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Exploring ways in which trainee therapists address autonomy when working with culturally diverse clients who have experienced trauma: a qualitative analysis of an aspect of posttraumatic growth

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EXPLORING WAYS IN WHICH TRAINEE THERAPISTS ADDRESS AUTONOMY

WHEN WORKING WITH CULTURALLY DIVERSE CLIENTS WHO HAVE

EXPERIENCED TRAUMA: A QUALITATIVE ANALYSIS OF AN ASPECT OF

POSTTRAUMATIC GROWTH

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Ani Khatchadourian, M.A.

October, 2012

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

This clinical dissertation, written by

Ani Khatchadourian

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

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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

Shelly Harrell, Ph.D.

Keegan Tangeman, Psy.D.

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EDUCATIONAL HISTORY

Doctoral Candidate, Clinical Psychology (APA-Accredited Program)
Pepperdine University, Los Angeles, CA
Anticipated Graduation: December 2012
Dissertation Title: Exploring ways in which trainee therapists address autonomy when working with culturally diverse clients who have experienced trauma: A qualitative analysis of an aspect of posttraumatic growth
Dissertation Oral Defense: June 2012

M.A., Clinical Psychology (APA-Accredited Program), May 2007
California State University, Northridge, Northridge, CA

B.A., English with Minor in Applied Developmental Psychology, June 2004
University of California, Los Angeles, Los Angeles, CA

CLINICAL EXPERIENCE

Pre-doctoral Intern, Clinical Psychology (APA-Accredited Program)
Kennedy Krieger Institute, Departments of Neuropsychology & Behavioral Psychology
Johns Hopkins University School of Medicine, Baltimore, MD
July 2011 – June 2012

Neuropsychology (July 2011 – December 2011)
Beth Slomine, Ph.D., ABPP, Director of Training, Inpatient Supervisor
T. Andrew Zabel, Ph.D. ABPP and Cynthia Salorio, Ph.D., Outpatient Supervisors
• Pediatric Inpatient Rehabilitation: Participate on an interdisciplinary team with a focus on evaluation and treatment of children and adolescents following traumatic or other acquired brain injuries. Conduct neuropsychological evaluations, provide education and recommendations to families, staff, and schools, provide cognitive rehabilitation, and assist with treatment and discharge planning. Conduct neuropsychological evaluations of children with a wide range of neurodevelopmental disorders and medical conditions affecting the central nervous system.
• Outpatient Neuropsychological Assessment: Conduct neuropsychological evaluations of individuals (infancy through young adulthood) with a wide range of congenital and acquired disorders affecting the central nervous system. Consult with medical providers, schools, and families regarding recommendations and treatment planning.

Behavior Management Clinic (January 2012 – June 2012)
Susan Perkins-Parks, Ph.D., Director of Training, Supervisor
• Provide brief, time-limited treatment to families and community care providers serving youth with common behavior problems, disruptive behavior disorders and co-morbid disorders (mild to moderate in severity). Conduct a behavioral assessment utilizing a

clinical/behavioral interview and administration of standardized behavior rating scales and questionnaires, in addition to a baseline, direct observation of parent-child interactions. Provide caregiver training in behavior management techniques and procedures. Also provide individual and group therapy for children and adolescents to address various internalizing problems. Services are provided in the clinic, home, and via consultation with a broad range of community agencies.

Neuropsychology Extern
UCLA Resnick Hospital and Semel Institute, Los Angeles, CA
August 2009 – June 2011

Aging and Memory Research Center (April 2010 – June 2011)
Karen Miller Ph.D., Director of Extern Training, Supervisor

Alzheimer's Disease Center Neuropsychology Laboratory (August 2009 – April 2010)
Po Lu, Psy.D., Director, Supervisor; Christine Kang, Ph.D., Post-Doctoral Fellow
• Provided weekly neuropsychological and psychological assessments to outpatient adults (ages 25-90) referred for neurological disorders including Alzheimer's disease, vascular dementia, frontotemporal dementia and stroke. Wrote assessment reports integrating patient history, medical records and available neuroimaging studies. Co-provided feedback sessions with patient and family to discuss results and recommendations. Conducted clinical interview and administered neuropsychological test battery to participants enrolled in various research studies related to aging and cognitive decline; generated a brief research report integrating background information, relevant medical records, neuroimaging findings, and neuropsychological test results, including a diagnosis for research classification. Administered neuropsychological research batteries to subjects for Dakim Brain Fitness project. Attended weekly individual and group supervision and provided formal case presentations. Presented PowerPoint lecture on etiology, symptoms, and neurocognitive functioning in vascular dementia to David Geffen School of Medicine psychiatry residents. Attended weekly neuropsychology didactics targeted for postdoctoral fellows through the UCLA Medical Center & Semel Institute. Attended case conferences for psychiatry residents.

Neuropsychology Extern
Children's Hospital Los Angeles, Los Angeles, CA
Sharon O'Neil, Ph.D., Director of Neuropsychology, Supervisor
August 2010 – June 2011
• Conducted comprehensive neuropsychological assessments for children, adolescents and adults (i.e. childhood cancer survivors) in hematology-oncology. Diagnoses included leukemia, brain tumors, neurofibromatosis and sickle cell anemia. Conducted neuropsychological evaluations for national Children's Oncology Group (COG) studies on long term effects of chemotherapies and irradiation. Wrote assessment reports and provided feedback sessions. Attended weekly multi-disciplinary neural tumors team meeting. Attended weekly neuroscience didactics and brain cutting/autopsies. Provided school consultation and attended Individual Education Program (IEP) meetings. Attended weekly hematology-oncology Grand Rounds and monthly HIV lectures. Completed six-

week National Institutes of Health (NIH) certification in Responsible Conduct of Research.

Psychotherapy Practicum Student
Pepperdine Community Counseling Center, Los Angeles, CA
September 2008 – June 2011

Anat Cohen, Ph.D., Clinic Director, Supervisor; Gitu Bhatia, Psy.D., Supervisor
• Provided outpatient individual adult, child, and family psychotherapy. Completed intake interviews and wrote intake reports for potential clients. Created and implemented treatment plans with clients. Participated in weekly group and individual supervision with supervisors representing a variety of theoretical orientations including behavioral, cognitive-behavioral, interpersonal, and psychodynamic.

Practicum Student
CSUN Psychology Clinics, Northridge, CA
August 2005 – May 2007

Assessment, Child and Adolescent Diagnostic Assessment Program (September 2006 – February 2007)
Jean Elbert, Ph.D., Supervisor
• Administered comprehensive psychoeducational assessments to elementary and school-aged children referred by parents and professionals for suspected Learning Disability, Attention Deficit/Hyperactivity Disorder, and their associate learning and behavioral issues. Interpreted scores and wrote assessment reports for each case. Attended weekly supervision meetings to develop individualized assessment batteries based on specific referral question.

Parent Training/Behavioral Intervention, Parent-Child Interaction Program (September 2005 – May 2007)
Dee Shepherd-Look, Ph.D., Director, Supervisor
• Presented modules based on ABA principles and techniques to parents of children diagnosed with autistic disorder. Provided parents with skills to teach appropriate behaviors and alter inappropriate ones. Offered parents tools and techniques to strengthen their attachment with their child(ren). Conducted weekly in-home visits to help parents implement skills learned in parent education classes, including modeling of techniques.

SUPERVISORY EXPERIENCE

Peer Supervisor
UCLA Medical Center & Semel Institute, Los Angeles, CA
Karen Miller, Ph.D., Supervisor
May 2010 – June 2011
• Participated in a vertical supervision model, providing feedback on test administration, and review of integrated reports for beginning assessment externs.

Peer Supervisor
Pepperdine Community Counseling Center
May 2010 – June 2011
• Participated in a vertical supervision model, providing clinical guidance to first-year doctoral trainee therapist regarding clinical management of cases, including case conceptualization, diagnoses, treatment planning, and legal/ethical dilemmas.

CLINICALLY RELEVANT EXPERIENCE

Social Work Provider
Inner Circle Foster Family Agency, Van Nuys, CA
Melissa Thompson-Jinariu, MFT, Supervisor
2006 – 2008
• Advocated for overall well-being, development, and adjustment of foster children (ages 0 – teens) in their foster homes. Facilitated all necessary services (e.g., therapy, medical treatment, visitation, education referrals) for each minor on caseload. Acted as liaison between Department of Children and Family Services, foster parents, and birth family. Developed Needs and Services Plan and Quarterly Report for each minor at intake and on quarterly basis. Attended weekly meetings with clinical supervisor to discuss areas of concern and intervention plans for each minor experiencing emotional and/or behavioral problems; supported foster parents with implementing interventions. Worked with caregiver of developmentally disabled client to develop and implement ABA-based intervention according to functional assessments conducted annually.

Assistant Clinic Director
CSUN Parent-Child Interaction Program, Northridge, CA
Dee Shepherd-Look, Ph.D., Clinic Director, Supervisor
2005 – 2008
• Recruited parents of authorized Regional Center clients for parent education classes and coordinated assignment of parents to groups and to behavioral interventionists based on diagnostic and demographic characteristics of child. Supervised practicum students in maintaining current and complete client files, including functional assessment and treatment summary report for each client; submitted complete and reviewed files to Regional Center at end of program. Worked closely with program director to generate and implement ideas for improving quality and efficiency of program.

Discrete Trial Training Instructor
Working With Autism, Encino, CA
Jackie Zaldua, M.A., Supervisor
2004 – 2005
• Provided behavioral therapy to children with autism (ages 2 – 8) in school- and home-based programs. Maintained data and observational information in client folder. Attended weekly clinic meetings with case supervisor, parents, child, and all case therapists to discuss case progress, goals, and areas of concern.

RESEARCH EXPERIENCE

Doctoral Dissertation Research, Trauma and Positive Psychology Lab
Dissertation Title: Exploring ways in which trainee therapists address autonomy when working with culturally diverse clients who have experienced trauma: A qualitative analysis of an aspect of posttraumatic growth
Pepperdine University, Department of Psychology, Los Angeles, CA
Susan Hall, J.D., Ph.D., Committee Chair
2008 - 2012
• Reviewed clinic forms/measures and videotaped psychotherapy sessions from clinic database to select participants. Developed coding manual based on posttraumatic growth and autonomy to be used in data analysis. Trained in both open and directed coding procedures and obtaining inter-rater reliability with codes. Served as a research assistant as part of the Pepperdine Applied Research Center (PARC)

Research Assistant
Pacific Child and Family Associates, Los Angeles, CA
Ira Heilveil, Ph.D., Clinic Director, Supervisor; Cara Entz, M.A., MFT, BCBA, Supervisor
2007 – 2008
• Worked closely with Clinic Director to compose assessment battery of empirically-supported tools to measure response of children with autism to ABA-based intervention. Coordinated and oversaw test administration by case supervisors for eight satellite offices; trained case supervisors and clinical directors in administration of measures. Administered intelligence (WISC-IV, WPPSI-III) and neuropsychological (NEPSY-II) tests to clients served by Los Angeles office.

