the negative and positive effects of exposure to trauma. Exposure to trauma can have harmful effects and lead to chronic psychological consequences for some individuals (Briere & Scott, 2006; Herman, 1992; Tedeschi & Calhoun, 2004). Research on interpersonal violence indicates that victimization can create responses such as depression, anxiety, anger, guilt, cognitive distortions, somatization of problems, physical health problems, substance abuse as well as more specific trauma related symptoms such as hyperarousal, intrusive thoughts, dissociation, and fear-related sexual difficulties (Briere & Elliott, 1997; Briere & Spinazzola, 2005; Hall & Sales, 2008; van der Kolk, 1995).

      Correspondingly, survivors of CSA experience a range of adjustment difficulties, including problems with intimacy and communication in relationships, depression, shame, grief, helplessness, struggles in parenting roles and increased risk for future trauma exposure (O'Dougherty Wright, Crawford, & Sebastian, 2007; Hall & Sales, 2008). CSA can also lead to a loss of safety, trust and purpose and meaning in life (O'Dougherty Wright et al., 2007; Frazier, Conlon, & Glaser, 2001). Additionally, childhood sexual trauma exposure can instigate emotion (affect) dysregulation (van der Kolk et al., 1996), identity confusion (Briere & Rickards, 2007), substance abuse (Ouimettte & Brown, 2003), and engagement in activities aimed at reducing tension, such as binge-purge eating, compulsive sexual behavior, impulsive aggression,

suicidality, and self-mutilation (Herpertz, Kunert, Schwenger, Eng, & Sass, 1999; Zlotnick, Najavits, Rohsenow, & Johnson 2003).

Although it is clear that trauma can produce a variety of negative effects, current literature also points out how for some people the aftermath of trauma can actually have the potential to be an experience that is intensely transformative and meaningful. According to Sheikh (2008):

> It is not that such individuals have somehow escaped the seriously negative impact of the losses, but rather that, in coping with the losses and rebuilding their lives, some individuals may unexpectedly arrive at a new level of meaning, a changed philosophical stance that represents a renewed and valued purpose, a redefined sense of self, and a changed relationship to the world. (p. 85)

Such experiences have been variously defined. One prominent construct related to interpersonal trauma is posttraumatic growth, which reveals that positive psychological change can be experienced by a person as a consequence of how he or she coped and struggled with extremely adverse and challenging life circumstances (Tedeschi & Calhoun, 2004). This phenomenon has been observed in males and females across the life span and across various cultures, including African American children with a history of PTSD following Hurricane Katrina (Kilmer et al., 2009) and refugee populations, such Latinas, Israelis, Germans, Americans, and British populations (Sheikh, 2008).

Tedeschi and Calhoun (1996) suggest that there are five main domains for assessing posttraumatic growth: (a) a greater appreciation of life, (b) closer relationships, (c) new possibilities, (d) increased personal strength, and (e) spiritual change. In the first domain, having a closer and more meaningful connection to every day life represents having a greater appreciation for the simple things. A second domain, closer relationships, occurs when trauma survivors become better at distinguishing between real and disingenuous relationships in their lives. Through this process they may become more equipped to disengage from unsatisfying

relationships and move towards more healthy and satisfying ones. Trauma survivors can also find new possibilities in their lives, a third domain, which can manifest in changes in career goals or participation in social advocacy. In the fourth domain, increased person strength, people may feel that they are stronger and more self-efficacious to cope with other difficulties as a result of surviving trauma. Lastly, in the fifth domain of spiritual change, individuals indicate that they are more spiritual and connected to something that is greater than themselves (Tedeschi & Calhoun, 1996).

Research with survivors of CSA supports some of Tedeschi and Calhoun's domains. Regarding the fourth domain, O'Dougherty Wright et al. (2007) found that their sample of survivors reported that they perceived themselves as having become better people after having to cope with their experiences of trauma. Similarly, another study demonstrated that when survivors of childhood sexual expressed positive emotion, they experienced a significant reduction in distress and were more capable of using cognitive and social resources (Bonanno et al., 2007). Covering multiple domains, Nolen-Hoeksema and Davis' (2005) study of individuals who had experienced a traumatic loss of a loved one, found that those who had demonstrated positive responses to the loss reported growing in personal character and gaining new skills, including new perspectives on life (domain 1) and strengthened their relationships (domain 2) which also had a positive impact on their level of distress, emotions, well-being and adjustment (domain 4).

Discussion of Trauma in Psychotherapy. Human beings often need to express their thoughts and feelings about events in their lives, especially when a major traumatic event has occurred. Research has shown that up to 85% of individuals exposed to trauma feel the desire and need to share their experience with others (Purves & Erwin, 2004). Research has shown that the exploration and sharing of traumatic experiences can come in other forms. For example, traumatized individuals may feel more comfortable expressing themselves and learn to adaptively cope with difficult experiences through activism, spirituality, engagement in the community and with community supports (i.e., outside of mental health professionals), including family members

and close friends, and creativity, such as through the mediums of music, visual art, dance, and creative writing (Bryant-Davis, 2005).

Given that survivors often disclose their trauma in various ways, the definition of trauma discussion itself needs to be differentially defined (London, Bruck, Ceci, & Shuman, 2007). Hence, for the purpose of this research study, the discussion of trauma was defined with a broad perspective so that it included the various ways in which trauma could be expressed. Specifically, this study's definition of trauma discussion encompassed the following: (a) the first time the client reports or tells someone else (i.e., the therapist) that he/she has had an interpersonal trauma(s), (b) the client has disclosed the trauma(s) before to another person, but is now discussing it again with the therapist within the context of psychotherapy, and/or (c) the client discusses trauma that has been disclosed before to someone else and also discloses for the first time another trauma or multiple traumas. Additionally, the term discussion was 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 the discussion of trauma takes place within a mental health setting, clinicians should be prepared to effectively engage traumatized clients in such discussions and understand what their role is in such discussions. According to Sano, Kobayashi, and Nomura (2003) the purpose of providing therapy to people who have experienced severe trauma "is to integrate the traumatic memories and to reestablish the continuity of all of the person's lifelong memories" (p. 13). They go on to say that if traumatic memories are not brought to awareness they will continue to torment the individual and unconsciously express themselves through mental illness or in the form of behavior reenactment. Behavior enactment may present itself in the form of an individual using the defense mechanisms of denial, repression and dissociation, which are

intended to protect the person from decompensation (Sano et al., 2003). Some psychodynamic

research has also suggested that disclosure of trauma can initially worsen clients' psychological

state because the releasing of highly disturbing repressed traumatic material can be extremely

distressing and jolting for clients (McNulty & Wardle, 1994).

At the same time, disclosure of stressful events has been shown to be related to improved

psychosocial adjustment, including decreased disturbing intrusive thoughts and stress levels, and

improved mood, physical health as well as school and work performance (Lutgendorf & Antoni,

1999; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Trauma disclosure also enhances self-

regulation, self-empathy and feelings of control (Hemenover, 2003). Additionally, disclosure of

trauma can help people facilitate insight, create personal meaning and build a more resilient self-

esteem and identity (Pennebaker, 1997).

In order for individuals to feel comfortable disclosing personal and often extremely

painful experiences, they need to feel safe and supported (Higgins-Kessler & Goff, 2006). For

this reason, therapists play an important role in the discussion process with their clients.

Therapist Factors Related to Trauma Discussion. There are several therapist factors

that affect trauma discussion in psychotherapy. As Courtois (2009) points out, therapists working

with trauma survivors must make every effort to abide by the principle of "Do no *more* harm" (p.

188) to patients and consistently facilitate a therapeutic environment in which they can be both

emotionally available and clear with their personal boundaries (Courtois, Ford, & Cloitre, 2009;

Kinsler, Courtois, & Frankel, 2009).

Research has also demonstrated that therapists need to be sensitive and aware of how

their behaviors can affect clients' willingness to discuss trauma. For instance, one study that

reviewed 50 adult women's experiences of trauma disclosure found that 38% of participants

reported that they felt ridiculed, encountered disbelief and blame reactions from their therapists,

which in turn made them feel more distressed and less likely to disclose further information

(Frenken & Van Stolk, 1990). Thus, McNulty and Wardle (1994) emphasized the significance of therapists comprehending their own attitudes, biases, beliefs and fears of trauma.

Other studies have indicated that therapists need to possess and display the following skills in order for clients to feel safe enough to disclose their traumatic experiences: a nonjudgmental approach, empathy, warmth, genuineness, compassion, building strong rapport and being attentive (Higgins-Kessler & Goff, 2006). When therapists convey emotional support and comforting feelings to clients during trauma discussions, therapists aid clients in confronting rather than avoiding stressful memories as well as establishing non-threatening emotional associations to those stressful memories (Lepore, Fernandez-Berrocal, Ragan, & Ramos, 2004).

Higgins-Kessler, Nelson, Jurich, and White (2004) also recommended that therapists should be responsive to timing, pacing and clients' readiness to confront traumatic material and use a strengths-based approach by acknowledging clients' strengths and courage to disclose their trauma. These researchers found that therapists were most effective with their clients when they assessed for clients' current psychological problems, the effects of the trauma on past and current functioning and current coping strategies used by clients. Additionally, therapists who attempted to understand the details of the clients' trauma experiences and asked questions regarding the clients' reasoning for disclosing their trauma gained important clinical information that guided their treatment focus (Higgins-Kessler et al., 2004).

The research studies mentioned above all combined samples of trainee and more experienced/licensed therapists. For this reason, additional research should investigate whether trainee and more experienced/licensed therapists differ in their approaches to trauma discussion.

Client Factors Related to Trauma Discussion. Research demonstrates that several client factors impact trauma discussion in therapy. One study found that people with a more ruminative coping style sought out more social support and experienced a decline in their depressive symptoms even though they were initially more uncomfortable sharing as compared to those who did not use a ruminating coping style (Tedeschi & Calhoun, 2004). Another study found that a

delay in disclosing trauma was associated with individuals who feared social rejection and were

mistrustful of others, including family members and the justice system (Somer & Szwarcberg,

2001). Similarly, one study investigating women's experiences of disclosure with a history of

CSA, found that the closer the survivor's relationship was to the perpetrator, the longer it took for

them to disclose the abuse (Foynes, Freyd, & DePrince, 2009). In a like manner, one study found

that peoples' experiences of past discussions also influenced whether they would disclose in their

current psychotherapy relationships (Linbald, 2007). For instance, a correlation was found

between past positive discussion experiences, and clients' perceptions of the therapists' ability to

be empathic, warm and willing to self-disclose (Lindbald, 2007). Likewise, Kahn, Achter and

Shambaugh (2001) revealed that clients' tendency to disclose more often was related to clients'

perceptions of a good social support network, personality characteristics such as having a positive

emotional response style and a lower amount of distressing symptoms at intake.

Research has also shown that cultural factors may affect trauma disclosure and its

discussion. According to Alaggia (2005), the disclosure of abuse may be delayed and/or inhibited

in certain cultures in which there is a strong value placed on privacy and family preservation.

Moreover, individuals who have been historically marginalized based on their race, ethnicity,

socioeconomic, religion, and/or sexual orientation status may feel too disempowered to disclose

their experience and therefore, may not do so (Alaggia, 2005). One study investigating disclosure

from the viewpoints of women of color who had experienced incest found that culture had an

impact on their disclosure of the trauma (Tyagi, 2002). Specifically, this study found that cultural

and familial values prevented the women from engaging in an open discussion with their

therapists in order to avoid dishonoring their family and to protect their own and their family's

interests. They essentially prioritized the value of needing to maintain "good" face within the

community, privacy, and virginity over the value of disclosing personal information (Tyagi,

2002).

Research has also shown that gender and age can influence the disclosure of trauma. Kogan (2004), who conducted a study with adult survivors of CSA, found that disclosure increased with age and occurred more often with female survivors than with male survivors. Another study revealed that men appeared to be less willing to engage in disclosure due to emotions of anxiety, fear and depression, as compared to women (Purves & Erwin, 2004). Similarly, another research study found that female clients, as compared to male clients, were more likely to intimately self-disclose as therapy progressed and especially in the later part of therapy (Pino & Meier, 1999; Strassberg, Anchor, Gabel, & Cohen, 1978). In reference to these findings, Strassberg et al. (1978) hypothesized that female clients probably demonstrated more intimate self-disclosure as compared to their male counterparts because as they became more comfortable with the therapist, they consequently, perceived less risks associated with intimate disclosure. Yet, when studying types of disclosure (i.e., accidental versus purposeful), factors such as race, intelligence level, socioeconomic status, parents' education and occupational levels did not significantly affect disclosure.

Studies have also shown that a client's expression of posttraumatic symptomology and ability to discuss traumatic material is additionally influenced by neuropsychological factors (Cozolino, 2006; Glaser, 2000; Harris, 2009; Kendall-Tackett, 2000; Pitman, Shin, & Rauch, 2001). It has been demonstrated that the combination of language development and emotional attunement from caregivers sets the stage for neural growth and the integration of various networks in the developing brain (Cozolino, 2006; Perry, 2009). These processes are impaired when children are traumatized, which makes it difficult for them to integrate and make sense of the different aspects of experience in a fluid and meaningful fashion (Cozolino, 2006; Ford, 2009; Glaser, 2000; Perry, Pollard, Blakley, & Vigilante, 1995; Perry, 2009). Research has further shown that traumatic experiences can contribute to subsequent long-term brain changes, which can negatively affect a person's expression of post-traumatic symptoms (van der Kolk & Saporta, 1991). For example, individuals who have experienced repeated and prolonged exposure to

traumatic events develop an amygdala that is in a constant hyperarousal state because it has been primed, at an early age, to overreact to any subsequent stressors, which makes them more vulnerable to developing PTSD, panic attacks, and depressive symptoms (Ford, 2009; Kendall-Tackett, 2000).

The client's capacity to verbally discuss his or her traumatic experience is also complicated by physiological changes related to the brain's functioning. For example, the size of the hippocampus, which is the area of the brain responsible for memory processing and spatial navigation, can also be negatively impacted by traumatic experiences (Bremner et al., 1997). Incidentally, research has shown that people with PTSD have a significantly smaller left hippocampal volume relative to healthy control participants, reflecting a disruption in the brain's ability to store and retrieve experience linguistically (Bremner et al., 1997; van der Kolk & Saporta, 1991). Similarly, Broca's area, which is the area of the brain responsible for transforming subjective experiences into expressive language becomes essentially deactivated during traumatizing circumstances; thus, making it more difficult for individuals to verbally express their traumatic experiences (Harris, 2009; Pitman et al., 2001). Thus, therapists should consider including other avenues of expression for traumatized clients that may help them integrate the traumatic experiences (Bryant-Davis, 2005; Harris, 2009).

Therapeutic Alliance

Background of therapeutic alliance. The therapeutic alliance, a collaborative bond jointly developed by the therapist and client, has been a "topic of intense theoretical and empirical interest during the last two decades" (Horvath, 2000, p. 365; Krupnick et al., 2006). It has been accepted by many in the psychology profession as one of the common standards that is shared by most psychotherapies practiced today (Horvath & Bedi, 2002), including psychodynamic, cognitive-behavioral, family, couples, and humanistic (Bordin, 1976; Bowlby, 1988; Rogers, 1951). Consequently, the therapeutic alliance has become known as a pantsheoretical or transtheoretical concept (Horvath 2000; 2006).

Historically, the therapeutic alliance has been a well-known and explored construct in psychodynamic therapy. Freud (1958) initially believed that the therapeutic alliance was primarily a manifestation of the client's positive transference feelings (i.e., unconscious feelings for one person(s) based on past experiences with others that are redirected onto another person(s)). Yet, in his later writings, Freud acknowledged that a relationship between the client and therapist is not only a representation of positive transference but also an "attachment grounded in reality," where the client and therapist also relate to each other as real human beings in a give and take relationship (Horvath & Luborsky, 1993, p. 561).

Since Freud, other psychodynamic clinicians have furthered the notion that the therapeutic alliance is "real and based primarily on the here and now of the therapist-client encounter" (Horvath, 2005, p. 259). They have also stated that the therapeutic alliance is a key component of therapy and often explored not only as a means to increase a client's trust and connection to the therapist and others in his/her daily environment but also to understand how a client's past relationships may be related to his/her current relationship struggles (Kohut & Wolf, 1978; Zetzel, 1956).

Within a cognitive-behavioral therapy (CBT) framework, Raue and Goldfried (1994) find that the therapeutic relationship is vital. In fact, effective CBT interventions are unlikely to occur unless a sound working alliance has been established (Raue & Goldfried, 1994). Cognitive behavioral therapists have also posited that the therapeutic alliance is therapeutic in and of itself because many people do not have frequent opportunities where they feel listened to in a caring manner (Goldfried & Padawar, 1982). Furthermore, the therapeutic alliance is found to be a critical feature as its impact has been demonstrated to be as robust in the CBT treatment model as it has been found to be in other approaches such as psychodynamic therapy (Holtforth & Castonguay, 2005). These results add to the findings that clients in CBT regard the therapeutic relationship as valuable (Morris & Magrath, 1983).

The therapeutic alliance is also a significant characteristic of couples and family therapy.

In couples therapy, the therapeutic alliance has been defined as encompassing the following two

dimensions: content and interpersonal (Pinsof & Catherall, 1986). The content dimension entails

the affective bond between the client(s) and therapist(s), objectives to be carried out in therapy,

and the agreement between the client(s) and therapist(s) on the therapeutic approach and tasks

that will be employed to attain the agreed upon treatment goals (Pinsof & Catherall, 1986). The

interpersonal dimension not only encompasses the alliance between the couple and the therapist

but also includes the alliance between the therapist and each partner in the dyad (Pinsof &

Catherall, 1986). In family therapy, the therapeutic alliance is also defined by the context and

interpersonal dimensions but includes an additional focus on how well family members

themselves are relating to each other (Pinsof, Zinbarg, & Knobloch-Fedders, 2008).

Humanistic psychology has also explored the role therapeutic alliance plays in

psychotherapy. Carl Rogers emphasized that the therapist's ability to be empathetic and

congruent and to accept the client unconditionally is "not only essential" but also a "sufficient

condition for treatment gains" (Horvath & Luborksy, 1993, p. 562). Rogers argued that positive

therapeutic change can occur when therapists demonstrate these "core conditions" and clients

perceive that they in fact exist in the therapeutic relationship (Kirschenbaum & Jourdan, 2005).

Accordingly, Rogers emphasized the value of core conditions over treatment techniques.

However, not all clinicians agree that the therapeutic alliance is an adequate condition for

treatment gains. The majority of clinicians deem that it is an essential condition but not a

sufficient one for change because there are also other necessary ingredients that impact treatment

progress and outcome, such as (a) common factors that include the client's belief about the

effectiveness of therapy, his/her hope and his/her expectation about change, (b) whether the

therapist's behavior fits the client's expectations, (c) whether the client and therapist can

formulate a mutual understanding of how they will work together, which goals will be set and

how they will be carried out during the course of therapy, and (d) client and therapist factors,

which include transference, countertransference, attachment styles, personality characteristics,

therapist experience level (Mallinckrodt & Nelson, 1991) and diagnostic considerations (Horvath,

2000; Horvath, 2006; Horvath & Symonds, 1991; Ligiero & Gelso, 2002; Martin et al., 2000;

Wampold, 2001).

      Definitions of therapeutic alliance. Several definitions of the therapeutic alliance have

been set forth to describe the nature of the relationship between the client and therapist. Horvath

and Bedi (2002) give a comprehensive definition that describes the alliance as the active,

conscious, and purposeful collaborative relationship between client and therapist in

psychotherapy, which can vary in quality and strength. Strong alliances involve a sense of

partnership between therapist and client, in which each participant is actively committed to

his/her specific and appropriate responsibilities in therapy, and believes the other is likewise

enthusiastically engaged in the process (Horvath, 2000; Horvath & Luborsky, 1993).

Accordingly, Horvath and Bedi (2002) posit that this concept includes positive affective bonds

between client and therapist, such as mutual trust, liking, respect, and caring, and the more

cognitive aspects of the therapy relationship, including achieving consensus about, and actively

committing to, the goals of therapy and the means by which these goals can be reached.

      Luborsky (1976) and Bordin (1976; 1994) also described the therapeutic alliance to be

based on a broad framework entailing "all types of helping relationships" and emphasized the

"reality based aspects of the alliance" (Bordin, 1994, p. 259). Bordin (1976) developed a

definition of the therapeutic alliance that is used by many clinicians and researchers that

constitutes the essential components of an active and real relationship between client and

therapist in the here and now of therapy. Bordin (1976; 1979) and Horvath and Luborsky (1993)

specifically defined the therapeutic alliance as encompassing three central mechanisms: (a) *tasks,*

which are the therapy behaviors and cognitions that form the substance of the counseling process,

and both the client and therapist must perceive the tasks as relevant and beneficial in order for

there to be therapeutic outcome; (b) *bond*, which is expressed through a mutual understanding,

trust, acceptance, and confidence in the relationship; and (c) *goals*, which are the actual targets of

the intervention. Although there are other definitions of the therapeutic alliance (Gaston et al.,

1995; Horvath & Luborsky, 1993; Saketopoulou, 1999), Bordin's (1976) definition was used

because it has been widely accepted and served as the basis for the measure that was used to

analyze the therapeutic alliance in this study.

      Factors that affect the therapeutic alliance. The therapeutic alliance is influenced by

both therapist and client experiences that occur within and outside the context of psychotherapy

(Bachelor & Horvath, 2002), including clients who have experienced trauma. Clients and

therapists in the therapy relationship bring unique experiences and characteristics to that

interaction, and are responsible for the creation and maintenance of the alliance throughout the

course of therapy (Horvath, 2000; Ligiero & Gelso, 2002; Watson & McMullen, 2005). This

section will review the following specific factors that have been theoretically proposed and/or

empirically shown to influence the therapeutic alliance with clients generally and with those who

have experienced trauma specifically: (a) complementarity/match/fit between therapist and client,

(b) transference, (c) countertransference, (d) client diagnostic classifications, (e) client and

therapist attachment styles, (f) culture, and (g) therapist experience level.

      First, complementarity refers to how well the interactions between the client and therapist

fit, match or complement, each other (Bachelor & Horvath, 2002; Tracey, 1994). The

complementarity of interactions between the therapist and client is usually measured by (a)

dominance, or control, and (b) affiliation, which is reflective of basic interpersonal behavior such

as support and friendliness (Wiggins, 1982). More specifically, fit or match in the interaction is

shown when there are "dissimilar responses on the dominance dimension (e.g., dominant

communications elicit acquiescent responses) and similar responses on affiliation (e.g., friendly

responses "pull" friendly responses, and hostility elicits hostility)" (Bachelor & Horvath, 2002, p.

153). When interactions are complementary on both of these dimensions then complementarity

between the therapist and client is at its highest level and is likely to have a positive influence on

the quality of the therapeutic alliance (Bachelor & Horvath, 2002). In other words, eliciting

submissive or passive responses from clients on its own does not reflect a positive therapeutic

interaction; rather both dissimilarity and similarity on both the dominance and affiliation

dimension need to simultaneously exist in order for complementarily to occur within the

therapeutic alliance. Similarly, complementary is also represented when the therapist and client

are in agreement on the goals and tasks of therapy (Tracey, 1994). However, one study that

focused on working with clients in psychotherapy who have experienced childhood sexual,

physical, and emotional abuse found that clients were more likely to respond to hostility with

appeasement; this reaction was hypothesized to be the way they learned as children to cope with

their hostile perpetrators (Alpher & France, 1993). Therefore, matching hostility may negatively

impact the quality of the therapeutic alliance with clients who have experienced abuse and

impede their ability to express their feelings regarding the therapist-client relationship.

Transference is another factor that is said to influence the therapeutic alliance. As

previously mentioned, transference is a psychodynamic term defined as the client's projection of

positive and/or negative thoughts and feelings from past relationships onto the therapist (Horvath,

2000). Through the psychodynamic technique of interpretation, the therapist attempts to bring

the transference into the client's consciousness so that it can be resolved and the client can begin

to relate and perceive others' actions and intentions that are occurring in the present moment

more accurately and as coming from present moment rather than from the past. Psychodynamic

clinicians reveal that the therapeutic alliance can be negatively impacted if the therapist does not

acknowledge or seek to understand the transference process (Safran & Muran, 1996). Moreover,

inaccurate interpretations or those that are rejected or resisted by the client are also theoretically

and shown in research to be related to a disruption in the therapeutic alliance (Rhodes, Hill,

Thompson, & Elliott, 1994; Watson & McMullen, 2005).

Third, countertransference has also "been theorized to negatively affect the

psychotherapy relationship…" (Ligiero & Gelson, 2002, p. 3). Countertransference is defined as

the therapist's thoughts/feelings/behaviors directed towards the client that are based on the

therapist's past relationships. Freud (S. Freud, personal communication, October 6, 1910)

believed the therapist's countertransference would negatively impede the therapist's ability to

understand the client because he/she would be overly impacted by his/her own needs rather than

the client's needs. Unlike Freud's focus on the therapist, Gabbard (2001) proposed that both the

therapist and client contribute to the formation of countertransference because they are in a

interdependent relationship with each other where they continually influence each other's

thoughts, feelings and behaviors. If and when the countertransference is made conscious,

Gabbard believes that it can contribute positively to a therapist's understanding of his/her client's

relationship patterns and also strengthen the therapeutic alliance.

Similar to Gabbard's ideas, Kiesler (2001) suggested there are two types of

countertransference that may affect the therapeutic alliance: (a) subjective or "the therapist's

reactions to the client [that] originate from the therapist's own unresolved conflicts and anxieties"

(Ligiero & Gelso, 2002, p. 4), and (b) objective or "the therapist's reactions to the client [that] are

evoked primarily by the client's maladaptive behavior" (Geltner, 2007; Ligiero & Gelso, 2002, p.

4) such as aggressiveness, lack of motivation, and defensiveness. When working with a client

who has experienced trauma, a therapist taking into account objective countertransference should

be cautious about conceptualizing these types of reactions as maladaptive since they could also be

considered as the client's way of coping. For example, "spacing out" in school or responding

with distrust, dissociation and/or resistance to treatment interventions/ recommendations could be

viewed as a survival mechanism rather than a lack of motivation to participate in therapy (Chu,

1988; Kerka, 2002; Shubs, 2008). When a therapist is experiencing subjective

countertransference, he/she may be unaware of his/her feelings and reactions towards the client,

which can have harmful effects on the client and the therapeutic alliance. Providing some support

for this idea, the one study located on this topic found that negative subjective

countertransference was associated with weaker alliances and positive subjective

countertransference was related to weak bonds in the alliance (Ligiero & Gelso, 2002).

Fourth, several studies have demonstrated an interaction among clients' diagnostic

classifications and premature termination and poor therapeutic alliance (Mohl, Martinez, Ticknor,

Huang, & Cordell, 1991; Yeomans et al., 1994). According to two studies, clients who present

with borderline, avoidant, obsessive-compulsive, and other personality disorders might have

greater difficulty establishing an effective therapeutic alliance with their therapists as well as

having significant trouble maintaining healthy social and family relationships (Horvath &

Luborsky, 1993; Strauss et al., 2006). It is hypothesized that these clients might prematurely

terminate therapy because they misperceived their therapists' and others' intentions and reacted

with defensiveness and hostility rather than openness (Greenspan & Kulish, 1985). Greenspan

and Kulish (1985) found that clients who terminated therapy prematurely and had difficulty

establishing a therapeutic alliance with their therapists "were more likely to perceive their

problems as situational and/or external to themselves, most typically describing their problems in

terms of marital or family discord" (p. 78). These clients were also more likely to receive the

diagnosis of "depressive reaction" in initial psychiatric evaluations, which Greenspan and Kulish

described as an indication of the "reactive nature of their problems" (p. 78).

However, therapist factors should be considered when evaluating the above findings.

Since the therapeutic alliance is co-created, therapists play a significant role in how clients

respond to treatment and whether they terminate therapy prematurely (Horvath, 2000; Safran &

Muran, 1996; 2000). For example, therapists may overpathologize clients or not know how to

effectively treat their presenting issue(s) and diagnosis(s). Studies of people who present with

complex trauma have demonstrated that therapists who are not equipped to manage clients'

complex reactions, which can include distrust, anger, and dissociation, may contribute to clients'

desires to end treatment prematurely (Courtois, 2008; Dalenberg, 2004).

Fifth, clients' and therapists' attachment to each other and their attachments styles appear

to affect the therapeutic alliance. The developers of attachment theory, Ainsworth and Bowlby

(1991), argued that all people, whether they are infants or elders seek to create an affective bond,

or attachment, to a particular caregiver to meet their needs for physical and psychological security

and safety (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988). The therapy relationship

is believed to encompass and model the critical characteristics of an attachment relationship,

where the therapist functions as the attachment figure/secure base from which the client can

explore significant personal material (Dozier & Tyrrell, 1998). Ideally, a strong bond between a

client and therapist "facilitates smooth collaboration, buffers the relationship from the strain of

therapeutic work…is considered a healing element of psychotherapy" (Obegi, 2008, p. 431), and,

in turn, should support a strong therapeutic alliance.

Additionally, Bachelor and Horvath (2002) indicate that clients' different attachment

styles impact the development of the therapeutic alliance. They have shown that clients who

presented with secure attachments reported more positive therapeutic alliances with their

therapists and "perceive[d] the therapists as responsive, accepting, and providing a secure base"

(p. 157). Others have found that adults with a secure attachment remember more coherent

relationship narratives and engage in self-disclosure more often as well as interpret and integrate

experiences from the past more fluently (Mikulincer & Nachshon, 1991), and make more

accurate cognitive appraisals of their interpersonal relationships (Fonagy, Gergely, Jurist, &

Target, 2002). The skills of self-disclosure, reflection, and appraisal of relationships support

clients' ability to explore their thoughts and feelings within the therapeutic alliance (Romano,

Fitzpatrick, & Janzen, 2008).

Regarding other attachment styles, "merger-type clients desire frequent and intensely

personal contact with their therapist; avoidant clients distrust the therapist and fear rejection; and

finally, reluctant-type clients seem engaged with the therapist, but appear unwilling to participate

in the self-revealing tasks of therapy" (Bachelor & Horvath, 2002, p. 157). Satterfield and

Lyddon (1995) also revealed that clients who have difficulty trusting that others are available and

dependable are more likely to evaluate the therapy relationship in a negative manner during the

early part of treatment. This finding could be considered clinically significant because such

difficulties early in the formation of the working alliance may ultimately lead to unfavorable

counseling outcomes (Horvath & Symonds, 1991).

However, clients who demonstrate such attachment styles might be distancing themselves

from others as a means of survival and coping. One study exploring various ways in which

African American women coped with childhood traumatic events recommends that clinicians

validate the strengths and capabilities their clients exhibited during childhood and now as adults

in order to fully appreciate their experiences (Bryant-Davis, 2005). Furthermore, therapists who

view these clients, some of whom have experienced trauma in interpersonal relationships, in a

more positive or strength-based light, may see such strategies as protective and help to build trust

with their clients.

In addition, by viewing attachment on a continuum rather than in distinct categories,

therapists can increase flexibility when attempting to engage their clients in therapy. This notion

is supported by Patricia Crittenden's (1999) work on the dynamic-maturational model of

development and attachment in traumatized children. Her model suggests that children develop

and use strategies or processes of relating that may appear on the outside as unhealthy or

disorganized but actually serve the purpose of protecting them from danger (Crittenden, 1999).

She further argues that attachment theorists often present a narrow view of attachment and overly

identify secure attachment as the hallmark of positive health. In overly idealizing secure

attachment in this way, "achievement of safety" and "flexible adaption" to traumatic

circumstances are overlooked as signs of positive human potential (Crittenden, 1999, p. 171).

This ability to flexibly adapt to traumatic circumstance is particularly evident in a case study that

focused on the childhood traumatic experiences of a young African American woman in

psychoanalytic therapy (Eisold, 2005). Although this client possessed a difficult and unstable

attachment to her biological mother who was frequently both physically and emotionally

unavailable, she was still capable of securely attaching to her loving grandmother (Eisold, 2005).

Research has demonstrated that therapists' own attachment styles are also related to the therapeutic alliance. Specifically, therapists who have secure attachment styles, as compared to therapists who have insecure attachment styles, are able to securely attach and bond to their clients, and also facilitate a more collaborative, trusting and safe environment in which clients feel comfortable exploring their presenting issues (Angus & Kagan, 2007; Black, Hardy, Turpin, & Parry, 2005). Furthermore, Dunkle and Friedlander (1996) found that therapists with secure attachment styles were more competent in creating early therapeutic alliances. Although such research indicates that both clients and therapists who demonstrate insecure attachment styles show greater difficulty creating effective and strong therapeutic alliances (Bachelor & Horvath, 2002), it does not consider strengths-based viewpoints or view therapists' attachments styles on a continuum and as malleable. For example, a therapist with an insecure attachment style could work on building more trust and security through the experience of his/her own therapy, which, in turn, can have positive benefits for his/her relationships, including the therapeutic alliance with clients who have experienced trauma.

Sixth, cultural factors also appear to play a role in the formation of a therapeutic alliance. Some studies have demonstrated a positive correlation between therapeutic alliance and client education, client age, and similarity in age of client and therapist (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Marmar, Weiss, & Gaston, 1989). In addition, it appears that most cross-cultural psychotherapy research agrees that a certain degree of similarity in culture and values strengthens the probability that clients will establish good relationships with their therapists and remain in therapy rather than ending prematurely; however, it is not certain whether this finding is equally supported and applicable to client-therapist dyads who come from more dissimilar cultural backgrounds (Beutler, Machado, & Neufeldt, 1994).

Studies have also focused on how differences in race/ethnicity between therapists and clients may account for weaknesses in the therapeutic alliance. For example, although there is

conflicting evidence, many clients of color report being more comfortable and staying in

treatment longer with therapists who are analogous to them in ethnicity and language ability

(Casa, Vasquez, & Ruiz de Esparza, 2002; Sue, 1998). Another study found that African

American clients, who perceived racial microaggressions ("subtle and commonplace exchanges

that somehow convey insulting or demeaning messages to people of color" [Constantine, 2007, p.