Research Assistant
CSUN Parent-Child Interaction Program, Northridge, CA
Dee Shepherd-Look, Ph.D., Clinic Director, Supervisor
2007 - 2008
•Collaborated with members of research team and Parent-Child Interaction Program director to develop test based on parent training curriculum as a partial measure of program effectiveness. Developed comprehensive codebook of measures within assessment battery to assist with current and future data entry and interpretation. Coordinated testing and interviews of participants for effectiveness study. Assisted with literature reviews of past research on parent management training and qualitative research. Developed possible hypotheses for a future attachment-related study.

Research Assistant
Longitudinal Study of Mother-Daughter Relationships for Girls with Attention-Deficit/Hyperactivity Disorder
University of California, Los Angeles, Los Angeles, CA
2004 - 2005
Private Investigator: Joyce Lee, M.A., Ph.D. Candidate, University of California, Berkeley

• Assisted with data collection and analysis for doctoral dissertation. Viewed videotaped interactions between mother-daughter dyads and used developed coding system to code their behaviors and affect. Attended weekly group meetings to establish inter-rater reliability. Utilized SPSS to enter and analyze collected data.

POSTERS & PRESENTATIONS

Khatchadourian, A., McCabe, M., Jacobson, L.A., & Ramos, V.L., (2012, February). Neuropsychological functioning in opsoclonus myoclonus syndrome: A case series. Poster to be presented at the annual meeting of the International Neuropsychological Society, Montreal, Canada.

McCurdy, M., **Khatchadourian, A**., Pritchard, A.E., Zabel, T.A., & Jacobson, L.A. (2012, February). Classification of ID using the WISC-IV: FSIQ or GAI? Poster to be presented at the annual meeting of the International Neuropsychological Society, Montreal, Canada.

Khatchadourian, A. & Hall, S.R. (2010, October). Exploring ways in which trainee therapists address autonomy when working with culturally diverse clients who have experienced trauma: A qualitative analysis of an aspect of post-traumatic growth. Poster presented at the Los Angeles County Psychological Association Convention, Culver City, CA.

Khatchadourian, A. & Hall, S.R. (2010, October). Addressing autonomy when working to promote posttraumatic growth with culturally diverse psychotherapy clients. Presentation at the Pepperdine University Multicultural Research and Training Lab Biennial Conference, Los Angeles, CA.

Khatchadourian, A. (February, 2010). Vascular dementia: etiology, clinical presentation, and neuropsychological profile. Presentation for the UCLA David Geffen School of Medicine psychiatry residents, Los Angeles, CA.

TEACHING EXPERIENCE

Teaching Assistant, Clinical Management of Psychopathology
Pepperdine University, Los Angeles, CA
2009 – 2010

HONORS & AWARDS

Colleagues Grant, Pepperdine University, 2008 – 2012
Robert Rainey Award, Most Outstanding Graduate Student in Department of Psychology, 2007

PROFESSIONAL ACTIVITES & AFFILIATIONS

APA Division 40 – Clinical Neuropsychology, Student Affiliate, 2010 – Present
International Neuropsychological Society, Associate Member, 2009 – Present
Los Angeles County Psychological Association, Student Member, 2009 – Present

LANGUAGES

Armenian (fluent)
Spanish (conversational)

ABSTRACT

A positive psychological approach to trauma involves acknowledging the distress that often results from traumatic experiences, while also focusing on trauma as an opportunity for posttraumatic growth. Organismic valuing theory posits that the social environment may serve as a facilitator of posttraumatic growth to the extent that it supports the survivor's basic psychological needs for autonomy, competence, and relatedness. Of these needs, autonomy has been the most debated, particularly by cross-cultural researchers noting that autonomy is equivalent to independence and therefore not a universal need. Although there is increasing literature on the importance of autonomy across cultures and its use as a common factor across various forms of psychotherapy, there are to date no evidence-based studies examining autonomy support in the context of psychotherapy for trauma-related issues within a multicultural context.

The purpose of this study was to qualitatively explore use of autonomy supportive factors by trainee therapists working with culturally diverse clients who had experienced trauma. A sample of 5 participants (3 collectivistic and 2 individualistic) across 2 community counseling centers were selected, and a trauma discussion within a videotaped psychotherapy session was analyzed for each. Directed content analysis using a coding system created for this study and derived from various theories was employed to analyze therapist responses to clients' trauma discussions. Results indicated that the therapists provided autonomy supportive responses for less than half of these discussions, with the majority of the responses characterized as empathic reflections of factual content. Also, our results indicated that autonomy supportive responses generally were

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provided more often to the collectivistic clients, and appeared to be mostly congruent with the cultural background of the client.

Given the findings in our study, increased education and training in providing culturally sensitive, evidence-based therapy for trauma-related issues appears to be indicated for therapists in graduate programs, such as through specific courses focusing on the intersection between trauma and culture. In addition, a treatment manual incorporating the autonomy supportive codes from this study could be developed for therapists early on in training to provide guidelines for implementing autonomy support in trauma-related therapy with culturally diverse clients.

Chapter 1. Literature Review

Positive psychology has been rapidly gaining momentum in the field since its inception approximately fifteen years ago, shifting the focus in psychology from repairing pathology and deficits in human beings to supporting flourishing and well-being. Congruent with this focal shift from the negative to positive aspects of human experience, there has been a growing body of literature exploring the phenomenon of growth through adversity, which is often labeled posttraumatic growth (Tedeschi & Calhoun, 1995). Posttraumatic growth refers to the positive psychological changes that can take place for individuals after they have experienced a highly stressful, traumatic event, including dimensions of life philosophy (e.g., gaining purpose and autonomy), perceptions of self (e.g., environmental mastery and acceptance), and more positive relationships with others (Calhoun & Tedeschi, 1999, 2006). According to organismic valuing theory, posttraumatic growth is possible because humans have an innate tendency towards growth, to the extent that their social environment meets their basic psychological needs of autonomy, competence, and relatedness (Joseph & Linley, 2005; Ryan & Deci, 2000). The chapters that follow will focus on the posttraumatic relationship between the client and therapist as a hypothesized medium for supporting these basic psychological needs, specifically the need for autonomy.

Arguably the most important of the three basic psychological needs (Ryan & Deci, 2008), autonomy has also been the most controversial (Chirkov, Ryan, Kim, & Kaplan, 2003) due to cultural and definitional differences. For example, some describe autonomy in terms of independence and individualism (Markus & Kitayama, 1991; Miller, 2003; Oishi, Diener, Lucas, & Suh, 1999) whereas others consider autonomy a

universal need (Chirkov & Ryan, 2001; Ryan & Deci, 2000, 2008). Also, persons from individualistic backgrounds may experience autonomy as being more independent and separate from others, whereas individuals from collectivistic cultures may be "autonomously dependent" on one another (Chirkov et al., 2003, p. 98), willingly choosing to be more dependent on others in their family or community.

Assuming this latter definition of autonomy as a universally salient construct, therapists can serve as significant figures for culturally diverse clients who have experienced trauma to support their needs for autonomy. Yet here seems to be a lack of studies looking at psychotherapy from a cross-cultural, autonomy-supporting perspective for clients dealing with posttraumatic issues. This dissertation aims to explore ways in which trainee therapists use common factors that have been found to support autonomy for culturally diverse clients who have experienced trauma.

To achieve this goal, the following review of the literature describes trauma and its effects from a positive psychological viewpoint, which posits that that there is opportunity for survivors of trauma to experience posttraumatic growth. Next, a specific growth theory, the organismic valuing theory of posttraumatic growth, is described in more detail, highlighting its position that humans have an innate tendency towards growth, given that their social environment meet basic psychological needs, particularly autonomy. An explanation of the varying definitions of autonomy and autonomy support is provided, followed by literature related to the dilemma regarding the cultural importance of autonomy. Finally, common factors research and studies that have examined the support for autonomy in cross-cultural contexts are reviewed, highlighting the suggestion by various researchers that autonomy support may be considered a

common factor across all forms of therapy. The literature review ends with a summary of the study and its research question.

A Positive Psychological and Cultural Understanding of Trauma

  Positive psychology. The positive psychology movement was launched over a decade ago and has flourished since then within the psychological community (Seligman, 2011; Seligman & Csikszentmihalyi, 2000; Seligman, Steen, Park, & Peterson, 2005; Snyder & Lopez, 2009). Positive psychology builds on and attempts to unite the pioneering work of Maslow (1954), Rogers (1961), and Deci and Ryan (1985) among many other theorists and researchers who have attempted to focus on promoting mental health rather than merely treating illness, with increasing empirical support and validation for its theory and interventions (Seligman, 2011; Seligman et al., 2005).

  In an attempt to redirect the field of theoretical and practical psychology to its pre-World War II origins, Seligman and Csikszentmihalyi (2000) suggested that psychology must shift its preoccupation with disease, pathology, and human suffering to reestablish its focus on helping individuals thrive within their communities and achieve well being, satisfaction, optimism, and other personal strengths inherent in human beings. Prior to World War II, psychology had three missions: curing mental illness, making people's lives more productive and fulfilling, and identifying and nurturing high talent (Snyder & Lopez, 2005). However, with the founding of the Veterans Administration in 1946 and the National Institute of Mental Health in 1947, economic and professional forces shifted the field and its focus away from the latter two missions and emphasized only the aim of curing and alleviating psychopathology.

The positive psychology movement, in turn, aims to reestablish the goals of making people's lives more fulfilling and productive, and identifying and nurturing high talent, based on the premise that these variables serve as protective factors against psychological illness (Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2005, 2009). Prevention of mental illness is the foreground of the positive psychological approach, which is in contrast with the disease model that has dominated the field for so long (Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2005, 2009).

With that said, positive psychology does not stand alone in its emphasis on fostering the strengths and virtues of human beings. Rather, it has built on existing knowledge and shares many of the ideas that have been established by humanistic and existential traditions (Joseph et al., 2005; Linley & Joseph, 2004; Linley, Joseph, Harrington, & Wood, 2006; Seligman & Csikszentmihalyi, 2000; Taylor, 2001). Nonetheless, it is important to note that while positive psychology expands on these existing knowledge bases, it contributes its own unique perspective on optimal human functioning (Linley et al., 2006; Peterson & Park, 2003). By focusing on systematically building individuals' competencies, rather than correcting their weaknesses, positive psychology aims to identify and nurture human strengths such as optimism, honesty, interpersonal skills, courage, hope, and capacity for insight (Snyder & Lopez, 2005, 2009).

According to Seligman and Csikszentmihalyi (2000), positive psychology encompasses three dimensions of human functioning. The first level is the subjective level, which includes important subjective experiences such as well-being, contentment, and satisfaction (constructs related to the past); hope and optimism (constructs related to

the future); and flow and happiness (constructs related to the present). The second level, the individual level, is about positive individual traits including interpersonal skill, ability to love, capacity to find a vocation, aesthetic sense, perseverance, ability to forgive, uniqueness, optimism, spirituality, and wisdom. The third level, the group level, concerns the civic virtues and institutions that promote better citizenship for individuals. These constructs include responsibility, altruism, tolerance, and work ethic (Seligman & Csikszentmihalyi, 2000). This dissertation will focus on the first two pillars of positive psychology: valued subjective experiences (posttraumatic growth), and positive individual traits (autonomy).

Albeit all of these aspects and dimensions of human functioning focus on the strengths and virtues of human nature, Linley and colleagues (2006) suggest that there is a misconception within the field that positive psychology places most of its emphasis on the client's strengths. They argue, rather, that the positive psychology movement aims to find a balance between the negative and the positive. In other words, the goal is to change focus from fixing the worst things in life to *also* building people's positive qualities. The movement stresses that clinicians must focus on the entire breadth of human experience, which includes suffering, illness, distress, and loss, as well as well-being, health, connection, and fulfillment. The authors explain the development of positive psychology in the context of Hegel's (1807, 1931 as cited in Linley et al., 2006) idea of the cycle of a thesis, antithesis, and synthesis. A thesis (e.g., belief, idea, argument) is followed by an antithesis (i.e., view that conflicts with, contradicts, or opposes the thesis), which is then proceeded by a synthesis (i.e., the resolution of differences between the thesis and antithesis), with this synthesis then becoming the new

thesis (Linley et al., 2006). In this case, the thesis can be described as *business-as-usual psychology*, which refers to the diagnostic, *DSM*-based traditional practice of categorizing and pathologizing individuals then *curing* the illness. The antitheses can be demonstrated by positive psychology, which embodies a greater focus on and fostering of individual strengths and psychological well-being. The synthesis, then, is the union of both *types* of psychology – this is the present and future challenge of researchers and clinicians (Linley et al., 2006), including the goal of the current study.

Another concern regarding positive psychology involves its attention to culture and context. Cross-cultural researchers within the field of positive psychology critique the existing literature on the cognitive aspects of positive psychology among different cultures, arguing that many make the assumption that the constructs are equivalent across the varying cultures (Lopez et al., 2005; Pedrotti, Edwards, & Lopez, 2009). They also note that most of the research examining positive psychological constructs has focused predominantly on white samples, so the generalizability and concurrent and predictive validity of these cognitive processes with non-white cultural groups is limited.

In response to critiques, researchers and clinicians are beginning to place positive psychology in a multicultural context and examine related constructs across different cultures (Lopez et al., 2005; Pedrotti et al., 2009).   Although it has been established that societal and cultural factors affect the ways in which individuals pursue identity development, goals, and happiness, minimal effort has been made thus far to identify the cultural factors that influence mental health and its various interpretations among people from different cultural backgrounds (Lopez et al., 2005; Pedrotti et al., 2009). Nonetheless, the field of positive psychology has begun to shift from findings that are

generalized across diverse individuals, to examining strengths within a culture or community that may be unique to that group, with qualitative research leading this mission (Pedrotti et al., 2009). In fact, researchers are beginning to investigate the role of culture-specific strengths, such as ethnic identity, familism, bicultural competence, and religion/spirituality, as buffers against the negative effects of stress (Lopez et al., 2002 as cited in Pedrotti et al., 2009). Consistent with the aim of positive psychology to simultaneously address weaknesses and strengths, Wright and Lopez (2002, as cited in Pedrotti et al., 2009) propose the four-front approach to identify strengths and positive coping strategies of individuals from various cultural backgrounds. Based on this approach, clinicians gather information about "(a) strengths and assets of the client, (b) deficiencies and undermining characteristics of the client, (c) resources and opportunities in the environment, and (d) deficiencies and destructive factors in the environment" (Wright & Lopez, 2002 as cited in Pedrotti et al., 2009, p. 55). Similarly, Chin (1993) developed the human diversity model to broaden the focus of research beyond racial, ethnic, and cultural issues to include heterogeneous groups with unique differences and strengths. Chin suggested that clinicians examine the cultural behaviors of their clients for their inherent health-promoting values, using the following guidelines: (a) displaying positive presentation of values, potentials, and lifestyles of culturally diverse clients; (b) abandoning the perspective that cultural differences are actually deficits; (c) recognizing that cultural differences do indeed exist; (d) exploring the frameworks that are biased against these differences; and (e) appreciating the adaptability of cultural behaviors which have survived over time. This dissertation attempts to examine more closely the construct of autonomy as a cultural behavior, consistent with emerging research that

highlights the importance of a multicultural approach to examining strengths and how they may or may not differ across diverse clients.

Culture defined. The concept of culture refers to "shared attitudes, beliefs, categorizations, expectations, norms, roles, self-definitions, values, and other such elements of subjective culture found among individuals whose interactions were facilitated by *shared* language, historical period, and geographic region" (Triandis, 1972, p. 3). Culture can be defined in a variety of ways; this study focused on a conceptualization of culture on the basis of *individualism* and *collectivism*, which are two distinct constructs that have been widely used in the literature to differentiate between different types of cultural organizations (Triandis, 1993, 2002).

Triandis (1993, 2002) refers to these differing cultural groups as empirically established *cultural syndromes,* defined as "a set of elements of subjective culture organized around a theme" (p. 156). In the case of individualism, the organizing theme is the centrality of the "autonomous" individual, whereas in the case of collectivism, the organizing focus is the collective (e.g., family, ethnic/religious group, tribe, work organization; Triandis, 1993, 2002). Kitayama, Park, Sevincer, Karasawa, and Uskul (2009) suggested the role of independence and interdependence as the unifying theme of a cultural syndrome. Countries that are considered to represent individualistic cultural syndromes or groups include the United States, Canada, Australia, New Zealand, Western Europe (e.g., France, Netherlands, United Kingdom) or the Pacific Islands (Schwartz, Unger, Zamboanga, & Szapocanki, 2010). In contrast, individuals from countries/ or regions such as Latin America, Asia, Africa, Caribbean, or the Middle East

typically embrace and embody collectivistic themes in terms of their organizing focus (Schwartz et al., 2010; Triandis, 1993).

There is a long history of scholars and researchers attempting to define the specific aspects of individualism and collectivism (Triandis, 2002). What is currently conceptualized in the literature as a difference between individualistic and collectivistic cultural patterns was defined by Toennis (1957 as cited in Triandis, 2002) as a distinction between *Gemeinshaft* (community) and *Gesellschaft* (society); by Weber (1947 as cited in Triandis, 2002), as communal or associative social relations; and by Kluckhohn and Strodtbeck (1961 as cited in Triandis, 2002) as collaterality or individualism. One approach has been a distinction between *mechanical solidarity* and *organic solidarity* (Durkheim, 1949 as cited in Triandis, 2002). Mechanical solidarity refers to a sense of feeling close to others because they are similar to oneself; in other words, there is a natural emotional connection because of inherent similarities among groups of people (e.g., such as in Greece or Japan). Organic solidarity, on the other hand, was used to describe heterogeneous and competitive cultures, with an emphasis on the "different self" (Triandis, 2002). This differentiation between mechanical and organic solidarity is similar to the current understanding of the difference between collectivism and individualism, respectively. A similar and more recent distinction has been found in discussions of the embedded, interdependent self versus the autonomous, independent self (e.g., Markus & Kitayama, 1991).

Triandis (1993) suggests a continuous approach to thinking about individualism and collectivism, noting that the independent and interdependent selves do not necessarily have to contradict one another. In fact, most cultural groups include a mixture

of both individualistic and collectivistic factors, and most individuals within those cultural groups have both patterns within their cognitive systems (Triandis, 1993). There are certain factors that make it more likely for an individual to have a collectivist or an individualist cognitive schema activated at any given time (Triandis, 1993). For a collectivist activation, the person must (a) know that the other people are collectivists, (b) be in a collective, such as in a family, (c) perceive an emphasis on what makes the person the same as the collective, and (d) be working on a collaborative task (Triandis, 1993). In order for an individualistic cognitive pattern to be activated, the following factors must be present: (a) the others in the situation are individualists, (b) the focus is on what makes the person distinct from others, (c) the task is a competitive one, and (d) the environment is a public one, such as the marketplace (Triandis, 1993).

Collectivism and individualism are further conceptualized on the basis of what is referred to as *horizontal collectivism, vertical collectivism, horizontal individualism*, and *vertical individualism* (Chirkov, 2007; Triandis, 1993). Table 1 below depicts sample cognitions that exemplify each of these cultural schemas.

Table 1

Cognitions exemplifying collectivistic and individualistic cultural schemas

	Vertical	Horizontal
Individualism	"I will do better than others."	"I will depend on myself rather than on others."
Collectivism	"I will do what pleases my family."	"I will consult with closer friends before making a decision."

Triandis (1993) suggests that extremes of either collectivism or individualism is undesirable, and that there must be a better understanding and striving towards choosing only the most productive and health-promoting elements of each cultural pattern. On one

extreme of maximum collectivism in which in-group homogeneity is exclusively valued,

there have been incidences of ethnic cleansings and genocides such as those of the Jews,

Armenians, and Bosnian Muslims. With extreme individualism, where the sole emphasis

is on being separate and better than everyone else in society, there are occurrences of

crime, homelessness, and a general weakening of the family system (Triandis, Bontempo,

Villareal, Asai, & Lucca, 1988 as cited in Triandis, 1993). Some researchers have even

suggested that individualistic attitudes and values may place a person at risk for health-

compromising behaviors (Schwartz et al., 2010). It is evident, then, that a good balance

of individualistic and collectivistic cultural values, worldviews, cognitions, and practices

would conduce optimal functioning and well-being of individual members as well as the

groups as a whole.