2]) coming from their White therapists, had weak therapeutic alliances and rated them low on

their multicultural counseling competence (e.g., knowledge about clients' culture; sociopolitical

awareness; cultural sensitivity; Constantine, 2007).

Other researchers have suggested that gender might influence certain facets of the

therapeutic alliance. For instance, in one study, female clients engaged in more self-exploration

than male clients (Hill, 1975 as cited in Bachelor & Horvath, 2002). In another study, female

therapists demonstrated greater responsiveness to clients' expression of painful feelings (Howard,

Orlinsky, & Hill, 1970) and appeared to be more direct by addressing in-session behavior more

often as it related to clients' life circumstances as compared to male therapists (Jones, Krupnick,

& Kerig, 1987). Male therapists in the same study reported more uneasy feelings with intimacy

and seemed to assuage conflict between themselves and their clients rather than address its

source. Some research has also noted differences in the alliance process "as a function of same

sex- or opposite-gender pairing" (Hill, 1975 as cited in Bachelor & Horvath, 2002, p. 161). For

example, clients seemed to be able to speak more openly about their feelings with same gender

therapists. Conversely, other studies have showed that clients self-disclose more often and in

greater depth in opposite gender pairings (Hill, 1975 as cited in Bachelor & Horvath, 2002).

Consequently, while certain research demonstrates some gender differences in both clients and

therapists, these findings require further examination and replication.

Finally, there is mixed evidence for therapist experience level affecting the therapeutic

alliance. Some researchers (Dunkle & Friedlander, 1996; Greenspan & Kulish, 1985) found that

therapists' level of experience was not correlated to the quality of the therapeutic alliance,

indicating that therapists' level of training did not increase and/or decrease their capability of

establishing a therapeutic alliance. On the other hand, other studies (Mallinckrodt & Nelson,

1991) have shown fractional support for such a relationship. For instance, Mallinckrodt and

Nelson (1991) proposed that therapists in their early stages of training may lack the necessary

skills needed to engage a client in the process of establishing goals and working collaboratively

on related tasks and interventions, despite being able to provide genuine respect and establish

effective emotional bonds with their clients. Others elaborate on this idea by stating that

experience may provide therapists with a broader base of knowledge that facilitates their abilities

to more adequately collect and process new information with clients (Hillerbrand & Claiborn,

1990). Such therapists might also be better equipped to detect deteriorations in the alliance as

compared to their less experienced counterparts (Mallinckrodt & Nelson, 1991). Supporting this

view, Kivlighan, Patton, and Foote (1998) found that clients who had more relational difficulties

were better able to establish stronger alliances with more experienced therapists while less

relationally challenged clients did not respond differently.

Measuring therapeutic alliance. The therapeutic alliance has been measured using

observer rating scales and self-report instruments. The most commonly used measures in

research and clinical practice, which have also been empirically tested, are the following:

Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983); California

Psychotherapy Alliance Scales (CALPAS; Gaston & Marmar, 1994); Helping Alliance

Questionnaire Method (HAq; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985); and

Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The VTAS is an observer

instrument that assesses the quality of the interaction between the therapist and client. Observers

rate the alliance for any given segment of a therapy session using a 44-item scale. The CALPAS

scales evaluate four aspects of the therapeutic alliance (i.e., patient's working capacity in therapy,

patient's commitment to therapy, therapist's contribution to the alliance and patient-therapist

agreement on treatment goals and tasks) and can be measured by both observer and self-report

ratings. The HAq is a self-report measure, which allows the client to rate the quality of the

alliance on 11 items. The WAI is a 36-item self-report instrument that measures the therapeutic

alliance between the client and therapist. Based on Bordin's definition of the three core features

of the therapeutic alliance, three subscales are included in this scale: agreement on tasks,

agreement on goals and development of a bond. Each item is rated on a 7-point scale, with

responses ranging from 1 (never) to 7 (always). Tracey and Kokotovic (1989) developed a

shortened version of the WAI, the instrument to be utilized in this present study. Both client and

therapist versions of the WAI are available.

 Therapeutic alliance and outcome. The quality of the therapeutic alliance has been

consistently related to positive treatment outcomes across different therapeutic approaches

(Bachelor & Horvath, 2002; Martin et al., 2000). Horvath and Symonds (1991) reviewed 24

studies and found a moderate but reliable effect size of the alliance on therapeutic outcome.

Years later, Martin et al. (2000) conducted a more comprehensive meta-analytic review of the

therapeutic alliance literature and also found that therapeutic alliance was moderately correlated

to treatment outcome. The therapeutic alliance has also been correlated with termination, such

that poorer alliances usually lead to earlier and premature terminations (Greenspan & Kulish,

1985; Horvath, 2000, 2006).

 Yet, studies provide contrasting evidence regarding the temporal relationship between

positive therapeutic alliance and positive therapy outcome. Some studies have indicated that a

strong alliance at intake or in the first three to five sessions is the best predictor of positive

therapy outcome (Barber et al., 1999; Tyron & Kane, 1993). Horvath (2000) suggests that there

are opportunities early in therapy (e.g., 1-5 sessions) to establish a collaborative alliance that is

"built on mutual respect, trust and personal commitment, as a sense of responsibility to the goals

of treatment" (p. 169).

 However, other studies have demonstrated that a gradually built alliance appears to be

most reliably associated with positive treatment outcome (Florsheim, Shotorbrani, Gest-Warnick,

Barratt, & Hwang, 2000; Joyce & Piper, 1998). Still other research has indicated the opposite;

"the course of the alliance over time is not linear, that is, it does not improve or deepen with

successive sessions, even in treatments that have very successful outcomes" (Horvath, 2000, p.

168). Horvath (2000) sees the alliance as malleable and vulnerable to all kinds of stressors and

disruptions throughout the course of treatment. Thus, it appears that building an alliance early on

in therapy is a valuable goal but consistent monitoring of the alliance is essential given how it can

fluctuate during the course of treatment.

The therapeutic alliance has also been seen by many to represent a common factor

accounting for positive therapeutic outcome (Wampold, 2001; Weinberger, 1995). Specifically,

the therapeutic alliance has been identified as one of many common factors that are responsible

for change processes that occur in therapy. Other common factors include, but are not limited to,

clients' expectations of therapeutic success, clients' confronting or facing the problem, clients'

having an experience of mastery of cognitive control over the problematic issue, and therapist

effects (Wampold, 2001; Weinberger, 1995). Weinberger (1995) and Wampold (2000) support

the idea that there are few significant differences in the effectiveness of different treatment

models and techniques of psychotherapy. They suggest that one reason for this lack of difference

is that common factors are found to be the actual effective agents of change in therapy across all

psychotherapy approaches.

Therapeutic Ruptures and Repair

Therapeutic ruptures. The therapeutic alliance is also a significant area of interest for

researchers investigating therapeutic ruptures and their effects. Safran and Muran (1996) define

ruptures as deteriorations in the relationship between the therapist and patient, and a disagreement

about tasks and goals of therapy. They have found that ruptures often emerge when therapists

and/or clients behave in ways that undermine or hinder the therapy process. Safran and Muran's

research has involved a combination of trainee and more experienced/licensed therapists;

therefore, these two groups are not differentiated when referring to therapists in the following

sections. Safran and Muran's research has also used samples of clients who presented with a

variety of Axis I and Axis II diagnoses, but excluding: psychosis, organic illness, mania or

bipolar disorder, substance abuse disorder, active suicidal or parasuicidal behavior, and a history

of severe impulse control problems. Thus, their model and findings may not apply to all clients,

including those who have experienced trauma.

According to Safran and Muran (1996), ruptures may appear in clients' behavior during a

therapy session in two alternative ways: (a) confrontational ruptures, in which clients directly

reveal their dissatisfaction with the therapist or with some aspect of the therapy, and (b)

withdrawal ruptures, in which clients emotionally or cognitively withdraw from the therapeutic

relationship and process (Safran, 1993a, 1993b). Other studies that have examined clients'

responses in therapy sessions have revealed five common indicators of ruptures (Hill, Nutt-

Williams, Heaton, Thompson, & Rhodes, 1996; Rhodes, Hill, Thompson, & Elliott, 1994): (a)

direct and indirect expression of a negative attitude towards the therapist, (b) disagreement about

goals or tasks of therapy, (c) non-engagement and avoidance behaviors (e.g., ignoring a

therapist's comment, arriving late, abruptly canceling an appointment or not attending an

appointment), (d) self-esteem-enhancing communications (e.g., exaggerating accomplishments in

the face of perceived censure from the therapist, and (e) nonresponsiveness to therapist's

treatment interventions (e.g., rejecting or failing to make use of specific interventions).

Examples of ruptures can also be found in the Inventory of Countertransference Behavior

(ICB; Friedman & Gelso, 2000). The ICB is a 32-item observer scale created for rating the

amount of countertransference behavior displayed by the therapist in a given session. On a 5-

point Likert scale, observers rate the therapist's reactions to the client, with responses ranging

from 1 (to little or no extent) to 5 (to a great extent). The ICB also contains two factors: positive

and negative countertransference behaviors and three scores are obtained for a participant: a

positive countertransference score, negative countertransference score and a total score. The

higher the score on this scale, the greater amount of countertransference behavior is demonstrated

in the sessions. Some of the items consist of the following statements: "The client indicated that

the therapist talked too much in the session," "The therapist was critical of the client," and "The

therapist spent time complaining during the session." Friedman and Gelso (2000) found an alpha

coefficient of .79 for each subscale (i.e., positive and negative countertransference) and .83 for

the total scale. Building upon these definitions of ruptures, this dissertation used the following

definition of ruptures: a break, impasse, or disruption in the flow of the therapy between the client

and therapist where negative affect and/or behaviors are likely to result in either or both the

therapist and client. Moreover, a rupture can be a single event, occur multiple times within a

therapy session, and/or continue into subsequent sessions. Furthermore, a rupture usually

includes a change in the client's affect and behaviors, expressed verbally and/or nonverbally (e.g.,

sadness, laughter, anger, posture changes, deep sighs, averting eye gaze, fists clench up). Finally,

ruptures can involve: "Therapist Provid[ing] too much structure," "Client indicat[ing] that

Therapist talked too much in the session," "Therapist Critical of the client," and "Therapist

Behav[ing] as if he or she were somewhere else" (items from the ICB; Friedman & Gelso, 2000).

Therapist factors related to therapeutic ruptures. In accordance with Safran and

Muran's (1996; 2000) definition of ruptures, and others' viewpoints on ruptures (Hill et al., 1996;

Rhodes et al., 1994), therapists' behaviors greatly impact the quality of the therapeutic alliance

and can incur and/or contribute to ruptures between clients and therapists. For example, a

therapist comes in late for a session without acknowledging his/her tardiness, or responds with

defensiveness or lack of empathy to a client's discussion. In a study that investigated clients'

reports of experiences that resulted in premature termination of treatment, Rhodes et al. (1994)

paraphrased the clients' comments and reported that they usually stated that their therapists

behaved in ways contrary to what they needed or desired (e.g., therapist was critical, nonattentive,

forgetful), leading to negative feelings about themselves (e.g., guilt, devastation) and their

therapists (e.g., anger, sense of abandonment).

Theoretical articles as well as empirical research also supports the notion that incongruent interpretations and the misuse of interventions not only negatively affects therapeutic alliance but also contributes to ruptures within the therapeutic relationship (Hill et al., 1996; Rhodes et al., 1994; Pinkerton, 2008). Another factor to consider is therapists' capability to effectively address ruptures in the alliance (Safran, 2002; Safran & Muran, 1996). When they do address ruptures well, therapists may play a significant role in improving therapeutic outcome (Safran, 2002; Safran & Muran, 1996). However, therapists, even those who are well trained and experienced, often have difficulty effectively managing interpersonal conflicts in which they are actively involved (Binder & Strupp, 1997). Theoretical writings have posited that the following therapist characteristics may influence the therapeutic alliance: (a) countertransference and (b) attachment style. As such, they may also be associated with therapeutic ruptures and affect therapists' abilities to effectively address them.

Although countertransference has not been specifically studied in the therapeutic rupture literature, it has been linked to deteriorations in the therapeutic alliance. Therefore, the researcher proposes that there is a connection between countertransference and therapeutic ruptures. For example, countertransference reactions, if acted upon by the therapist, can have detrimental consequences on the client and the therapeutic alliance. For example, in one study, therapists with weaker alliance ratings were found to be exploitive, critical, moralistic and defensive as well as virtually devoid of adequate warmth, respect and confidence (Eaton, Abeles, & Gutfreund, 1993). Another study also revealed that therapists who were perceived by their clients as being distracted, tired and bored were rated as having poorer alliances (Saunders, 1999). In contrast, researchers across different treatment approaches have demonstrated that positive treatment outcomes are characterized by a high amount of therapist statements that communicate attentive listening, understanding and openness (Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003). It is thus evident that therapists play a valuable role in facilitating the therapeutic alliance; therefore, awareness of countertransference reactions is highly significant. Moreover, as

suggested by various theorists, disclosure of a therapist's feelings to the client can advance

treatment and potentially preclude or even address impasses or strains in the relationship

(Dalenberg, 2004).

Studies on therapeutic alliance suggest that therapists' attachment styles influence the

quality of the therapeutic alliance. Since therapists' attachment styles contribute to the alliance,

the researcher proposes that therapists' attachment styles are also related to therapeutic ruptures.

For example, Dunkle and Friedlander (1996) indicated that therapists who have secure

attachments styles characterized by supportive relationships with family, friends and colleagues

are more capable of forming strong therapeutic alliances with their clients, regulating their

emotions and responding with less hostility in sessions with clients, than compared to therapists

with insecure styles. Ligiero and Gelso (2002) also reported that "more secure clinicians are able

to use their own countertransference feelings by reflecting on what the client elicits in them and

by providing feedback instead of acting out the countertransference" (p. 5) as compared to

therapists with insecure attachment styles.

In some instances, therapists' contribution to therapeutic ruptures is clear (e.g., poorly

timed interventions); yet, in other cases, the clients' or patients' processes play a greater role.

(Safran & Muran, 1996). For that reason, theorists and the researcher of this study support the

idea that client factors also may play a significant role in the creation of therapeutic ruptures in

the therapeutic alliance.

Client factors related to therapeutic ruptures. Various client factors seem to influence

the development of therapeutic ruptures. Several studies and theoretical findings have identified

the following factors that appear to have the most impact on clients' interactional patterns and

their abilities to resolve ruptures: (a) transference, (b) relationship schemas, (c) attachment style,

and (d) diagnostic considerations.

First, negative transference is defined as the client's unconscious projected negative

sentiments onto the therapist that are based on the client's past experiences in relationships with

other people (Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003). Therapists are invited to view a client's experience of negative transference as an opportunity to explore with the client how s/he thinks and feels in relation to his/her therapist and how past negative events have influenced his/her current relationships including the therapist-client relationship (Spinhoven, Giesen-Bloo, Van-Dyck, Kooiman, & Arntz, 2007). For example, if a client experiences shameful feelings and begins to unconsciously displace those feelings onto the therapist and view him/her as unempathetic, this is a situation in which the therapist can explore the client's negative affect and how it impacts the therapeutic relationship. Through this mutual exploration, clients can gain a better understanding of themselves and their emotional responses in relationships. With raised awareness, clients may be able to relate more effectively with others because they may be more present and attuned to their needs and consequently the needs of others. However, if a therapist is not aware of his or her client's negative transference, then the client might be more apt to perceive the therapist's actions more negatively and hence a rupture event may be ripe to occur.

Second, client's interpersonal schemas have been shown to affect therapeutic alliance. Sommerfeld, Orbach, Zim, & Mikulincer (2008) say that clients' behaviors in therapy are often guided by dysfunctional interpersonal schemas that represent unconscious and conflictual forces stemming from clients' history of relating with others. One of the most well known approaches for assessing clients' dysfunctional schemas is Luborsky and Crits-Christoph's (1998) Core Conflicutal Relational Themes (CCRT) method. According to CCRT, dysfunctional interpersonal schemas have three basic features: (a) a client's wishes, needs, or intentions during an interpersonal interaction with a specific other; (b) actual or expected responses of that other; and (c) expressed or unexpressed responses of the self during the interaction with that other Sommerfeld et al., 2008). These themes develop from a client's history of painful relationships, and consequently, are seen to establish unrealistic expectations from others, including the therapist, and tend to be a source of relational tensions, misunderstandings, conflicts and

maladjustment (Luborsky & Crits-Christoph, 1998). Additionally, Sommerfeld et al. indicate that ruptures are likely to occur when clients' CCRTs emerge unconsciously in therapy because when clients are behaving in ways that are solely based on their past maladaptive relationship patterns, they have less capacity to engage in collaborate therapeutic work. With this in mind, therapists are encouraged to help clients become aware of their CCRTs so that they do not interfere with therapeutic progress and cause clients to withdraw from the therapeutic relationship (Safran & Muran, 1996; Sommerfeld et al., 2008).

Third, studies suggest that clients' adult attachment styles may significantly influence the therapeutic alliance (Ligiero & Gelso, 2002; Mallinckrodt, Porter, & Kivlighan, 2005). Attachment theorists propose that securely attached adults are more open and willing to explore their thoughts and feelings and also more equipped to regulate their anxiety and emotional responses in novel situations such as psychotherapy (Bartholomew & Horowitz, 1991). For instance, Buchheim and Mergenthaler (2000) found that securely attached adult clients in psychotherapy, compared with insecurely attached counterparts, were more likely to recall more positive and negative coherent relationship narratives and were more capable of integrating and interpreting past experiences. Therefore, insecurely attached adult clients may be more vulnerable to feeling distrustful and unsafe in the psychotherapy relationship. These feelings, if not explored as well as validated in therapy, may influence the development of ruptures in the therapeutic alliance.

Finally, clients with certain psychological problems have demonstrated difficulties with developing the therapeutic alliance. For example, clients who have been diagnosed with personality disorders, either as a sole diagnosis or comorbid one, often present with the most challenges due to the longstanding nature of their problems (Horvath & Bedi, 2002). Clients with borderline personality disorder, many of whom have experienced interpersonal trauma, in particular, show greater difficulties in affect regulation and maintaining a sense of stability and trust, especially within the context of intimate relationships (Cloitre, Stovall-McClough, Miranda,

& Chemtob, 2004; Spinhoven et al., 2007). Therefore, these difficulties may predispose clients to the occurrence of more ruptures in the therapeutic alliance (Llewelyn, 2002).

Repairing Therapeutic Ruptures

Therapeutic outcomes depend not only on clients' and on therapists' abilities to form an initial therapeutic alliance, but also on their abilities to deal with and resolve ruptures in this alliance (Safran, 1993a; Safran & Muran, 1996; 2000; Sommerfeld, Orbach, Zim, & Mikulincer, 2008). According to Safran and Muran (1996), ruptures are actually good opportunities for therapists to learn more about the dysfunctional relational patterns that bias clients' cognitions, feelings and behavior in their interpersonal lives. They should also be considered as opportunities to engage in repair or rupture resolution.

Safran and Muran (1996; 2000) developed a four stage-process model of alliance rupture resolution. Informed by Rice and Greenberg's (1984) psychotherapy research procedure called task analysis, Safran and Muran created their repair model after examining the psychotherapy process for recurring, identifiable patterns with samples of clients who, as previously mentioned, presented with a variety of Axis I and Axis II diagnoses (excluding, psychosis, organic illness, mania or bipolar disorder, substance abuse disorder, active suicidal or parasuicidal behavior, and a history of severe impulse control problems). Safran and Muran observed 15 active, integrative (i.e., interpersonal, experiential, and cognitive approaches) psychotherapy sessions in which there appeared to be some degree of resolution for alliance ruptures. They then asked therapists and clients to conceptualize a therapy session as consisting of three parts (a beginning, middle and end) and rate each session using six items that were taken from the WAI (Horvath & Greenberg, 1989). They used these ratings along with coded sessions of clients' and therapists' verbalizations and/or actions to create an initial repair model. Then, Safran and Muran performed a preliminary test of this model on a new sample that came from the initial group of cases, in which they compared sessions deemed resolved versus not resolved based on conflicting therapist and client ratings on post-session measures, including the WAI. Results from this preliminary

test along with subsequent replication studies led to refinements of the initial repair model and the development of the current repair model.

Informing their current model, Safran and Muran (1996; 2000) found that the repair process involved the client and therapist engaging in a push and pull negotiation meant to increase both the client's and therapist's awareness of their thoughts, feelings and disappointments regarding the rupture event. By facilitating an open dialogue and negotiation between the therapist and client, it is hoped that the rupture marker or event will be repaired and consequently the therapeutic alliance will be strengthened. Accordingly, Safran and Muran's (1996; 2000) model of alliance rupture resolution is meant to be flexible, guiding therapists in ways of developing better pattern-recognition abilities (i.e., identifying rupture markers or events and addressing them effectively with their clients as they unfold in the here and now of a given therapy session) that can facilitate more effective therapeutic interventions.

More specifically, in the first stage of the four stage-process model (Safran & Muran, 2000), the therapist is instructed to attend to the rupture marker by being attuned to the client's verbal and nonverbal messages and pointing out the rupture marker to the client in a nonjudgmental, open, and empathic manner. Through the use of metacommunication, whereby the therapist comments on the moment to moment interaction unfolding between the client and therapist, the therapist is able to focus on the client's immediate experience of the rupture. In the second stage, the therapist engages the client in exploring the rupture experience (Safran & Muran, 2000). For example, the therapist facilitates self-assertion in the client by helping the client express his or her negative sentiments in a more constructive fashion by using I statements and labeling emotions. In stage three, the therapist further validates the client's thoughts and feelings and explores whether or not the client is expressing avoidance of any thoughts or feelings associated with the rupture. Lastly, in stage four, the therapist continues to help the client become more assertive and comfortable with stating his/her disapproval with something he/she believes the therapist has done or failed to do and reinforces the client for any spontaneous

assertiveness or expression of a wish or need that has occurred without the assistance of the

therapist (Safran & Muran, 2000).

      Benefits of repair. Safran and Muran (1996; 2000; Sommerfeld et al., 2008) state that

the key ingredient in processing and resolving alliance ruptures involves helping clients learn that

they can express their needs and assert themselves without destroying the therapeutic alliance.

Although these types of interactions challenge clients' interpersonal schemas and expectations for

relationships, they serve to empower clients to feel more confident in confronting conflictual or

rupture events in their daily lives with other relationships (Safran & Muran, 1996; 2000;

Sommerfeld et al., 2008). Accordingly, the resolution of therapeutic alliance ruptures provides a

critical corrective emotional experience where "working through an alliance rupture can play an

important role in helping the client to develop an interpersonal schema that represents the self as

capable of attaining relatedness, and others as potentially available emotionally" (Safran &

Muran, 2000, pp. 238-239).

      Resolving ruptures in the alliance can also present clients "with opportunities to

acknowledge disowned parts of themselves and to learn to negotiate the dialectically opposed

needs for self-agency and relatedness in a constructive fashion" (Safran & Muran, 1996, p. 448).

Additionally, clients' initial negative emotional responses may be alleviated through the repair

process and then replaced by positive feelings and a sense of accomplishment (Orlinsky, Grave,

& Parks, 1994). In a like manner, the repair of ruptures can afford clients with corrective

interpersonal experiences that promote change and also improve symptoms of certain personality

disorders (i.e., Avoidant and Obsessive-Compulsive) and depression (Strauss et al., 2006).

Finally, according to Ellman (2007), solving each rupture brings about more trust and intensifies

the bond between clients and therapists.

      Several studies investigating the processes involved in repairing ruptures suggest that it

can be beneficial and valuable for therapists to be aware of the following guidelines as they

practice therapy:

- Therapists should be aware that clients may have negative feelings about therapy or the therapeutic relationship which they might be hesitant to voice due fears of rejection and negative reactions from therapists.

- Thus, it is crucial that therapists be attuned to any subtle markers of ruptures in the alliance and take the initiative to directly explore with the client what is unfolding in the therapeutic alliance and therapy process when they suppose that a rupture has occurred.

- It seems necessary for clients to have experiences of expressing both positive and negative or uncomfortable feelings about therapy to their therapists and to assert their perspectives when they differ from the therapists' views.

- When disagreements arise between therapists and clients, it is critical for therapists to try to respond in an open, nonjudgmental and non-defensive manner, and to be willing to accept responsibility for their parts in the interactions.

- The process of exploring clients' fears, expectations, thoughts, and feelings that impede their clients' abilities to assert their negative feelings about treatment and/or the therapists' behaviors may actually positively contribute to the process of repairing the rupture and strengthen the therapeutic alliance (Hill et al., 1996; Rhodes et al., 1994; Safran & Muran, 1996; 2000; Samstag, Batchelder, Muran, Safran, & Winston, 1998).

Limitations of the rupture and repair model. Although the Safran and Muran rupture and repair model is designed to aid clients in being able to more openly and securely express their needs in interpersonal interactions with their therapists and consequently, in other relationships outside of treatment, it also has its limitations.

First, it may not be applicable or generalizable to all clients, including those with interpersonal trauma histories. More specifically, the model does not extend its definition of ruptures to include those that might be incurred by the therapist within the context of a trauma discussion. For instance, the model does not take into account how a premature focus on topics such as reporting abuse rather than first establishing rapport and safety can lead to a significant

rupture. Additionally, nonverbal behaviors on the part of the therapist, including facial

expressions signifying shock and horror, can also trigger ruptures and possibly reinforce clients'

already existing fears of judgment and criticism regarding the trauma experience. Similarly, the

model does not account for more specific types of questions that can also lead to ruptures in the

therapeutic relationship (e.g., "so why didn't you call the police?"; "did you fight the

perpetrator?"). Furthermore, questions or statements, including the relabeling of words (e.g., "did

you have sex with?" instead of using the word rape) can also contribute to ruptures as they

potentially redefine the meaning of trauma for the client and lay blame on the survivor rather than

on the perpetrator. In a similar fashion, therapists' misaligned attempts at offering comfort or

reassurance to a traumatized client (e.g., "I'm sure your friends will be there for you") may also

instigate a disruption in the therapeutic relationship, especially if that client does not feel

comforted or reassured by such attempts.

Second, since the process of discussing interpersonal trauma is often a dynamic rather

than static occurrence that involves many different stages and cycles (Alaggia, 2005; Lindbald,

2007), the immediate focus on identifying ruptures and then repairing them through four stages,

may not adequately fit. For instance, it may not fit in cases where traumatized clients are not yet

ready to engage in discussions surrounding feelings and interpersonal intimacy, especially given

their experiences of being violated and blamed in interpersonal exchanges (Pino & Meier, 1999).

Likewise, the model's instructions for repairing ruptures directs the therapist to first

explore the client's feelings, potentially causing the client to feel exposed and vulnerable too

soon. Moreover, in this type of interaction where the therapist expects the client to first share

his/her feelings, the client may feel blamed as the focus is primarily on him/her rather than on the

therapist's feelings and/or his/her need to take responsibility.

Lastly, there may be times when the therapist's attempt to repair a rupture can potentially

be more harmful than beneficial for a client, specifically for those who have experienced trauma.

For example, if the therapist causes a rupture in the therapeutic relationship where the client feels

unsafe or even humiliated (e.g., asking "why didn't you fight back?"), it might be culturally

appropriate and/or adaptive for the client to exit the session and/or terminate therapy instead of

openly sharing his/her thoughts and feelings about the rupture. Correspondingly, the model's

assumption that expression of feelings and assertiveness are necessary ingredients to repair is

problematic in that not all cultures value sharing feelings or being assertive in the same way as

Western cultures do.

Purpose of the Current Study and Research Questions

Although the struggle with trauma exposure can lead to posttraumatic growth, it may also

result in certain avoidance behaviors, hyperarousal, and hypervigilance because many

traumatized individuals learn to anticipate danger, may be sensitive to unsafe situations, and can

misperceive even safe environments and interactions as potentially harmful (Briere & Scott,

2006). Additionally, research has revealed that individuals who have experienced trauma may be

vulnerable to therapeutic difficulties and have difficulty trusting others, including their therapists.

Thus, it is possible that they may be less capable or willing to engage in the therapeutic process

and to disclose trauma to their therapists, especially without first establishing a strong and secure

therapeutic alliance (Cloitre et al., 2004; Llewelyn, 2002). For these reasons, therapists are

encouraged to be aware of how their behaviors impact psychotherapy and the alliance, including

how they facilitate and/or hinder clients' processes of discussing trauma. Since a part of the

therapeutic alliance is agreeing on treatment goals, a mismatch between clients' and therapists'

treatment goals regarding the discussion process (e.g., timing; pace) can potentially result in

ruptures. For instance, a therapist could potentially "push" the client to disclose too much or not

enough, which will result in the client feeling stagnated. Sano et al. (2003) specifically suggest

that therapists must foster a therapeutic environment where clients feel safe and are not judged or

stigmatized so that they can focus on expressing and integrating their traumatic memories.

However, Dalenberg's (2004) question, "how can the therapist present no evidence of danger in

the context of a real relationship?" (p. 438) implies that ruptures are likely to occur. Therapists,

therefore, should anticipate and attempt to repair ruptures, especially as it has been suggested that

"competent clinicians acknowledge errors, blunders, and imperfections; are not afraid to express

sorrow and regret; and work to repair damage to the therapeutic relationship when it occurs"

(Kinsler et al., 2009, p. 189).

As indicated by several studies, attending to ruptures can be beneficial and create space

for reparative work, which can produce an even stronger alliance between clients and therapists

(Safran & Muran, 1996; Llewelyn, 2002; Sommerfeld et al., 2008). Additionally, since trauma

survivors are often not accustomed to being in relationships where others readily admit to being

flawed or making errors, repairing therapeutic mistakes, although at times challenging for

therapists, can also be incredibly refreshing and advantageous (Kinsler et al., 2009). Dalenberg

(2000) found that patients who were asked to reflect back on their completed trauma treatments

indicated that it would have been more beneficial had their therapists been more open and

transparent regards their own feelings as they came up during therapy. Not having this

information left the clients feeling anxious and wondering about how their therapists felt.

Although effective clinicians maintain clear and consistent boundaries and judiciously reveal

personal information when there appears to be a clear therapeutic rationale for such a disclosure,

they also use their personal reactions "as a means of modeling collaborative problem-solving

approaches and of negotiating relational impasses" (Kinsler et al., 2009, p.189).

The repair process is not only intended to increase understanding within the therapeutic

relationship but also to help clients generalize their abilities to confront difficult feelings to other

situations and people outside of therapy. In addition, repairing ruptures gives clients and

therapists an opportunity to understand clients' relationship patterns and ways of dealing with

conflict and can also shed light on how clients are interpreting and managing the discussion of

traumatic material.

However, there is a paucity of knowledge on how ruptures in the therapeutic alliance are

repaired during discussion of trauma in psychotherapy with clients who have interpersonal trauma

histories. In the same way, how therapist behaviors (e.g., countertransference) relate to ruptures

that occur in the alliance when clients specifically discuss interpersonal trauma has not been

studied. In addition, existing studies of rupture and repair by Safran and Muran and others as

well as studies of trauma discussion have not examined differences between experienced and

trainee therapists.

This research study therefore endeavored to further understand the process of trauma

discussion as it relates to Safran and Muran's model of therapeutic ruptures and repairs, and the

therapeutic alliance within the context of psychotherapy. As previously noted, discussion was

used in this research to denote any conversations that occurred between the therapist and client

about a traumatic event(s), and the expressed emotions and reactions, including thoughts and

beliefs associated with that traumatic event(s).

The following research questions directed the case study: Do ruptures, as defined by

Safran and Muran (1996) and a rupture coding system developed by the researcher, including

select items from the ICB (Friedman & Gelso, 2000)), occur during discussion? How does a

therapist-in-training attempt to repair ruptures (according to Safran and Muran's four-stage model

of repair), and in particular when the client is discussing material related to his/her interpersonal

trauma experience(s)? Additionally, how are the client's and therapist's therapeutic alliance

ratings impacted? More specifically, do the client's and therapist's ratings of the alliance

strengthen upon a successful repair exchange and conversely, do they weaken without its

resolution?

Chapter 2

Method

The purpose of this chapter is to provide a detailed overview of the methods and procedures used in this qualitative case study on therapeutic ruptures and repair during discussion of interpersonal trauma in psychotherapy. Included is a description of the study's research design, participant, instrumentation, procedures, and data analysis.

Research Design

Qualitative research focuses on human experience and action and encompasses a set of interpretive and material practices that attempt to make the world more transparent and transformative (Creswell, 1988; Mertens, 2005). This discipline investigates the "how" and "why" of decision-making processes, not just on "what," "where" and "when," as is the case in quantitative research (Morrow, 2007). Thus, smaller, concentrated samples are often included. Qualitative inquiry is also well suited to clinical and counseling psychology research whose methods of evaluating and interpreting data in naturalistic settings closely mirrors those of psychotherapy (Creswell, 1988; Morrow, 2007). Additionally, qualitative methods can be used to analyze and evaluate topics for which there is scarce or no previous research (Morrow, 2007).

The role of the researcher is also given greater attention in qualitative research because the possibility of the researcher taking a neutral or removed stance is viewed as more problematic in practical terms (Hill, Knox, Thompson, Nutt-Williams, Hess, & Ladany, 2005). For this reason, qualitative researchers are often expected to recognize the part they play in the research process as it specifically relates to their level of training, personal values, expectations, biases, and background (Hill et al., 2005). Researchers should make their roles clear in their analyses so that readers can evaluate findings based on this information (Hill et al., 2005; Creswell, 1988). Thus, this researcher provides such information in the Participant section below.

The present study was a qualitative, descriptive case study within a bounded system (Creswell, 1988; Yin, 2003). In this framework, the "investigator explores a bounded system (a

case) over time through a detailed, in depth data collection involving *multiple sources of information (*e.g., observation of sessions tapes, interviews, written materials, etc) and reports a case description and case-based themes" (Creswell, 1988, p. 73; Ryan & Bernard, 2003). Further, a single case was used to conduct this research in order to provide the opportunity for rich, in-depth exploration of the research topic and questions. Accordingly, the case study approach offered researchers the opportunity to preserve the holistic and significant aspects of real-life events, which relate to individual and societal life cycles and phenomena as well as the practice of psychology, sociology, political science, social work, business, economics and community planning (Yin, 2003). Likewise, Yin (2003) adds that this type of design is suitable to studying a single case longitudinally, over various time points.