Although much psychological and cross-cultural research has focused on the

distinction between individualism and collectivism, this dichotomous categorization does

not account for all the different facets of subjective culture, let alone culture in its broader

sense (Matsumoto, 2007; Matsumoto, Kudoh, & Takeuchi, 1996). In a broader view,

culture has been described as having both objective and subjective aspects, with

objectives aspects including things like social institutions, architecture, food, and

physical artifacts, whereas subjective culture includes attitudes, opinions, beliefs, and

values (Triandis, 1972 as cited in Matsumoto et al., 1996). The dimensions of

individualism versus collectivism are aspects of subjective culture that have been shown

to vary in terms of perceptions of the self in the context of others (Markus & Kitayama,

1991). However, researches have argued that there is substantial variability *within*

cultural groups that is not accounted for in the dichotomization of subjective culture

(Matsumoto et al., 1996). In other words, the same aspect of subjective culture that is characteristic of individuals within one cultural group (e.g., strong value of family ties in collectivistic cultures) may be manifested in differing ways (Matsumoto, 2007; Matsumoto et al., 1996). Cultural values, customs, behaviors, and beliefs change across time and for varying reasons, and individuals within a distinct cultural group endorse cultural values, beliefs, and practices to different degrees (Matsumoto, 2007; Matsumoto et al., 1996). As such, it is important to consider not only the homogeneity within cultural groups (e.g., individualistic and collectivistic) that separate them from one another, but also the heterogeneity that exists *within* these groups.

     Understanding trauma and growth in a multicultural context. With the aforementioned idea of a synthesis of the negative and positive aspects of human experience (Linley et al., 2006) serving as a framework for this study, we recognize that individuals suffer from stressful and traumatic events, and the reactions that result from this suffering, such as posttraumatic stress disorder (PTSD), must be addressed. Concurrently individuals also grow as a result of their experiences with adversity, and clinicians must foster this opportunity for posttraumatic growth as well. Snyder and Lopez (2005) argue that human strengths are "the fundamental conditions of experience, and if they are present, any amount of objective obstacles can be faced with equanimity, and even joy" (p. 8). They also note "building strength is the most potent weapon in the arsenal of therapy" (Snyder & Lopez, 2005, p. 3). Indeed, literature is beginning to address and support the importance of incorporating positive psychological tenets into psychotherapy, particularly with individuals who have experienced a traumatic event (Joseph & Linley, 2005, 2008, 2011; Levine, Lauger, Hamama-Raz, Stein, & Solojkmon,

2008; Linley & Joseph, 2004; Sheikh, 2008; Tedeschi & Calhoun, 1996). The following sections discuss the various definitions of trauma that have evolved and are in use within the field, offer an integrative definition of trauma that will be used throughout this dissertation, and describe both the negative and positive effects of trauma, focusing on posttraumatic growth. When presenting this information, the similarities and differences for individuals across cultures is provided in terms of their experiences of trauma, traumatic stress, and posttraumatic growth.

 Trauma defined. There are many different ways to understand trauma and PTSD, and researchers and clinicians conceptualize and operationalize the constructs in varying ways, presenting a challenge in the field. The definitions and conceptualizations of trauma and PTSD have undergone much debate, revision, and criticism, particularly since the birth of the modern field of traumatic stress following the Vietnam War (Briere & Scott, 2006). The term *posttraumatic stress disorder* was first introduced to the field in 1980 in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III; APA, 1980), and was developed to capture psychopathology that was associated with trauma experienced by adults (van der Kolk, 2003). In fact, the validity of the diagnosis has had a recent history of skepticism, as it has been suggested to be better understood as a form of malingering, a personality disorder, or another form of psychopathology (Davidson & Foa, 1991). As Rosen (2004) states: "It is the rare moment when most every assumption and theoretical underpinning of a psychiatric disorder comes under attack, or is found to lack empirical support. Yet, this is the situation faced by PTSD" (p. xi). It has been suggested that the problem with understanding trauma-related conditions, including but not limited to PTSD, and their treatments is that the sources are widely

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dispersed, not easily available to clinicians, tend to refer to a single theoretical

orientation, focus on a single group of victims, and often do not provide adequate

information on how to actually implement a given treatment approach (Briere & Scott,

2006; Davidson & Foa, 1991). The following sections will address some of the

differences in understanding trauma and its related disorders, namely, physical versus

psychological threats to individuals, an isolated incident of trauma versus multiple

occurrences or events with longer durations, and an event- versus perception-based

understanding of the concept of trauma.

     Physical versus psychological. One of the most profound arguments within the

field is whether trauma should include events that impact only an individual's physical

integrity, or an individual's physical and psychological integrity (Briere & Scott, 2006).

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text

Revision* (*DSM-IV-TR*; APA, 2000) takes the first stance in the argument, and requires

that "the person experienced, witnessed, or was confronted with an event or events that

involved actual or threatened death or serious injury, or a threat to the physical integrity

of self or others" (Criterion A1; APA, 2000, p. 467). The *DSM-IV-TR* includes the

following list, albeit not comprehensive, of experienced events that may be considered

traumatic: military combat, violent personal assault (i.e., sexual or physical assault,

robbery, mugging), being kidnapped or taken hostage, terrorist attack, torture,

incarceration as a prisoner of war or in a concentration camp, disasters (natural or

manmade), severe automobile accidents, receiving a diagnosis of a life-threatening

illness, or, in the case of children, developmentally inappropriate sexual experiences that

do not include threatened or actual violence or injury. Traumatic events that may be

witnessed or otherwise indirectly experienced may include observing the death or serious

injury of another person due to violent assault, accident, war, or disaster; unexpectedly

seeing a dead body or body parts; serious injury to a family member or close friend;

unexpected death of a family member or close friend; or learning that one's child has a

life-threatening disease (APA, 2000).

The *DSM-IV-TR* definition of trauma has been criticized because many events

that do not include a life threat or physical injury may lead to just as much suffering as

those events that do pose a threat to life or physical integrity (Briere, 2004; Briere &

Scott, 2006; Long et al., 2008). Further, it has been argued that those individuals who

suffer threats to their psychological integrity respond just as well to trauma-focused

therapies (Briere & Scott, 2006). According to Briere and Scott (2006), who propose a

broader, more inclusive, definition of trauma in the context of treatment, an event is

considered to be traumatic "if it is extremely upsetting and at least temporarily

overwhelms the individual's internal resources" (p. 4).

Whereas some experts argue that the *DSM* definition of trauma has become too

broad and inclusive over the evolutions of the text (Elhai, Kashdan, & Frueh, 2005;

McNally, 2003), others have argued that Criterion A1 of the *DSM-IV-TR* should be

broadened further to include experiences that are less severe but still considered to be

serious events, such as sexual harassment, chronic illness, or childbirth complications

(Olde, van der Hart, Kleber, & van Son, 2006; Palmieri & Fitzgerald, 2005; Smith,

Redda, Peyserb, & Vool, 1999). Long and colleagues (2008) built on recent empirical

studies and examined the differences in symptom ratings between PTSD's Criterion A1

and non-Criterion A1 events, and found that, compared to criterion A1 events, non-

Criterion A1 events were associated with greater likelihood of PTSD diagnoses and greater PTSD symptom frequency. These authors, among others, suggest that the definition of a trauma has broad implications for the identification of trauma victims/survivors, allocation of resources for those individuals, and clarification of trauma-related research (Long et al., 2008; McNally, 2003). For the purposes of the current study, we combine the *DSM-IV-TR* and Briere and Scott (2006) conceptualization of trauma, defining trauma more broadly to include threats to both the physical as well as psychological integrity of individuals, and that are extremely upsetting and overwhelm the individual's internal resources.

Isolated versus multiple incidents. Trauma can refer to an isolated event that is highly stressful, or to multiple such events (van der Kolk, 2000). Most people who seek treatment for trauma-related problems have histories of multiple traumas (Kessler, 2000; van der Kolk, 2000, 2003). Many of these individuals present with a variety of other primary psychological issues in addition to PTSD symptoms, including behavioral impulsivity, affective lability, aggression towards self or others, depersonalization and dissociation, chronic feelings of shame and self-blame, and unsatisfactory interpersonal relationships (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Davidson, Hughes, Blazer, & George, 1991; Kessler, 2000; van der Kolk 2000, 2003). These multiple traumas, typically occurring in childhood, are collectively referred to as complex trauma, or developmental trauma disorder (DTD; van der Kolk, 2005), because of the dual nature (i.e., immediate and long-term) of their impact (Cook et al., 2003; Ford & Courtois, 2009). Complex psychological trauma is defined as resulting from exposure to severe stressors that (a) are chronic and repetitive, (b) involve abandonment or harm by

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caregivers/other responsible adults, and (c) occur at developmentally vulnerable periods in the victim's/survivor's life (e.g., early childhood or adolescence) during critical periods of brain development or consolidation (Ford & Courtois, 2009).

Complex trauma often has both immediate and long-term impacts on the child, including impairments in attachment and self-regulation, behavioral disorders (e.g., substance abuse eating disorders, aggression), dissociative and somatoform disorders, medical disorders, sexual disorders, and revictimization (Cook et al., 2003; Whealin & Slone, n.d.). The child may be left unable to self-regulate (control feelings, cognitions, beliefs, actions), achieve a sense of self-integrity (belief that one is unique, whole, worthy), or experience relationships as nurturing, reliable and supportive resources (Ford & Courtois, 2009). As such, these individuals often present with safety concerns that need to be the primary focus of treatment (Ford, Courtois, Steele, Van der Hart, & Nijenhuis, 2005). Ensuring safety involves managing maladaptive behaviors such as self-harm, suicidality, substance abuse, eating disorders, unhealthy risk taking, and relational aggression (Ford et al., 2005). An empathic and consistent therapeutic relationship may serve as a model for "containing" rather than avoiding or becoming overwhelmed by intense emotions and impulses (Ford et al., 2005).

In an attempt to better capture the complex symptomatology and clinical presentation of this majority of survivors seeking treatment, members of the PTSD taskforce for the *DSM-IV* Field Trial proposed a syndrome of psychological problems which have been frequently associated with histories of prolonged abuse, called *Complex PTSD*, or *Disorders of Extreme Stress Not Otherwise Specified* (DESNOS; Briere & Scott, 2006; Herman, 1992; van der Kolk, 2000). This syndrome includes a complex set

of issues associated with early interpersonal trauma, including affective dysregulation, changes in attention and consciousness leading to episodes of amnesia and dissociation, difficulty forming and sustaining interpersonal relationships, somatization, and changes in systems of meaning (van der Kolk, 2003).

Particularly in the case of interpersonal traumas (e.g., sexual abuse, physical assault), survivors are at statistically greater risk for additional interpersonal traumas (Briere & Scott, 2006). This situation in which a history of childhood abuse makes it significantly more likely for an individual to be victimized again as an adult is sometimes referred to as *revictimization* (Briere & Scott, 2006). A vicious cycle tends to develop, where childhood abuse results in symptoms and maladaptive behaviors in adolescence and adulthood (e.g., substance abuse, indiscriminate sexual behavior, reduced awareness of the environment through dissociation and denial), leading to an increased likelihood for further interpersonal victimization (Briere & Jordan, 2004; Briere & Scott, 2006). Studies have pointed to direct links between early traumatic attachment experiences and the inability of people with certain types of personalities to regulate fear-terror states, which eventually put individuals at higher risk for developing PTSD (Schore, 2003).

This presentation of multiple trauma histories leads to a complicated situation for clinicians working with individuals seeking treatment for trauma, since both childhood and current traumas can produce psychological difficulties (Briere & Scott, 2006; Cloitre et al., 2009). Current symptoms in adult survivors of childhood abuse might represent one or more of the following: (a) effects of childhood trauma that have lasted into adulthood; (b) effects of more recent trauma; (c) additive effects of childhood and adult trauma; and/or (d) exacerbating interaction of childhood and adult trauma (Briere & Scott, 2006).

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Complex Trauma Disorder is currently under consideration for *DSM-V*, and would be an invaluable diagnostic addition because patients with histories of multiple traumas typically do not respond to conventional PTSD treatment, including interventions such as cognitive processing therapy, eye movement desensitization and reprocessing, and prolonged exposure therapy (Briere & Scott, 2006; Ford & Kidd, 1998 as cited in Briere & Scott, 2006). Thus, it may be important to differentiate clients who are seeking treatment for an isolated traumatic event from individuals whose abusive histories are more appropriately diagnostically conceptualized through a complex PTSD framework.

Event-based versus perception-based definition. The construct of *trauma*, when first introduced in the *DSM-III*, was defined as an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone (Criterion A). The magnitude and severity of the stressor were emphasized, and the rarity of occurrence of this type of event was minimized. However, as epidemiological research began to show that traumas of this nature and magnitude were more prevalent than originally believed, criticism over the wording of the original definition forced the authors of *DSM* to modify their diagnostic criteria for the subsequent revision of the text (Weathers & Keane, 2007).

The definition of PTSD has been modified in an effort to better account for the statistical frequency of traumatic events as well as the subjectivity of dimensional interpretations of extreme distress (Weathers & Keane, 2007). In the *DSM-IV*, the requirement that the event needed to be of a particularly high magnitude was removed, and the definition of trauma became more dependent on an individual's *perception* of an event as being highly physically threatening, rather than based on a more objective

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measure (Weathers & Keane, 2007). Weathers and Keane (2007) used the term

potentially traumatic event (PTE) in their research to reflect the subjectivity and

perception-based nature of trauma. The *DSM-IV* (APA, 2000) definition allows events

that do not necessarily fall outside of usual human experience (e.g., traffic accidents,

invasive medical procedures) to be considered traumatic. The A2 criterion, which

specifies that "the person's response involved intense fear, helplessness, or horror," (p.

467) acknowledges the subjective nature of the individual's interpretation of an event as

traumatic. Accordingly, *trauma* has been used to refer both to negative events that are

distressing to an individual (i.e., event-based definition) and to the distress itself (i.e.,

perception-based definition, Briere & Scott, 2006).

　　　Nonetheless, the authors of the current diagnostic standards for PTSD kept the

diagnosis consistent with the original intended meaning and application, with the *DSM-*

IV-TR defining trauma as involving the following:

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

Based on this conceptualization, traumas as defined diagnostically continue to be

identified as specific major events *that fall outside of normal human experience* and are

psychologically overwhelming for individuals (Briere & Scott, 2006; Weather & Keane,

2007).

　　　In an attempt to tighten the definition of a traumatic event and eradicate

ambiguities, the *DSM-V* PTSD Task Force proposes to change Criterion A to specify an

"exposure to actual or threatened a) death, b) serious injury, or c) sexual violation"

(http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=165)

through direct experience, witnessing the event occur to others, learning of an event

occurring to a close family member or friend, and/or experiencing repeated or extreme

exposure to aversive details of the event (APA, 2012). Further, the *DSM-V* plans to omit

Criterion A2 (i.e., "the person's response involved intense fear, helplessness, or horror,"

p. 467) on the basis that it does not provide any clinical utility; the criterion will instead

be listed as an associated symptom (APA, 2012; Hinton & Lewis-Fernandez, 2011). This

omission of the negative subjective appraisal criterion lends itself to a more objective,

event-based definition of a traumatic event for purposes of diagnosing PTSD, though it is

argued whether or not this would increase the validity of a PTSD diagnosis (Hinton &

Lewis-Fernandez, 2011). For the purposes of the current study, an event- and perception-

based definition of trauma will be used – trauma will be defined in terms of both the

nature of the event experienced by the client (directly or indirectly) as well as the client's

perception of an event as being traumatic.

>   ***Negative effects of trauma.*** Psychological trauma can have profound adverse

effects on its survivors (Briere & Scott, 2006; Foa, Keane, & Friedman, 2000; Janoff-

Bulman, 2002; Joseph et al., 2005; van der Kolk, 2003). Briere and Scott (2006) note

that most people in Western society will experience at least one traumatic event during

their lives, and a significant number of these individuals will suffer lasting psychological

distress, ranging from mild lingering anxiety to symptoms that interfere with all aspects

of functioning. The negative effects of trauma impact one's cognitive (Janoff-Bulman,

2002; Joseph & Linley, 2005), emotional (Briere, Hodges, & Godbout, 2010; Briere &

Jordan, 2004; Briere & Scott, 2006; Janoff-Bulman, 2002; Olde et al., 2006; Palmieri &

Fitzgerald, 2005; van der Kolk, 2003), and/or physical functioning (Briere & Scott, 2006;

Cook et al., 2003; Felitti, 2009; Felitti et al., 1998).

   Cognitive. On a cognitive level, psychological trauma has the potential impact of

changing survivors' basic assumptions about themselves and the world (Janoff-Bulman,

2002; Joseph & Linley 2005, 2008, 2011). Cognitive schemas play an important role in

perception, memory, and interpretation of information (Janoff-Bulman, 2002). Humans

have a tendency to preserve already-established beliefs, which are typically positive

feelings of comfort and security (Janoff-Bulman, 2002). When one experiences a

traumatic event, these core assumptions and beliefs often shatter, leaving the individual to

struggle with the propensity for cognitive conservatism (Janoff-Bulman, 2002). Joseph

and Linley (2005) suggest that trauma-related information may be processed in one of

three ways: it can be (a) *assimilated* (i.e., return to pre-trauma baseline of functioning),

(b) *negatively accommodated* (resulting in psychopathology), or (c) *positively

accommodated* (leading to growth). Assimilation is an individual's attempt to

incorporate information to fit his or her existing assumptions about the world as just and

fair, whereas accommodation requires individuals to change their worldview to better fit

the new trauma-related information, in either a positive or negative direction (Janoff-

Bulman, 2002; Joseph & Linley, 2005). Positive accommodation, then, is suggested to be

most conducive to positive outcomes following trauma (Joseph & Linley, 2005).

   Psychological/emotional. The adverse emotional and psychological impact of

trauma has been well documented (Briere et al., 2010; Briere & Jordan, 2004; Briere &

Scott, 2006; Janoff-Bulman, 2002; Olde et al., 2006; Palmieri & Fitzgerald, 2005; van der

Kolk, 2003). Some of the common psychological reactions to trauma include: depression (e.g., major depressive disorder, psychotic depression, feelings of loss, abandonment, and isolation), complicated or traumatic grief, anxiety (generalized anxiety disorder, panic disorder, posttraumatic phobias), stress disorders (PTSD, acute stress disorder, complex PTSD), somatoform responses (e.g., conversion disorder, undifferentiated somatoform disorder), dissociative disorders, substance abuse, and personality disorders (e.g., borderline personality disorder; Briere & Scott, 2006; Herman, 1992; Schore, 2003; van der Kolk, McFarlane, & Weisaeth, 1996). Other reactions, particularly to complex trauma, may include helplessness, shame, grief, loss of connection with one's spirituality, and disruption of one's ability to hope and trust (Briere & Scott, 2006; Cook et al,, 2003; Hall & Sales, 2008). In extreme cases, the horror and threat resulting from a traumatic event may temporarily or permanently alter the survivors' capacity to cope, their perception of biological threat, and their self-concept (van der Kolk, 2003). These individuals frequently develop PTSD, in which memory of the traumatic event(s) can dominate their consciousness and deplete their lives of meaning and pleasure (van der Kolk, 2003; van der Kolk & van der Hart, 1991 as cited in van der Kolk, 2003). Briere and Scott (2006) suggest that the psychological effects of trauma may be evaluated subjectively by a clinician observing the client's verbal and nonverbal behavior for *process responses*, which include activation responses (e.g., negative emotions that emerge in response to a triggering stimulus), avoidance responses (e.g., withdrawal from persons or topics related to the traumatic stressor), affect dysregulation, and relational difficulties.

Physical/ neurobiological. Psychological trauma can also affect the survivor's

physical functioning (Briere & Scott, 2006). Schore (2003) suggests "the concept of

trauma, which is by definition psychobiological, is a bridge between the domains of both

mind and body" (p. 109). Individuals diagnosed with PTSD have been shown to have

increased occurrences of back pain, hypertension, arthritis, lung disease, nervous system

diseases, circulatory disease, cancer, stroke, digestive disorders, and endocrine disorders

(Briere & Scott, 2006; Cook et al., 2003). Other conditions that may develop as a result

of experiencing trauma include alcoholism, drug abuse, suicide attempts, smoking,

sexually transmitted disease acquired from promiscuous behavior, physical inactivity and

obesity, ischemic heart disease, skeletal fractures, hepatitis, diabetes, and liver disease

(Felitti, 2009; Felitti et al., 1998). Some researchers suggest that poor physical and health

outcomes in adult survivors of childhood trauma may be due either to the impact early

life stress has on the immune system, or to the greater tendency for adult survivors to

engage in high-risk behaviors such as promiscuity or drug abuse (Sachs-Ericsson,

Cromer, Hernandez, & Kendall-Tackett, 2009). In general, trauma-related disorders have

been associated with lower physical health status, higher use of medical services, and

higher health care costs (Briere & Scott, 2006).

The adverse impact of complex trauma may be particularly debilitating given

neurobiological findings of the effects of trauma on brain development (Heim &

Nemeroff, 2001; Schore, 2003, 2008; Siegel, 1999). Severe traumatic attachments during

early childhood result in structural limitations of the early developing right brain

responsible for attachment, affect regulation, and stress modulation (Schore, 2003, 2008).