An embedded analysis or analysis of themes was used, where a specific aspect of the case was studied and a few keys issues and themes were examined (Creswell, 1988; Ryan & Bernard, 2003). The researcher focused on a client's discussion(s) of interpersonal trauma in psychotherapy, during which she specifically examined any ruptures and repairs, as well as possible associations between the repair of a therapeutic rupture and the client's and therapist's rating of the therapeutic alliance. The researcher also analyzed any consistencies and inconsistencies in the client's experience of the therapeutic rupture and repair process and his/her rating of the therapeutic alliance as compared with Safran and Muran's (1996; 2000) therapeutic rupture and repair model.

Participant

A single case study design was chosen for this qualitative study. Archival data from an adult client's written measures and video-recorded psychotherapy sessions at a southern California university's community counseling center were used for this case study. Furthermore, Institutional Review Board (IRB) approval was obtained prior to accessing participant data from the archival research database, which contained written measures and video-recorded psychotherapy sessions of various clients whose cases had been closed.

Inclusion and exclusion criteria. To establish eligibility for participation in this study, specific inclusion and exclusion criteria were proposed for the case selection process. The possible participant must have been an adult (i.e., age 18 or over), English speaking client who had been in individual psychotherapy (see Instrumentation section for definition) and given prior written consent (Appendix A) for his/her written and audio or videotaped records to be included in the clinics' research database. In addition, he or she must have also completed at least 20 psychotherapy sessions because the researcher must have been able to assess a change in the client's therapeutic alliance measures over time, as this measure is supposed to be given after every 5th psychotherapy session. The participant's therapist must have also given written consent (Appendix B) to have his/her therapy session tapes and written measures placed in the research database. In addition, there must have been videotape recordings of most of the psychotherapy sessions (at least 14) for the researcher to adequately assess therapeutic alliance, ruptures and repair during discussion(s). To protect the therapist's and client's confidentiality and privacy as well as reduce chances of bias, the researcher was not personally familiar with the client and therapist. Lastly, the participant must have discussed (see *Discussion of Interpersonal Trauma* for definition) some type of interpersonal trauma during the course of treatment to evaluate how ruptures are repaired within the context of trauma discussion (see Instrumentation section for definition). Clients who had come in for child, couple or family therapy were excluded from participation in this current study. Finally, gender, race/ethnicity, socioeconomic status and religious affiliation were not used as selection criteria, but these variables were taken into account in order to gain a richer understanding of the participant.

The current study's client-participant. The client-participant selected in this study presented at the time of intake as a 28-year-old, able-bodied, heterosexual, African-American, Christian, female. The client-participant attended college for three years and at the time of the intake, was working full time as an assistant at a travel agency. The client-participant was born and raised in the southern United States and moved on her own to Los Angeles, CA, four months

before the commencement of individual therapy. She noted that she was currently living with a roommate in an apartment. Although the client-participant noted that she was single on the intake paperwork, she reported during the intake interview that she maintained a long-distance committed relationship with her boyfriend who still resided in her hometown. On the intake documentation, she also indicated that she never met her father and only spoke with her mother by phone approximately every two months. Her support system also included an older brother and cousin, with whom she only spoke to by phone about every month. She reported she had substantial financial constraints with her yearly salary being $10,000. Moreover, the client-participant indicated that she had experienced "sexual abuse," "addictions," "death and loss," and "drug use or abuse." She also reported that she was experiencing difficulty at her current job due to conflict with her boss. Specifically, she stated that her boss was verbally abusive towards her and made racist comments towards her and her co-workers.

The client-participant was assigned an Axis I diagnosis of Partner-Relational Problem (V61.10) and a GAF score of 75 upon intake by the therapist-participant. The therapist-participant did not assign a diagnosis on Axis II and noted social support problems and a tense relationship with her current boyfriend on Axis IV. No general medical conditions were listed on Axis III. The therapist-participant noted using a psychodynamic theoretical approach to treatment with a specific focus on the client-participant's past and current relationship history.

Researchers. The researcher completed her study with a team of researchers, including three coders and one auditor (Coder 1, Coder 2, Coder 3, and Auditor 4). This researcher (coder 1) is a 31 year-old, able-bodied, heterosexual, married first generation Russian-American female doctoral student in clinical psychology who typically conceptualizes clients from a psychodynamic perspective and works from an integrated therapy approach, using psychodynamic, cognitive-behavioral, and mindfulness techniques. From her experience and perspective as a clinician over the past nine years, she believes that therapists can benefit from becoming more familiar with strategies that can be used to solve ruptures and conflict with their

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clients because conflict appears to be a part of every close human relationship, including

therapeutic interactions where clients and therapists often develop very close relationships. 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 conflict is managed effectively, it can create

new opportunities for individual and relationship development because it can bring about greater

understanding and meaning. Thus, she expected to find ruptures occurring in the therapy sessions

and she also hoped to find evidence of repair.

      Coder 2 is a 27 year-old able-bodied, heterosexual female of European descent. Coder 2

was raised Catholic in a family of middle socioeconomic status and identifies as Italian-American

and Irish-American. She is currently enrolled in a clinical psychology doctoral program and

tends to conceptualize clients from a cognitive-behavioral perspective and finds value in having

structure and specific interventions when working with clients. Based on her experience working

with clients she feels that applying some sort of structure or theoretical model to work with

survivors/victims of trauma may be beneficial in helping the client through a difficult time.

Furthermore, coder 2 believes that understanding what interventions or techniques therapists can

use with survivors of trauma in helping them progress through therapy may be beneficial.

      Coder 3 is an able-bodied, 29 year-old, heterosexual, progressive, Caucasian, Russian-

American female who comes from a family with a middle to high socioeconomic status and is a

doctoral student in clinical psychology. As a clinician, she generally conceptualizes clients and

conducts psychotherapy from both cognitive-behavioral and dialectical behavioral orientations.

Through her experience and training in these orientations and through her own personal life

experience, she has come to believe that the experience of positive emotion can aid in the

recovery from problems rooted in negative emotions such as depression, suicidality, anxiety, and

stress-related disorders, increase general well being and serve as a buffer against stressful life

events.

Auditor 4 (the dissertation chairperson) is an able-bodied, 43 year-old, progressive

Christian, European-American, 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 expected that a

client who had experienced trauma and discussed it in therapy may have experienced a rupture,

and hoped to find evidence of subsequent repair of that rupture.

Instrumentation

Assessment measures and video recordings of the psychotherapy sessions from the

archival database in the community counseling clinics as well as coding systems to analyze the

case study data were used for this research. The following variables were examined.

Determining experience of an interpersonal trauma. In order to determine if the

possible participant had experienced an interpersonal trauma, the clinic-created Client

Information Adult Form (Appendix C) was examined. In the Family Data Section, which asks,

"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. The client indicated "yes, this

happened" in the Self-column for the following items: financial strain or instability, inadequate

access to healthcare and other services, death and loss, drug use or abuse, addictions, and sexual

abuse. The researcher also referenced the clinic-created Intake Evaluation Summary (Appendix

D) for further supporting information. On this form, the potential participant must have noted 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, including

social history. The client shared that she had experienced an interpersonal trauma, specifically

CSA and verbal abuse within the workplace, in the history of the presenting problem & history of

other psychological issues sections of the Intake Evaluation Summary form. In addition, the

participant must have discussed the interpersonal trauma during at least one videotaped

psychotherapy session; she did so in sessions 1, 6, 7, 9, and 12, of video-taped sessions that were

found.

Moreover, supplemental materials were assessed when determining if the possible

participant had experienced an interpersonal trauma. For example, on the clinic-created Phone

Intake form (Appendix E), the possible participant might have indicated that interpersonal trauma

is his/her reason for scheduling psychotherapy under the "Reason for Referral – Please tell me a

bit about your reason for calling today?" In addition, on the newest version of the University of

Rhode Island Change Assessment Stages of Change Scale (URICA; DiClemente & Hughes,

1990; Appendix F) at the top of the form, the possible participant may have specified that

interpersonal trauma is the primary problem or one of the problems he/she wanted to work on in

therapy. The client did not specifically indicate that interpersonal trauma was her reason for

scheduling psychotherapy or a problem she wanted to work on in treatment.

Determining discussion of interpersonal trauma. In addition to reviewing written self-

reports about experiences of trauma noted by the client-participant on the Client Information

Adult Form, Intake Evaluation Summary, and URICA, researchers reviewed videotapes of the

psychotherapy sessions with the intent of finding a discussion(s) of the trauma. As previously

noted, discussion was defined as encompassing the following: (a) the first time the client reports

or tells someone else (i.e., the therapist) that he/she has had an interpersonal trauma(s), (b) the

client has disclosed the trauma(s) before to another person, but is now discussing it again with the

therapist within the context of psychotherapy, and/or (c) the client discusses trauma that has been

disclosed before to someone else and also discloses for the first time another trauma or multiple

traumas. Additionally, the term discussion was 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.

The research assistants (RAs) that were hired to transcribe the therapy sessions, were additionally trained to understand the definition of a discussion of interpersonal trauma as it was defined in this study and then to identify it in the therapy sessions, including noting the start and stop times of when the discussion(s) occurred. When the interpersonal trauma discussion was recognized, the RA made note of the time in which the discussion began and ended by writing the word Start and then the time in bold, highlighted (in green) brackets. When the discussion changed to a topic other than an interpersonal trauma discussion, the RA paused the video and then wrote the word Stop and then the time in bold, highlighted (in red) brackets. Once this process was completed, the researchers first individually reviewed the transcripts that were identified to include a trauma discussion(s) and then met as a team to discuss whether they agreed or disagreed with what was found by the RAs. If full agreement or at least two-thirds of the researchers agreed with the trauma discussion(s) that was identified and/or when it started and stopped, that trauma discussion became official. This was then reviewed and approved by the research team's auditor. From this point, the researchers then broke the trauma discussions that were identified into two separate categories: CSA and WPH.

Working alliance inventories. The Working Alliance Inventory-Client Form (WAI-C) and Working Alliance Inventory-Therapist Form scales (WAI-T; Horvath & Greenberg, 1989) were used to examine the quality of the alliance between therapist and client from the client's and therapist's point of view. Based on Bordin's (1976; 1994) definition of the three core features of the therapeutic alliance, each includes three subscales: agreement on tasks, agreement on goals,

and development of a bond. They consist of 36 items with responses given on a 7-point Likert scale, ranging from 1 (never) to 7 (always). Reliability estimates for this instrument range from .84 to .93 (Horvath & Greenberg, 1989; Cecero, Fenton, Frankforter, Nich, & Carroll, 2001). Tracey and Kokotovic's (1989) shortened version of the WAI-C Form (Appendix G) and WAI-T Form (Appendix H) was used in this study. Also based on Bordin's definition, they consist of only 12 items instead of 36 and their reliability matches up favorably with the long version (e.g., alpha coefficients ranging from .90 to .92; Tracey & Kokotovic, 1989).

Other contextual measures to inform case study. In addition to being used for the selection process, the following measures were used to gather more information about the client's process and experience in therapy. First, the Outcome Questionnaire (OQ-45.2; Burlingame, Lambert, Reisinger, & Neff, 1995; Appendix I), a self-report measure that consists of 45 items on a 5-point Likert scale, was used. This instrument includes the following three subscales, which are rated based on the course of the past week: Symptom Distress, Interpersonal Relations and Social Roles. 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).

Second, the University of Rhode Island Change Assessment (URICA) is a self-report measure comprised of 32 items and responses to items are on a 5-point Likert scale. There are the four subscales that are included in this assessment tool (precontemplation, contemplation, action, and maintenance) and each assesses the individual's stage of change (i.e., the client's readiness to change during therapy). The URICA has internal consistency reliability ranging from .79-.89 (McConnaughy, Prochaska & Norcross, 2001; Prochaska, & Velicer, 1983).

Third, the Multidimensional Scale of Perceived Social Support (MSPSS; Appendix J) is a 12-item self-report measure designed to assess perceived social support that comes from three different sources: family, friends, and a significant other (Zimet, Dahlem, Zimet, & Farley, 1988). The instrument measures the extent to which respondents perceive social support from each of those sources noted above and is separated into three subscales: family, friends, and significant

other. Items are on a 7-point Likert scale with "7" signifying "Very Strongly Agree" to "1" representing "Very Strongly Disagree." The MSPSS has been studied with various diverse populations (Cheng & Chan, 2004; Kazarian & McCabe, 1991; Stanley, Beck, & Zebb, 1998) and has internal consistency reliability of .91 for the total scale and between .90-.95 for the subscales (Zimet et al., 1988).

Fourth, the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Appendix K) is a 38-item self-report measure asking about religion and spirituality and how they relate to the client's overall well being as well as the role they play, if any, in the client's every day life (Fetzer Institute & National Institute on Aging [NIA], 1999). This measure was created to specifically evaluate distinct dimensions of religion, including private religious practices, organizational religiosity, religious support and spirituality, encompassing daily spiritual experiences, values/beliefs, meaning, forgiveness, religious/spiritual coping (Fetzer Institute & NIA, 1999). The instrument uses a Likert scale format with lower scores reflecting a greater degree of religiosity or spiritual experience across all of the items. Each of the domains measured by this instrument are simply moderately correlated, providing further support for the distinctiveness of the domains (Fetzer Institute & NIA, 1999; Idler, Hudson, & Leventhal, 1999; Masters et al., 2009). Therefore, 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).

Finally, one measure was used to give the researcher a potentially different way to understand the therapeutic alliance and therapeutic process as it unfolded over the course of therapy: the clinic-created Treatment Summary form (Appendix L). On this form, the therapist was supposed to indicate the goals and tasks for therapy as well as reasons for transfer to another therapist or termination of the case. The therapist-participant in this study did not specifically

identify the goals and tasks of therapy on the Treatment Summary form but did state the reasons

for termination of the case. These reasons are further discussed in the results section.

       Ruptures. Ruptures were coded using a system developed by the researcher. The

coding system was grounded in Safran and Muran's (1996; 2000) model of ruptures whereby

ruptures were represented in a client's behavior during a therapy session in two alternative ways:

a) *confrontational ruptures*, in which a client directly reveals his/her dissatisfaction with the

therapist or with some aspect of the therapy process, and b) *withdrawal ruptures*, in which the

client cognitively and/or emotionally withdraws from the therapeutic relationship. The

researcher's coding system also included her own definition of ruptures (Appendix M) and four

items from the ICB (i.e., The "Therapist Provided too much structure" in the session, The "Client

indicated that Therapist talked too much in the session," The "Therapist was Critical of the

client," and the "Therapist Behaved as if he or she were someweher else"). Repairs were coded

following Safran and Muran's (1996; 2000) repair model, wherein the therapist first attends to the

rupture marker and then proceeds through four stages to repair that rupture collaboratively with

the client (Appendix M).

Procedures

       Sampling procedures. This research used the Pepperdine Applied Research Center's

archival research database located at the Pepperdine Graduate School of Education and

Psychology (GSEP) Community Counseling Centers to obtain its participant. The participant and

his/her therapist completed a written consent form indicating permission to use written and/or

audio or videotaped materials for research purposes. A purposive sampling procedure was used

to determine which client from the archival database best fit the pre-established

inclusion/exclusion criteria. First, a list or research record numbers was obtained. Second,

English speaking adult clients over the age of 18 were only purposively selected. From that list,

clients who had reported an interpersonal trauma experience were selected (see Instrumentation

section for criteria). And only those clients from that list with Intake session written materials

and at least two sets of follow-up written materials were selected. This process eventually

narrowed down the list of possible participants to one possible participant who was subsequently

included in this research study.

     Transcription. Five master's level psychology graduate students were hired to transcribe

parts of the therapy sessions in which discussion of an interpersonal trauma was discussed. Each

graduate student was trained by the researchers on how to transcribe psychotherapy sessions

verbatim and identify a potential discussion of trauma.

     Coding. The three doctoral level researchers served as coders for this study and their

research supervisor served as the auditor for this study. Following Yin's (2003)

recommendations, the coders and auditor trained each other to further understand basic

constructs, terminology and issues related to the research, including ruptures and repair as well as

the procedures to accurately code the occurrence of trauma discussions. Once the coding team

had achieved at least 75% interrater reliability on practice cases, they moved on to coding the

actual client-participant's sessions.

     As previously mentioned, after the trauma discussion sessions had been transcribed, they

were reviewed, first individually, and then as a group by the coding team to confirm the

transcriber's identification of the trauma discussion. The following two traumas were identified:

CSA and WPH, as they met criteria for what constituted an interpersonal trauma discussion.

     Each of the psychotherapy sessions that were identified to contain a discussion of

interpersonal trauma were then coded for themes both across and within the sessions. In order to

code for themes across and within these sessions, the three coders and auditor read through each

transcript individually, looking for any repetitions (i.e., topics that occurred and reoccurred) and

transitions in the 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 was

remarkable in the client-participant's therapy process (Ryan & Bernard, 2003). The researchers

and auditor also employed an open approach to the coding process where what naturally emerged

from the client-participant's experience in therapy was identified. This open approach was taken as opposed to using a strength-based method or a rupture and repair lens so that the coding could be as neutral as possible regarding both the positives and challenges this client-participant experienced in her life and overall treatment. To facilitate diverse viewpoints and limit the biases of any one person, each team member first individually reviewed the transcripts before convening with the rest of the team to discuss them (Hill et al., 2005; Hill, Thompson, & Nutt Williams, 1997).

The three coders subsequently met to discuss each transcript that contained a trauma discussion. They noted any recurring topics that were previously recorded individually by each team member. When the research team came to a line in the transcript that contained an individually noted theme, each coder then presented her ideas and discussed the potential theme until two-thirds agreement was reached that an overall theme did in fact exist in that line of the transcript. If it was agreed that a theme category label was necessary, the coders discussed how each member had labeled that theme individually until a consensus was reached on that theme category label. For example, each coder identified various emotions that were expressed by the client. When a team member identified a specific emotion as a theme, it was subsequently discussed as a team to ensure that this theme appeared across the course of the therapy sessions rather than only in that particular session. If that emotion was evident across the course of the therapy, rather than in just in one or two sessions, it was identified as a theme.

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

The fourth research team member (auditor) for the study subsequently 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 comments and made changes based on the agreement reached about theme categories that would 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 made a final approval of the final themes key. Lastly, each coder individually went through each session containing a trauma discussion and found specific quotes that exemplified each theme and sub-theme. The frequency of themes and its corresponding subthemes was also calculated and recorded on a themes occurrences sheet (Appendix O).

Finally, the transcriptions that contained discussions of interpersonal trauma were coded for therapeutic ruptures and repairs. A rupture and repair coding sheet was created to represent all of the rupture and repair codes, including examples of what constituted those codes, and a comments column to provide further information regarding the assignment of the codes (Appendix M).

The rupture and repair coding process followed a similar process to the themes and subthemes identification. Each researcher first individually coded the rupture and repair codes on her own using both the videotaped sessions and transcripts. Subsequently, the three researchers met multiple times to discuss each person's coding designation and reasons for why she assigned that particular code. If two-thirds or all of the researchers agreed with a particular code, then that code was then considered to have full consensus.

A summary table with all of the rupture and repair consensus codes was then sent to the auditor for her review and feedback (Appendix P). The team reconvened again on a couple of occasions to discuss the auditor's feedback. Once two-thirds or full consensus was achieved with all of the previous and revised codes, those codes were considered finalized. The number of ruptures was counted and recorded.

Human subjects/ethical considerations. The research database materials and procedures that were used in this study were created with Institutional Review Board (IRB) consultation and

approval. In addition, prior to selection of the participant data, IRB approval was obtained. The

researchers also reviewed the consent forms from both the therapist and client prior to beginning

research to ensure proper documentation had been gathered. To maintain participant

confidentiality, all client-names are removed from written materials and audio/videotapes and

replaced with research codes once they are placed in the database. As previously noted, the

researchers were not personally familiar with the client and did not personally interact with the

therapist in order to protect the therapist's and client's confidentiality and privacy as well as

reduce chances of bias. Lastly, all researchers and transcribers completed Health Insurance

Portability and Accountability Act (HIPAA) and IRB certification courses, signed confidentiality

statements, and maintained confidentiality.

Data Analysis

The data was analyzed using a variety of methods. Videotaped psychotherapy sessions

were reviewed for potential discussions of interpersonal trauma, transcribed by trained master's

level graduate students, and identified segments were coded for ruptures and repair. The

researchers also analyzed themes that emerged within and across the videotaped sessions

containing trauma discussions.

More specifically, as previously noted, a themes key (Appendix N) and themes

occurrences sheet (Appendix O) were created to track any themes, and the number of occurrences

of those themes. Themes were then 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 also compared across the psychotherapy sessions in order to determine any patterns.

Furthermore, the client-participant's quotes that best exemplified each theme and sub-theme were

recorded on the sheet.

Then, therapeutic ruptures and repair were analyzed using an existing coding system

created by the researcher (Appendix M). To examine the rupture and repair data, as previously

noted, the researcher created a table summarizing the rupture and repair codes that were identified

during the coding of sessions that contained a trauma discussion (Appendix P). The comments

column describes the rationale for the code by describing its context and explaining the coders'

thinking processes for the determination of the code. The quotes column shows the discussion

that received a code as well as some conversation around it for further contextualization.

       As part of the embedded analysis of the rupture/repair process, the researcher initially

endeavored to find possible associations between the repair of a therapeutic rupture and the

client's and therapist's rating of the therapeutic alliance, For example, she had planned to refer to

the client's and therapist's ratings of the therapeutic alliance on the WAI-C and WAI-T forms

before and after a session where a rupture(s) occurred to determine whether there was a

successful repair of a rupture(s) and examine whether a successful repair increased the client's

and therapist's subsequent rating of the therapeutic alliance. The researcher also planned to

analyze the client's rating of the therapeutic alliance as compared with Safran and Muran's

therapeutic rupture and repair model. However, these goals were not able to be carried out given

a lack of data related to the therapeutic alliance. Specifically, the client-participant's file only

included three working alliance measures (i.e., a WAI-C and WAI-T at session 7 and then only a

WAI-C for session 14) and therefore, did not provide enough information for the researcher to be

able to accomplish her above stated plans.

       The rest of the analysis included any consistencies and inconsistencies in the client's

experience of the therapeutic rupture and repair process as compared with Safran and Muran's

(1996; 2000) therapeutic rupture and repair model. These consistencies and inconsistencies

included the types of traumas discussed in this case, the content and process of interaction

between the two participants, including themes and subthemes, and how they related to existing

literature.

Chapter 3

Results

The purpose of this chapter is to present the results of the single case study. An overview of the course of therapy is given, including the results obtained from the rupture and repair analysis. The chapter concludes with the researcher presenting the themes analysis based on the coding of themes found in sessions containing a trauma discussion.

Course of Therapy Introduction

The client-participant's course of therapy lasted 21 sessions. Six of the therapy sessions contained discussions of an interpersonal trauma.

During the phone intake interview, the client-participant reported that she had just moved to Los Angeles by herself "from the country" and was looking for "some help in adjusting to LA." She also mentioned that she moved to LA "with $300," worked everyday (i.e., Monday-Friday) until 5pm, and kept things in a lot and wanted someone with whom to talk. The client-participant denied any legal problems and past or current thoughts of suicide or homicide. Additionally, when asked a question about having a bad temper or whether she had ever been violent towards others, the client-participant responded by saying that she had never acted out physically towards anyone. The client-participant initially presented to therapy requesting to work on issues related to adjustment after her recent move and a desire to have someone to talk to, as she felt she "ke[pt] things in a lot."

The client-participant additionally endorsed items such as, "Difficulty expressing emotion," "Lacking self-confidence," and "Difficulty controlling [my] thoughts" on the intake documents. According to the Intake Report, the client-participant identified her racial identity as African American. She also mentioned that people often asked her of she was of "mixed race" because "she [was] a light skinned African American with exotic features." She further noted that she grew up in a financially unstable and dangerous neighborhood. The client-participant additionally alluded to the "LA entertainment culture" being foreign to her. In terms of the role

religion or spirituality played in the client-participant's life, she reported that even though she

attended a Catholic school she was never a "serious believer." She noted becoming interested in

Islamic beliefs but did not identify as Muslim. After seeing her boyfriend "getting all of his

wishes" met by praying to God, the client-participant indicated that she identified herself as

Christian.

In terms of the CSA that was noted during the intake, the client-participant reported that

her uncle had sexually abused her when her mother left her and her brother in his care. She

further indicated that her uncle tried to sexually abuse her a second time but after she informed

him that she would tell her mother what he had done, he did not follow through with his attempt

and did not try to abuse her in future. The client-participant informed the therapist-participant

that she had never disclosed this sexual assault to anyone, including her mother, and had never

received any medical or psychological treatment to address any symptoms, reactions, thoughts,

and feelings associated with the traumatic experience. The client-participant also reported upon

intake that she wondered if the sexual assault contributed to her difficulty with communication, as

she had difficulty opening to her friends and wanted to explore her emotions in order to prevent

herself from "shut[ting] down." The client-participant reported that she noticed her hands getting

cold when she discussed uncomfortable topics, including the sexual assault. The client-

participant denied the presence of any self-harm behavior, including suicidal or homicidal

ideation or attempts. The client-participant also indicated that she did not like her current job

because she did not get along with her boss who was verbally abusive and made derogatory

comments towards her and her co-workers.

According to the OQ-45.2 given at intake, it appeared the client-participant was

experiencing distress about social roles related to her work circumstance. The therapist-

participant noted on the score summary sheet of the OQ-42.2 that the client-participant had

endorsed the item "I feel angry enough at work/school to do something I might regret" with

"frequently," which prompted her to make a note to herself to pay close attention to any anger

management issues the client-participant may be experiencing.

On the MSPSS intake form, the client-participant indicated that she perceived the most

social support coming from her significant other (possibly her boyfriend) followed by her friends

and family. Specifically, she strongly agreed that her significant other cared about her feelings,

yet she only mildly agreed that she could share her joys and sorrows with this person. She

additionally mildly disagreed with the idea that this person was around for her when she needed

[him], reflecting some potential disappointment in how much she could rely on [him] despite

feeling that he cared for her. In terms of her friendships, the client-participant only mildly agreed

that her friends help her and are there to share in her joys and sorrows, as she primarily appeared

to feel a lack of support from them (e.g., disagreeing strongly with the statement: "I can talk

about my problems with my friends"). Even though the client-participant appeared to have mixed

perceptions regarding the support she received from her significant other and friends, she was

very clear in her perception that she did not feel supported by her family. For example, she felt

that they did not try to help her, including providing her with emotional support when needed and

help in making decisions, and being there for her when she needed to talk to them about her

problems. All of this self-report information gathered from the measure was also corroborated by

the client-participant's verbal report.

On the BMMRS measure at intake, the client-participant identified her religious

preference as Christian yet also noted that while she was very spiritual, she was not religious at

all. She also indicated that she attended religious services every week or more often, yet she did

not spend any time engaging in any other activities on behalf of her church nor did she contribute

financially to her church during the last year. She further noted praying and reading the Bible or

other religious literature a few times per week. Additionally, the client-participant indicated that

she found great strength and comfort in her faith and a strong desire to be closer to or in union

with God many times a day. In terms of forgiveness, the client-participant indicated that God

always or usually forgave her and she often forgave herself for things she had done wrong; yet, she seldom forgave others who had hurt her. In regards to domain of spiritual coping, the client-participant stated that she looked to God for strength, support, and guidance a great deal, and that her faith was very involved in helping her understand and manage stressful situations. Information obtained from this form matched the client-participant's verbal report.

On the URICA intake form, the client-participant indicated that she wanted to work on changing her level of confidence in therapy. Her responses showed that she was in the pre-contemplation stage of change, indicating that she was potentially unaware of her problem or the extent to which it interfered with her life and may have not had the intention of taking the necessary steps needed towards working on that problem.

The client-participant completed the measures again at sessions seven and 14. At the time of session seven, the client-participant continued to exhibit notable distress with social roles at work and the therapist-participant noted that the client did express that her problems were out of her control. On the URICA, the therapist-participant indicated that the client-participant was working on lack of emotional expression while the client-participant reported she was working on communication. The client-participant also continued to demonstrate that she was in the pre-contemplation stage of change and the therapist-participant made a note to explain this result by saying that "the client likes to come to therapy but is not ready to face some of the more difficult emotional issues." Despite this difference regarding problem identification between the client-participant and therapist-participant's and the therapist-participant's indication that the client-participant was not ready to confront certain difficult emotional issues, a strong working alliance between the client and therapist during this point in the therapy was reflected by the results obtained from the WAI-C and WAI-T for session seven.

At the time of session 14, the client-participant did not experience significantly distressing symptoms as shown by her total score on the OQ-45.2; however, her score on the social roles scale continued to represent distress related to work and the symptom distress scale

increased from the previous set of measures and reflected similar scores from the intake

measures. On the URICA, the client-participant indicated that she could not remember the

problem she had noted on the form the last time she had completed it but stated that she was

working on "the voice inside of [her]" in therapy. Her measures at this point in therapy

demonstrated that she had moved from the pre-contemplation stage of change to the

contemplation stage of change suggesting that she was planning to make changes towards her

problem. The strong working alliance between the client and therapist as reflected on session

14's WAI-C continued throughout this portion of the therapy as well with no notable changes

reflected.

The termination paperwork based on the total of 21 therapy sessions, which lasted about

seven months, completed by the therapist-participant approximately one month after the last

therapy session stated that the client-participant terminated treatment due to not wanting to

transfer to a new therapist once she was informed that her current one was leaving the clinic. The

therapist-participant further noted that their termination had ended amicably.

Rupture and Repair Results across the Course of Therapy

During the course of therapy, as previously alluded to, two different types of

interpersonal traumas were discussed and explored by the client-participant and therapist-

participant: the CSA experienced by the client-participant and work-related harassment, including

the verbal abuse incurred by her boss. These discussions appeared in six (i.e., 1, 6, 7, 9, 12 and

18) out of the 21 therapy sessions. However, since there were only video recordings of 16 of the

21 sessions, it is unclear how many more, if any, of the other therapy sessions contained other

discussions of interpersonal trauma.

In addition, a total of 36 ruptures and repairs (i.e., 33 ruptures and 3 repairs) appeared in

five out of the six therapy sessions (i.e., sessions 1, 6, 7, 9, and 12) that included a trauma

discussion (Appendix P). Specifically, two Confrontational Ruptures (CR), seven Withdrawal

Ruptures (WR), 10 Disagreement on Task ruptures (i.e., 1 DT, 7 DT1, 1 DT3, and 1 DT5), and 14

Misalignment in Bond (i.e., 1 MB, 8 MB1, and 5 MB3) ruptures were found. The three repairs

that were found related to the therapist-participant validating the client-participant's assertiveness

(4T occurring in session 1 only), the therapist-participant taking responsibility for the rupture

(2TR taking place once in session 12), and focusing on the client-participant's immediate

experience using metacommunication and self-disclosure (1TM occurring once in session 12).

The rupture codes MB1 (eight times), WR (seven times), DT1 (seven times), and MB3 (five

times) occurred with the most frequency across the sessions. Given that ruptures occurred with a

disproportionate frequency in comparison to repairs reflects a pattern where the majority of

ruptures were not repaired.

Rupture and Repair Results within Trauma Discussion Sessions

> **Session 1.** In the client-participant's first therapy session, 12 separate discussions of

interpersonal trauma occurred. These discussions encompassed both the CSA the client-

participant experienced and WPH she was enduring at her workplace. In addition, a total of five

ruptures (i.e., 2 DT1s, WR, MB, and MB1) and one repair (i.e., 4T) transpired in session 1, most

occurring within the context of a trauma discussion.

> The session opened with the therapist-participant expressing that she was glad to see that

the client-participant had shown up to the appointment and the client-participant acknowledged

this with a "thank you," and then both engaged in laughter. The session then immediately turned

to the therapist-participant thanking the client-participant for sharing her trauma of CSA in the

previous session and implying to her that she understood that discussing this matter may have

been difficult for her (i.e., "…it was a little bit rough, you know?"). The client-participant

responded by uncomfortably smiling and laughing while continuing to discuss her experience of

the CSA. As the client-participant was talking however, the therapist-participant abruptly

interrupted this discussion and switched to asking the client-participant about her week (i.e., "ok,

so um, how was your week today?), which signified the first rupture (DT1) in the session. DT1

was coded because it represented the therapist-participant providing too much structure in the

session, as she did not continue to follow the client-participant's lead while she discussed her experience of CSA. This rupture also suggested that the therapist-participant potentially demonstrated a countertransferential reaction to the client-participant's discussion of trauma; and/or the therapist-participant, sensing that the client-participant was herself uncomfortable with this subject, switched to another more mundane topic as a way to "save" the client-participant from continuing to experience feelings of discomfort and/or embarrassment.

In response to this abrupt transition, the client-participant then proceeded without any apparent opposition, to describe a recent outing with her friends where she drove home after drinking several alcoholic beverages. The therapist-participant after a few minutes of discussing these events reminded the client-participant that one of her initial goals for therapy was to be more emotionally open and capable of communicating her emotions. The client-participant responded by smiling and laughing and acknowledged, once pointed out by the therapist-participant, that her hands became cold whenever she felt nervous. The client-participant also indicated that her heart beat "really fast" and she noticed herself laughing "too much" when she became nervous. Soon after this exchange, the second rupture in the session occurred.

The second rupture identified in this session was a withdrawal rupture (WR), which occurred just before the second discussion of CSA. More specifically, while the client-participant was in the midst of talking about her friends and her disappointment that she was not able to speak with them more often since they were busy with their families, she abruptly changed the topic by saying "I have a confession, I'm sorry." The client-participant's affect changed as she became more sullen and slightly withdrawn and the therapist-participant, although she allowed her to continue sharing her "confession," did not explore this change in the client-participant's verbal and nonverbal behavior.