As a result, a variety of functional impairments may occur, including an inability to

regulate emotional states under stress, which can lead to later physical and psychological

coping deficits characteristic of PTSD symptoms (Schore, 2003, 2008).

 Cultural variations of trauma and PTSD. With regard to understanding trauma

and its effects there may be variability across individuals from different cultural and

subcultural groups in the manifestation of posttraumatic symptoms and experiences

(Briere, 2004). Posttraumatic stress disorder as a clinical diagnosis is considered to be

partially culture bound, since it best describes posttraumatic symptom presentations of

those born and raised in Anglo/European countries (Briere, 2004). Individuals from other

cultural groups may experience and express the effects of trauma differently from the

DSM-IV criteria that is required to diagnose PTSD. The *DSM-IV-TR* acknowledges

several culture-bound syndromes defined as "recurrent, locality-specific patterns of

aberrant behavior and troubling experience that may or may not be linked to a particular

DSM-IV diagnostic category" (p. 898). These culture-bound syndromes are differentiated

from societal or cultural variations of *DSM-IV* diagnoses in that these clusters of signs

and symptoms are "localized, folk, diagnostic categories that frame coherent meanings

for certain repetitive, patterned, and troubling sets of experiences and observations" (p.

898). These culture-bound syndromes include symptoms such as dissociation,

somatization, and anxiety-related responses (e.g., attaques de nervios) that can be related

to experiences of trauma for individuals from ethnic and cultural reference groups that

are different from those found in Western cultures, and are important to consider when

considering trauma-related issues in assessment and treatment.

 Differences in the prevalence and manifestation of PTSD are found within the

United States, particularly given the increasing diversity and heterogeneity of the

population (U.S. Census Bureau, 2011) and the underrepresentation of ethnoracial

minorities in the psychology literature despite their growing numbers (Pole, Gone, &

Kulkarni, 2008; Stephens, Sue, Roy-Byrne, Unutzer, Wange, Rivara, et al., 2010 as cited

in Pole & Triffleman, 2010). Pole and colleagues (2008) reviewed the evidence for

differences in prevalence and treatment of PTSD across and within different racial groups

(i.e., European Americans, African Americans, Latino Americans, Asian and Pacific

Islander Americans, and American Indians), and found varied prevalence rates, including

differences between subgroups within the larger ethnoracial groups. Despite these within-

group differences, Latino Americans were most consistently found to have higher PTSD

rates than their European American counterparts; other group differences were found to

be accounted mostly by differences in trauma exposure (Pole et al., 2008).

In contrast, a study of the variance between Hispanic and White college students

on self-report of PTSD symptoms suggested no significant differences between groups in

the experience of PTSD, even when the disorder was measured using different factor

models of the construct (i.e., presence of different number and types of PTSD symptoms

as defined by *DSM-IV-TR* criteria, Hoyt & Yeater, 2010 as cited in Pole & Triffleman,

2010). The authors noted that these findings may be attributable to factors related to

acculturation, as Hispanics who have acculturated to American society may be more

similar to than different from non-Hispanic Whites, precluding any expected differences

in their manifestation of trauma-related symptoms (Hoyt & Yeater, 2010 as cited in Pole

& Triffleman, 2010). This limitation highlights the importance not only of considering

ethnoracial group differences in the prevalence and manifestation of PTSD in the United

States, but differences *within* those groups, since acculturation of immigrants and their

children is a phenomenon that is particularly salient in contemporary American society (Schwartz et al., 2010). This will be discussed in further detail below.

Other recent studies have found factors such as length of residence in the United States and marital status to be a key source of variation for PTSD in Hispanic Americans (Pole & Triffleman, 2010). For example, one study that compared adult Latina immigrants who had lived in the United States for varying number of years found that those who had lived in the United States for fewer years had a greater number of co-occurring symptoms of PTSD and depression than those participants who had lived in the United States for a longer period of time. In addition, married participants were found to be at lower risk for these disorders than unmarried participants, the latter of whom may be especially vulnerable to PTSD psychopathology because of the cultural emphasis on *familismo* (family) commonly observed within Latino culture (Kaltman, Green, Mete, Shara, & Miranda, 2010 as cited in Pole & Triffleman, 2010).

There have also been differences found in trauma and PTSD issues for African Americans. Specifically, Munroe, Kibler, Ma, Dollar, and Coleman (2010, as cited in Pole & Triffleman, 2010) found that PTSD symptoms may contribute to the risky sexual behaviors that place Black women at heightened probability for developing HIV and AIDS. Liebschutz and colleagues (2010) conducted a qualitative study of the factors that preclude urban African American men, a group at high risk for exposure to violence, from participating in research and otherwise seeking out support for trauma-related issues. Factors that impeded research participation included fearing involvement by police, being perceived as a "snitch" in disclosing personal information, distrusting the motives related to the research as well as the process of informed consent, other issues

related to logistics, and the emotional impact of the trauma itself. On the other hand, factors that facilitated participation in research included monetary incentives and motivation to help oneself and others (Schwartz et al., 2010). These findings indicate that qualitative approaches may provide useful information for clinicians working with trauma issues in this specific population, as they can help to identify potential motivating variables for urban African American men to seek out help or support for their trauma related issues. Future research should examine motivating factors related to support-seeking in other ethnoracial minority groups.

With respect to Asian Americans, psychosomatic presentation of PTSD symptoms has been a consistent finding in the literature (Hinton et al., 2010 as cited in Pole & Triffleman, 2010; Hsu & Folstein, 1997 as cited in Hinton, Pich, Chhean, Safren & Pollak, 2006; Park & Hinton, 2002 as cited in Hinton et al., 2006). In a study of Cambodian refugees, for example, Hinton and colleagues (2010 as cited in Pole & Triffleman, 2010) identified objective evidence that culture-related cognitions play a mediating role in the psychosomatic syndrome observed among many Asians. The authors used an outcome measure for culture-relevant fears, such as "death" of their arms and legs, heart arrest, neck-vessel rupture, and fainting, and they recommended that such cognitions could serve as targets of treatment in psychological interventions, particularly via cognitive-behavioral therapy.

Growth in the aftermath of trauma. It has long been established that traumatic events can have severe and chronic psychological consequences, but there is a growing body of literature documenting the positive psychological changes that can result from people's struggle with traumatic experiences (Calhoun, Cann, & Tedeschi, 2011;

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Calhoun & Tedeschi, 1999, 2006; Joseph & Linley, 2008, 2011; Linley & Joseph, 2004; Tedeschi & Calhoun, 1995, 2004a, 2004b; Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2011). With the growth of the positive psychological movement, experts in the field are finding or rediscovering that stressful and traumatic experiences may be an opportunity for personal growth. Joseph and Linley (2005) note:

> At first glance, the study of stressful and traumatic events might appear to be the nemesis of positive psychology. However, a number of literatures and philosophies throughout human history have conveyed the idea that there is personal gain to be found in suffering. (p. 262)

The idea that there can be benefit and positive change resulting from trauma and adversity has an extensive history in philosophy, literature, as well as humanistic-existential and other domains in the field of psychology (Frankl, 1963; Joseph & Linley, 2005; Linley et al., 2006; Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2005; Yalom, 1980). More recently, in the context of positive psychology, this positive change has been referred to as *growth through adversity* (Joseph & Linley 2005). Other terms include *adversarial growth* (Linley & Joseph, 2004), *perceived benefits* (McMillen & Fisher, 1998 as cited in Joseph & Linley, 2005), *stress-related growth* (Park, Cohen, & Murch, 1996), *thriving* (O'Leary & Ickovics, 1995 as cited in Joseph & Linley, 2005), *benefit-finding* (Affleck & Tennen, 1996 as cited in Joseph & Linley, 2005), *heightened existential awareness* (Yalom & Lieberman, 1991 as cited in Joseph & Linley, 2005), *positive by-products* (McMillen & Cook, 2003 as cited in Joseph & Linley, 2005), *positive illusions* (Taylor, 1983), *posttraumatic success* (O'Hanlon, 1999), and *posttraumatic growth* (PTG; Tedeschi & Calhoun, 1996).

 Defining growth. In *Becoming a Person*, Carl Rogers (1961) refers to growth as an individual's tendency to reorganize his personality and his relationship to life in ways

that are regarded as more mature. According to Rogers, this drive toward self-actualization is a forward-moving directional tendency, an urge that is evident in all human life to develop, mature, become autonomous, express, and activate all capacities to the extent that such activation enhances the self. This actualizing tendency allows the individual to continually aim to fulfill his or her potential as a fully functioning person (Rogers, 1961). Rogers' research emphasizes how psychotherapy can serve as a suitable psychological climate to release this growth tendency.

The various models of growth in the literature have been described as representing two basic processes by which personality growth occurs: stage models of personality development and catastrophe models (Sheldon, Kasser, Smith, & Share, 2002). In stage models of personality development, growth occurs during particular stages in life when transitions occur in life tasks or social roles, and the person successfully negotiates these role transitions; in other words, growth occurs during important developmental transitions in life such as from adolescence to adulthood. This type of growth typically involves increasing self-awareness, self-acceptance, and social integration (Hy & Loevinger, 1996 as cited in Sheldon et al., 2002; Snyder & Cantor, 1998 as cited in Sheldon et al., 2002). In contrast, the catastrophe model posits that personal growth occurs in response to various emotional or psychic traumas (Tedeschi & Calhoun, 1995) or as a result of dramatic changes in life circumstances or locations (Showers & Ryff, 1996 as cited in Sheldon et al., 2002). Such challenges force the individual to develop a new organization of his or her personality system (Ryan, 1993 as cited in Sheldon et al., 2002), which leads to new insight or rediscovery of important values (Tedeschi, Parks, & Calhoun, 1998 as cited in Sheldon et al., 2002). Both models

are similar in that growth is thought to occur in response to challenging circumstances in life; the models differ in their ideas regarding the causes and timing of personal growth. The growth that is described in the "catastrophe" (e.g., trauma or drastic life circumstance change) models has been termed posttraumatic growth (PTG), and refers to positive psychological change that occurs through the experience of struggling with trauma, crisis, or adversity (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 2004b).