This rupture was soon followed by another rupture during the discussion of CSA, which was indicative of a misalignment in bond (MB) between the client-participant and therapist-participant. While the client-participant was exploring her difficulty in expressing sadness,

specifically within the context of her experience of CSA, the therapist-participant quickly

transitioned to making an interpretation that appeared not only poorly timed but also not well

received by the client-participant, as her tone of voice and facial expression reflected slight

discomfort and defensiveness. The defensiveness was particularly evident in the client-

participant's lack of response to the therapist-participant asking, "can I tell you what I think?" and

then her quick transition to defensively sharing that she did not think she grew up too fast.

When the client-participant shifted a few moments later to describing how she had never

seen her mother cry, the therapist-participant induced another rupture (DT1) by again imposing

too much structure on the session. She specifically provided another interpretation rather than

listening to and being present with the client-participant's experience of her relationship with her

mother. Although the client-participant did not appear particularly bothered by this

interpretation, she also did not directly respond to it but instead continued to share her

disappointment regarding not ever seeing her mother express sadness.

The last rupture was another misalignment in bond (MB1), occurring later in the session

when the client-participant was discussing her WPH. In this exchange, the therapist-participant

appeared critical of the client-participant as she asked her "why are you there?" with the client-

participant responding, "I don't want to start, you're going to get mad at me," while

simultaneously looking away and uncomfortably smiling. Sensing that the client-participant was

worried about the therapist-participant getting mad at her, the therapist-participant attempted to

repair (4T) this rupture by first asking why the client-participant felt that way and then by

validating the client's assertiveness by telling her, "no, don't refrain yourself, you don't—." The

client-participant did not directly respond to the therapist-participant's repair and instead

continued to express her frustration and anger towards her boss and overall working situation,

saying, "I hate it. Absolutely hate it." Yet while continuing to talk about this subject, the client-

participant's emotional demeanor shifted from readily smiling and laughing to showing intense

anger and hatred towards her boss. This affective change appeared be the first time in the session

where there was an extended period of congruence between what the client-participant was talking about and how she was communicating, both verbally and nonverbally. For example, instead of smiling and laughing when she was discussing a serious topic, she was frowning and the intensity and volume of her voice and gestures increased. It was unclear however whether any of this shift in emotional demeanor was also influenced by the ruptures or repair that had occurred between the therapist-participant and client-participant.

Despite expressing frustration and a lack of control (e.g., "I feel trapped because I can't do what I want to do") in these abusive exchanges with her boss, the client-participant also noted there were several instances in which she was able to stand up for herself by telling him, "you're not going to talk to me like that." After a few moments though, the client-participant jokingly expressed, "okay, I'm back" while laughing and smiling, potentially communicating to the therapist-participant that she felt embarrassed by her expression of intense anger and disdain for her boss. And later on in the session, as the client-participant continued to discuss her thoughts and feelings related to her work situation, there was a notable pattern of client-participant expressing her anger using profanity and then pausing for a few seconds while nervously laughing and playing with her hair.

As the session progressed, the client-participant alluded to a trauma that occurred when she first moved to Los Angeles, stating that this event had caused her to cry in front of her boyfriend. She stated that her boyfriend "was very comforting" during this time, which made her in turn feel more at ease with expressing this emotion. The client-participant also jokingly added that crying in front of her boyfriend turned out "okay" as "[she] didn't die." She further stated that her boyfriend is the only person who has seen her cry, indicating, "people never see [her] sad" and that she "repress[es] stuff." The client-participant also added that whenever she discusses the CSA it "comes out as mad or not happy about it," but never as sadness. The client-participant indicated that she does not know why she responds in this fashion, only saying, "it's always been like that."

Session 6. In the 6th therapy session, two separate discussions of interpersonal trauma occurred. The first discussion focused on the participant's history of CSA and the other one centered on her WPH. In this session, eight ruptures (5 WRs, DT1, DT3, and MB1) were identified with WRs occurring at the highest rate; yet no ruptures took place during actual discussions of interpersonal trauma.

The session started with the therapist-participant inquiring about how the client-participant was doing. In response to this question, the client-participant expressed that she was "good," while looking down at the ground several times and responding with nervous laughter. The therapist-participant, possibly sensing the discomfort in the client-participant's demeanor, then asked her "why [are you] laughing?" The client-participant quickly responded with "I don't know. Stupid" along with an abrupt change in her posture, which was also indicative of the first rupture (WR) in the session. Specifically, the client-participant appeared to slightly withdraw from the interaction by slouching down into her seat and looking down and away from the therapist-participant. Although the client-participant sat up straighter in her seat a few moments later, she continued to exhibit uncomfortable laughter until the therapist-participant, instead of engaging the client in a repair about the WR, changed the topic to inquiring about a recent fight the client-participant had with her boyfriend.

 The client-participant shared that she was continuing to have difficulty trusting her boyfriend due to his relationship with his ex-girlfriend. During this exchange, the client-participant also expressed feeling "disrespected" and disappointed in her boyfriend, saying that he was a "coward" for not being able to severe ties to his ex. While the client-participant expressed not liking the way her boyfriend was behaving, she also adamantly expressed not caring about him or his actions, potentially as a way to help protect herself from further disappointment. After discussing this topic for a while, the therapist-participant shifted the focus back to a previously discussed subject regarding the client-participant's difficulty in being able to identify and express her emotions.

The client-participant stated that she had trouble identifying any emotion other than anger, even though she was also aware of feeling sad. The client-participant tied this to her experience of CSA, specifically saying that although she did feel immense anger towards what had happened to her, she also tried her best to not only feel anger but to also experience the sadness. The therapist-participant initially listened intently while the client-participant shared but then induced another two ruptures (i.e., DT1 and DT3). Specifically, the therapist-participant implemented too much structure in the session while the client-participant was exploring her reactions within the context of her experience of CSA, as she abruptly changed the focus of discussion to inquiring about whether the client-participant's hands were feeling cold. To this inquiry, the client-participant responded by saying, "yeah" while laughing. Although it appeared the therapist-participant was trying to aid the client-participant in being able to link her emotions to her immediate physical sensations, she nonetheless seemed to move the client-participant too quickly and abruptly away from talking about her trauma by drawing her attention to her hands.

A few moments later during this same interaction, the therapist-participant triggered another set of ruptures (i.e., two WRs) when she offered to give the client-participant a teddy bear to hold (e.g., "Do you want a little teddy bear?"). The client-participant responded to this question by saying, "Heck no!" while sliding down into her seat and smiling nervously. Another WR was evident just a few seconds later when the therapist-participant, seemingly ignoring the client-participant's response that she did not want the teddy bear, signaled again that she could grab a teddy bear for the client-participant. In response to the therapist-participant's second attempt of offering the teddy bear, the client-participant's facial expression reflected embarrassment as she uncomfortably laughed and expressed that holding a teddy bear would make her look like an "idiot." She also immediately changed the topic by saying that she had "fun stuff to talk about." Potentially sensing that the client-participant was feeling uncomfortable and wanting to discuss something more "fun," she assured the client-participant that she did not "need to entertain [her]."

Soon after this exchange, the conversation then shifted to the client-participant exploring her decision of whether or not to act in a movie she felt would objectify and degrade her as a woman. The client-participant shared that she felt uncomfortable with the idea of posing in a bikini in a car wash commercial but entertained the idea of going through with it because she needed the "money." Although the therapist-participant spent some time helping the client-participant reflect on her dilemma of not wanting to objectify herself but also not wanting to turn down the money, she nonetheless caused another rupture (MB1) by asking the client-participant in a critical tone of voice "why did [she] choose acting as one of [her] careers?" The client-participant appeared bothered by this question as she began to speak rapidly and explained that she did not like "dancing around shaking [her] ass", but that she did not want to leave the business altogether because she enjoyed modeling when she is able to do work she felt good about. The therapist-participant did not follow up with her initial question regarding why the client-participant chose acting as one of her careers and instead mainly listened while occasionally saying, "Mm-hmm." Soon after this interaction, the client-participant changed the topic to discussing her fears about singing in public.

The client-participant specifically shared that despite her friends encouraging her to sing, she continued to struggle with her "confidence" and was upset with herself for not being able to "do anything about it." In response, the therapist-participant initially listened attentively and then, potentially as a way to deepen the conversation, shifted the topic to asking the client-participant if she was interested in delving back more into her past. Even though the client-participant answered by asking, "whatcha want to talk about?" she appeared to withdraw, signifying another WR, as her posture changed and her affect became more serious. The therapist-participant responded by clarifying that it was the responsibility of the client-participant to share what she wanted to discuss in session. This exchange progressed into another WR (the last one of the session) as the client sunk further down into her seat while keeping her head down, and was also speaking to the therapist-participant in a whisper as well as laughing nervously. The

therapist-participant did not comment on the client-participant's change in affect and behavior but instead reengaged the client-participant in a discussion about her fears of singing in public. The client-participant appeared to willing revert back to this subject as her posture became straighter again and her affect appeared less serious and she was talking in her regular voice. This conversation soon evolved to the client-participant describing her relationship to her mother.

The client-participant explained that she was forced to grow up fast and become independent because her mother was always "broke." She also mentioned feeling pressure to continue helping financially support her mother and family and coming to the realization that she was "more of a parent to [her] brother" than [her] mother was."

Just as the session was ending and the client-participant was on her way out the door, she abruptly stopped to ask if she could play a saved voicemail from her boss for the therapist-participant. In the voicemail, the client-participant's boss was heard using insulting and disparaging language towards the client-participant and her co-workers and threatening that one of them will "burn in hell every time one of these things happens…" Once the message was completed, the therapist-participant asked a clarifying question regarding to whom the boss meant to leave this message. After the client-participant answered that it was intended for her and her co-workers, the therapist-participant proceeded to participated in the conversation minimally by mainly nodding and saying, "mm-hmm." During this time, the client-participant shared how this message further ignited her anger towards her boss while the therapist-participant continued to listen and then explain why the client-participant became so angry in response to the verbal abuse. The session ended with the client-participant sharing that her boss should not be talking to her friends in this way and the therapist-participant acknowledged this by saying, "no it's inappropriate."

Session 7. Five separate instances of interpersonal trauma were discussed during the 7th therapy session. Two of those discussions were related to the client-participant's harassment at work, and three of the discussions were about the sexual abuse she experienced as a child. Five

ruptures (3 DT1s, 1 DT, and 1 MB1) were also found in session 7 with DT1s occurring with the most frequency (three times). Three of those ruptures occurred during trauma discussions, and the other two took place outside of a trauma discussion.

In the beginning of the session, the therapist-participant asked if the client-participant would feel comfortable completing a set of follow up measures once the session was over. The client-participant agreed to complete these measures and shared that "everything has been good" during her week. The session then shifted to the therapist-participant engages the client-participant in a game she explained was a "feeling game" meant to help people "work through things." During this game, the discussions of interpersonal trauma occurred, with the client-participant first describing how difficult it was for her to continue being harassed at work and then sharing memories in regards to "the molestation."

The first interpersonal trauma discussion of WPH occurred soon into playing the game when the client-participant shared that she felt "very challenged by people at work" and did not know how to "escape the hell." While discussing this experience of WPH, the therapist-participant incurred the first rupture (DT1) by sticking too rigidly to the agenda of the game. Instead of following up with questions and helping the client-participant further explore this dilemma of being challenged at work, the therapist-participant immediately went back to the game by moving her piece to the next spot. However, after several minutes had passed, the client-participant began to discuss her experience of CSA, signifying the second discussion of trauma, in response to a game card asking her to share something that "she will never forget."

Within the context of answering this question, the client-participant indicated that she has "been so detached," from her experience of CSA, as she is able to listen to others share their experiences of abuse without experiencing much of her own memories or feelings. The client-participant additionally expressed a curiosity regarding the extent to which she was affected by the CSA. After the client-participant agreed to continue discussing her experience of CSA, she described in more detail how the molestation occurred, where her mother and brother were at the

time, and how she protected herself from it happening again. She further described how she

thwarted her uncle's subsequent attempts to abuse her by telling him "no" and informing him that

she would tell her mother what he had done. The client-participant shared that these experiences

contributed to her distrust in adults, as she learned at an early age to not "respect all adults cause

they don't deserve it…" She then informed the therapist-participant that she had never shared the

CSA with her mother, and that she felt relieved when her uncle died. When asked by the

therapist-participant how the CSA and distrust in adults affected the client-participant's

relationships with men, she indicated that "it [made her] a little bit rougher with men" and made

her feel like she could not ask anyone for "help" but that she was "getting better now." She

elaborated further by sharing that she did not like asking people for money in particular as she did

not want to be perceived as a "beggin black woman." The second rupture (DT1) occurred during

this discussion when the therapist-participant again abruptly switched back to playing the game

while briefly validating the client-participant's feelings (e.g., "well that's a heavy one") regarding

her not feeling comfortable with relying on others and not wanting to be perceived in a negative

light or stereotyped.

The third discussion of interpersonal trauma occurred when the therapist-participant

picked a card asking her to "say something about child abuse." The therapist-participant

answered this question by saying, "it's never the victim's fault, and it's always the perpetrator's

fault." The client-participant responded with laughter and drew a card, saying with a smile, "I

gotta get a good one now." This then lead to the therapist-participant asking the client-participant

to asking the client-participant in a critical tone, "why did you act so upset when you had to

answer a question from [her] childhood." This also represented the third rupture (MB1) in the

session as the therapist-participant's question not only appeared critical, it also appeared to spark

defensiveness on the part of the client-participant rather than curiosity and reflection, as she

adamantly shared, "…Like I don't know, like, I don't know. I never thought about it. I don't

know."

In response to this, the therapist-participant asked, "you don't like to think about something from the past? Or--," and the client-participant defensively again shared, "No I do, I do…I don't know why I said that." The therapist-participant responded by saying, "Mm, ok" and directed the client-participant to move her game piece so that she could pick up the next card. The client-participant got a card that asked her to "comment about something" and from this she came back to the therapist-participant's earlier comment about abuse never being the victim's fault.

The client-participant shared that she disagreed, representing the fourth rupture (DT) with the therapist-participant, as she believed that the victim could indeed contribute to his/her own abuse. She used the example of R. Kelly's case, suggesting that although he was a "dirty old man," the young girls "definitely [wanted] to have sex with him." She further noted that although R. Kelly "should have asked for ID," the girls "asked for it" by dressing "older." The therapist-participant responded by asking about the client-participant's rationale for endorsing such views, and then explaining that children are not to blame because as "kids…they don't have enough maturity to be able to decide." Despite her initial disagreement with the therapist-participant's view, the client-participant was open to this explanation as she took the time to understand what the therapist-participant was attempting to convey, and stated towards the end of the conversation, "I learned something."

The discussion then changed to the client-participant expressing once again her frustration regarding her boyfriend's inability to set appropriate boundaries with his ex. The last rupture (DT1) occurred during this segment of the session because the therapist-participant moved abruptly back to playing the game (e.g., "Ok. Should we move on?"), rather than further exploring this very distressing issue the client-participant was bringing up. Shortly after, the session ended with the therapist-participant reminding the client-participant to complete the measures she had briefly alluded to at the beginning of the session.

Session 9. Two discussions of WPH occurred in session 9. Four ruptures (2 MB1s, 1 DT1, and 1 DT5), with MB1s occurring with the most frequency (two times), took place in this session, none occurred during a trauma discussion.

The therapist-participant started this session by asking the client-participant if she wanted to play the same game she had had initially brought to the 7th session. The client-participant agreed. Although the client-participant initially expressed not having anything in particular to discuss while picking up her first card (e.g., "I don't have anything to comment on, though"), with the encouragement of the therapist-participant, she then stated that her mother called her for the "first time in months" for her birthday. The client-participant expressed anger at her mother's lack of communication with her, saying, she is a "bitch" and "…somebody must have died…because like she'll never call." After a brief discussion of this issue, the therapist-participant triggered a rupture (DT1) by imposing too much structure on the session (e.g., abruptly gesturing back to playing the board game), instead of spending some more time discussing this topic and potentially validating the client-participant's feelings. The client-participant just responded to this transition by following the therapist-participant's lead. They continued to play the game for some time while discussing various topics, including their favorite movies, television shows, foods, holidays, birthday celebrations, and things the client-participant did when she was "bored to death."

The discussion about being bored subsequently led into the first discussion of trauma, in which the client-participant continued to express frustration and anger towards her work environment (e.g., "I sit in a box at work") and boss. This discussion concerning the client-participant's feelings of frustration and anger towards her boss then led into a related discussion of the client-participant sharing that she was "looking for another job on the weekend" so that she could be free of her current abusive work environment and the long hours she currently worked (e.g., "I just don't want to work those hours anymore").

During this exchange, the therapist-participant did not go back to the game right away. Instead, she focused on listening while occasionally providing validating and reflective statements (e.g., that's good. You sound motivated now to pursue other things") to the client-participant, which facilitated further discussion of the client-participant looking for new jobs that could pay more money and trying to get a modeling agency to represent her.

The client-participant then went back to playing the game and picked up a card that asked her to share how she behaves when she is angry. In response to this question, the client-participant shared that it depended on "what level of anger" she experienced, further adding that when she is upset with someone she will do the following: "First step is say something smart. Second step is say something even smarter. Third step is ignore before I go off. Fourth step is go—say something to let them know…okay bitch stop. Okay I'm going to pull out this gun in my purse if you don't fucking stop!" The therapist-participant listened while the client-participant shared these sentiments, but then when she mentioned having a gun in her purse, the therapist-participant induced a rupture (MB1) by asking the client-participant in a critical way, "you're not serious—you don't have a gun?" while also uncomfortably chuckling.

In response to this MB1 rupture, the client-participant said, "oh heck no!" She clarified that she did not really carry a gun in her purse, but was instead just saying that she had a gun as a "metaphor" to express how angry she can become with someone. Both the therapist-participant and the client-participant engaged in laughter, and then the therapist-participant shifted the focus back to playing the game.

This shift back to the game then triggered the second discussion of trauma in which she described her boss "getting in [her] face," and her response of either avoiding him or warning him that she will do "something really rude" if he "doesn't stop." The therapist-participant mainly listened and asked clarifying questions to further understand the client-participant's reactions to her boss' harassment. This discussion of WPH was followed by the client-participant sharing her

view that "positivity comes out of stuff", and the importance of her not only being positive but also able to "not…ignore what's going on."

The third rupture (DT5) occurred just after the therapist-participant was done responding to one of the game cards that asked her to describe a favorite teacher. Although the therapist-participant initially appropriately engaged in self-disclosure by sharing that she liked a particularly teacher who was "direct," she then appeared to engage in too much unnecessary self-disclosure by saying, "I'm too old to be in school." The client-participant did not appear bothered by this self-disclosure, but it nonetheless took the focus away from the client-participant, as it did not pertain directly to what she was talking about. The therapist-participant looking slightly embarrassed by her disclosure, then shifted back to playing the game.

The topic of religion came up next when the next game card asked the client-participant to share whether she had attended religious services as a child. In response to the question, the client-participant shared that she attended Catholic school for three years and church "a heck of a lot." She further described that while everybody at her church "was really cool," being there was "hella boring." She also discussed her feelings of anger towards her mother for forcing her and her brother to attend church while she would often watch her mother sleep during the services. The client-participant also expressed having "the dumbest confessions" and feeling "ashamed" for not knowing more about the Bible after being in a Catholic school for three years. The therapist-participant joked with the client-participant by saying, "you learned shame from Catholic school I guess." The client-participant laughed along and then continued to discuss her views regarding religion and in particular, how her friends introduced her to the teachings of "Islam." The client-participant described liking the family values that are taught as part of the Muslim faith, but stated that she "never joined" the religion because the "spirituality [was] missing."

The last rupture (MB1) in this session occurred during a conversation in which the client-participant, intrigued by the therapist-participant sharing earlier that her favorite teacher was

someone that was "direct," asked whether the therapist-participant liked "stuff to be told bluntly."

The therapist-participant, appearing uncomfortable by this question, asked the client-participant

in an abrupt and critical fashion why she was asking her such a question. The client-participant in

response, appearing uncomfortable herself, said, "I don't know," and then explained that she

enjoyed hearing the therapist-participant share that she liked people who were direct because it

normalized her feelings of liking people who say how they feel as opposed to "when people

don't."

   The session ended with the client-participant discussing her boyfriend, his ex, and their

child. The client-participant continued to share her frustrations regarding her boyfriend's

inability to stand up to his ex and how their relationship as a result, had suffered the

consequences, as the client-participant struggled to respect and trust him.

   The session came to a close after the therapist-participant informed the client-participant

"times actually up," and that she had another client waiting outside for her. The client-participant

apologized for keeping the therapist-participant beyond the time limit. In response, the therapist-

participant informed her that she purposely let the session run longer in order to give the client-

participant a chance to finish discussing her upset feelings. As they were both exiting the room,

the therapist-participant further assured the client-participant that they would pick up where they

left off in the next session by "tack[ling] that problem."

   Session 12. During the 12th session, two separate discussions of interpersonal trauma

occurred. The first one focused on the client-participant's work harassment and the second one

on the sexual abuse she experienced as a child. Eleven ruptures (i.e., 5 MB3s, 3 MB1s, 2 CRs,

and 1 WR) and two repairs (i.e., 2TR and 1TM) occurred in this session with MB3s occurring the

most (five times). No ruptures or repairs took place during a trauma discussion.

   The session opened with the client-participant returning the follow-up clinic measures

she had taken home to complete after the seventh therapy session to the therapist-participant. The

session subsequently shifted to the client-participant bringing up an issue regarding talking to her

boyfriend about something important. She mentioned trying something the therapist-participant

had suggested to her in a previous session, saying, "uh, ok so I did what you told me." When the

therapist-participant asked for clarification as to what the client-participant was referring to, the

client-participant nervously attempted to explain what she meant but had difficulty finding the

exact words. She was eventually able to express that she had talked to her boyfriend about their

communication difficulties, including her concerns regarding his relationship to his ex and their

child. This discussion regarding the client-participant's boyfriend then led into a discussion in

which the client-participant confessed to breaking into her boyfriend's computer where she

secretly read his ex's emails by guessing the password to his email account. Initially, the client-

participant laughed as she shared this story, but then appeared embarrassed by her actions, as the

therapist-participant appeared uncomfortable with what the client-participant was sharing. All of

the ruptures and corresponding two repairs took place during this discussion.

The first two ruptures (MB1 and MB3) occurred, when in response to the client-

participant sharing that she "guessed" the ex's email password and secretly checked the ex's

email, the therapist-participant, in a critical tone without offering any validation and also

laughing, asked the client-participant, "You guessed the password to her email?" The client-

participant, appearing increasingly embarrassed by her actions, then began explaining that she

could not help herself from checking the email because she was very curious. While the client-

participant shared this, the therapist-participant did not validate the client-participant's feelings of

embarrassment, nor did she aid the client-participant in more deeply understanding the mistrust

she felt, but instead continued to laugh and cover her face, which triggered the next two ruptures

(MB3 and CR).

The client-participant appeared bothered and became increasingly uncomfortable, as she

started to nervously laugh and play with her hair, but then she finally told the therapist-

participant, "ok quit laughing." In response to this statement (CR), the therapist-participant made

her first repair attempt (2TR) by immediately saying, "I'm sorry" and then tried to validate the

client-participant's experience by asking questions about her decision making process related to

finding out the email password and what led her to share the news with her boyfriend.

However, another rupture (MB1) occurred when the therapist-participant next critically

said, "you know that's illegal right? You know that?" The client-participant immediately

responded to this with a CR, as she said in a very matter of fact way, "I don't care." Sensing that

the client-participant was upset, the therapist-participant then engaged in the second repair

attempt (1TM). Specifically, she tried to use metacommunication as a way to comment on the

process of the interaction by sharing, "I can't do that. Don't worry I'm not reporting you."

Seconds later, the seventh (MB3) and eighth (MB3) ruptures occurred when the therapist-

participant continued to inappropriately laugh while the client-participant continued to share

about how her boyfriend has also tried to check her email. These ruptures appeared to trigger

more shame on the part of the client-participant, as she referred to herself as "crazy" and a

"psychopath."

Soon thereafter, the client-participant switched the topic to her experience of work

harassment. The client-participant described again the discomfort she felt working in such close

quarters and how her boss' office was located next to where she sat. The client-participant then

shifted her attention to discussing her feelings regarding a women she knew "who basically got

herself pregnant" because she needed "money" from her boyfriend. During this story, the

therapist-participant primarily listened and occasionally asked clarifying questions regarding the

intentions of the woman about whom the client-participant was talking.

The client-participant then reverted back to expressing feelings of anger towards her

boyfriend and his ex, again sharing that she was disappointed in his inability to deal effectively

with the issues of childcare and financial support. In response, the therapist-participant initially

struggled again to provide any validation, triggering the ninth rupture (MB3). The client-

participant's response signified the 10th rupture (WR), as she appeared embarrassed and there was

a significant shift in her tone of voice and posture. Although the therapist-participant did not

attempt to repair these ruptures, she shifted her focus to aid the client-participant in using a more assertive approach when talking to her boyfriend about her concerns. The client-participant was open to the therapist's suggestions.

As this discussion was wrapping up, the last rupture (MB1) took place when the therapist-participant, appearing critical of the way the client-participant brought this subject up to her boyfriend, said, "maybe next time you need to bring this up again. Maybe we'll do it in a less dramatic way." The client-participant did not appear bothered by the therapist-participant's statement, as she agreed that next time she will work on being more "mindful" of her boyfriend's "feelings."

The client-participant then soon shifted to talking about her singing career. She specifically mentioned that her fears of singing in public precluded her from advancing in her career and this caused her embarrassment and self-doubt. The client-participant continued to talk about her feelings of insecurity and how she has an "inner voice" that "keeps bothering [her]." The client-participant described how this "inner voice" was representative of her having a "lack of confidence" and contributed to her feeling "afraid to come to therapy." When the therapist-participant attempted to explore this issue of the client-participant being afraid to come to therapy, the client-participant did not directly answer but instead alluded to "somethin [that] happened in 2005" concerning her difficulty of singing in public. The client-participant discussed how the "the inner voice" had "control" over her and was judgmental of her, which then led into the second discussion of interpersonal trauma.

In response to the client-participant talking about this "inner voice," the therapist-participant asked how the voice had functioned in the client-participant's life, and then offered an interpretation of how this voice was there to help protect her as a child from her uncle. The client-participant agreed with this interpretation, saying "oh yeah." This part of the discussion lasted for only a brief time as the client-participant shifted her attention back to sharing how this "inner voice" affected her singing career and overall, current life circumstances.

Towards the end of the session, the therapist-participant provided psychoeducation regarding phobias and shared that she could help the client-participant work on her fear of singing in public. The client-participant responded with excitement to this possibility, expressing, "yeah that would be great…" The session ended with the client-participant asking for a pen so that she could write a check as payment for the session.

Session 18. The last recorded session to contain discussions of interpersonal trauma was session 18. During this session, two separate discussions of the harassment the client-participant was experiencing at her job were noted. No ruptures or repairs were identified in this session.

The session began with the client-participant expressing how she had "gotten to speaking it out," by referring to a previous discussion where the therapist-participant suggested she try being more vocal about her feelings. While nervously smiling and laughing, the client-participant then shared that she did like people listening to the music she played or what she "[she was] doing in [her] house." She additionally explained that she did not even want her roommate to hear her, as she preferred to "stay under the radar because [she] d[idn't] even want [anyone] to know [her]," further adding that she "just want[ed] to be "alone."

The session continued with discussions regarding the client-participant's desire to "control" her environment and the insecurities she continued to face in terms of singing in public. The therapist-participant attempted to help the client-participant see things through different perspectives, with the aim of reducing the client-participant's avoidance of approaching new or fearful situations, including singing in front of others. The client-participant was open to the therapist-participant's feedback, and herself expressed wanting to learn new ways to better manage her "nervousness." The therapist-participant used the analogy of running a "marathon" to further help the client-participant understand that working on her goals of singing in public was akin to preparing for a long marathon where the runner has to train gradually, mile by mile, before reaching his or her ultimate goal. While the client-participant was confused (e.g., "I'm a little confused, so…") by the connection between her fear of singing in public and running a

marathon, she appeared appreciative of the therapist-participant's use of the metaphor as she listened attentively and asked for clarification.

Approximately half way through the session, the topic of discussion moved to the client-participant discussing her frustration regarding having to stay at a job she "c[ouldn't] stand" due to financial constraints. The therapist-participant just listened intently to the client-participant while she expressed her frustration regarding not only her job but also how her boyfriend had not offered to help the client-participant buy a new computer or give her the one he had taken from "this lady." The conversation continued to revolve around client-participant's financial stressors, including her angry feelings towards her boyfriend. The therapist-participant continued to listen carefully and did not ask any follow up questions related the previous discussion of the WPH. Instead, the remainder of the session focused on the various concerns the client-participant had with her boyfriend, including his jealousy towards her meeting new people while he was living back in their hometown.

The session ended with the therapist-participant assigning a homework assignment requiring the client-participant to begin practicing singing (e.g., in the shower) with the larger goal of the client-participant singing in session and then in public. The client-participant was willing to complete this assignment, but also expressed some nervousness and ambivalence regarding having to confront her fears.

Rupture and Repair Analysis and WAI. Although the researcher initially hoped to examine the association between the rupture and repair process and the WAI measures, this analysis could not be completed given the lack of data in this area. If all of the WAI measures had been administered according to the clinic's protocol (i.e., at the start of every 5th session) and all therapy sessions were recorded and made available, the researcher would have ideally been able to examine whether any of the ruptures and repairs that occurred within a trauma discussion in those sessions related to the client-participant's rating of the therapeutic alliance on the WAI-C and the therapist-participant's rating on the WAI-T.

However, only three WAI measures were available: two WAI-C measures, specifically for sessions 7 and 14, and one WAI-T measure for session 7. Although it would seem that ruptures and repairs from sessions 6 and 7 could be compared to the session 7 WAI-C, given what was observed during the session videotapes, the measure was not given on schedule and it is not clear when it was completed. The WAI-C for session 7 was not turned in until session 12. Similarly, the researcher was not able to determine the exact date when the WAI-C for session 14 was completed, which made it difficult to make any credible associations between the ruptures and repairs that occurred in sessions 9 and 12 and session 14's WAI-C. Although it appears that the WAI-T was completed around the time frame of session 7, it is not clear exactly when this measure was completed; hence, making it difficult to make any associations between its data and the session content.

Moreover, it could not be determined what instructions the client was given about the time frame to use when completing the measure (e.g., based on the last session, all previous sessions, only sessions up to the last given measure), since the measure itself does not clarify this point. Thus, while sessions 1, 6, 7, and 9 might be relevant to the "session 7" WAI-C turned in at the start of session 12, the researcher could not make this determination. Similarly, it could not be ascertained whether session 18 was relevant to the "session 14" WAI-C.

With that said, as previously noted, both WAI-C measures reflected a strong therapeutic alliance, as all of the ratings ranged between 6-7 (with 7 representing the strongest alliance). A similar finding was obtained from the therapist-participant's session 7 WAI-T measure.

Her ratings on this measure reflected a positive therapeutic alliance as most fell into the range that represented the strongest alliance. This finding was also consistent with the therapist-participant's notation of how she perceived the therapeutic relationship in the treatment summary documentation. For example, on that form, the therapist-participant indicated that she and the client-participant "established a good, trusting relationship and the client responded well to [her] approach."

Additionally, despite observing the many ruptures that occurred in the various sessions, including those that were left unresolved, this researcher found the client-participant's overall emotional demeanor and engagement with the therapist-participant in the videotaped sessions reflected a fairly strong therapeutic alliance. For instance, the client-participant seemed to be actively interested and engaged in sessions, and openly shared her strengths and weaknesses, including her painful experiences of trauma. She additionally sought out the support and help of the therapist-participant, and thoughtfully considered her feedback. The therapist-participant also appeared to reflect a similar sentiment towards the client-participant, as she often listened attentively and worked diligently to understand and provide insight into the client-participant's varied experiences. However, at the same time, she was also observed to struggle at times with knowing how to appropriately respond and validate some of the client-participant's feelings, particularly related to certain discussions of CSA, WPH, and the client-participant's conflictual relationship with her boyfriend. For example, there were several instances where the therapist-participant abruptly switched the topic and inappropriately smiled and laughed while the client-participant shared some very confusing thoughts and feelings.

Themes Analysis

During the course of therapy, six themes and 28 subthemes best captured the overall essence and experiences of the client-participant. As previously noted, each theme and subtheme was defined and specific quotations representing the subthemes were recorded for each session containing a trauma discussion in a themes key and themes summary table (Appendix N; Appendix Q). Additionally, the frequency of each theme and subtheme within each session containing a trauma discussion was calculated and then recorded (Appendix O). The next section provides a summary of the descriptions of each theme category, including each category's corresponding subthemes and quotes from the client-participant, which emerged across the course of therapy and within the context of each trauma discussion. Themes are related to ruptures and repairs in the discussion section.

Self-protection. Over the course of therapy, the client-participant displayed a theme of *self-protection*, which was evident in her maintenance of physical and psychological safety as well as avoidance of experiencing negative life events. The theme of self-protection appeared 131 times across the sessions containing a trauma discussion with 25 occurrences in sessions 1 and 6, 31 occurrences in session 7, 10 occurrences in session 9, 19 occurrences in session 12, and 22 occurrences in session 18. The subthemes, *avoidance of trauma discussion, avoidance of emotions, mistrust of others, distancing from others, respect for others, financial security*, and a *sense of responsibility*, represented the various ways in which the client-participant protected herself from experiencing painful thoughts and affect, particularly, within the contexts of relationships. 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.

Avoidance of emotion. The first subtheme, *avoidance of emotion*, was evident in the client-participant's difficulty and reluctance to discuss feelings other than anger during therapy and to others in her life, including family, friends, and her significant other. In addition, this subtheme was representative of the client-participant's frequent use of humor, which appeared to help mask her deeper feelings of potential shame. This subtheme occurred 11 times during the sessions containing a trauma discussion and 11 times during specific discussions of CSA. However, this subtheme did not appear during any discussions of WPH.