It is important to mention, however, that one critique of these growth models is that they do not explicitly address multiple, chronic traumas that occur in early childhood known as DTD (van der Kolk, 2005). The interpersonal and developmental markers of DTD include the repetitive and chronic nature of the stressors, harm or abandonment by caregivers or other responsible adults, as well as the occurrence of these events at developmentally vulnerable times in the survivor's brain development (Ford & Courtois, 2009). Tedeschi and Calhoun's (1996) definition of PTG, as one example of a growth theory, includes a qualitative change in functioning indicative of individual development that involves surpassing one's pre-trauma level of functioning, as opposed to simply returning to baseline functioning (Tedeschi & Calhoun, 2004a, 2004b). This pre-trauma level of functioning is difficult to measure in individuals who have survived many years of chronic abuse with onset in their early childhood years (prior to or concurrent with key developmental milestones); thus, these survivors of DTD are not easily accounted for in the growth model.

Posttraumatic growth. The term posttraumatic growth (PTG), coined by Tedeschi and Calhoun (1996), refers to positive psychological changes experienced by people as a result of their struggle with highly challenging and adverse life circumstances. It

describes a qualitative change in functioning indicative of individual development that involves surpassing one's pre-trauma level of functioning, as opposed to simply returning to baseline functioning (Tedeschi & Calhoun, 2004b). In relation to other terms for positive change following adversity, posttraumatic growth encompasses the following essential components of the concept that are unique to PTG: (a) occurring during or after conditions of major crises and significant life disruption rather than those of lower levels of stress; (b) genuine transformative life changes rather than mere reported "illusions" of change; (c) an ongoing process or outcome of trauma, rather than a coping mechanism for it; and (d) occurring during or after significant psychological distress secondary to a significant threat to or shattering of fundamental schemas, not captured by terms such as *flourishing* (Tedeschi & Calhoun, 2004b). In their definition, Tedeschi and Calhoun (2004b) broadly used the term *trauma* interchangeably with *crisis* and *highly stressful events* to signify that these expressions represent significant challenges to one's ability to adapt and understand the world and one's place in it (Janoff-Bulman, 2002).

According to Tedeschi and Calhoun (2004b), their definition of trauma within the PTG model is less exclusive than the one used in the *DSM-IV,* and does not restrict trauma to exposure to actual or threatened death, physical integrity, or serious injury to oneself or loved ones. As such, findings of PTG have been reported in multiple contexts that would not be considered relevant to trauma or PTG according to the *DSM-IV* definition, such as among socioculturally diverse patients in health care settings. For example, Cordova, Cunningham, Carlson, and Andrykowski (2001) found that female breast cancer survivors reported posttraumatic growth, especially in the areas of relating to others, appreciation of life, and spiritual change. In terms of racial demographics, the

sample consisted of 90% Caucasian, 9% African-American, and 1% "other" participants. In a study by Milam (2004), the process of experiencing posttraumatic growth in HIV/AIDS patients was associated with lower levels of depression. The demographics of the sample were 39.5% White, 36.8% Hispanic, 17.0% African American, and 6.7% "other." Notably, posttraumatic growth was more positively associated with African-American participants in comparison to the White participants in this study (Milam, 2004).

Joseph and Linley (2005) noted that among the models of growth available, Calhoun and Tedeschi's PTG model was the most comprehensive to date. They highlighted, however, that even this model was lacking in that it did not account for *why* people would be motivated to move toward growth following an adverse event or experience. In their own attempt to account for individuals' motivation towards growth and adaptation beyond a return to their pre-trauma state, Joseph and Linley developed the organismic valuing theory of growth following adversity, which accommodates the existing PTG theory but also provides an explanation for why some individuals are able to achieve psychological well being following an adverse event, and others are not. The organismic valuing theory attributes the process of self-actualization innate in humans for the potential for posttraumatic growth (Joseph & Linley, 2005), and emphasizes the social context as a mediator of this process. This dissertation focuses on this specific theory of posttraumatic growth because of its emphasis on the social environment fulfilling one's basic psychological needs for autonomy, competence, and relatedness (Joseph & Linley, 2005). Given that the need for autonomy has been considered the most controversial due to divergence among experts on its application and relevance across

cultures (Chirkov et al., 2003), the current study examined ways in which autonomy support may or may not differ cross-culturally in the treatment of trauma-related issues.

Organismic valuing theory of posttraumatic growth. According to Joseph and Linley (2005), the organismic valuing theory of growth through adversity suggests that individuals who have experienced a trauma are intrinsically motivated toward rebuilding their assumptive world in a direction that is consistent with their innate tendencies toward growth and actualization. The organismic valuing process, one of the most important concepts within humanistic psychology, was originally discussed by Carl Rogers in 1961 (Sheldon, Arndt, & Houser-Marko, 2003). It refers to one's innate tendency to know and choose his or her best pathway toward well-being and fulfillment in life; in other words, to self-actualize one's potentialities. The organismic valuing theory of growth following adversity is an attempt to address certain salient theoretical considerations that have surfaced from research on and models of growth following adversity.

Joseph and Linley (2005) synthesize several theoretical principles to support their integrative theory of growth, emphasizing that the following theoretical considerations must be addressed by a growth theory. First, growth theory must accommodate the theoretical assumption of a completion tendency (Horowitz, 1982, 1986 as cited in Joseph & Linley, 2005) that drives the cognitive-emotional processing of post-traumatic reactions. They emphasize the idea that a survivor's adjustment to a traumatic event emerges from an underlying inherent tendency toward integrating the new trauma-related information.

Second, a growth theory must explain how new trauma-related information is cognitively and emotionally processed either by assimilation or accommodation (Hollon

& Garber, 1988 as cited in Joseph & Linley, 2005), the latter of which is conducive for growth. In other words, the survivor can either assimilate the new trauma-related information within existing models of the world (e.g., *The world is a just place, and it is therefore my fault that I had this trauma*), or existing models of the world must change or adjust to accommodate the information (e.g., *Maybe the world is not as just and safe of a place that I imagined it to be, and so bad things can happen to good people*). According to Janoff-Bulman (2002), accommodation requires individuals to change their worldview, perceiving the world as an unjust place in which random, traumatic events can and do happen to people. In order for survivors to move beyond their pre-trauma baseline of well-being and functioning, they must accommodate rather than assimilate the trauma-related information, adopting new worldviews that are indicative of growth.

Third, a theory of posttraumatic growth must explain the role of meaning making in growth (Janoff-Bulman & Frantz, 1997 as cited in Joseph & Linley, 2005). Specifically, there is a distinction made between meaning as comprehensibility (i.e., understanding what happened, how it happened, and why it happened) and meaning as significance (i.e., understanding the implications of the event for how one leads his/her life, worldview, or philosophy); growth theories are concerned with meaning as significance. Joseph and Linley (2005) clarify that survivors of trauma are initially concerned with *understanding* the traumatic experience (meaning as comprehensibility), but as time goes by and they are in the process towards growth, survivors want to find some type of benefit and worth from the experience (meaning as significance).

Finally, an integrative growth theory must bridge the gap between subjective well-being and psychological well-being. Subjective well-being is concerned with

affective states and overall happiness, whereas psychological well being is more concerned with an individual's personal strengths and meaning in life and is associated with posttraumatic growth (Ryan & Deci, 2001 as cited in Joseph & Linley, 2005). Thus, a positive psychological approach to treatment of trauma in the form of facilitating growth must emphasize an increase in psychological well being rather than just subjective well being.

It is suggested that the organismic valuing process inherent in humans and necessary for growth following adversity is contingent on one's social environment; as such, it is more likely to occur within an environment that is supportive of the basic psychological needs for autonomy, competence, and relatedness (Joseph & Linley, 2005; Ryan & Deci, 2000). To the extent that the external environment is supportive of these needs, individuals will be able to modify their existing views of the world to positively accommodate new trauma-related information, thereby facilitating growth following trauma (Joseph & Linley, 2005). If the individual's basic psychological needs for autonomy, competence, and relatedness were not met in the pre-trauma social environment, the organismic valuing process was likely to have been impeded, and the individual is therefore more vulnerable to blame oneself for the occurrence of the trauma in an attempt to retain the pre-trauma schema that the world is a safe and secure place (Joseph & Linley, 2005). This negative accommodation of the trauma-related information may manifest as psychopathology and distress, such as helplessness or hopelessness (Joseph & Linley, 2005). Therefore, it is important for the trauma survivor to have both pre- and post-trauma social conditions that were and continue to be supportive of the needs for autonomy, competence, and relatedness for the optimal functioning of the

organismic valuing process, and consequently for the experience of growth (Joseph & Linley, 2005).

Joseph and Linley (2005) incorporate theories of psychological and subjective well being (Keyes, Shmotkin, & Ryff, 2002; Ryan & Deci, 2000) to support the implications of the organismic valuing process and posttraumatic growth for psychotherapeutic treatment of trauma-related issues. They integrate the work of Calhoun and Tedeschi (1999; Tedeschi & Calhoun, 2004b) to conclude that a therapist can help facilitate the client's positive accommodation of new trauma-related information and well-being by listening attentively and actively to the client as well as by helping the client more clearly articulate his or her own new meanings as they begin to emerge (Joseph & Linley, 2005). In addition, they suggest that the therapist's goal should be increasing psychological well being and fostering the client's growth by focusing on his or her strengths and finding meaning and purpose in life. Fostering growth in therapy indirectly promotes subjective well being related to positive affective states and overall happiness via the reduction of distress. Thus, the experience of growth following trauma is associated with subsequent decreases in symptoms over time, whereas decreases in symptoms do not necessarily lead to growth over time (Joseph & Linley, 2005). Given that psychological well-being is associated with an individual's character strengths, one of which is self-determined and autonomous behavior (Ryan & Deci, 2000; Seligman & Csikszentmihalyi, 2000), we suggest that psychotherapists can serve as important figures in the post-trauma social environment that support the basic psychological need for autonomy, thereby facilitating posttraumatic growth.

Cultural variations of PTG. In addition to cross-cultural differences in the manifestation of traumatic stress, differences in the experience and expression of positive changes following adversity should also be considered when working to understand and foster posttraumatic growth. Park and Lechner (2006) have argued that one's culture has a significant impact on the types of growth that are likely to occur. For example, changing one's priorities and finding new paths in life may imply a level of flexibility and independence characteristic of Western cultures that emphasize individuality over collectivism (Park & Lechner, 2006). However, Ho, Chan, and Ho (2004) suggest that there are some universal dimensions of posttraumatic growth that are less determined by cultural characteristics of the population based on findings from their study comparing factors and dimensions of posttraumatic growth between the original English-language Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) and the Chinese translation of this measure they developed for future research. Specifically, they found that the social, cognitive, and spiritual/philosophical dimension of posttraumatic growth found in Western studies were applicable to their sample of Chinese cancer survivors. On the other hand, the authors could not find a distinct dimension similar to the emotional dimension of posttraumatic growth in their Chinese sample, which they attributed to a tendency in Chinese culture to focus less on emotional experiences and the integrated mind-body relationship. Their results suggest that the emotional dimension (e.g., individuals being more aware of their own feelings) in self-report growth measures may be more culturally bounded (Ho et al., 2004) than the other dimensions of posttraumatic growth.