In the first session when the client-participant expressed having difficulty in being able to express emotion, she mentioned, "Like, if you're asking me something hard or if I have to talk about something hard I still feel that way. I just—it's just like, 'man I don't want to talk about it, you know what I'm saying?" Another example of this subtheme occurred later in session 1 when the client-participant stated, "I'm laughing because that's how I am, and I don't want to talk. You know?" In addition, when the second discussion of CSA occurred, the client-participant expressed, "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 was noted during the first discussion of CSA in

session 7 when the client-participant stated, "You know, so all that hugging and stuff I don't

understand."

      Avoidance of trauma discussion. The second subtheme, *avoidance of trauma*

discussion, was observed during two sessions throughout the course of psychotherapy, and was

related to the client-participant's reluctance to discuss the sexual abuse she experienced as a child

and the associated emotions she had related to this very painful experience. This subtheme did

not appear during any of 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. This subtheme specifically appeared five times during session 1, and

then four times during session 7.

      In session 1, when the first discussion of CSA occurred within the context of the

therapist-participant alluding to the sexual trauma incident the client-participant had discussed in

the previous session, the client-participant stated, "About what?" without directly naming the

trauma itself. Additionally, during the first discussion of the client-participant's CSA in session

7, the client-participant noted, "It don't affect me, but kind of like what you said, I'm wondering

if it does and I just don't know it" and then moments later, "…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. *Mistrust of others* was the third self-protection subtheme. This

subtheme included the client-participant's reluctance to confide in others her feelings and secrets,

and her disbelief that others would want to help her without wanting something in return.

Mistrust of others appeared 25 times across sessions 1 (six times), 7 (seven times), 12 (nine

times), and 18 (one time). The only examples of the client-participant's mistrust of others that

took place during a discussion of trauma occurred during the first discussion of CSA in session 7,

as she stated, "…it took a long time for me for me accept help or to accept something." Yet,

mistrust of others did not appear during any of the discussions of WPH.

There were several instances of this subtheme occurring outside of a trauma discussion. For instance, during session 1, the client-participant stated, "…I may as well just tell the wall, because I'm going to get the same response" and "…so I just kind of weed them out" when talking about her relationship to her friends. In session 7, when the client-participant was discussing the subject of communication in relation to her boyfriend, she expressed, "I was wondering what was gonna happen because it was just too, we was just getting along way too good." Moreover, during session 18, she stated, "…but I'm the type of person, I'll figure out what you got to offer, and I'm not fully prepared to accept it."

Sense of responsibility. The *sense of responsibility* subtheme was defined by the client-participant's strong feelings of obligation to care for herself and others in her life (e.g., her family; boyfriend). This subtheme occurred a total of 23 times across all of the sessions. Specifically, it occurred three times in session 1, once in session 6, one time in session 9, nine times in the 12th session, and once in the 18th session.

For example, during the 6th session, the client-participant stated, "…like when somebody leaves it's like you just like you know that you're counted on…but me, I'm expected or I'm counted on to do this, and this." During session 18, when talking about her decision to move to L.A. and start a career in entertainment, she noted, "…I want to have a skill, somethin I can bank on." The subtheme sense of responsibility did not occur during any specific discussion of CSA or WPH between the client-participant and therapist-participant.

Financial security. The fifth subtheme that developed under the larger theme of self-protection was *financial security*. This subtheme was represented in the client-participant's strong feelings and actions related to money and the importance of having money in order to prevent her from having to rely on others for financial support. The subtheme also included the client-participant's feelings about having to provide financial support to her family and boyfriend. Financial security appeared 36 times in sessions 6 (14 times), 7 (eight times), 9 (six times), 12

(five times), and 18 (3 times). The subtheme of financial security did not appear during either type of trauma discussion, CSA or WPH.

In session 6 when the client-participant was discussing her feelings related to not having enough money growing up, she expressed, "I was wondering was it because we was broke, like we didn't get to have everything everybody else had so I always had an attitude." During session 7, the client-participant stated, "I don't like taking off work…I'm kind of in debt and, I mean, I don't like that." Additionally, in session 9, when discussing her views regarding her mother praying for more financially stability, she reported, "we're poor, we're broke. We don't got shit, we never had shit. And you're telling me to do what you do?" Then in session 18, she expressed "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?"

Distancing from others. The sixth subtheme noted under the category of self-protection was *distancing from others*. This subtheme represented the client-participant's avoidance of forming and maintaining close relationships with others in her life in order to avoid being emotionally hurt by others. Although this subtheme appeared similar to the subtheme of mistrust of others, it differed in that the client-participant, despite her mistrust of others, was able to form relationships (i.e., with friends and her boyfriend) where she would nonetheless try to distance herself in order to preclude herself from being disappointed and potentially abandoned. Distancing from others occurred 10 times throughout the course of therapy with one occurrence in session 7 during the first CSA trauma discussion and nine occurrences during session 18. This subtheme was not evident in any discussions of WPH.

For example, in session 7 within the context of discussing the CSA, the client-participant stated, "I'm like, so I just developed an attitude. I was like no, I don't care." Then in session 18, she reported "it makes me hard, it makes me a little bit rougher with me because, well I'm getting better now."

Respect for others. The final subtheme in the self-protection category was *respect for others*. The client-participant shared that she had strong feelings of consideration and courtesy for others especially for those who treated her with respect and also deserved her respect, including elderly people and people of importance. The subtheme also included the client-participant's views on how people should treat each other in the workplace.

The subtheme of respect for others appeared seven times throughout the course of therapy including during discussions of CSA and WPH. It occurred in session 1 (one time), specifically during the third (two times) and ninth (one time) discussions of her WPH, session 7 during the first discussion of her CSA (two times), and session 9 (one time).

In session 1, while referencing an incident when her boss threw a piece of paper on the ground and expected an elderly employee to pick it up, she expressed, "It's just not respectful." She also reported, "…where I grew up, dudes don't really deserve respect," during session 7. Then in session 9, she stated "he don't see how that's disrespectful—that's disrespectful to you. You don't do that" when talking about a time her boyfriend's ex invited herself to one of his family's events without first asking for his permission.

Power and control. The theme of *power and control* appeared in every session containing a discussion of trauma. This theme was representative of the ways in which the client-participant attempted to gain command over her environment and her life experiences, and felt competent. 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. The subthemes that best captured the client-participant's attempt at gaining power and control over her feelings and environment were the following: *assertiveness, aggression, the desire/attempt to control self, the desire/attempt to control environment/others*, and *independence*.

Assertiveness. 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 nine times across all aspects of therapy, including in trauma

discussions of CSA and WPH. It specifically occurred during the second, seventh and ninth

discussions of WPH in the first 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 instance, the client-participant noted during the 1st session, "I just started talking

back. I don't care, like you're not going to talk to me like that," in response to her boss' verbal

abuse and harassment. During the 9th session, she also stated, "…I know positivity comes out of

stuff. But when I'm in a negative situation, I'm not one to like—I'm not one to say, 'oh fuck the

world.' But I'm also not one to ignore what's going on." And in the 7th session when the client-

participant described how her uncle attempted to sexually abuse her the second time, she stated,

"hell no. I'm like say something. Like no. I'm not doing this…" In the 12th session, she also

reported "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", when talking about her boyfriend

and their difficulties with communication and trust. Also in session 12, in reference to a

discussion concerning her thoughts of breaking up with her boyfriend, she shared, "…I tell him,

you want to dump me, do it whenever you feel like it cause I'm gonna bring it up anytime I feel

like it…you know, so I'm taking the more assertive approach."

Aggression. The second subtheme of *aggression* fell under the larger theme category of

power and control. It included the client-participant's hostile feelings and attitudes expressed

during psychotherapy. The subtheme of aggression was evident 15 times in both the discussions

of CSA and WPH. Specifically, it transpired during the 5th discussion of work trauma in session

1 (one time), in the discussion of work harassment in the 6th session (one time), session 7 (five

times) including the first discussion of CSA (three times) and the last discussion of WPH (two

times), and session 9 (one time) including the last discussion of work trauma (two times).

For example, when talking about her workplace situation and interaction with her boss, she stated during session 6, "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." Additionally, in session 8, when talking about how she manages conflict, she indicated, "…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."

Desire/attempt to control self. The third subtheme in power and control was *desire/attempt to control self.* This subtheme captured 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). However, this subtheme did not occur during any specific discussion of CSA or WPH.

For instance, in the first session the client-participant reported, "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?" in reference to her boyfriend. In addition, the client-participant noted in session 7, "I have to keep constantly telling myself calm down, calm down, just wait, just wait." While discussing her dissatisfaction with the entertainment industry and objectification of women in session 9, she stated, "so I feel like I have no direction, so it's kinda like, I'm like havin to sit around people and meet people that I probably don't meet."

Desire/attempt to control environment/others. The fourth subtheme of *desire/attempt to control environment/others* also appeared under the category of desire/attempt to control environment/others. This subtheme was represented in the client-participant's wishes and trials at gaining command of the reactions of others and the responses of the environment to her life experiences. Overall, this subtheme occurred 50 times in sessions containing trauma discussions and four times during discussions of CSA. Specifically, the subtheme appeared three 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, eight times in session 12, and 11 times in session 18.

For example, during the first discussion of CSA in session 7 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?" Additionally, in session 6, while discussing her feelings regarding asking for help, she noted, "…don't give me shit cuz I don't want you asking for nothing. 'cause I don't want you holdin nothing over my head." Moreover, 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."

Independence. The final subtheme in the power and control category was *independence*. This subtheme was apparent in the client-participant's desire 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; yet, it did not appear during discussions of her WPH. This subtheme occurred four times in session 1, 14 times in session 6, two times in session 7, four times specifically during discussion of CSA, two 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." In session 12, the client-participant also discussed her independence from her family, and in particular her mom, stating, "so it's like I gotta take care of myself. And that's the attitude I have with my mom…" Additionally, during the 18th session, in reference to buying herself a computer, she reported, "…I always get it for myself anyways. I'll just get another one."

Sense of self. The third theme that appeared throughout the course of therapy containing discussions of trauma was *sense of self*. This theme was representative of the client-participant's feelings about self-efficacy and her place in the world, and contained the subthemes *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 three 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 was not present in every session.

   Fear of judgment. The first subtheme, *fear of judgment*, was developed to capture the client-participant's distress at being thought of negatively by others, including strangers and her therapist. This subtheme appeared a total of 22 times and specifically, occurred during the first discussion of WPH (one time) in session 1 (one time), as well as during session 6 (two times), session 7 (one time), session 9 (one time), session 12 (four times), and session 18 (12 times). Fear of judgment did not occur during any discussions of CSA.

   For instance, in session 1, during a discussion of WPH, the client-participant expressed to the therapist-participant, "I don't want to start, you're going to get mad at me." During session 6, the client-participant also reported, "I cannot do that, totally not on camera, looking like an idiot." And in session 12, when the therapist-participant asked her whether she brought back one of the clinic measures, she shared in response, "ok. I'm sorry, but I folded it in my purse."

   Insecurity. The second subtheme that appeared in sense of self was *insecurity*. This subtheme was defined as encompassing 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, as it only occurred during session 6 (five times), session 9 (three times), session 12 (25 times), and session 18 (seven times). Additionally, the subtheme of insecurity did not appear during any discussion of CSA or WPH.

   For example, in session 6, the client-participant stated, "I don't really have anything interesting to talk about" in response to the therapist-participant asking her what she wanted to focus on in therapy that day. Another example of insecurity surfaced in session [x] when the client-participant shared how she felt in regards to her work situation as she stated, "like, it just makes me have a lack of confidence…"

   Self-critical. The third subtheme noted was *self-critical*. It was represented in the client-participant's disparaging and belittling beliefs she expressed about the ways in which she

navigated her life experiences. Self-critical occurred less frequently as compared to the other general theme categories, as it only occurred two times (in session 18). This subtheme also did not appear during any of the discussions of WPH that took place during session 18.

More specifically, the client-participant reported, "I guess it's because to me, my mistakes are so horrible." Another example of her self-criticism represented in her statement:

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.

Respect for self/pride. The final subtheme in the sense of self general theme category was *respect for self/pride*. This subtheme entailed 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 nine instances of respect for self/pride, which appeared during the ninth discussion of WPH in session 1 (one time), and 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.

In session 1, during one of the discussions of WPH, the client-participant stated, "I try to be respectful, but at the same time I can't let him verbally abuse me." In session 6, the client-participant also expressed, "I feel disrespected…" when talking about her relationship with her boyfriend.

Gender role struggles. The theme of *gender roles* appeared over the course of therapy. 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. This theme appeared 29 times across each session containing a trauma discussion, though it only occurred during discussions of CSA, not WPH. Three subthemes related to the client-participant's experiences of gender role struggles*, stereotypes of men, stereotypes of women* and *role reversals*.

Stereotypes of men. The subtheme *stereotypes of men* concerned the client-participant's beliefs about the conventional roles males play in society, and more specifically, how these

beliefs were reflected in how she perceived her boyfriend's behavior. This subtheme occurred

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. For

example, during the first session, the client-participant stated, "…he's not gonna cry because he's

a man, especially not in front of me." This quote represented the ways in which the client-

participant often projected generalized stereotypes of men's behavior on how she believed her

boyfriend would respond. The client-participant also reported, "he didn't act up, act crazy. He

didn't cry and stuff, so that was good" in session 12.

 Stereotypes of women. In addition to stereotypes about men, the client-participant also

expressed stereotypes about women. Therefore, a subtheme of *stereotypes of women*

encompassed the client-participant's ideas about the standard roles of females in her/United

States 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 primarily appeared when the client-participant discussed her desire to

break into the entertainment and music industries.

 For example, during session 6, the client-participant indicated, "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 was evident when the client-participant expressed her feelings about the mother of her

boyfriend's child, when in session 9, she reported, "…But it's just—a I don't know how—just

a—the whole baby mamma shit that baby mammas do." In session 7, another stereotype of

women came out during the first discussion of CSA when the client-participant 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." In another discussion

of CSA during session 7, she noted "…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."

      Role reversals. The final subtheme in the gender role struggles category was *role reversals*. This subtheme encompassed the struggles 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 surfaced 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.

      During session 1, 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." In addition, in session 6 when discussing her frustration regarding having to pay for her boyfriend's meals, she noted, "if it wasn't for me he wouldn't have been eating for two weeks." Moreover, in session 18, while continuing to discuss her feelings regarding having to take care of her boyfriend, she reported, "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."

      Emotional difficulties. The fifth theme that occurred during the course of therapy was *emotional difficulties*. This theme was created in order to capture the complications the client-participant experienced in being able to experience, express, and share her feelings about her life experiences with others. This theme occurred 54 times across every session containing a trauma discussion, as well as during specific discussions of WPH and CSA. The specific feelings the client-participant experienced within the context of therapy were further categorized into the following subthemes: *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.

Anger towards boss. The subtheme *anger towards boss* encompassed the client-participant's feelings of animosity, annoyance, and hatred experienced when discussing or working with her boss. This subtheme occurred six times in session 1, specifically during most discussions of WPH, as well as two times in session 6, one time in session 7, and two times in session 9. Each of the 11 instances of anger towards her boss occurred during a discussion of WPH. This subtheme was most evident in situations where the client-participant struggled in interactions with her boss.

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." Additionally, in session six, she expressed "…I swear I'm gonn hit this fat man in his eye." The client-participant additionally expressed her anger towards her boss for treating her and her co-workers disrespectfully. She specifically shared during session 9:

> 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.

Anger towards mother. The second subtheme in the larger theme category of emotional difficulties was *anger towards mother*. This subtheme entailed the client-participant's feelings of agitation and impatience expressed when discussing her past and current relationship to her mother. Anger towards her mother occurred 15 times over the course of therapy. Specifically, it appeared 11 times during session 6 and four times during session 9. However, no occurrences of anger towards mother occurred during a discussion of trauma.

During session 6, while reflecting on interactions that took place in the client-participant's childhood she stated, "I've always had a snotty attitude towards her. I used to make her cry when I was little, I didn't even know it 'til I got older…" When discussing how her mother often complained of her not calling her enough, 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. The third subtheme that appeared in the

emotional difficulties theme category was *difficulty identifying and expressing emotion*. This

subtheme represented the client-participant's problems labeling and discussing feelings other than

anger about her life experiences during psychotherapy and with others. This subtheme was noted

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).

     For instance, in the first session when sharing how she tends to laugh when she feels

nervous, she stated, "Well I think I laugh a lot and I laugh too much." Additionally, in response

to the therapist-participant's question about the client-participant wanting to be able to

communicate her emotions, the client-participant, smiled and confirmed, "yeah, yeah."

Furthermore, in the same session, she shared, "because people never see me sad." During session

6, she expressed, "…my first instinct is sad but it turns to anger. I'm so used to being not sad, but

angry."

     Frustration with boyfriend's lack of responsibility. The fourth subtheme was *frustration*

with her boyfriend's lack of responsibility, which captured 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 occurred 18 times in sessions 6

(five times), 7 (two times), 9 (four times), 12 (three times), and 18 (four times). This subtheme

was only apparent during a discussion of WPH once in session 9. Yet, there were no instances

during discussions of CSA.

     This subtheme was mainly representative of the many discussions concerning the client-

participant's frustration about the way her boyfriend managed his relationship to the mother of his

child. For example, in session 6, 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…" A similar pattern was evident in session 7 when the client-participant

shared, "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."

  Jealousy. The final subtheme in the emotional difficulties category was *jealousy*. This

subtheme best captured the client-participant's feelings of resentment and spite towards other

women involved in her boyfriend's life. This jealousy was primarily directed towards both the

mother of her boyfriend's child and the child they had together. Instances of jealousy occurred

four times, once in sessions 6, two times in session 7, and then once in session 9. None of the

occurrences of jealousy occurred during any discussions of CSA or WPH.

  In session 6, 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." During the 7th session, 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 example, in session 9, 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. *Job dissatisfaction* was the final theme that occurred throughout the

course of therapy for the client-participant. This theme was evident in many of the discussions of

trauma that particularly focused on the client-participant's experiences of WPH. As such, there

was a great deal of discontent and unhappiness concerning the client-participant's place of

employment that was shared in each session. There were 22 occurrences of the overall theme of

job dissatisfaction in sessions 1, seven, 9, and 18; however, not all took place within the context

of a specific trauma discussion. There were 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*.

Disengagement from job. *Disengagement from job* was the first subtheme noted in the job dissatisfaction category. It was representative of the client-participant's feelings of detachment, disconnection, and indifference in regards to her job duties and workplace. Disengagement from job appeared three times, and only during discussions of WPH. It occurred during the ninth discussion of WPH in session 1 (one time) and during session 9 (one time), specifically during the first discussion of WPH (one time).

For example, in session 1, while the client-participant was sharing her feelings of anger regarding her boss, she stated, "…and I don't care and I hope I get fired." When describing how she managed to get through her time at work, she indicated, "just sit there and be ok. In two weeks we get paid."

Hatred toward job. The second subtheme in job dissatisfaction was *hatred toward job*. This subtheme accounted for the client-participant's feelings of anger, disgust, and contempt toward her work and the need to go to work. Hatred toward job appeared 10 times throughout the therapy. It occurred 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 7 during the first discussion of WPH (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 shared, "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. This sentiment of hatred towards her job continued to be expressed, as she reported, "I hate this f***ing job. I hate, hate, hate," during the 18th session.

Frustration with job responsibility. The third subtheme to fall under the overall category of job dissatisfaction was *frustration with job responsibility*. This subtheme was created to

represent the client-participant's feelings of dissatisfaction, annoyance, and irritation with her required duties at work, specifically those not related to her job description. This subtheme was noted only in session 1, and occurred three times during that session within the context of WPH.

For example, 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 expressed, "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."

Feeling trapped in job. The last subtheme in job dissatisfaction was *feeling trapped in her job*. This subtheme defined the client-participant's expressed emotions of being stuck and obligated at work despite her strong desire to leave. The client-participant often shared that she wanted to leave her current job, but due to many external factors such as financial instability, she could not. The client-participant's feelings of being trapped at work occurred throughout the sessions containing trauma discussions, as well as during specific discussions about her WPH. 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 WPH, during the first discussion of WPH in the 9th session (one time), and in the second discussion of work trauma in session 18 (two times).

For instance, in the first session, while sharing her frustration regarding not being to leave her job, she noted, "I feel trapped because I can't do what I want." She also added, "Yeah, because I sit in a box at work," in the 9th session. During the 18th session while comparing herself to some of her coworkers, the client-participant reported, "I feel like I'm their age. I feel like I may as well be 50."

Chapter 4

Discussion

The current case study retrospectively investigated the process of trauma discussion as it related to Safran and Muran's model of therapeutic ruptures and repairs within the context of psychotherapy with an adult client at a university community counseling center. Although researchers have examined the rupture and repair process, there is little research on how therapist behaviors relate to ruptures that occur in the alliance when clients specifically discuss interpersonal trauma, and how they are repaired within such a context. Qualitatively analyzing written psychotherapy data and videotaped sessions containing a trauma discussion, the researcher examined what types of traumas were discussed, the content and process of interaction between the two participants, including the occurrence of ruptures and repairs, and themes that best captured the essence of the client-participant's many experiences. For a visual summary of these results, please see Appendix S.

This chapter first provides a brief case summary of the client-participant's therapy experience and describes the experience of trauma discussion and the manner in which it was discussed over the client-participant's course of therapy. Second, the research questions are addressed by relating the rupture and repair results, themes, and other relevant information observed across and within the course of therapy. Third, methodological limitations are discussed. Lastly, implications and future directions for prospective research are proposed.

Case Summary

This case study involved a 28-year-old (at the time of intake) single, Christian, African American female who moved to southern California from the south just before she entered individual psychotherapy. The client-participant reported that she was in a long-distance committed relationship with a man from her hometown with whom she continued to have trust and communication difficulties. The client-participant worked full-time at a travel agency as a bookkeeper and part-time in the entertainment industry, primarily modeling and acting. The

client-participant also noted wanting to become a professional singer but harbored fears of having to perform in public. Despite working full-time at the travel agency and supplementing her income with money earned from her burgeoning entertainment career, the client-participant struggled financially. She often shared that she barely made ends meet to take care of herself, while also having the burden of sometimes helping her boyfriend and mother back home, which she appeared to greatly resent. She also expressed that she experienced WPH by her boss at the travel agency. Although she desperately wanted to leave this job, she felt she could not as she needed the stable income.

The client-participant presented to therapy reporting that she was having substantial difficulty adjusting to her recent move to L.A. and desired to have someone to talk to, as she felt she lacked social support. She also noted having problems expressing emotion and communicating her feelings to others. The client-participant's OQ-45.2 scores also reflected significant distress about social roles, particularly related to her job situation and the associated anger and helplessness she experienced.

The course of treatment spanned a total 21 sessions, 18 of which were videotaped. The videotaped sessions contained content related to the client-participant's problems at her current employment, and problems beginning a new career in the entertainment industry, as well as problems related to her relationships with her boyfriend, mother, and friends. Six of those videotaped sessions included discussions of interpersonal trauma (i.e., sessions 1, 6, 7, 9, 12, and 18), including the CSA incurred by her uncle and WPH from her boss. According to the treatment summary, therapy ended due to the client-participant not wanting to transfer to a new therapist after she was notified that her current one was leaving the clinic.

Trauma experiences. Based on the initial intake documentation and verbal report of the client-participant over the course of treatment, it was apparent that she experienced at least two forms of interpersonal trauma in her life, specifically the CSA by her uncle during her middle school years and the ongoing WPH at her current place of employment. The client-participant

informed the therapist-participant that her uncle molested her on one occasion while she and her

brother were in his care and on another occasion when he tried to molest her the second time, she

informed him that she would tell her mother if he tried again and after this, he stopped. She also

shared that she had never disclosed the abuse to her mother or anyone else out of fear that her

mother would wind up in jail after having hurt the uncle.

Moreover, the client-participant expressed that she and some of her co-workers were

experiencing ongoing WPH from her boss. She shared several incidences in which her boss

would threaten her and her co-workers, often calling them derogatory names with the insinuation

of racial prejudice. She shared at length how her boss would yell at her and her fellow

employees, often criticizing their work and blaming them for any mishaps. On one occasion, the

client-participant shared a phone message left by her boss, which reflected the WPH the client-

participant had discussed in previous sessions. She often described how she would respond to her

boss in such exchanges and shared her strong desire to quit once she was able to find stable

employment and income elsewhere.

Research demonstrates that individuals exposed to interpersonal trauma tend to be at

greater risk for experiencing additional forms of interpersonal trauma throughout their lives

(Briere & Scott, 2006; Courtois, 2004; Pine & Cohen, 2002). Furthermore, experiencing multiple

forms of trauma is frequently associated with increased levels of distress, psychiatric

symptomology, and difficulties staying connected in relationships, including therapeutic ones, as

compared to experiencing a single trauma (Buchanan & Fitzgerald, 2008; Courtois, 2004). The

client-participant's experience of CSA may have potentially made her more vulnerable to

experience other forms of trauma, including WPH; and her ability to manage the many stressful

incidents of this trauma were likely associated with how she processed and coped with the CSA.

It also may have hampered her ability to feel close in relationships, including with her

mother and friends, and to identify and express her emotions, particularly, feelings of anger and

sadness (Cohen, Mannarino, & Deblinger, 2006; DiLillo, 2001). This tendency to remain at a

safe distance from important relationships and avoid painful affect was particularly captured in

the subthemes of distancing from others (i.e., occurring 10 times) and avoidance of emotion (i.e.,

occurring 22 times), both falling under the larger theme category of self-protection. The client-

participant's struggle to maintain closeness in relationships was also reflective in the subtheme of

aggression and larger theme of power and control, as she often displayed overt feelings of anger

and hostility towards her mother and other relevant persons in her life. Other literature examining

the relationship between emotion and sexual abuse found that many African American women

who have experienced CSA can be disconnected from healthy expressions of anger, and

incapable of identifying and expressing their own anger particularly because they are often

depicted in the media as having to be strong, independent, and angry figures (Greene, 1994).

Accordingly, numerous African American women, including those who have experienced CSA

> internalize the stereotype of the ubiquitous strong matriarch: In the tradition of the
>
> mammy, she acknowledges no personal pain, can bear all burdens, and will take care of
>
> everyone. Consequently, many African American women feel deficient if their burdens
>
> are too heavy, and will resist asking for help. (Greene, 1994, p. 21)

Throughout the course of treatment, the client-participant demonstrated difficulty in

expressing healthy forms of anger where she was able to more deeply explore and understand the

triggers to her angry reactions as well as "reclaim" her anger. For example, Wilson (1993)

discusses the importance of African American female CSA survivors voicing/externalizing their

anger specifically towards those who have abused them in order to free themselves of the

internalization of the abuse and the anger that has been directed towards themselves and others.

The client-participant also reflected a strong need to present herself as a strong and independent,

often struggling to ask for help. This struggle for independence was best represented in the theme

of power and control and specifically, within the subtheme of independence, which occurred 41

times in sessions 1, 6, 7, 12, and 18. Literature examining the relationship between the theme of

power and control and African American women highlights the importance of historical factors.

For example, African American women's experiences throughout history of discrimination, oppression, inequality, and being stereotyped has for some, contributed to a sense of powerlessness and inhibition in various domains including, social interactions, the workplace, education, and politics (Cook, Arrow, & Malle, 2011; Greer, 2005; May 2009). However, Black feminist writers point out that breaking the silence about childhood sexual abuse and all other forms of abuse, including racism, poverty, sexism, heterosexism, gives survivors a chance to recover their humanity while empowering themselves by providing new meaning to their own experiences (Collins, 1998; Wilson, 1993).

In addition, the experience of CSA at the hands of a family member and an authority figure, such as an uncle, may have specifically contributed to her difficulties with trusting other authority figures and men in general, including her boyfriend (Burkhardt & Rotatori, 1995; Sano et al., 2003). This was particularly evident within the theme of self-protection, and specifically the subtheme of mistrust of others, which occurred a total of 25 times, as the client-participant shared a disbelief that others would want to help her without wanting something in return. For example, this sentiment is related to the client-participant's experience of her uncle coercing her into sexual relations after giving her many presents.

Moreover, the client-participant's experiences of specific types of interpersonal trauma are to a certain extent consistent with current research findings. Specifically, studies have shown that it can be common for African American women to experience repeated sexual retraumatization (Campbell, Greeson, Bybee & Raja, 2008; Wyatt & Riederle, 1994). In addition, research has demonstrated that African American women as well as Caucasian women are more likely to be subjected to sexual retraumatization in adulthood if they experienced at least one sexual abuse incident in childhood (Bryant-Davis et al., 2009; Campbell et al., 2008; Wyatt & Riederle, 1994). Although the client-participant reported experiencing more than one instance of CSA, she did not experience sexual abuse in adulthood. Yet, it is possible that she did face difficulties related to the development of her sexuality and comfort level with sexual intimacy as

research has shown that survivors of CSA, including African American women, are at greater risk

for developing such problems (Noll, Trickett, & Putnam, 2003).

In addition, research suggests that being of low socioeconomic status is also a risk factor

for sexual trauma as women whose income falls at or below the poverty line are at increased

danger for sexual retraumatization (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010;

Kalichman et al., 2009). Furthermore, since research reveals that approximately 25.6% of

African American women live in poverty, the client-participant may have been particularly at risk

for retraumatization (Bryant-Davis et al., 2010). For instance, throughout treatment, she noted

growing up with significant financial burden, often describing her family as "poor" and not

having enough money to buy food and pay the water and electricity bills. She also described

similar financial stress in relation to her current financial circumstances, specifically sharing that

she sometimes went without food and gas for her car when she was on the brink of running out of

money. She also noted having to financially provide for her mother and boyfriend, which added

additional financial stress. Given the salience of these struggles, financial security was a

particularly evident subtheme under the theme of self-protection, occurring 36 times across

sessions 6, 7, 9, 12, and 18.

The client-participant's experiences of WPH are also consistent with research on African

American women's harassment in the workplace. It is often the case that ethnic minority women,

including African American women, experience greater degrees of workplace incivility in the

form of disrespect, condescension, and degradation, than do their male counterparts, contributing

to significant declines in their emotional and psychological functioning and work performance

(Cortina, Magley, Hunter-Williams, & Day-Langhout, 2001). Furthermore, experiencing

multiple forms of interpersonal trauma has been associated with generalized work stress as well

as supervisor and co-worker dissatisfaction (Buchanan & Fitzgerald, 2008). These experiences of

repeated trauma, including continuous degradation within the workplace, may have challenged

the client-participant's sense of self-efficacy and place in the world; and this sentiment was

represented in several themes throughout the client-participant's course of therapy, most notably within the domain of sense of self under the subthemes of fear of judgment, insecurity, and self-criticism. For example, the client-participant expressed distress about the possibility of being negatively evaluated by others, including strangers, feelings of doubt, and insecurity about being able to make good choices and achieve her goals.

The client-participant appeared to cope with the several stresses of her workplace abuse by forming close bonds with certain co-workers and helping protect them against some of the boss' vitriol. Although she did not explicitly say whether she also changed her typical demeanor in order to adapt to the daily WPH she experienced, it is possible that she used "shifting" as described by Jones and Shorter-Gooden (2003) as an additional way to cope. For example, despite expressing a strong desire to directly share how frustrated and angry she was by her boss' behavior, she tended to avoid such discussions, potentially out of fear of instigating further problems. Therefore, in order maintain a sense of stability, avoid further conflict with her boss and associated distress, she may have changed the way she spoke and avoided controversial topics. Therapy instead may have become one of the safe places where she could, without holding back, truly express how upset, angry, and at times, helpless she felt about her experience of WPH as well as gain some sort of mastery and control of the situation. Her assertiveness and goal of wanting to have a more positive self-esteem was specifically represented within the subthemes of assertiveness (occurring 9 times) and respect for self/pride (occurring 9 times), both occurring within WPH discussions.

Despite these notable difficulties related to trauma, the client-participant's experiences also matched some of the literature on positive outcomes following trauma. For example, she learned to say no and to stand up for herself in difficult situations, particularly within context of her experience of childhood sexual abuse. She additionally learned to protect herself by not simply trusting and following the rules and expectations adults set for her. Instead, she learned that her trust and respect needed to be earned; and this was exemplified in the subtheme, respect

for others (occurring 7 times), where she shared about people needing to show consideration and courtesy, especially with elders and with those she deemed important. Additionally, despite having difficulty in a variety of areas, the client-participant came to treatment because she wanted to understand and communicate her feelings more effectively and try to rebuild her inner world by addressing issues related to her self-worth; and make more thoughtful choices about being surrounded by more positive people (O'Dougherty et al., 2007). Furthermore, her increased sense of personal strength, quest for new possibilities, including her goal of changing careers, and a desire for continued spiritual growth is consistent with domains of posttraumatic growth (Tedeschi & Calhoun, 2004). This interest in deepening her spiritual growth and healing was also particularly apparent in her endorsements on the BMMRS at intake where she expressed having a strong desire to be close to God, finding strength, support, comfort, and guidance in her faith, as well as when she discussed having an interest in Islam teachings related to family values during session 9.

     Trauma Discussion. The client-participant discussed her experiences of CSA and WPH in six out of the 21 sessions of videotaped psychotherapy sessions. She also shared her history of CSA on the intake paperwork. It is unclear from the written measures and videotaped sessions whether the client-participant had previously discussed her traumatic experiences with anyone outside of the treatment, including family members, intimate partners, and friends. However, given that she did not share the CSA experience with her mother and reported having a somewhat emotionally distant relationship to her boyfriend and friends, it is likely that this was the first disclosure/discussion of the CSA trauma.

     Certain aspects of the client-participant's discussions of trauma are consistent with current literature. For example, research has shown that age and gender can affect the disclosure of trauma. Specifically, a study examining the experience of CSA from the perspective of adult survivors revealed that disclosure increased with age, and occurred more often with female survivors than with male survivors (Kogan, 2004). This matches the client-participant's

experience of disclosure as she also discussed the CSA when she was older. Her timing of the disclosure of trauma is also consistent with other research suggesting that individuals are less likely to initially disclose CSA when the perpetrator is a family member due to the social consequences relating to the family structure (Nagel, Putnam, Noll, & Trickett, 1997). In particular, individuals might fear social rejection, causing a disruption in the family's relationships, socioeconomic status if separation results, and fear regarding the involvement of authorities, including removal from the home (Nagel et al., 1997; Somer & Szwarcberg, 2001). In addition, given that the client-participant was sexually abused by a trusted family member (i.e., her uncle), it is likely that this also influenced her ability to discuss the events of the abuse, including telling her mother. For example, the client-participant shared that she did not tell her mother about the abuse mainly because she was afraid that her mother would be arrested and sent to prison after seeking retaliation against the uncle. Similarly, other research investigating women's experiences of CSA disclosure revealed that the closer the survivor's relationship was to the perpetrator, the longer it took for them to disclose the abuse (Foynes et al., 2009). Although it is unknown how close the client-participant felt to her uncle before the abuse, it is clear from her report that her uncle was likely a trusted family member as her mother was comfortable enough to leave the client-participant and her brother in his care. Therefore, this violation of trust, particularly by someone so close to the family, may have made it more difficult for her to share what had happened. Furthermore, the client-participant may not have disclosed the sexual abuse to her mother because she may have lacked education about sexuality, as research has shown that women of diverse ethnic backgrounds are less likely to disclose sexual abuse to their parents if as children they did not have conversations with their parents about sexual development and intimacy in an open and positive manner (Smith & Cook, 2008).

Moreover, the client-participant's discussion of trauma appeared to be a fluid rather than static process whereby she briefly shared that she had experienced sexual abuse as a child during a few initial sessions prior to delving a little more deeply into certain aspects of the trauma with

the therapist-participant (Alaggia, 2005). This progression in how the client-participant discussed

her experience of CSA could have also been influenced by the fact that the client-participant did

not explicitly identify the discussion and processing of trauma as one of her treatment goals.

Instead, this subject primarily surfaced when the client-participant was asked to endorse items

related to abuse on the intake forms and when the therapist-participant directly asked the client-

participant about this topic during initial therapy sessions. Although the subject of the client-

participant's CSA was not a direct treatment goal and a topic she felt comfortable discussing at

length or in more depth, she nonetheless appeared to benefit from the little talk that transpired

over the course of therapy. For example, keeping in line with research that suggests that trauma

disclosure can help facilitate insight, create personal meaning, and build a more resilient self-

esteem and identity (Pennebaker, 1997), the client-participant appeared to gain some benefit from

having another person present to listen and validate her feelings. For example, the discussion

may have increased her understanding into how children are not to blame for abuse, especially

when the therapist-participant talked to her about how sexual abuse is never the "victim's" fault.

The client-participant's discussion of traumatic material related to her experience of CSA

most likely was additionally influenced by whether she felt safe and comfortable with the

therapist-participant's therapeutic approach, as the ability to be both emotionally available and

clear with personal boundaries has been shown to enhance clients' sense of safety and ability to

discuss painful material, including trauma (Courtois et al., 2009; Lindbald, 2007; Kinsler et al.,

2009). Also, one study examining adult women's experiences of trauma disclosure found that

38% of participants reported that they felt ridiculed, encountered disbelief, and blame reactions

from their therapists, causing them to feel more distressed and less likely to disclose further

information (Frenken & Van-Stolk, 1990). Although the client-participant may have benefited

from the discussions of her CSA and reported a positive WAI, it is unclear how safe and

supported she felt by the therapist-participant and whether the therapist-participant's reactions of

abruptly changing the topic, smiling and laughing at inopportune times, as well as other behaviors that imposed ruptures, may have impeded her ability to share more about the CSA.

Over the course of treatment, the client-participant also discussed experiences of WPH she was dealing with almost on a daily basis at her place of employment. These discussions occurred with more frequency as compared to her discussions of CSA, as she often instigated these conversations on her own and appeared to provide more detail about how she reacted to her boss' harassment of her. Yet, just like her discussion of CSA, she did not seem to find resolution or particular relief about this subject, as she primarily focused on her anger towards her boss and appeared to leave sessions increasingly distressed. This was especially evident during the one session where she played a voicemail from her boss while the therapist-participant listened for a few moments and then soon after ended the session because the time had expired.

The client-participant's description of her work situation is consistent with literature on WPH, as her experience involved repeated and persistent hostility, disrespectful language, and aggression over an extended period of time, which in turn undermined her confidence in her skills and competence as an employee (Duffy, 2009; Keashly & Harvey, 2005). Additionally, given that workplace harassment can impact African American's relationships outside of the workplace (e.g., instigates conflict with significant others about finances and concern over having enough money to cover bills; Hauenstein & Harburg, 1977 as cited in Mays, 1995), it is not surprising that the client-participant also discussed material related to having frequent arguments with her boyfriend about finances and worry about paying her expenses. These discussions were also best represented within the theme of job satisfaction as it encompassed the client-participant's disengagement from her job, sense of feeling trapped, hatred and frustration with her job responsibilities, and strong desire to leave her job in order to fulfill her dream of having a fruitful career in the entertainment industry.

Rupture and Repair

This section addresses this study's three research questions. The first research question

was: Do ruptures, as defined by Safran and Muran (1996) and a rupture coding system developed

by the researcher, including select items from the ICB (Friedman & Gelso, 2000), occur during

discussion? Thirty-three ruptures occurred during five out of the six therapy sessions (i.e.,

sessions 1, 6, 7, 9, and 12) that included a discussion of trauma. Regarding the ruptures that were

found, nine rupture codes (seven WRs; two CRs) were specifically apart of Safran and Muran's

model, and 14 ruptures codes (seven DT1s and seven MB1s) were particular to the ICB measure.

A study conducted by Sommerfeld et al., (2008) also found a sizeable amount of ruptures

occurring in sessions when they examined the relationship between ruptures, the working

alliance, clients' CCRTs, and their evaluations of sessions. Specifically, of the 151 sessions that

were transcribed and analyzed across five different clients, CRs appeared in 104 sessions and

WRs in 75 sessions; and in 63 sessions, both confrontational and withdrawal ruptures were found.

Similarly, a study investigating therapists' reactions to clients' real life traumatic stories also

found that therapists on the whole responded with more negative countertransference, as

measured by the ICB, specifically to the story that involved the description of rape, as compared

to the one that detailed the sudden death of a person (Goldfeld et al., 2005).

The ruptures that appeared with the most frequency across the sessions included the

therapist-participant imposing too much structure (DT1 occurring 7 times), not providing enough

validation (MB3 occurring 5 times), and being critical of the client-participant (MB1 occurring 8

times), and the client-participant withdrawing from certain interactions (WR occurring 7 times).

Although there is lack of research specifically addressing ruptures characterized by the therapist

imposing too much structure in sessions, there is research suggesting that too much structure in

sessions can negatively influence the quality of the therapeutic relationship. For example,

according to Young and Beck's (1980) CBT treatment manual for depression, a competent CBT

therapist should impose structure when necessary to establish a consistent therapeutic frame while

also leaving room for the client's feedback, including any negative reactions and difficulties

regarding the session's structure (e.g., therapeutic formulations, interventions, assigned

homework). Another commentary paper particular to the field of family therapy suggests

"tipping the balance in the direction of too much structure can lead to a stilted session, where the

therapist imposes his or her direction on the family at the expense of the therapeutic relationship"

(Rhodes, 2008, p. 35). Also, there is ample literature supporting this study's findings that

ruptures can be visible when clients withdraw from therapeutic interactions and when therapists

are critical and invalidating of clients' experiences (Eaton et al., 1993; Pinkerton, 2008).

Despite the large amount of ruptures identified, not all of the rupture codes transpired

over the course of the trauma discussion sessions. For example, none of the following ruptures

were noted: DT (specific to the Safran and Muran model), DT2 (specific to the researcher's

coding system), DT4 (ICB item), and MB2 (ICB item). This finding is not surprising given that

these ruptures codes in particular were difficult to operationally define, and for this reason may

not have been as easily or reliably identified throughout the various sessions. Case in point, the

rupture code of DT was meant to capture any disagreements that may have occurred between the

therapist-participant and client-participant regarding the tasks of therapy that did not fall within

the specific different disagreement on tasks rupture codes of DT1, DT2, DT3, DT4, and DT5. It

is possible that this DT code was not identified because other codes were inclusive of potential

ruptures in this case study (e.g., confrontational ruptures where the client reveals her

dissatisfaction with the therapist or some aspect of the therapy).

DT2 (i.e., therapist providing too little structure) was also difficult to identify. After this

code was initially identified by some of the researchers as referring to the whole session and

patterns across sessions, discussion among the researchers and auditor determined that the

researcher's coding system was designed to code more discrete meaning units rather than larger

patterns of interactions. Furthermore, although the therapist-participant displayed a low structure

pattern of ending sessions late, the researcher was not able to tell from the videotaped data when

the session was supposed to actually start and end, and often did not see how the session actually

ended, as the therapist-participant and client-participant often walked out the door as they

discussed the ending of the session. Therefore, because it was difficult to capture whether a DT2

rupture occurred within this context, DT2 was not coded. And although DT4 was meant to

capture all instances of the therapist talking too much, given this code's similarity to the therapist

providing too much structure (DT1), it is likely that it was already included in that code and

therefore, did not need to stand on its own.

 In a like manner, MB2 may have not been coded since it was difficult to determine

moments in which the therapist-participant behaved as if she was "somewhere else" without

having to impose too many assumptions or inferences about her behaviors. However, with that

said, this code may not have been identified because the therapist-participant appeared for the

most part to be attentive in sessions, as she did not inappropriately engage in overt behaviors such

as checking the clock, yawning a lot, or making infrequent eye contact.

 Ruptures occurred at a disproportionate amount in comparison to repairs, reflecting a

pattern where the bulk of ruptures were left unresolved. Although little research is available on

the comparison between the occurrence of ruptures versus repairs, one study investigating

alliance ruptures and symptom change in a nonrandomized trial of cognitive therapy for people

diagnosed with Avoidant and Obsessive-Compulsive Personality Disorders reported that just over

half (i.e., 56%) of the participants experienced resolution as part of the rupture-repair process

resulting in significant symptom reduction, while 27% did not (Strauss et al., 2006). The finding

that the majority of ruptures identified were repaired is in direct contrast to this study's finding

that the majority of ruptures were in fact not resolved.

 This study's finding may be the result of many different factors, including difficulties

studying the process by which ruptures are identified and repaired given the complexities

surrounding logistical and methodological issues. For example, it appears that in order to gather

the most detailed and accurate information related to this process, the researcher has to take into

account a variety of different variables (e.g., verbal and nonverbal communication, ratings of

ruptures and repairs, the working alliance, cultural factors), which simultaneously influence the

interaction between the client and therapist. It is possible that during the rupture and repair

exchanges where the risk for relationship dissolution and rejection is possibly increased, the

client-participant may have shifted (e.g., toned down her mannerisms, avoided controversial

topics) her behavior in order to avoid the conflict as well as displeasing the therapist-participant,

and risking rejection (Jones & Shorter-Gooden, 2003). And given that shifting often occurs

subtly, if the therapist-participant was unaware of the client-participant's possible shift in

behavior, she may have not identified these moments as potential entry points into discussions of

rupture and repair. Few researchers or clinicians may embark on such a time-and labor-intensive

process.

The client-participant's experience of and responses to the ruptures may have also been

impacted by the themes of self-protection (subthemes of avoidance of emotion and distancing

from others), power and control (subtheme of assertiveness), sense of self (subtheme of

insecurity), and emotional difficulties (subtheme of difficulty identifying and expressing emotion)

that were identified through her course of treatment. For instance, the subtheme of avoidance of

emotion, under the larger theme of self-protection, potentially impacted the client-participant's

ability to directly share how she felt about the ruptures, and so instead of directing addressing

what would transpire during those interactions, she may have felt more comfortable sharing her

reaction nonverbally and then changing the topic to avoid experiencing any further negative

affect. The method used to review the themes and their possible relationship to the ruptures that

occurred across the sessions was based on the researcher's assumptions that some of the above

mentioned themes were potentially directly relevant to the client's experience and reactions to

some of the ruptures across the sessions. Therefore, this method did not entail going back to the

sessions themselves and identifying where particular subthemes/themes occurred directly within

the context of ruptures.

Another may be related to the fact that many of the studies investigating the rupture and

repair process reference working alliance ratings as the only way to examine whether any

fluctuations in the therapeutic relationship occur (Safran & Muran, 1996; Strauss et al., 2006). Although the WAI measures that were available in this study all reflected positive ratings of the alliance, had these measures been given with more frequency as noted by the clinic's policy, the therapist-participant may have seen more fluctuations occur in the ratings. Furthermore, had the therapist-participant directly referenced the WAI measures in sessions, specifically using it to discuss the relationship with the client-participant, the therapist-participant may have been able to more accurately identify and repair ruptures. The therapist-participant's use of the WAI measures may have also been influenced by factors related to her training experiences (e.g., not being adequately trained on how to use such a measure in session with clients), experience level (Mallinckrodt & Nelson, 1991), and familiarity with literature examining the processes of rupture and repair (Safran, 2002; Safran & Muran, 1996).

The second research question was: How does a therapist-in-training attempt to repair ruptures (according to Safran and Muran's four-stage model of repair), and in particular when the client is discussing material related to his/her interpersonal trauma experience(s)? The following three repair codes identified across the sessions containing a trauma discussion were: validating the client-participant's assertiveness (4T) in session 1, the therapist-participant taking responsibility (2TR) for a rupture, and focusing on the client-participant's immediate experience using metacommunication and self-disclosure (1TM) in session 12.

The first repair code (4T) occurred during the first session within the context of the client-participant saying that she thought the therapist-participant would become "mad" at her if she continued to discuss her thoughts and feelings regarding her job situation, specifically expressing, "because I think I talk about it too much." Although the therapist-participant did not directly identify this as a rupture or explore what the client-participant meant when she expressed that she feared the therapist-participant would get "mad" at her, she did validate the client-participant's ability to be assertive by letting her know that she did not have to censor herself but instead could express herself freely. This validation of the client-participant's assertiveness was

well received by the client-participant, as she smiled and then continued to discuss the topic of

WPH. The client-participant's positive response to the therapist-participant's repair attempt is

consistent with research suggesting that solving ruptures creates more trust and strengthens the

bond between clients and therapists (Ellman, 2007), and also demonstrates warmth and empathy,

further aiding clients in feeling safe enough to continue exploring traumatic material (Lepore et

al., 2004).

The other two repair codes (2TR and 1TM) both took place during session 12 when the

client-participant shared her experience of secretly uncovering her boyfriend's ex's email

password. Understanding that the client-participant was reacting negatively to her laughing by

hearing the client-participant say, "Ok quit laughing," the therapist-participant apologized and

actually changed her sentiment to reflect that it was a good thing that she had guessed the email

password, saying "I'm sorry. It's good that you guessed." Although most rupture-repair research

does not exclusively highlight the importance of apologizing to clients as part of the repair

process, one commentary paper in particular suggests that apologizing directly to clients is

actually required as part of the repair exchange, as apologizing communicates respect for the

client's feelings and a willingness on the part of the therapist to accept culpability (Pinkerton,

2008). Likewise, research shows that countertransferential reactions (e.g., laughing), if not made

conscious and used to inform treatment, can instead pose barriers to the therapist's ability to

identify ruptures as well as display openness, warmth, and respect (Eaton et al., 1993).

The last repair attempt (1TM) occurred a few moments later within the same context of

discussion but more specifically when the therapist-participant informed the client-participant that

her behavior of breaking into the email account was illegal. Sensing again that she may have

made the client-participant uncomfortable with this bit of information, she reassured the client-

participant that she would not report her to authorities for breaking into the email account,

expressing, "I can't do that. Don't worry I'm not reporting you." Although there is limited

research on ruptures specifically related to legal/ethical issues, including the issue of mandated

reporting of safety concerns regarding the client's behavior, there is a body of literature

examining the relationship between mandating reporting and its impact on the therapeutic alliance

(Steinberg, Levine, & Doueck, 1997). For example, one study found that when therapists had to

make reports against their own clients rather than third parties, the quality of the relationship

deteriorated (Watson & Levine, 1989). In contrast, another study investigating the experiences of

clinicians who had reported incidents of child abuse directed towards their own clients indicated

that in over 72% of the cases, making the report did not appear to negatively impact the

therapeutic relationship and in some cases, served to strengthen the bond between the therapist

and client (Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller, 2000). Thus, the therapist-

participant may have wanted to repair this rupture, as she sensed that a statement about reporting

could potentially weaken the strength of the therapeutic alliance.

　　　　Although the therapist-participant attempted to repair ruptures on these three occasions,

including taking responsibility during one particular instance by saying she was "sorry," she did

not appear to repair ruptures as outlined by Safran and Muran's model. Repair codes were found

in isolation from each other, and from a variety of stages/levels; most other repair codes were not

found: 2CC, 2CD, 2TM, 2TE, 3Ca, 3TS, 3TD, 3Cb or 4C. As such, she did not follow a stage

approach where she initially directly identified the rupture marker (e.g., I noticed that you

changed position when I said X") and then progressed through various stages of exploring the

rupture experience and any avoidance that surfaced on the part of the client to discuss the rupture

experience. Instead, she appeared to, without a specific plan in mind, inadvertently note the

occurrence of some ruptures by either laughing or moving onto another topic, or deliberately

apologizing or taking back what she said, in hopes that the client-participant did not feel offended

or thwarted in her sharing and exploring of material. The therapist-participant's approach to

repairs may have been influenced by a lack of training in how to identify, openly acknowledge,

and then repair ruptures. In addition, it also may have inadvertently sent the message to her that

making mistakes with clients is not acceptable.

In addition, although the therapist-participant attempted to facilitate the client-participant's assertiveness, the client-participant herself did not appear to spontaneously express a wish or need (e.g., I think I need X") concerning the therapeutic relationship. Instead, her focus remained mostly on her other outside relationships rather than the one she had with the therapist-participant. The therapist-participant also tended to focus more on the client-participant's experience of other relationships rather than explore how the rupture and repair process affected the therapeutic relationship. Nor did she discuss any of the content of the client's assessment measures, including the ratings obtained on the WAI. This tendency for the therapist-participant to avoid directly addressing therapeutic relationship or use the WAI as a tool to gather information related to the client-participant's perspective on the alliance is explained by various factors.

First, the therapist-participant may not have known how to effectively treat the client-participant's presenting problems and diagnosis, which in turn made it more difficult for her to know how to evaluate the therapeutic alliance. For example, if the therapist-participant was not equipped to manage the client's complex reactions particularly as it related to her abuse history, including her strong feelings of anger and distrust in relationships, she may have not known how to address how those dynamics may have, if at all, played out in the therapeutic relationship (Courtois, 2008; Dalenberg, 2004). Second, given that some research has shown that therapists with more secure attachment styles are more competent in establishing therapeutic alliances (Dunkle and Friedlander, 1996), it is possible that the therapist-participant's own attachment style may have influenced the way she interacted with the client-participant, including how comfortable she felt addressing the dynamics within their specific relationship. Third, although there is mixed research regarding the relationship between a therapist's level of experience and the quality of the therapeutic alliance, it is possible that this therapist-participant who was in her early stages of training lacked some of the skills necessary to facilitate direct discussions about ruptures and their potential impact on the alliance (Mallinckrodt & Nelson, 1991).

However, the reasons behind why Safran and Muran's model of repair was not followed during this client-participant's treatment may be due to other factors more specific to the design of the model. For example, since the discussion of interpersonal trauma is often a dynamic rather than static process that involves varying stages and cycles (Alaggia, 2005; Lindbald, 2007), the immediate focus on identifying ruptures and then repairing them through four stages, may not have been the best fit in this particular case. More specifically, the therapist-participant may have sense that the client-participant was not yet ready to engage in discussions surrounding feelings and interpersonal intimacy, especially given her past and current experiences of being assaulted and blamed in interpersonal interactions (Pino & Meier, 1999). Similarly, the therapist-participant may not have felt comfortable herself with the exploration and self-disclosure that is required in the repairing of ruptures according to Safran and Muran's model. In particular, the therapist-participant may not have been able to discern the types of self-disclosure that are most suitable to therapy and necessary to the repairing of ruptures (Dalenberg, 2000; 2004; Romano et al., 2008).

The third research question was: Additionally, how are the client's and therapist's therapeutic alliance ratings impacted? More specifically, do the client's and therapist's ratings of the alliance strengthen upon a successful repair exchange and conversely, do they weaken without its resolution?

Despite the researcher's initial hope of finding an association between the rupture and repair process and the WAI measures, this analysis could not completed given the lack of WAI data. Specifically, not all of WAI measures were administered according to the clinic's protocol (i.e., at the start of every 5th session) and not all therapy sessions were recorded and made available. Therefore, the researcher was incapable of examining whether any of the ruptures and repairs that occurred within trauma discussion sessions has a temporal relationship to the client-participant's rating of the therapeutic alliance on the WAI-C and the therapist-participant's rating

on the WAI-T. The only WAI measures made available were two WAI-C measures, specifically

for sessions 7 and 14, and one WAI-T measure for session 7.

Despite this lack of data, the researcher explored the existing data. WAI measures for

both the client-participant and the therapist-participant that were available for analysis all

represented a strong working alliance, with all of the ratings falling into a range that represented

the strongest alliance. These WAI findings are partially consistent with research on the topic of

therapeutic alliance. First, scores obtained on the WAI are often high, particularly for clients'

rating of the alliance (Kramer, de Roten, Beretta, Michel, & Despland, 2008). As such, they may

not always represent the most accurate rating or capture any fluctuations that may occur between

the times when measures are completed. Second, there are times when client's and therapist's

ratings of the working alliance differ (Hanson, Curry, & Bandalos, 2002; Hatcher & Barends,

1996), but in this study, they appeared to be quite similar. The finding that the WAI ratings were

similar could be due to the alliance indeed being viewed as positive by both parties, and/or

because not all of the alliance ratings were captured (fluctuations may have occurred given the

infrequent administration of the WAI measures).

WAI findings appeared to be consistent with other data in this case study. First, the

therapist-participant's indicated on the treatment summary form that she and the client-participant

had "established a good, trusting relationship and the client responded well to [her] approach."

She also noted that treatment came to a close when the client-participant informed her that she

"was not interested in transferring to another therapist," which may or may not have been due to

the quality of their relationship. Third, in spite of the many ruptures that took place in the various

sessions, including the majority that were not repaired, the researcher observed that the client-

participant's general emotional disposition and interactions with the therapist-participant

appeared to represent a fairly positive therapeutic alliance. Specifically, the client-participant's

approach to therapy seemed to signify openness and an interest in sharing her strengths and

weaknesses, learning how to improve her communication difficulties, and take in the therapist-

participant's feedback, particularly in relation to her WPH experiences and relationship to her

boyfriend and his ex.

There may have been other common factors at play within the treatment that accounted

for the client-participant's overall positive response to the therapist-participant and treatment

process. For example, the client-participant's expectations of therapeutic success, including her

ability to confront or face her presenting issues and the experience of gaining some control or

mastery over her problems could have facilitated her openness to feedback and willingness to

display vulnerability in the sessions (Wampold, 2001; Weinberger, 1995). Nonetheless, given

that these were mainly observations based on the limited data that was available, it is difficult to

determine how strong the therapeutic relationship was from both the client-participant and

therapist-participant's perspectives and how much it may have fluctuated over the course of

therapy and in between sessions.

Methodological Limitations

Several limitations exist when using a case study approach. First, one of the most

common limitations noted in the quantitative literature relates to generalizability. That is, the

findings of a case study cannot be generalized to the general population due to the nature of the

data analysis procedures and sample size of only one participant (Yin, 2003).   However, Yin

(2003) also points out that a qualitative researcher intends to make an analytic generalization

where the results of the case study are generalized to a particular theory rather than a population.

In a similar fashion, from a qualitative standpoint, external validity is parallel to transferability,

which is the idea that it is the researcher's responsibility to gather all of the necessary data and

provide a rich description of it so that the reader can decide if it can be applied to other people

and circumstances (Merrick, 1999). To account for the transferability of this study, the researcher

gathered detailed information related to the case and its findings so that the reader, including

other researchers, could gain a detailed description and understanding of this particular client-

participant's experience in therapy in order to decide whether it could be applicable to other clients and situations.

Second, people who have been critical of case study methods point out that investigators conducting this type of research often fail to create "a sufficiently operational set of measures and that 'subjective' judgments are used to collect the data" (Yin, 2003, p. 35). According to a qualitative viewpoint, objectivity can be achieved when researchers carefully examine their data, findings and interpretations and base them on accurate literature reviews (Merrick, 1999). To combat this limitation, the researcher carefully reviewed the literature pertaining to the various aspects of this research topic and examined whether they were any consistencies and inconsistencies found between this research study and past research.

Others comment that case study research is vulnerable to internal validity threats (Yin, 2003). For example, investigators need to be mindful of not stating causal relationships when there are other factors that contribute to the outcome and misleading consumers by passing off inferences as fact (Yin, 2003). Internal validity in qualitative research is defined as credibility (Merrick, 1999). Researchers use the following techniques to ensure that their findings are credible and will generate worthwhile interpretations:

- *Prolonged engagement* with the research material (the researcher immersed herself in the data for many months and discussed the various aspects of this case, including processes used for defining coding procedures, on multiple occasions with her coding team and the auditor to ensure proper and prolonged engagement with the material).

- *Triangulation,* which means that the researcher checks the accuracy of the data by using multiple sources (the researcher gathered information from multiple sources to accurately inform data collection, such as clinic documentation, including clinic measures, and observations through audiovisual material).

- *Peer debriefing*, which includes discussing the results of the study with peers (meetings with the research team also included discussions regarding the findings of this study to ensure findings were being interpreted accurately, with all viewpoints considered).

- *Negative case analysis*, which involves editing hypotheses when findings emerge that contradict original hypotheses (the researcher edited her hypotheses to account for contradictory findings; for example, the researcher openly explored how the definition of ruptures in this study may not have fit the client-participant's experience in therapy).

- *Referential adequacy*, the task of setting aside certain data that can be compared to the findings following data analysis.

- *Member checking*, the process of checking the literature and with experts in the field to determine whether the constructs in the research are being defined adequately (Merrick, 1999).

In further enhance credibility, the researcher guided her study using procedures suggested by Yin (2003). These procedures included (a) initially determining the appropriateness of a case study approach for the stated research problem of examining the rupture and repair process within the context of trauma discussion, (b) employing purposeful sampling to identify a client that best fit the inclusion/exclusion criteria, (c) using an embedded analysis approach to provide a rich detailed description of the case, including information related to how therapy sessions progressed as well as behavioral observations of specific interactions occurring within the sessions between the therapist-participant and client-participant, (d) analyzing the case using themes and subthemes to further capture the richness of the case, and (e) understanding the meaning of the case by comparing its findings to the rupture and repair model and other relevant literature on the topic of inquiry.

Yin (2003) also indicates that "in the past, case study research procedures have been poorly documented, making external reviewers suspicious of the reliability of the case study" (p. 38). Therefore, investigators need to take necessary steps to reduce error and make know their biases. For instance, the researcher tried to be mindful of her reactions and of not imposing her values and beliefs onto the client-participant and therapist-participant, as well as refraining from being overly judgmental or critical of the therapist-participant when she was unable to successfully identify and/or repair a rupture(s). Additionally, the cultural context of the coders and auditor may have also introduced bias into the study, as the coders and auditor were of a different race, ethnicity, and socioeconomic status as the client-participant (and possibly the therapist-participant) and were not experts in working with African American traumatized women, including the client-participant's specific culture. In order to address this bias, the researcher openly shared her own cultural context, including providing relevant information related to her own race, ethnicity, age, gender, and socioeconomic status, and compared the research findings from this study to pertinent research on African American women as it related to specific areas of the current study.

In addition, qualitative researchers strive to have their data be dependable so that readers can understand all of the procedures involved and potentially replicate findings (Merrick, 1999). To address the issue of replication and transparency, a training and coding manual (Appendix R) was developed to document all of the steps taken throughout the study, including the procedures used for training research assistants to transcribe the videotaped therapy sessions and code for discussions of trauma, training research team members to code ruptures and repair, and the process by which the research team coded themes and sub-themes. Tables were also created in order to track rupture and repair findings, the occurrences of trauma discussions, and the themes and sub-themes that transpired over the course of treatment.

In terms of this present study, it contained the following limitations. First, the use of an archival database did not allow the researcher to gather additional information and check in with

the participants. As such the researcher was not able to study other relevant variables, such as

therapists' perspectives on countertransference behaviors and how they possibly impacted

therapeutic ruptures and the repair process. Additionally, the researcher's method of making

associations between the client-participant's themes/subthemes, and her experience and reaction

to ruptures potentially introduced bias into the study as she did not directly analyze the

themes/subthemes occurring during specific discussions of ruptures.

Second, the instruments obtained from the database had their limitations. For example,

as previously mentioned, as was the case in this study, scores obtained on the WAI are often high,

especially for clients' rating of the alliance (Kramer et al., 2008), do not always converge

between client and therapist ratings (Baldwin, Wampold, & Imel, 2007; Hersoug, Hoglend,

Monsen, & Havik, 2001), and may vary based on therapist experience level (Hersoug et al.,

2001).

Furthermore, the case in this study itself reflected particular limitations. For example,

although the therapist-participant noted using a psychodynamically oriented approach to therapy,

she did not appear to consistently conduct therapy from a particular theoretical orientation. For

example, she did not appear to establish a consistent therapeutic frame, including the

identification of any particular treatment goals in collaboration with the client-participant. It is

also not known whether the therapist-participant was knowledgeable about the rupture and repair

model. Thus, this lack of overall therapeutic structure and consistency made it somewhat difficult

for the researcher to make meaningful comparisons between the case and the rupture and repair

process. Although, the researcher tried her best to make relevant associations between the case,

themes, and the rupture and repair process, it is not surprising that the model did not fit the case.

In a like manner, despite the client-participant's experience and discussion of

interpersonal trauma, the therapist-participant did not appear to engage the client-participant in a

specific trauma-focused discussion, specifically related to her experience of WPH, where she

helped her identify those events as specifically traumatic and potentially related to her initial

experience of interpersonal trauma of CSA, nor did she use a trauma-focused theoretical

approach. For this reason, the researcher does not know whether there would have been a

different outcome of therapy had the therapist-participant used more trauma specific treatment

interventions.

Additionally, although the researcher focused on viewing the client-participant using a

balanced positive psychological lens where both strengths and challenges were highlighted, she

did not use a strength based positive psychology approach, or a rupture and repair approach when

creating themes, subthemes, and analyzing other aspects of the client-participant's course of

treatment, including the trauma discussions. As such, this method potentially limited the

researcher's ability to fully explore and identify all of the strengths, positive qualities, and

resilience this client-participant expressed during her course of treatment, as well as other

qualitative ways of assessing rupture and repair.

Moreover, the temporal relationship between ruptures and repair and the therapeutic

alliance ratings was not synchronized since WAI measures were not given consistently according

the clinic's protocol (i.e., every 5th session), resulting in the client-participant only completing

two alliance measures and therapist-participant only completing one over the entire course of

treatment. In addition, the researcher was not able to find any associations between ruptures and

repairs and the client's rating of the therapeutic alliance from the videotaped psychotherapy

sessions, as the therapist did not appear to explicitly invite the client to discuss whether the

rupture and repair process affected the quality of the therapeutic alliance. On the clinic created

treatment summary form, there was also no mention of whether ruptures and repairs had occurred

and if those events impacted the therapeutic alliance and/or related to the client-participant's

reason for termination.

Furthermore, while Safran and Muran's (1996; 2000) rupture and repair model is meant

to facilitate an open dialogue between clients and therapists and encourage clients to express their

needs interpersonally, both within and outside of the therapeutic relationship, it also has several

limitations that are particular to the context of this study. Specifically, the generalizability and applicability of this model to adult trauma survivors is limited, as the research informing it does not extend to individuals with interpersonal trauma histories or extend its definition of ruptures to include specific verbal (e.g., "why didn't you call the police first?") and nonverbal behaviors (e.g., laughing) that are more particular to the context of working with traumatized clients.

In a similar vein, the samples used to research this model were not representative of more racially/ethnically/culturally diverse populations, including African American women. For this reason, it is unclear whether a model such as this one that asks therapists to actively engage clients in discussions about expressing vulnerable feelings, interpersonal intimacy, and metacommunication, would also work with traumatized African American female clients, including the client-participant in this research study. Additionally, since information related to the therapist-participant's cultural background was unknown to the researcher, she could not use this information to further enrich the findings of this study. More specifically, the possible interaction between the client-participant and therapist-participant's cultural identities (e.g., ethnicity, gender, religious affiliation, and sexual orientation) as it related to the rupture and repair process, including formation of the therapeutic alliance, could not be examined as has been explored in past research (Casa, Vasquez, & Ruiz de Esparza, 2002; Marmar et al., 1989).

Implications of the Current Study

This study proposed to contribute to the discourse on the discussion of interpersonal trauma, therapeutic ruptures and repairs, and their impact on the therapeutic alliance within psychotherapy from a positive psychology perspective. The coding system developed in this study provided a way to identify and explain the rupture-repair process in this context. It expanded Safran and Muran's (1996; 2000) definition of ruptures to capture other manifestations of ruptures that were more specific to the therapist's behaviors (e.g., ICB items, including the therapist providing too much structure and therapist being critical of the client, and other behaviors, such as therapist not providing validation of the client), rather than just the client's (in

the form of CRs or WRs), giving the reader a richer understanding of what particular therapist

behaviors can trigger the onset of ruptures. Given that these additional items were frequently

coded in the present study, others researching the topic of ruptures and repair should consider

adding countertransference variables as another way to operationally define ruptures.

Also, in order to make Safran and Muran's (1996; 2000) definition of CRs and WRs

clearer, this study also provided specific examples of both verbal and nonverbal forms of

communication (e.g., "I am so mad at you right now," posture changes, deep sighs) that could

signify CRs and WRs. It was particularly helpful to operationally define WRs using specific

examples because this form of communication can often be subtler, and therefore, somewhat

more difficult to capture, as compared to verbal communication. For example, subtle shifts in eye

movement or posture may not be as easily identified unless the researcher is purposefully attuned

to these types of changes. Given that nonverbal forms of communication can at times be more

difficult to reliably capture, researchers studying ruptures within this context should consider also

using a standardized assessment tool such as the Emotional Facial Action Coding System

(EMFACS; Friesen & Ekman, 1984), which is designed to code emotional facial actions through

viewing video-tapes or live viewing of human interactions, to circumvent this problem.

Given that the findings of this study demonstrated that ruptures do occur specifically

within the context of trauma discussion sessions, and occurred more frequently than repairs, it is

important that therapists understand how to identify ruptures occurring in this context. For

instance, therapists should be mindful of how an immediate focus on topics related to the

reporting of abuse rather than building trust and safety can lead to ruptures. Also their nonverbal

behaviors, including facial expressions of dismay or surprise, can trigger ruptures and may

contribute to traumatized clients' existing fears of blame regarding the trauma experience.

Additionally, based on findings from this study that the therapist-participant did not

directly identify and discuss the experience of ruptures and repair, with the exception of an

apology that occurred in session 12, it is hoped that therapists will be more comfortable admitting

to their own mistakes and biases as well as being more open, willing, and able to repair ruptures in the therapeutic alliance, and more specifically, with clients presenting with interpersonal trauma histories. For example, when working with individuals who have had traumatic experiences, therapists are encouraged to reflect on such factors in order to better facilitate relationship connection, prevent further disappointment related to conflict, and avoid retraumatization. Furthermore, when repairing ruptures with clients who have been traumatized, it is important that the therapists take responsibility for the rupture and initially maintain focus on him or herself when discussing the experience of the rupture in order to avoid inadvertently holding the client responsible for the interaction. For example, instead of saying, "I noticed you changed position when I said X," it would be more effective to say, "I may have said something that bothered you, so I am sorry for that" as a way to open up a dialogue about any possible ruptures unfolding in the relationship.

Moreover, given that the therapist-participant in this study may not have known or been adequately trained on how to identify and repair ruptures, this study reflects the need for training programs to provide students with psycho-education, supervision, and hands on training on the topic of ruptures and repair (e.g., role playing ruptures and repairs with other students and/or the supervisor; reviewing psychotherapy sessions where ruptures and repairs occur) in order to help students become more aware of how to address and repair any possible ruptures that occur in the therapeutic alliance, particularly with clients who have a trauma background.

Similarly, given that past literature identifies the importance of using WAI ratings to inform identification of possible fluctuations occurring within the therapeutic alliance (Horvath & Greenberg, 1989), it is suggested that clinical graduate programs also include education related to the specific use of WAI measures in therapy sessions. Specifically, it is recommended that training programs not only teach students on how to administer such measures, but also provide them with detailed education on how they can also use these measures in sessions to better inform treatment (e.g., treatment goals and planning) and to open up discussions regarding any possible

ruptures and repairs occurring with clients. For example, seminars regarding the topic of ruptures and repairs should be a part of the curriculum to further enhance knowledge and comfort with this subject matter.

Furthermore, since the therapist-participant in this study may not have known how to utilize her countertransference to better inform the rupture and repair process (Dalenberg, 2000), training approaches would also likely benefit from including an intensive focus on promoting therapist self-care and self-acceptance, as this latter variable has been shown to play a vital role in allowing therapists to use their countertransference experiences as sources of significant information rather than acting them out in a negative manner (Gelso & Hayes, 2001; Hayes, Gelso, & Hummel, 2011; Safran & Muran, 2000). Although it is unknown whether self-care and self-acceptance were a part of the therapist-participant's training, the idea of self-acceptance appeared to relate somewhat to her experiences. For instance, the therapist-participant appeared to struggle with her professional demeanor in sessions, as she would often laugh when she was uncomfortable. This behavior was captured under the rupture code of MB3 during session 12 (i.e., therapist not providing validation) and may have represented some of her insecurities regarding her work as a therapist. Had she been more comfortable with her skill set and approach, hence, more accepting of her strengths and weaknesses, she may have been able to use her negative countertransference in ways that may have enhanced treatment rather than hindered it. Thus, this study's inclusion of countertransference variables through the coding system developed by the researcher, which includes pertinent ICB findings, lends support to including countertransference variables in a future rupture and repair model.

Although not a part of the present study, it is also suggested that positive countertransference (e.g., wanting to be the client's friend) be included in a model of rupture and repair given that this type of countertransference can also have harmful effects on the therapeutic relationship (Freidman & Gelso, 2000), and contribute to the creation of ruptures. For example, if the therapist-participant likes the client so much that he/she has fantasies of wanting to be

friends with the client and always maintain a positive connection in therapy, then he/she is more

likely to avoid discussing difficult topics and being curious about any possible ruptures occurring

in the relationship.

Future Directions for Prospective Research

Future research would benefit from using another longitudinal methodological approach,

which would include the study of multiple clients from various populations. Such a study might

also allow for comparison between psychotherapy cases, including therapists' approaches to the

rupture and repair process as well as greater diversity by including people of other ethnicities, age

ranges, religions, and regional locations and who have experienced other types of trauma (e.g., a

natural disaster). Moreover, when conducting a study similar to the present one, researchers

should use data obtained from live current psychotherapy sessions as opposed to only relying on

an archival database where the gathering of additional data from participants is not possible. That

way, researchers can ensure measures are given to protocol and speak to the clients and therapists

in order to gather additional information needed to have a richer and more accurate understanding

of their experience of the rupture and repair process. Additionally, it would be worth exploring in

future studies whether the use of a purely strength based positive psychology approach to the

identification of themes, subthemes, and ruptures and repairs could facilitate a deeper exploration

and identification of clients' inherent strengths, positive qualities, and resilience.

Researchers should also continue to accurately assess clients' and therapists' working

alliance ratings at various stages of their treatment. More specifically, future research should

assess clients and therapists WAIs during the initial stages of therapy (e.g., at the 5th session;

Barber et al., 1999; Tyron & Kane, 1993; Horvath, 2000), as is suggested by research and was

intended by this study's clinic's protocol, and continue to assess the clients' and therapists' WAIs

after every 5th session thereafter. This would aid therapists in being mindful of clients'

perceptions of the alliance as treatment progressed as well as their own perceptions of the

alliance. Keeping track of the WAIs would also make it easier for therapists to note the

occurrence of any ruptures, specifically when WAI ratings appeared to significantly decline. The

accuracy of WAIs would also be helpful in increasing therapists' awareness of any possible

countertransferential reactions, particularly if they noticed themselves rating the alliance

significantly higher or lower in comparison to past measures. These WAIs could then be used in

sessions with clients to facilitate discussions about treatment goals, treatment planning, and the

quality of the therapeutic relationship, giving the therapist an opportunity to identify and repair

any ruptures that may have been overlooked in prior sessions.

Additionally, future studies should consider developing a rupture and repair model more

applicable to working with clients presenting with trauma backgrounds as this study revealed the

limitations of using a standard model. More specifically, taking into account trauma literature

that highlights the importance of creating a therapeutic environment characterized by warmth,

genuineness, and safety (Briere & Scott, 2006), researchers should survey clients about the types

of ruptures they have encountered in past treatments where they discussed their experiences of

interpersonal trauma. Using this information, researchers should then develop a rupture and

repair model that specifically addresses the needs of traumatized individuals within the context of

rupture and repair. For instance, ruptures should include examples pertaining to nonverbal means

of communication (e.g., facial expressions of shock), reporting issues (Steinberg, Levine, &

Doueck, 1997), and therapists' countertransference reactions (Dalenberg, 2000), and use a repair

approach that instructs the therapist to take responsibility for the interaction and maintains the

focus on the therapist rather than the client to ensure clients do not feel blamed or criticized.

Given that Safran and Muran's model of rupture and repair did not extend its research to

include diverse populations, future studies should also focus on gaining a better understanding of

how cultural factors either promote or hinder therapists and clients' abilities to engage in

successful repair exchanges (Constantine, 2007; Lopez, Prosser, Edwards, Magyar-Moe, Neufeld,

& Rasmussen, 2005), especially since research has shown that these factors play a role in the

formation of an working alliance (Horvath, 2000) and clients' comfort with discussing trauma

material (Alaggia, 2005). Specifically, it would be important to learn whether clients experienced

any barriers related to cultural factors (e.g., race/ethnicity, religious affiliation, sexual orientation)

in having meaningful repair interactions with their therapists or whether the interactions between

clients and therapists' similarities and differences in culture have an impact on the rupture and

repair process. In the current study, considering research and literature on cultural factors such as

race/ethnicity, gender, religious affiliation, and geographic location of the client-participant was

useful in being able to determine whether any patterns of trauma discussion were specific to the

client-participant's life experiences. Therefore, the consideration of cultural factors would also

enhance the creation of a rupture and repair model that is more culturally informed and applicable

to real life experiences of diverse clients.

It would also be interesting to see the creation of a rupture and repair model specific to

child trauma survivors, as the process of how ruptures are identified and then repaired is likely

different from how it unfolds with adults; an adult model of rupture and repair expects therapists

and clients to engage in verbal dialogues about the experience of the rupture(s) and its impact on

the relationship. In particular, it would be important to research the types of ruptures that can

commonly occur when working with traumatized children and their families, including how the

reporting of child abuse against offending-parents versus third parties affects the child's and

parents' perception of the alliance and willingness to continue in treatment (Steinberg et al.,

1997). Given that children do not always possess the cognitive and language abilities to verbally

express their experiences of ruptures, research should specifically learn whether ruptures can be

identified through other means of communication that do not require the client or therapist

pointing them out verbally. For example, it would be important to see whether ruptures occur

during the medium of play therapy and whether therapists can use this medium to work on

repairing ruptures with their younger clients. It is also suggested that future research investigate

how ruptures can be repaired with the parents/caregivers/families of traumatized children as they

serve as important figures in the child's life and treatment course/participation as well as outcome

(Cohen et al., 2006).

Lastly, given that deteriorations in the alliance have been associated with early

termination and/or poorer treatment outcomes (Horvath, 2000), it is suggested that future research

not only continue to study the relationship between the rupture and repair process and therapeutic

alliance, but also include a focus on the rupture and repair process and its possible association to

clients' posttraumatic symptoms and treatment outcome. For example, researching whether

successful repair exchanges relate to a decrease in posttraumatic symptoms and/or a more

positive treatment outcome would be a valuable contribution to the existing literature on trauma,

therapeutic alliance, and ruptures and repairs. This future research endeavor is also consistent

with the positive psychology framework that believes positive growth can follow difficult life

experiences, including traumatic ones (Joseph & Linley, 2008), aims to build upon the inherent

strengths and positive qualities of an individual, including his/her interpersonal skills in

relationships, and attempts to create balance in the existing literature by placing greater emphasis

on research related to positive outcomes rather than merely negative ones (Seligman, 2005;

Seligman & Csikszentmihalyi, 2000; Seligman et al., 2006).

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APPENDIX A

Client Consent Form

Pepperdine University

Counseling and Educational Clinics

Consent for Services

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

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

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

I understand and agree with the above three statements.

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

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

Psychological Assessment: The clinic provides psychological and psychoeducational assessments. These assessments may be initiated by you, your therapist or a third party. Assessment sessions are longer than therapy sessions and can take several hours to complete. The number of sessions required for conducting the assessment will be determined based on the nature and number of tests administered. You have the right to request a copy of your assessment report and test data. You also have the right to receive feedback regarding your assessment results. However, there are some situations in which we may not be able to release test results, including test data, to you: a) When such a disclosure may cause substantial harm or misuse of the test results and test data, and/or b) When you were notified and agreed in advance and in writing that the assessment was ordered and/or paid for by a third party and that we would release your

results only to that third party. The benefits of psychological assessment include a clearer understanding of your cognitive and emotional functioning. Although the risks of participating in a psychological assessment are generally no greater than the risks of counseling, test results may reveal information that may be painful and/or difficult to accept. If that is the case, we recommend that you review with the examiner options for addressing your concerns.

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

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

  _____ Video/audiotaping

  _____ Direct Observation

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

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

- I understand and agree that information from my services

will be included in the Research Database (check all that apply).

_____   Written Data

_____   Videotaped Data

_____   Audiotaped Data

OR

- I <u>do not</u> 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 <u>do not</u> wish to be contacted in the future about the opportunity to participate in other specific research

  programs.

<u>Fees</u>: 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.

<u>After Hours and Emergency Contact</u>: 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.

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

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

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

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

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

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

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

Treatment & Evaluation of Minors:

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

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

- All disclosures to parents or guardians will be discussed with minors, and efforts will be made to discuss such information in advance.

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

_____   and/or   _____

Signature of client, 18 or older   Signature of parent or guardian

(Or name of client, if a minor)

_____

Relationship to client

_____

Signature of parent or guardian

_____

Relationship to client

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

_____   _____

Clinic/Counseling Center   Translator

Representative/Witness

_____

Date of signing

APPENDIX B

Therapist Consent Form

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

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

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

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

My participation in the research database project can involve 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. Mesha Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this

research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.

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

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

_____ _____

Participant's signature   Date

_____

Participant's name (printed)

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

_____   _____

  Researcher/Assistant signature   Date

_____

  Researcher/Assistant name (printed)

APPENDIX C

Client Information Adult Form

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 _____

MARITAL STATUS:
☐ MARRIED   ☐ SINGLE   HOW LONG? _____

☐ DIVORCED   ☐ COHABITATING   PREVIOUS MARRIAGES? _____

☐ SEPARATED   ☐ WIDOWED   HOW LONG SINCE DIVORCE? _____

LIST BELOW THE PEOPLE LIVING WITH YOU:

NAME	RELATIONSHIP	AGE	OCCUPATION

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:
NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

CLIENT INFORMATION **ADULT FORM

ID# _____

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

_____

MEDICATIONS BEING TAKEN: _____

_____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

_____

_____

_____

OTHER SERIOUS ILLNESSES

DATE

_____

_____

_____

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHOLOGIST/PSYCHIATRIST, MARRIAGE COUNSELING, GROUP THERAPY, ETC.)

DATE

_____

_____

_____

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

☐ ELEMENTARY/MIDDLE SCHOOL: LIST GRADE _____

☐ HIGH SCHOOL: LIST GRADE _____

☐ GED

☐ HS DIPLOMA

☐ VOCATIONAL TRAINING: LIST TRADE _____

☐ COLLEGE: LIST YEARS _____

☐ GRADUATE EDUCATION: LIST YEARS OR DEGREE EARNED _____

☐ CURRENTLY IN SCHOOL? SCHOOL/LOCATION:

_____

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATES/DURATION

REVISION DATE 05/15/2006

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CLIENT INFORMATION **ADULT FORM

ID#_____

HOUSEHOLD INCOME:

☐ UNDER $10,000

☐ $11,000-30,000   OCCUPATION:_____

☐ $31,000-50,000

☐ $51,000-75,000

☐ OVER $75,000

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)

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

Sample

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

_____

Social/Cultural (Optional)

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

APPENDIX D

Intake Evaluation Summary

Pepperdine Community Counseling Center
Intake Evaluation Summary

Client: **Intake Therapist:**
Intake Date(s):   **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)

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

V.   <u>Mental Status Evaluation</u>

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

VII.   <u>Summary and Conceptualization</u>
(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):

Revised 12/2007

VIII. DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

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

IX. Client Goals

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

_____   _____
Therapist   Date   Supervisor   Date

Revised 12/2007

APPENDIX E

Phone Intake Form

ID#_____

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

Pepperdine Community Counseling Center
Telephone Intake Interview

Caller Information

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

WHAT IS YOUR NAME?:_____

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

_____ ☐ M ☐ F DOB:_____ AGE:____

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

WHAT IS (CLIENT'S) ADDRESS?: _____

_____

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

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

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

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

WHO DOES (CLIENT) LIVE WITH? ☐ SELF ☐ OTHERS -

LIST:_____

DOES (CLIENT) HAVE CHILDREN?: _____

_____

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

_____

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

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

Type of Service

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

☐ Therapy   ☐ Child   ☐ Individual

☐ Assessment   ☐ Adolescent   ☐ Couple (Ask if there has been any domestic violence)

☐ Don't know or unsure   ☐ Adult   ☐ Family

☐ Don't know or unsure   ☐ Group

☐ Don't know or unsure

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ID#_____

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

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

_____

_____

_____

_____

_____

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

    IF SO, LIST:_____

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

_____

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

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

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

    IS THERE DOCUMENTATION AVAILABLE (IN CUSTODY PAPERS ABOUT WHO IS RESPONSIBLE FOR HEALTH CARE) THAT YOU CAN

    BRING TO THE INTAKE SESSION? ☐ Y ☐ N

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

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

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

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY? ☐ Y ☐ N

Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL? ☐ Y ☐ N

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

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

        WHAT IS (CLIENT'S) OCCUPATION?:_____

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

Intake Interviewer Checklist

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

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

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

ID#_____

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?:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 TEMBER" OR THAT YOU GET MAD EASILY?: ☐ Y ☐ N
   IF SO, PLEASE PROVIDE EXAMPLES:_____
ANY PAST VIOLENCE TOWARDS OTHERS?: ☐ Y ☐ N _____

ID#_____

☐ I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT VIDEO (AND SOMETIMES AUDIO) TAPED SAMPLES OF THEIR SESSIONS DURING SUPERVISION.

☐ (PER CLINIC POLICY) I ASKED THE POTENTIAL CLIENT FOR PERMISSION TO HAVE THE INTAKE THERAPIST GIVE THEM A CALL PRIOR TO THE INTAKE SESSION

☐ I INFORMED THE POTENTIAL CLIENT THAT THE INTAKE SESSION IS 2.5 HOURS IN LENGTH AND THAT THIS SESSION HELPS THE THERAPIST AND HIS/HER SUPERVISOR GAIN A BETTER UNDERSTANDING OF THE POTENTIAL CLIENT'S PRESENTING PROBLEMS. GATHERING THE INFORMATION DURING THIS FIRST SESSION IS CRUCIAL FOR TREATMENT PLANNING. I ALSO INFORMED THE POTENTIAL CLIENT OF THE IMPORTANCE OF ARRIVING PROMPTLY FOR THE SESSION.

☐ I INFORMED THE POTENTIAL CLIENT THAT FOLLOWING THE INTAKE SESSION, THE THERAPIST WILL PROVIDE HIM/HER WITH FEEDBACK AND MAKE TREATMENT RECOMMENDATIONS WHICH MAY BE FOR CONTINUED TREATMENT IN OUR CLINIC OR MAY BE A REFERRAL TO ANOTHER CLINIC.

☐ I INFORMED THE CLIENT THAT THEIR PLACEMENT WITH A THERAPIST IS SOMEWHAT DEPENDENT ON THE POTENTIAL CLIENT'S TIME FLEXIBILITY.

☐ (PER CLINIC POLICY) I CREATED A CLIENT FILE AND PLACED THE TELEPHONE INTAKE INTERVIEW IN IT.

☐ (PER CLINIC POLICY) I PROVIDED THE CLINIC DIRECTOR WITH THE TELEPHONE INTAKE INTERVIEW.

☐ (PER CLINIC POLICY) I ASSIGNED THE POTENTIAL CLIENT TO A THERAPIST.
THERAPIST:_____

☐ I INFORMED THE POTENTIAL CLIENT ABOUT THE CLINIC LOCATION AND PARKING ARRANGEMENTS.

☐ I CONTACTED THE RFERRAL SOURCE AND THANKED THEM.

☐ (PER CLINIC POLICY) I SCHEDULED THE INTAKE SESSION.
DATE:_____
TIME:_____
THERAPIST:_____

sample

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APPENDIX F

URICA

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

	1	2	3	4	5
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 a recurrence 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

Rev 8/27/07

APPENDIX G

Working Alliance Inventory-Client Form

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

Rev 5/30/06

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:

Rev 5/30/06

APPENDIX H

Working Alliance Inventory-Therapist Form

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 I

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

ID# _____ M ☐ F ☐

Session # _____ Date ___ / ___ / ___

	Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
1. I get along well with others.	☐4	☐3	☐2	☐1	☐0			
2. I tire quickly.	☐0	☐1	☐2	☐3	☐4			
3. I feel no interest in things.	☐0	☐1	☐2	☐3	☐4			
4. I feel stressed at work/school.	☐0	☐1	☐2	☐3	☐4			
5. I blame myself for things.	☐0	☐1	☐2	☐3	☐4			
6. I feel irritated.	☐0	☐1	☐2	☐3	☐4			
7. I feel unhappy in my marriage/significant relationship.	☐0	☐1	☐2	☐3	☐4			
8. I have thoughts of ending my life.	☐0	☐1	☐2	☐3	☐4			
9. I feel weak.	☐0	☐1	☐2	☐3	☐4			
10. I feel fearful.	☐0	☐1	☐2	☐3	☐4			
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	☐0	☐1	☐2	☐3	☐4			
12. I find my work/school satisfying.	☐4	☐3	☐2	☐1	☐0			
13. I am a happy person.	☐4	☐3	☐2	☐1	☐0			
14. I work/study too much.	☐0	☐1	☐2	☐3	☐4			
15. I feel worthless.	☐0	☐1	☐2	☐3	☐4			
16. I am concerned about family troubles.	☐0	☐1	☐2	☐3	☐4			
17. I have an unfulfilling sex life.	☐0	☐1	☐2	☐3	☐4			
18. I feel lonely.	☐0	☐1	☐2	☐3	☐4			
19. I have frequent arguments.	☐0	☐1	☐2	☐3	☐4			
20. I feel loved and wanted.	☐4	☐3	☐2	☐1	☐0			
21. I enjoy my spare time.	☐4	☐3	☐2	☐1	☐0			
22. I have difficulty concentrating.	☐0	☐1	☐2	☐3	☐4			
23. I feel hopeless about the future.	☐0	☐1	☐2	☐3	☐4			
24. I like myself.	☐4	☐3	☐2	☐1	☐0			
25. Disturbing thoughts come into my mind that I cannot get rid of.	☐0	☐1	☐2	☐3	☐4			
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4			
27. I have an upset stomach.	☐0	☐1	☐2	☐3	☐4			
28. I am not working/studying as well as I used to.	☐0	☐1	☐2	☐3	☐4			
29. My heart pounds too much.	☐0	☐1	☐2	☐3	☐4			
30. I have trouble getting along with friends and close acquaintances.	☐0	☐1	☐2	☐3	☐4			
31. I am satisfied with my life.	☐4	☐3	☐2	☐1	☐0			
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4			
33. I feel that something bad is going to happen.	☐0	☐1	☐2	☐3	☐4			
34. I have sore muscles.	☐0	☐1	☐2	☐3	☐4			
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	☐0	☐1	☐2	☐3	☐4			
36. I feel nervous.	☐0	☐1	☐2	☐3	☐4			
37. I feel my love relationships are full and complete.	☐4	☐3	☐2	☐1	☐0			
38. I feel that I am not doing well at work/school.	☐0	☐1	☐2	☐3	☐4			
39. I have too many disagreements at work/school.	☐0	☐1	☐2	☐3	☐4			
40. I feel something is wrong with my mind.	☐0	☐1	☐2	☐3	☐4			
41. I have trouble falling asleep or staying asleep.	☐0	☐1	☐2	☐3	☐4			
42. I feel blue.	☐0	☐1	☐2	☐3	☐4			
43. I am satisfied with my relationships with others.	☐4	☐3	☐2	☐1	☐0			
44. I feel angry enough at work/school to do something I might regret.	☐0	☐1	☐2	☐3	☐4			
45. I have headaches.	☐0	☐1	☐2	☐3	☐4			

SD IR SR — DO NOT MARK BELOW

+   +

Total=

APPENDIX J

MSPSS

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**

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 K

BMMRS

ID #_____

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

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 measure1st 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!

Revised 8/28/08

#_____

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

10. I have forgiven those who hurt me.
    1-Always or almost always
    2-Often
    3-Seldom
    4-Never

11. I know that God forgives me.
    1-Always or almost always
    2-Often
    3-Seldom
    4-Never

Private Religious Practices

12. How often do you pray privately in places other than at church or synagogue?
    1-More than once a day
    2-Once a day
    3-A few times a week
    4-Once a week
    5-A few times a month
    6-Once a month
    7-Less than once a month
    8-Never

13. Within your religious and spiritual tradition, how often do you meditate?
    1-More than once a day
    2-Once a day
    3-A few times a week
    4-Once a week
    5-A few times a month
    6-Once a month
    7-Less than once a month
    8-Never

14. How often do you watch or listen to religious programs on TV or radio?
    1-More than once a day
    2-Once a day
    3-A few times a week
    4-Once a week
    5-A few times a month
    6-Once a month
    7-Less than once a month
    8-Never

15. How often to you read the Bible or other religious literature?
    1-More than once a day
    2-Once a day
    3-A few times a week
    4-Once a week
    5-A few times a month
    6-Once a month
    7-Less than once a month
    8-Never

16. How often are prayers or grace said before or after meals in your home?
    1-At all meals
    2-Once a day
    3-At least once a week
    4-Only on special occasions
    5-Never

Religious and Spiritual Coping

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

17. I think about how my life is part of a spiritual force.
    1-A great deal
    2-Quite a bit
    3-Somewhat
    4-Not at all

18. I work together with God as partners.
    1-A great deal
    2-Quite a bit
    3-Somewhat
    4-Not at all

19. I look to God for strength, support, and guidance.
    1-A great deal
    2-Quite a bit
    3-Somewhat
    4-Not at all

20. I feel God is punishing me for my sins or lack of spirituality.
    1-A great deal
    2-Quite a bit
    3-Somewhat
    4-Not at all

)#_____

Brief Multidimensional ... .surement of Religiousness/Spirituality for Us... .. 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?

_____

****

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

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

****

APPENDIX L

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*):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Revised 4-15-2009

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*):

_____

_____

_____

_____

_____

_____

Recommendations for Follow-Up (*if the case if 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** _____

Revised 4-15-2009

APPENDIX M

Rupture and Repair Coding Sheet

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

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

Identifying a Rupture(s)

Rupture Codes	Examples	Comments
Confrontational Rupture (CR) *Def:* client explicitly reveals his/her dissatisfaction with the therapist or with some aspect of the therapy	- "I am so mad at you right now." - "You don't know what you are talking about." - "I don't think you understand me at all." - Client's fists clench up - Client moves head back and grimaces	For CR and WR, you will be looking at the client's verbal and non-verbal behavior to determine a rupture(s).
Withdrawal Rupture (WR) *Def:* client emotionally or cognitively withdraws from the therapeutic relationship	- Changes topic - Avoids eye contact - Looks withdrawn - Affect change (e.g., client becomes sad, happy, laughs, etc) - Posture changes - Deep sigh(s)	
Disagreement on goals (DG)	Client: - "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." Therapist: - "I understand that you are really	For these subsequent codes, you will be looking at the therapist and client to determine whether a rupture has occurred.

	coming to talk about X, but it seems that Y is the real - issue."	
Disagreement on tasks (DT)	Anything other than DT1-DT5	
DT1: <u>Therapist Provided too much structure</u>	- 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	
DT2: Therapist Provided too little structure	- 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."	
DT3: Therapist changed the topic at any point	- Changing the topic and/or Client responds negatively	
[DT]4: <u>Client indicated that Therapist talked too much in the session</u>	- "You never let me say anything." - "I feel you never let me get in a word." " - I feel like I never get a chance to speak."	

	- Therapist interrupts client	
DT5: Therapist Engaged in unhelpful self-disclosure	- Discussing personal material that is not related to the client or treatment	
Misalignment in bond (MB)	MB – any misalignment in bond not falling into MB1- MB3	
MB1: <u>Therapist Critical of the client</u>	- Asking "why questions?" - Using "should" statements with judgmental quality - Blaming statements implying client is at fault	
MB2: <u>Therapist Behaved as if he or she were "somewhere else"</u>	- Not present - Looking at clock or watch - Yawning a lot - Not making eye contact	
MB3: Therapist does not provide validation	- 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
Stage 1 – attending to the rupture **1TM:** Therapist focuses client on immediate experience using **metacommunication (M)** and self-disclosure through the use of I statements	"I am feeling confused about our communication right now" "I noticed that you changed position when I said X." "I have a sense that I am potentially being critical, rather than allowing you to really explore and express your concerns more fully."	For the repair process, you will be coding both the client's and therapist's verbal and nonverbal behavior.

Stage 2 – Exploration of Rupture Experience
 	
2C: Client expresses negative feelings mixed with rupture
 	
    o **2CC:** Constructive
 	
    o **2CD:** Destructive
 	
2T: Therapist facilitates self-assertion in 3 different ways:
 	
  ▪ **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
	2C not a code – only 2CC & 2CD
	
	2CC: "I am feeling angry about what you just said."
	
	2CD: Client expresses feelings (verbally or nonverbally) in a blaming or belittling way.
	
	2T: Not a code, just a category
	
	"I apologize for saying X."
	
	"I have a feeling that you may be upset with me."
	
	"Can you experiment with telling me directly how you	

	are feeling right now."	
Stage 3 – Exploration of Avoidance *(this stage is necessary only if client is displaying avoidance)*		
3Ca: Client displays block	Changing the topic	
	Speaking in a flat voice tone	
	Speaking in general terms rather than the here-and-now specifics	
	"Everything is fine."	
3T: Therapist probes block	*3T is not a code, only a category*	
	Need a 3Ca to occur for a 3TS to happen	
▪ **3TS:** Therapist probes block on surface level	"It feels to me like you attack and then soften the blow. Do you have any awareness of doing this?"	
	"I noticed that you changed the subject."	
▪ **3TD:** Deeper level of connecting to client's interpersonal relationship style	"I wonder if this relates to your style of relating in other relationships?"	
	"Do you notice yourself reacting in this way in other relationships?"	
	"Has managing conflict always been difficult for you?"	

3Cb: Client explores block	"I guess I do feel kinda of hurt and confused right now."	
Stage 4 – Self-Assertion **4C:** Client self-asserts (expressing a wish or need) spontaneously without therapist's help	"I am noticing that I tend to get angry and lash out when I don't know how to express that anger." "I think I need (X)." "I really want X in my relationships." "I need X but I feel I am not getting it."	
4T: Therapist validates assertion directly in response to Client's assertion (4C)	"I see." or "I hear you." "I'm so glad you have shared your feelings with me." guggles, reflecting back what client has just said, head nodding, eye contact, leaning forward	

APPENDIX N
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 whom 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 O

Themes Occurrences Sheet

x.x = Session #.Trauma Discussion #

(x)= # of occurrences

s = Discussion of Sexual Trauma

w = Discussion of WPH Trauma

o= Discussion in which a theme occurred outside of a trauma discussion

	Occurrences Per Session						
	Session 1	Session 6	Session 7	Session 9	Session 12	Session 18	Total [by sub-theme]
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	1.11(1)w	None	None	9(1)o	None	None	1 o

from job				9.1(1)w			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 P

Rupture & Repair Coding Summary Table

Note: Below is a table summarizing the R&R codes that were identified during the coding of sessions that contained a trauma discussion(s). The comments column describes the rationale for the code by describing its context and explaining the coders' thinking processes for the determination of the code. The quotes column shows the discussion that received a code (and what is quoted in blue represents the specific part of the quote that is reflective of the rupture or repair code) as well as some conversation around it for further contextualization.

Legend: T = Therapist; C = Client

Session #	R&R code	Context	Quotes
1	DT1	T switches topic to talking about the week today. T appears to be "saving" C and/or herself from embarrassment or difficulty discussing topic	T5: "Yeah, and then, so you know, I just wanted to kind of thank you and its"— C6: "Oh you're welcome—" T6: "It's very courageous"— C7: [Client laughs] "Yeah but you [unintelligible] I was like what? Ah man"—END T7: Ok, so um, how was your week today?
1	WR	C changes topic and T allows change in topic without exploration	C44: "Yeah. I actually do have two friends—three friends [Client holds up three fingers] that are like that. It's just that they're unavailable because they're married with kids and they live in Kentucky. So its like if I call them know, its like "I'm getting either me

			ready for bed or the kids ready for bed." You know. It's kind of like that. They call when they can. But sometimes its like so much time has passed in between, I have to talk so much about it, its like, Oh forget it, <u>lets just talk about fun stuff</u>." T44: "Uh-huh, you catch up"— C45: "Yeah." T45: "So its not that your having difficulty talking, communicating your emotions to—in general. Its just that the people who you're surrounded by at this point you don't think they have a"— C46: "I have a confession, I'm sorry." T46: "Ok, go ahead [Therapist smiles and leans forward in her chair toward client]."
1	MB	C partially disagrees with T's interpretation; 1st session/intake. May be too early for such an interpretation or poor timing. L & K both agree that it is an MB because C's tone of voice and facial expression appears to	T49: "Why not? Why never sad?" C50: "I don't know." T50: "When did this start?" C51: "It's always been like that."

		reflect discomfort and slight defensiveness in her response to T.	T51: "It's always been like that?" C52: [Client nods] "Mm-hmm." T52: "Can I tell you why I think?"-- C56: "But I don't know if I grew up too quick, because I felt like a kid, even [unintelligible] I was really big on…So I can't complain. So I can't say I grew up too fast, its just, its like sometimes I feel like you can know too much, its just not good. You know what I'm saying?"
1	DT1	T seems too focused on providing an interpretation rather than listening to/being present with client's experience with her mother; T possibly imposing what she thinks C should feel/or is feeling	T59: "If you were always crying and stuff, then you know, people are going to [Therapist briefly looks down and away from Client]"— C60: "I've never seen my momma cry." T60: "You've never seen your mom cry?" T61: "Well I mean there's another obvious reason"-- T62: "Yeah, yeah. But you're a human being so obviously you feel sad"--

| 1 | MB1 | T appearing to be critical of C; asking "why?" | T83: "Oh, okay. And you don't like you job."

C84: "Heck no! You can put absolutely hate it. [Client makes pointing gesture as if to indicate writing something down] I don't care if it's bold-faced. Can't stand it."

T84: "Why are you there"—

C86: I don't want to start, your going to get mad at me. [Client looks away momentarily and grins]. Okay, first off"—

T86: "So I'm going to get mad at you?" [Therapist smiles and points to herself]

C87: "Yeah [Client smiles and leans forward] because I think I talk about it too much and I have to tell myself, Okay enough about the job [Client chuckles]." |
| 1 | 4T | T attempting to repair by using an open ended question and then a reassurance, letting C know that she can express herself freely without censoring herself about this topic | T85: Tell me, tell me about this guy [Therapist gestures to encourage client to tell more].

C86: I don't want to start, your going to get mad at me. [Client looks away |

			momentarily and grins.] Okay, first off—
			T86: So I'm going to get mad at you? [Therapist smiles and points to herself]
			C87: Yeah, [Client smiles and leans forward] Because I think I talk about it too much and I have to tell myself, Okay enough about the job [Client chuckles].
			T87: "No, don't refrain yourself, you don't"—
6	WR	C looking withdrawn, posture is slouching, looking away, laughing nervously	C2: [Client laughs] "I'm good" [Client sits down, laughs, sits back in couch and hunches over looking down]
			T2: "Why are you laughing?" [Therapist smiling and laughs]
			C3: "I don't know. Stupid. [Laughs] I don't know, Um, [Client looks up] I was wondering what you was going to talk to me about today [Client laughs nervously] [Therapist maintains eye contact] (3) [Client looks down at ground] I don't really have anything interesting to talk

			about" [Client laughs and looks down] T3: "You don't have anything interesting to talk about? Or you do? Or?" C4: "I don't" [Client shakes head]
6	DT1 & DT3	T does not follow up with appropriate questions regarding C's trauma discussion and T changes topic from trauma discussion to asking about hands getting cold. Although it appears T is trying to help C link her emotions to physical sensations (e.g., hands getting cold), she nonetheless moves C away from talking about the trauma and associated thoughts/feelings by asking about her hands	C29: "So ya, I-I I'm more conscious of what I'm doing" Stop [6:24] T29: "Mm-hmm. Really _____ (??) So it um- how about your hands getting cold?" [Therapist rubs hands together]
6	WR WR	C changes posture, appears bothered by the question about wanting a teddy bear C laughing/changing affect, appearing embarrassed	T37: Do you want a little teddy bear? C38: "Heck no [Client sits up straight put off by question] looking like a little" C39: I cannot do that totally not on camera looking like an idiot [Client laughing covering face with one hand] [Therapist laughing] Yea I- that is true. Let's see what

			else. Ok I do have fun stuff to talk about.
6	MB1	T appearing to be critical (in her tone & asking why ?) of C's choice to focus on acting as one her careers C appears to be disagreeing with T	T59: "I'm wondering though if you are uncomfortable with um you know making a um, uh getting a job because of your looks then why did you choose acting as one of your careers?" C60: "See it's not really because of my looks it's more- I don't like putting on bik- I don't like the skimpy clothes um the running around…"
6	WR	C's affect appears to change as it becomes more serious and timid; no smiling	Page 21 of session 6 transcript: C: "Yea, whatcha want to talk about?" T: "What do you want to it's about you you need to estab- what's coming up in your head first?" C: (5) "I don't know. I don't know. Ah I'm not good at it can you just ask me something? You can ask me anything but (3) just, just ask me" [Client talks in almost a whisper]
6	WR	Another affect change occurs where C looks more serious after she laughs and her posture	C: (2) "That's the only thing, other than that, nothing, you know [Client laughs]

		changes (C sits/slouches back in the couch)	nothing bad" [Client sits back in couch]
7	DT1	T sticking to an agenda too rigidly (goes back to game) as C is talking about her job dissatisfaction in C41.	C41: "Because I can name a couple people, well, really just two [client puts 2 fingers up] but I'm very challenged by people at work. Because I don't want to be there with them. So it's like a challenge for me to not really-- [client makes motion with both hands towards herself] so it's really a challenge for me to hold my tongue. Because [client counts off points on fingers] me not wanting to be there, any little thing they say that is kind of like annoying, I just say anything, like, so it's like ya I'll be like, I shouldn't have said, I shouldn't have said anything [client shakes head], it was true, but it's all good, things like that, can't escape the hell though" T42: "Mm, ok, alright [End] [Therapist picks up client's game piece] I don't know what you're supposed to do with this. Oh re-enter" [Therapist moves client's game

			piece]
7	DT1	T sticking to an agenda too rigidly (goes back to game) as C is talking about her relationship to boyfriend. Trauma discussion starts on C48 and stops on C119 in the transcript.	C118: "That, is my plan, you know it sucks, it's like you always got to watch people [therapist nods] (3) So, plus I mean, it's just that, and a whole lot of you know, you know a black, a [client makes air quotations] beggin' black woman. [Client rests cheek on hand] You know what I'm saying? It's like I don't want to be one of those [client readjusts herself in chair] I'm not [client shakes head and chuckles]." T119: "Mm-hmm." C119: "So, that's it" **Stop [18:18]** T120: "Mm-hmm, ok, [Therapist turns the card over] well that's a heavy one" [Therapist moves forward on chair]
7	MB1	T appears critical of C; asking a why question with a critical tone of voice and potentially assuming that C is upset T's question appears to trigger defensiveness rather than curiosity/reflection	T210: "…why did you act so upset when you said, when you had to answer a question from your childhood?" C210: "Umm, because we forget and I got to think back, like oh man. Like I don't know [Client

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224

			rests chin on hand] like, I don't know, I never thought about it. I don't know. Cause I had fun when I was younger [Client looks down] I guess I would just think of something, just…" T211: You don't like to think about something from the past? or" C211: No I do, I do, but I don't know why I did. I really don't. My childhood wasn't horrible. I don't know why I thought that." T212: "Mm ok" C212: "Well (2) [Client laughs] I don't know. I guess I just had to actually think of something to say. I'm like childhood, huh, and then that popped up and I was like" [Client shrugs shoulders]
7	DT	C disagrees with T's statement re: "never the victim's fault"	C213: "…How are you gonna say, that a victim for it, in a way as abuse me, but they, what about if you heard, or if you know of when you seen something that's kind of like, I can understand why it happened to you. You know that type of

			thing."
7	DT1	T sticking to agenda of game too rigidly as she goes back to game too fast as C is talking about her relationship	C312: "You can't tell him, cause then he'll cry [client points away form self]. Well not actually cry. He'll [client makes air quotes] man cry and not say anything and look sad." T313: <mark>"Ok. Should we move on? Or"</mark>
9	DT1	T sticking to agenda of game too rigidly/little flexibility as she goes back to game as C is talking about going back home; Not validating C's affect	C28: "So I keep trying to tell them every time I say I'm coming home, I'll be meaning to but the year goes so fast [Client snaps fingers]. Because I'm trying to do stuff and it's just going so fast. She'll just say, "Oh my God I waited four years, oh my God." It's not like the four years at home—like that" [Client nods] T28: <mark>"Mm-hmm."</mark> C29: "So, yeah" [Client smiles and chuckles] T29: "Okay <mark>[Therapist gestures back to board game and client hand's therapist the dice]</mark> Thank you" [Therapist rolls dice, moves piece, and both client and therapist

			laugh]
			C30: "Today's your day for the cards" [Client smiles]
9	MB1	T appearing critical of C	T94: "You're not serious—You don't have a gun"— C95: "Oh heck no! [Client and therapist laugh] No, like, that's just how you have to—like its just a metaphor"
9	DT5	T engaging in unhelpful self-disclosure/not pertaining to C	T127: "Yeah. It's just—because I'm too old to be in school, so I-I"— C128: Why you saying that?! I don't know how old you are but I always thought you was younger than me [Client chuckles and therapist smiles]. Oh my goodness, I've met people in college that was like hella old. And they look like it--
9	MB1	T asked "Why…?" which appears to make C initially feels criticized as she immediately answers, "I don't know."	T188: [Therapist nods] "Mm-hmm. I guess so. [Therapist looks out window] Yeah. [Therapist looks back at client] Why are you asking?" C189: "I don't know. Because I felt like when you said that it was weird because I'm the same way and

			I hate when people don't just—if you don't just say I don't get it, then sometimes I be feelin like—like I'm wrong. But when you said it, it made me feel like, Okay. It made me feel like it is okay."
12	MB1 & MB3	T appears critical of C in her questioning and laughing; C appears embarrassed as she also laughs and covers face	T33: "You just guessed the password [Therapist laughs] to her email? [Client laughs and covers face with both hands] [Therapist laughs]
	MB3 & CR	T continuing to laugh; C appears frustrated by T's laughing and possible critical tone saying "ok quit laughing" while laughing herself and playing with her hair (looks nervous/uncomfortable)	C33: I'm like, I told you like, I think I told you. If you [client claps her hands] sit me in front of a computer, if I want to know somethin', I will find out. [Therapist laughs and rests face in pals of hand]. It may take me [client claps hands several times] a little bit, but I'll investigate it. And I'll find, I just guessed it. Like you know if you know somethin' about somebody [Client motions with both hands palms up and away from her] [Therapist leans forward in chair] it doesn't really take much [Therapist

	2TR	T appears to apologize/attempts to repair rupture sensing that C is bothered	covers chuckling with hand] [Client laughs and plays with hair] Ok quit laughing [Client laughs]." T34: I'm sorry. [Therapist and Client laugh] It's good that you guessed it.
12	MB1	T appears critical of C	T39: "Ok, You know that's illegal right? You know that?"
	CR	C sensing the criticism appears to respond with defensiveness	C39: "I don't care" [Client shakes head] T40: "You don't care?" C40: "It don't matter [Therapist nods head]." C41: "Ya I guessed it [Client nods head]."
	1TM	T attempts to repair here by reassuring C that she can't/won't report her so she shouldn't worry about going to jail but the repair does not seem clear. C appears self-critical, calling herself a "psychopath."	T42: "I can't do that don't worry I'm not reporting you." C42: "I mean if you do I'll just go to prison [Client smiles] like I shouldn't [Client shrugs shoulders and holds both hands palms up] have did it [Client

			laughs] but, um, ya, so I guessed it, and like, How do you go to jail for guessing, like what the f***. I just guessed it [Client smiles and holds both hands palms up] and like ok let me like, so I guess."
			T43: I don't think you go to jail, but like that's, that's somethin'—anyway, so go ahead [Therapist motions to Client] so you guessed her e-mail."
			C43: Yeah and I checked it. I check it everyday cuz now I'm a psychopath about it, but umm, so I found out that she was writing a book so I told him. And he was like, he just [Client shakes head] you know like, [Client motions away from self with both hands] I know that he don't really need to know the password, but he's really manipulative [Client holds hands up and shakes them] and he can get me to tell him. [Therapist nods head] Make me [Client motions to self and then away from self with both hands] feel like I

			should tell him."
12	MB3	T laughing at C's statement and then covering up laugh with hand; appears to not be validating/mirroring Cs affect	C55: "I mean, I ain't gonna lie, he probably knows I have, but he's tried to guess mine. [Therapist laughs] Cuz sometimes I could tell. Like, because if I go on myspace, all of a sudden, too many failed log-in attempts. Really? Oh for real. Who else cares that much [client brings hands out palms facing upward] about what I do? [Therapist laughs] Nobody, cuz I don't have sh** to do. You know what I'm sayin'? [Therapist chuckles] I don't do nothing. People who know me a lot, know I ain't doing nothing."
12	MB3	T laughing at C's behavior; not validating	C58: [Client grinning] "He know that I tried. I'm sure he'd a got the too many failed log-in attempts [Client and Therapist laugh]. Well I told you I was crazy." T59: "I'm sorry [Therapist laughing and covers face] C59: "It's ok [Client laughing]." T60: "No, just guessing. No umm, cuz we all think about it. We all think about
		C is observed to	

		nervously play with her hair while T is laughing	it. [Client laughs and covers face with both hands]."
12	MB3	T laughing at C but then attempts to cover this up by communicating that she is proud of C; T appears invalidating; C looks embarrassed	T141: "Uh-huh [Therapist laughs] That sounds good. [Client laughs and covers face with both hands] So, umm, I'm proud of you. I mean you communicated."
	WR	Change in C's affect. C appears embarrassed as she thinks she did something wrong. Visible in tone and body posture.	C141: "Oh thanks [Client smiles and shrugs shoulders]."
12	MB1	T appears critical of C	T144: "Yeah? [Client nods] Maybe next time you need to bring this up again. Maybe we'll do it in a less dramatic way.
18	NONE		

APPENDIX Q

Themes Summary Table

Session #	Theme Category	Theme Sub-Categories	Contextual Quotes

APPENDIX R
Training and Coding Manual

DISCUSSION OF INTERPERSONAL TRAUMA IN PSYCHOTHERAPY TRAINING AND CODING MANUAL

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

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

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

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

When identifying who is speaking, us a "**T**" to indicate the therapist is speaking and a "**C**" to indicate the client is speaking. In addition, please use numbers to indicate how many times each person is speaking. For example, the first time the therapist speaks represent it as T1: and the second time as T2, T3, etc., and vice versa for the client (C1, C2, C3, etc.)

In addition to capturing the actual words, speech patterns and thought patterns of the speakers, we would like to try and capture some of the more important non-verbal behaviors/communication taking place between the therapist and client. In order to do so, please use parentheses with numbers inside of them to indicate pauses in a speaker's response. For example, use (3) to represent a three second pause or (10) for a ten second pause. Use this whenever there are significant pauses or moments of silence between the speakers.

When attempting to capture non-verbal behaviors/movements that are significant to the therapeutic interaction taking place, use brackets [ ] to indicate these movements and clearly state which person—the therapist or client—is performing the movement and what specifically he/she does. For example, [Client turned away from the therapist and looked down at the ground] or [Client laughs] or [Therapist sighed deeply and looked away briefly]. Only note hand gestures that have meaning. For example, the therapist gestures toward her heart when asking about how the client feels, or gestures hands toward self when asking client to say more. Do not note hand gestures that do not carry meaning, such as simply moving hands in the air while talking. Also use brackets to indicate the inability to hear/understand a word or sentence: [Unintelligible] or [Inaudible]. Please make every effort to hear and understand what is said. Sometimes you can figure out a word by the context of what the speaker is saying. If you can make an educated guess, type the closest possible approximation of what you hear, underline the questionable portion, and add two question marks in parentheses.

Example: I went to school in <u>Maryville</u> (??) or <u>Maryfield</u> (??).

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

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]	
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. 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. C2.2: I had been smoking marijuana for the longest time, since the eighties, but I had done nothing else. And then when I moved to California, I started drinking because I hung out with younger people, and we would drink, I don't mean just beers, we'd drink hard liquor.	
T3: Yeah, you get thrown along with the lifestyle	
C3: Exactly, and that was also a problem because I have an addictive personality and it's, I believe it's hereditary and it's part of other problems that I have. C3.1: It just manifested itself very quickly. I did in perhaps one year, what some people would do 3, 4, 5 years. I just crammed it all together. I got started with the speed, and then I switched to cocaine. Now, people call it crack or rock, whatever you want to call it. Free, the freebasing. You buy the, buy it in the rock form or in the powdered form, and I	

spent, I spend $7000 in 3 months on that.	
T4: So you're very efficient about the drug use, packing it into a short period of time.	
C4: Well I packed it in, unfortunately, I don't know if it's good or it's bad, I went from buying it from people I didn't really, trying to get what I could from wherever, to climbing up the ladder to finding the main source, so to speak. C4.1: And I was one of those people, who I'm always proud to say, I never did any sex or anything for drugs or anything like that. Now, I didn't do any, anything… prostitution, or there was a lot of girls that would, a lot of women that would do that.	
T5: [Head nodding] So it was very common.	
C5: And, I was the kind of person, I got my nose broken because I wouldn't sleep with somebody's; this one fella wanted me to sleep with him when his girlfriend was at work and I wouldn't do it so he busted my nose. That's the kind of person I am. I don't believe in, that the two have to meet. My love was drugs. I didn't need a man, I didn't need relationships. If I had the money, if I didn't have the money, I had a way to get, you know, get it through people. I had, I didn't just party you know. I partied with uh--	
T6: Contacts.	
C6: Yeah, people who used to be in the show business industry, so to speak. You know, or who were related, A girl that was related to a guitarist in a famous rock star's band, and I'm not gonna name names, and she unfortunately—she died of AIDS but she had the money and she had, always, there was always partying going on with her. We'd go to the hotel and party, party, party.	
T7: And you got caught up in that very quickly.	

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

C11.1: It's like okay, but I've not, I've never gotten arrested for drugs, or for selling, you know, one of those people who was too smart to keep it in the house and you know, I even though I never had money I had the common sense of well, you don't keep it in the house, don't drive around with it, you don't drink and drive, you don't drink and use. You know, why ask yourself for trouble? C11.2: One time I had drank and drove, and that was because I was at my boyfriend's, we were out, I had an argument, and we both went our separate ways. So, I ended up having to go home inebriated. And, um, fortunately nothing happened so I was pretty lucky. 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…	
T12: So the change again of, of moving--	
C12: Right, they say geographics; you are running away from yourself. But I left California for many reasons. And uh.	
T13: And coming back here in a way set off--	
C13: It set off, right. It set off everything because I felt like I had the freedom. There was nobody there, I had no sponsor, no clean and sober neighbor, nobody checking up on	

me so to speak to make sure I was still, I was still smoking pot. I hadn't quit marijuana and, but the alcohol was the one that really got to me. I had been, I had quit marijuana for about a 7-8 months after I got out of recovery, but ended up getting back into that situation when I moved in, uh, out of sober living and I ended up eventually moving in keeping a roommate who was a friend of mine from my drinking and using days who was dying of AIDS. But he needed someone to take care of him. And I was going back to school at night plus working, so basically, my drug use was limited to marijuana and alcohol, sometimes doing coke or whatever. I never liked speed really because I saw people, the more they did that their teeth would rot out and, you know, it's Drain-o or rat poison, it comes in so many different colors. I've noticed it's not that big here in Illinois, in Chicago.	
T14: So when you say your in and out of recovery now, its alcohol and marijuana your talking about—and every now and then cocaine.	
C14: Right, ya, well the cocaine, basically I've stopped, ah, pretty much avoided that because the individual who introduced me to that again, I avoid seeing him at all costs…which I do for my own well being. I don't want to ride the dragon again. I don't want to go there, even though I know that if I do, I'm not going to be going there again every day. I won't be getting loaded every day because of the medication I take. But, and, he was paying for it, but I realized it was just something that I wasn't even enjoying.	
T15: So why do it?	
C15: Right, you know, to me, everybody, I believe has an addiction. We all have addictions be it food, sex, drugs, alcohol, gambling, family life, work. You know, whatever it may be, I think everybody has one, one thing at least that they crave and that	

in the back of their mind that they focus on and they really desire.	
T16: And you said you think you have an addictive personality--someone who easily gets drawn into things	
C16: Yeah, well right, I have been. I'm an artist, freelance artist as well, and my addiction used to just be drawing. As a child, I would just come home and draw, you know.	
T17: So whatever you do like that you do it intensely	
C17: Yeah, I wish I could do it to make money and do it, you know. [Therapist laughs] Get a money making idea and do like that, I'd probably be rich, it's just um, but not able to find a proper substitute, you know. At this time, I'm trying to get back into drawing and being more creative, and my personal life, though I feel so mentally, emotionally, and physically exhausted after all I've been through in my life, that all I want to do is almost not do 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.	
T18: And you've used up your chances, huh?	
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.	
T19: Now what is recovery for you besides not using alcohol or marijuana?	
C19: To me recovery would be going to meetings, having a sponsor, working a twelve step program, um, I still try to incorporate 12 step beliefs and behaviors in my life as far as, "Let go, Let God," the use the steps, resentment, a lot of people say if you're drinking and using you cannot work the steps, but I think you can use them in a behavior, method of behavior modification if you're, instead of turning to getting loaded or anger or what have you, when you have a problem in life, try to do something positive, call somebody, read if you have an AA Big Book or an NA Big Book, pick something up in there and try to read it. Try to keep yourself as close to the, that behavior as you can because it helps you to get…the closer I try to stay to meetings, even if I'm drinking, if I go to meetings it helps me from not wandering too far off track to where I'll say drink more, or just stop totally leaving in that whole lifestyle or that whole belief process.	
T20: There's a piece here which were missing before we go, which is what are you wanting to move toward? What do you--	
C20: What I want to move toward is to just be able to totally not have to drink or use. And at this point--	
T21: Which is doing nothing.	
C21: Right. Well, at this point I still enjoy my pot. I'll be the old person sitting out there smoking a joint on the steps with all my cats around me, you know, and that's okay with me, but I don't want to drink. That's what I'm trying to avoid, and I'll be, I'll go a couple	

weeks without drinking and then maybe I'll drink again. But it's getting to where I want it less and less again.	

II. CODING TIMING OF INTERPERSONAL TRAUMA DISCUSSION INSTRUCTIONS

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

Definition of Interpersonal Trauma:

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

Definition of Trauma Discussion:

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

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

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

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

T = Therapist; C = Client

CONFIDENTIAL VERBATIM TRANSCRIPT

Verbatim Transcript of Session	Initial Coding Impressions
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].	
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 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. <mark>Start</mark> **[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.	
T2: [therapist nodding] Fighting physically or verbally or both?	
C2: sometimes it was physical with my brothers, and, but it was verbal with me because I wouldn't I wouldn't get into fights with her because I was afraid of her because I watched how angry she would get with my brothers and my brothers were (2) they were pretty, violent too, and, um, one of my brothers, one of my younger bothers was in a gang, was a gang member, and she would fight with him. [therapist nodding] She, I saw her one time, um, put an iron right to his chest and when I saw these things happening, I just I grew really afraid of her. And so when we would argue I knew what she was capable of so, I I would stay clear of any like physical, anything physical with her. I would try to talk my talk my way out of it.	
T3: [therapist nodding] Mm-hmm. Were there ever times where she was physically violent	

with you?	
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.	
T4: Mm-hmm [therapist nodding]	
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.	
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—	

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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 a arm's length [client extends one arm forward with palm open indicating an arm's distance] in, in a relationships. I seem to have what's, um, what's called a problem with intimacy, [client gestures with both hands facing one another towards the therapist] [therapist nods] uh, and I don't know if there's, um, if there's a, a better psychological [client motions with hands in a circle in front of middle of body] description of, of what the cause is, of, of that problem might be, [therapist nods head] um, whether I have some kind of a fear [client motions towards self with hand] of intimacy [therapist nods] uh, or if I had— if I had, uh, some sort of traumatic experience [client shakes head side to side] um either with my parents [client gestures to side with one hand and then the other side with the other hand] or with with any of my siblings or or perhaps even in an early [client gestures	

with both hands facing one another toward therapist] relationship and that, uh, that that baggage [client motions with one hand in front of chest toward therapist] from that has has now developed to the point where, um, how I interact with people [client gestures with both hands at sides towards therapist] is is really in in some way affected by this, um, by this this [client gestures towards self with both hands] fear of intimacy. [therapist nods] Um,	
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.	
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 of time] this problem with intimacy that I have today it, it seems— it really does seem to me that there, there are some unresolved things, uh, with my parents that are that are preventing me from from really expressing [client gestures with one hand in a circular motion towards self in front of body] the kind of physical affection, uh that um, that my that my girlfriend is looking for and I'm not, um, I'm not sure exactly how [client nods head and gestures with hands towards therapist] how a psychologist [client motions with one hand towards therapist in repetitive motion] would describe that but [client motions towards self with one hand] the way that I've been thinking about it though is 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].

T3: [therapist nods head] Ok. Um, I mean [therapist leans forward in chair, re-positions self, sits back, and gestures with one hand in a circular motion towards client] as as I'm listening to you talk, I'm sort of sitting here struggling [therapist gestures with one hand towards client] um, to come up with [therapist nods head] something to say and for some reason, you know I'm I'm having difficulty thinking of [therapist places elbow on arm of chair and leans head on hand] a meaningful response. And I'm trying to figure out why that is, and and I think part of it is that it it— (3) You know on one hand [therapist gestures in a downward motion with both hands] you're sort of laying out what the problem is in in you know in a really sort of good clear terms, but there's also way in which it sort of feels almost as if [therapist motions with one wrist in circular motion in front of body] you already know the the answer. It's it's like you're sort of— [therapist nodding]	
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.	
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 had 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?	
C4: Um, well I feel like I feel like [client gestures with both hands towards therapist] you're you're trying to help help draw out my [client gestures in circular motion with one hand in front of body and nods head] thought process in all of this. That that, you know, I might I might have come to some conclusions about what the problem is and and you're trying to help me do that, but at the same time [client gestures towards self with both hands] I mean I have to tell you what I think the answers are. I mean I have to give you some sense of of where my head is in all of this [client continues to speak with hands] and then you know maybe, you know, I don't know, your, maybe you can help me, maybe you can't.	
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…	

C5: Right, well I mean I have I have to start [client gestures with both hands palms up towards the therapist] somewhere…	
T6: Right	
C6: …you know and I, you know I have certainly I have read a few books in psychology and I've [client gestures with hands as speaks] thought about, you know, how how, um, my young situation, you know, might might be described based on different theories in psychology and stuff like that. But I mean, don't don't get me wrong [client gestures with both hands palms facing toward therapist] I mean I'm I'm really hoping that that you will be able to help me, uh, you know and gi- and give me a different, I guess a different perspective in all of this, but, um, uh, but I want I want to participate in all that. [client gestures with both hands as speaks] I want I want you to value my insights about where things are, [therapist nods head] where my head is in all this. [client nods head]	
T7: Ok, so tha- that's important right [therapist leans forward in chair] that you, you know, that you have thought about it, [therapist adjusts self in chair] that you have some understanding [therapist gestures with one hand as speaks] of what's going on…	
C7: Right [client nods head]	
T8: …and it's important for me to to recognize [therapist gestures with hands as speaks] that and and value it. [client and therapist nodding in agreement]	Segment #2 begins
C8: Right, and the same thing happens, you know in the relationship. I'm mean, if my girlfriend wants me to behave in a certain way and that's just not how I feel [client using hands to gesture], I mean, I want to be able to tell her, what my real feelings are, and, and, if you have thoughts about what's going on with me, I would want to be able to express my, my feelings to you [client gesturing with open	

hands towards therapist]. You know, know, the same way. I mean I'm the one here who's looking for help	
T9: I mean, I'm wondering, uh, are you feeling, um, so far that I am hearing and valuing, the, the sorts of things you're saying [therapist gesturing with hands], sort of 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, allright, 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?	
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.	
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…	
C12: different from mine…	
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.	
	STOPPED transcription at 31:50 (end of segment 2)

Safran & Muran Therapy Vignette 2 from Resolving Therapeutic Impasses

Disk 2 – Repairing Ruptures

Therapist: Drs. Saffron and Muran   Session Number: 2

Client: Ms. X   Date of Session: xx/xx/xxxx

CONFIDENTIAL VERBATIM TRANSCRIPT

Verbatim Transcript of Session	Initial Coding Impressions
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.	
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 [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]?	

T2 : Oh Okay, so you know I I'm hearing that you're not [leans forward in chair and then sits back again] very happy about our last session and you're feeling frustrated and also if I understand correctly that you'd like to hear more from me as as as to what as to how the therapy works or	
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?	DT2
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…	1TM
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].	DT2
T4: Yeah I mean is my job to do my best to help you and to try to answer your questions [client nodding], yeah, there's just something about the, um, it's a bit [therapist grins] difficult for me to put it into words but something about the sort of intensity [pumps fists forward] with which your asking for things [client nodding] that makes me, um, sort of a little bit [therapist grins], um, sort of	1TM

question my ability to give you the- the answer you're wanting but I'll- I'll try [therapist nods].	
C4: Okay [client nods].	
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…	
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].	CR (2); DT2
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	2TM

exploring things together.	
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	1TM

something, that makes it difficult for me to…	
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 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.	2TM
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,	2TR; 2TM

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?	
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 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?	2TM
C15: [Client nodding] Okay. Yeah, okay.	2CC

Coding System for Ruptures and Repair:

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

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

Identifying a Rupture(s)

Rupture Codes	Examples	Comments
Confrontational Rupture (CR) *Def:* client explicitly	- "I am so mad at you right now." - "You don't know what	For CR and WR, you will be looking at the client's verbal and non-verbal behavior to determine

	you are talking about."	a rupture(s).
reveals his/her dissatisfaction with the therapist or with some aspect of the therapy	- "I don't think you understand me at all." - Client's fists clench up - Client moves head back and grimaces	
Withdrawal Rupture (WR) *Def:* client emotionally or cognitively withdraws from the therapeutic relationship	- Changes topic - Avoids eye contact - Looks withdrawn - Affect change (e.g., client becomes sad, happy, laughs, etc) - Posture changes - Deep sigh(s)	
Disagreement on goals (DG)	Client: - "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." Therapist: - "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	

DT1: <u>Therapist Provided too much structure</u>	- 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	
DT2: Therapist Provided too little structure	- 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."	

DT3: Therapist changed the topic at any point	- Changing the topic and/or Client responds negatively	
DT4: <u>Client indicated that Therapist talked too much in the session</u>	- "You never let me say anything." - "I feel you never let me get in a word." " - I feel like I never get a chance to speak." - Therapist interrupts client	
DT5: Therapist Engaged in unhelpful self-disclosure	- Discussing personal material that is not related to the client or treatment	
Misalignment in bond (MB)	MB – any misalignment in bond not falling into MB1- MB3	
MB1: <u>Therapist Critical of the client</u>	- Asking "why questions?" - Using "should" statements with judgmental quality - Blaming statements implying client is at fault	

MB2: <u>Therapist Behaved as if he or she were "somewhere else"</u>	- Not present - Looking at clock or watch - Yawning a lot - Not making eye contact	
MB3: Therapist does not provide validation	- 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
Stage 1 – attending to the rupture **1TM:** Therapist focuses client on immediate experience using **metacommunication (M)** and self-disclosure through the use of I statements	"I am feeling confused about our communication right now" "I noticed that you changed position when I said X." "I have a sense that I am potentially being critical, rather than allowing you to really explore and express your concerns more fully."	For the repair process, you will be coding both the client's and therapist's verbal and nonverbal behavior.

Stage 2 – Exploration of Rupture Experience
 	
2C: Client expresses negative feelings mixed with rupture
 	
    o **2CC:** Constructive
 	
    o **2CD:** Destructive
 	
2T: Therapist facilitates self-assertion in 3 different ways:
 	
▪ **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
	2C not a code – only 2CC & 2CD
	
	2CC: "I am feeling angry about what you just said."
	
	2CD: Client expresses feelings (verbally or nonverbally) in a blaming or belittling way.
	
	2T: Not a code, just a category
	
	"I apologize for saying X."
	
	"I have a feeling that you may be upset with me."
	
	"Can you experiment with telling me directly how you are feeling right now."	

Stage 3 – Exploration of Avoidance *(this stage is necessary only if client is displaying avoidance)* **3Ca:** Client displays block	Changing the topic Speaking in a flat voice tone Speaking in general terms rather than the here-and-now specifics	

	"Everything is fine."	
3T: Therapist probes block	*3T is not a code, only a category*	
	Need a 3Ca to occur for a 3TS to happen	
▪ **3TS:** Therapist probes block on surface level	"It feels to me like you attack and then soften the blow. Do you have any awareness of doing this?"	
▪ **3TD:** Deeper level of connecting to client's interpersonal relationship style	"I noticed that you changed the subject."	
	"I wonder if this relates to your style of relating in other relationships?"	
	"Do you notice yourself reacting in this way in other relationships?"	
3Cb: Client explores block	"Has managing conflict always been difficult for you?"	
	"I guess I do feel kinda of hurt and confused right now."	
Stage 4 – Self-Assertion		
4C: Client self-asserts (expressing a wish or need) spontaneously without therapist's help	"I am noticing that I tend to get angry and lash out when I don't know how to express that anger."	
	"I think I need (X)."	
	"I really want X in my	

	relationships."	
	"I need X but I feel I am not getting it."	
4T: Therapist validates assertion directly in response to Client's assertion (4C)	"I see." or "I hear you." "I'm so glad you have shared your feelings with me." guggles, reflecting back what client has just said, head nodding, eye contact, leaning forward	

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.

<u>D. General Themes:</u> 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 S

Visual Summary of Results

Interpersonal Discussions of Trauma

- Childhood Sexual Abuse (CSA)
- Workplace Psychological Harassment (WPH)
- Themes/sub-themes emerging during trauma discussions:
    - Self-protection (Avoidance of talking about trauma, avoidance of emotion, mistrust of others, sense of responsibility, financial security, distancing from others, respect others)
    - Power and Control (Assertiveness, aggression, desire to control self, desire to control others, independence)
    - Sense of Self (Fear of judgment, insecurity, self-criticism, respect for self/pride)
    - Gender Role Struggles (Stereotypes of men, stereotypes of women, role reversals)
    - Emotional Difficulties (Anger toward boss, anger toward mother, difficulty identifying/expression emotion, frustration with boyfriend's lack of responsibility, jealousy)
    - Job Dissatisfaction (Disengagement from job, hatred toward job, frustration with job responsibilities, feeling trapped in job)

Therapeutic Alliance (TA)

- An active, conscious, and purposeful collaborative relationship between client and therapist in psychotherapy, which can vary in quality and strength
- WAI results: Lack of WAI data → limited associations between TA and R & R; Data available: WAI-C for sessions 7 and 14, and one WAI-T measure for session 7
- Despite ruptures, the client's general emotional disposition and interactions with the therapist reflected a positive TA

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Ruptures

- Ruptures: deteriorations in the relationship between the therapist and patient, and a disagreement about tasks and goals of therapy
- 33 ruptures found:
    CR (confrontational rupture; 2 times)
    WR (withdrawal rupture; 7 times)
    DT (disagreement on task; 10 times total; 1 DT, 7 DT1, 1 DT3, and 1 DT5)
    MB (misalignment in bond; 14 times total; 1 MB, 8 MB1, and 5 MB3)

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Ruptures & Themes

- Self-protection (avoidance of emotion, distancing from others) Power and control (assertiveness), Sense of self (insecurity), emotional difficulties (difficulty identifying and expressing emotion)

- Both the therapist and client displayed a theme of avoidance, particularly when ruptures occurred, as both were observed to look away, laugh and/or change the topic rather than directly engaging in addressing the rupture

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Repair Ruptures

Safran & Muran's Four Stage Model

Stage 1: attending to rupture: 1TM in session 12 (focuses on R using self-disclosure)
Stage 2: exploration of rupture: 2TR in session 12(takes responsibility for interaction)
Stage 3: exploration of avoidance
Stage 4: validating self-assertion: 4T in session 1 (validates client's assertion)