Calhoun and colleagues (2011) suggest that there is a complex interplay between specific cultural factors and aspects of PTG that vary across cultural groups and impact the potential for and/or manifestation of PTG. They argue that the type and degree of growth that is experienced and acknowledged by individuals depends on (a) the idioms of trauma, coping, and growth, and (b) the social norms and rules about trauma, its aftermath, and views about what is helpful. These variables are considered to be present in both proximate and distal levels of cultural influence, with proximate forms including the primary references group of people with whom the individual interacts (e.g., family, close friends, gangs, religious groups), and distal forms involving the broad cultural views and narratives (e.g., individualism and collectivism) that may influence a person's view of the self, others, and world (Calhoun et al., 2011). In terms of the idioms of trauma, coping, and growth, one perspective may be consistent with the worldview that there is a master plan from God and that events in life (even traumatic ones) are part of a great unfolding of that plan. Idioms such as *everything happens for a reason* or *God never gives you more than you can handle* are representative of these cultural expressions related to trauma and growth (Calhoun et al., 2011). On the other hand, perspectives such as *random shit happens* are consistent with a cultural view of trauma and growth that misfortune and tragic events are a part of living in a world in which events are uncontrollable and have purposeless consequences. These different perspectives are thought to influence the way in which an individual copes with a traumatic event, how others respond to the individual, and the extent to which PTG is possible (Calhoun et al., 2011).

There are two components within the PTG model that are thought to be influenced by proximal and distal cultural factors, rumination and self-disclosure (Calhoun et al., 2011). Rumination, in the context of PTG, refers to the cognitive work that must be done due to the need to revise beliefs that comprise one's assumptive world following a traumatic or severely distressing event (Janoff-Bulman, 2002). Although posttraumatic rumination can be intrusive, negative, and result in depressive symptoms, rumination in the context of PTG can also be deliberate, reflective, and focused on making meaning of the event (Calhoun et al., 2011). Studies have shown that rumination (particularly negative rumination) occurs across various cultures; however, only one study to date has compared rumination following a traumatic experience between samples from two different cultural backgrounds (Taku, Cann, Tedeschi, & Calhoun, 2009 as cited in Calhoun et al., 2011). In comparing the relationship between PTG and deliberate versus intrusive rumination in a sample of participants from Japan and the United States, Taku and colleagues (2009 as cited in Calhoun et al., 2011) found similarities in the patterns of rumination and PTG, suggesting that rumination following traumatic experiences occurs across groups from different cultural backgrounds.

It is argued, however, that the nature of ruminations is impacted by cognitive processes and content that vary across different cultural groups (Calhoun et al., 2011). Specifically, there are differences in perceptions on personal control, sources of causation, and stability over time that have been found to differ between individuals from Western and Eastern cultures. As far as personal control, Westerners and Easterners differ in that Westerners tend to believe they have the potential for personal control over traumatic events in their lives, whereas Easterners tend to believe they should adjust

themselves to life situations rather than attempt to control or change them (Morling, Kitayama, & Miyamoto, 2002 as cited in Calhoun et al., 2011). Westerners tend to perceive more responsibility for a traumatic event or situation so they attempt to explain the trauma based on their own actions; similarly, they assume personal responsibility for the positive changes and personal strengths that may develop in the aftermath of trauma (Calhoun et al., 2011). In terms of sources of causation, Westerners tend to assume that personal qualities are more causal forces for a trauma than are the situations in which the events occur, resulting in individuals searching for those personal qualities a s a means to understand the event; on the other hand, Easterners tend to seek answers and meaning in the context of the traumatic event itself (Calhoun et al., 2011). Finally, individuals from Western cultural backgrounds tend to see time and future events as stable, predictable, and occurring in a linear fashion, such that not much change is expected. Individuals from Eastern cultural backgrounds, on the contrary, view time and the unfolding of events as a nonlinear cycle, anticipating changes and possible contradictions to what is expected to occur (Calhoun et al., 2011). With respect to PTG, this cognitive belief system within Eastern cultures leads to less cognitive disruption of the assumptive world following a traumatic event, and this is less likely to promote PTG (Calhoun et al., 2011).

In addition to differences in the cognitive process of rumination, there are also differences in the content of ruminations following a trauma that are influenced by broad cultural factors, namely individualistic and collectivistic values, norms, and views of the self and others (Calhoun et al., 2011; Markus & Kitayama, 1991). Individualistic cultural group members tend to value independence and define the self in terms of how one is different from others and prefer individual action and pursuing personal goals, and

collectivistic individuals focus on their relationship with others, try no to stand out from the group, seek harmony with others, and are sensitive to their potential impact on others within their collective group (Calhoun et al., 2011; Markus & Kitayama, 1991). As such, during the rumination process following a trauma, collectivistic individuals prioritize the consideration of how their reactions to the event might affect others, and any concern about the traumatic experience is filtered through a lens based on how the experience would be viewed by others within their primary references group (Cohen, Hoshino-Browne, & Leung, 2007 as cited in Calhoun et al., 2011). Studies have shown that the emotional content of information considered when ruminating differs along the individualistic-collectivistic continuum, such that collectivistic, interdependent cultures encourage display of positive emotions and discourage the expression of negative emotions based on the belief that expression of the latter would disrupt the harmony of the group (e.g., Matsumoto, Takeuchi, Andayani, Kouznetsova, & Krupp, 1998 as cited in Calhoun et al., 2011). Thus, individuals from interdependent cultures must work through their negative emotions alone in their ruminations in the aftermath of trauma (Calhoun et al., 2011).

Self-disclosure is the other aspect of PTG that is influenced by culture through general societal norms about what kinds of information are appropriate for disclosure, and what contexts and individuals are appropriate for disclosure (Calhoun et al., 2011). Posttraumatic growth theory emphasizes the important of self-disclosure and the social responses to it for new schemas to develop and help facilitate coping and growth, through empirical studies are lacking in terms of the patterns of these influences across different cultures (Calhoun et al., 2011). Psychotherapy may be thought of as its own proximate

culture, with its unique norms and rules regarding self-disclosure and ruminations for

culturally diverse individuals who have experienced trauma (Calhoun et al., 2011).

Calhoun and colleagues (2011) suggest that psychotherapeutic work must continuously

consider both the client's and clinician's sociocultural influences, and should be sensitive

to potential contradictions in ideas regarding ruminations or self-disclosure that may

occur along the process. Accordingly, "the likelihood of PTG may increase in this social

setting of support, acceptance, and exploration of ideas about existential issues that is

congruent with the client's distal and proximate sociocultural contexts" (Tedeschi &

Calhoun, 2006 as cited in Calhoun et al., 2011, p. 11).

     Cultural factors influential in PTSD and PTG. Although certain similarities do

exist and generalizations can be made cross-culturally regarding the nature and

presentation of trauma and posttraumatic growth, it is important to note that more

research is needed to truly understand and appreciate the impact that one's cultural

orientation and identification may have on the manifestation of mental illness as well as

mental health (Chin, 1993; Lopez et al., 2005; Pedrotti et al., 2009; Schwartz et al.,

2010). There are various culture-related variables that have been studied in terms of their

impact on an individual's mental health and psychological well being, including one's

immigration experience as well as acculturation process (Foster, 2001; Greenman & Xie,

2008; Schwartz et al., 2010).

     Regarding migration, the term *migrant* is used in the literature to collectively refer

to groups of voluntary immigrants, refugees, and asylum seekers, who are living in

countries or regions other than where they were born (Schwartz et al., 2010). According

to researchers, rates of international migration have reached unprecedented levels in the

United States and throughout the world (Schwartz et al., 2010). Specifically in the United States, the current wave of immigration is larger than those of the 19th and early 20th centuries and represents a more heterogeneous group than earlier waves (i.e., more immigrants from non-European backgrounds, Portes & Rumbaut, 2006 as cited in Schwartz et al., 2010). Immigration is occurring on a worldwide scale, and regions such as the United States, Western Europe, Canada, and Australia are experiencing a variety of immigrants from Latin American, Asian, African, Caribbean, and Middle Eastern countries (Schwartz et al., 2010). These regions are predominantly characterized as collectivistic cultures, where the focus is on collectives such as the family, clan, country, or religious group (Scwhwartz et al., 2010; Triandis, 1993). These migrants are settling in regions such as the United States and Western Europe, where individualism and the emphasis on independence is far more important than that on interdependence (Triandis, 1993). Consequently, there appear to be gaps in cultural values between many migrants' heritage culture and the receiving culture of the societies they are immigrating into, which can have adverse effects on individuals' psychological well-being (Schwartz et al., 2010).

The process and experience of migration has been connected to significant adjustment stressors, and the impact of these stressors on immigrants' mental health is variable and complex (Foster, 2001). Foster (2001) differentiated immigration stress from immigration trauma. *Immigration stress* is defined as the psychological state resulting from variables that are inherent in any immigration experience, including loss of family, community, and familiar social networks, a reduction in job and/or socioeconomic status,

lack of fluency in the host language, and actual or perceived discrimination (Foster, 2001;

Greenman & Xie, 2008; Schwartz et al., 2010).

Immigration trauma is characterized by specific stressors related to immigration

and their cumulative effects that precipitate symptoms of PTSD and clinical levels of

anxiety and depression. These specific stressors may occur in at least one of four

migration stages: (a) *premigration trauma* (i.e., unsafe events experienced just prior to

migration that led to the relocation and seeking a safer haven); (b) *trauma during transit*

(e.g., tragic events experienced during the physical move to the new country, such as

Cubans and Haitians lost at sea); (c) *asylum/temporary resettlement* (e.g., situations of

overcrowding, fear, and lack of provisions in the host country); and (d) *settlement in the*

host country (e.g., substandard living conditions in the host country due to

unemployment, inadequate supports, and minority persecution, Foster, 2001). Depending

on the nature and severity of experiences during any or all of these stages of the

migration process, the migration experience can be one that leads to significant

psychopathology and psychological distress for immigrants. The emotional distress for

immigrants typically peaks in the premigration phase shortly after departure, when a

great sense of loss is experience when the person is separated from the familiar (Weiss &

Berger, 2008). During the transit phase, the level of emotional distress tends to be

variable, and it peaks again during the settlement phase when an intense sense of loss

emerges after several months of initial euphoria (Weiss & Berger, 2008).

There is a developing body of research examining the concept of PTG as it relates

to immigration (Weiss & Berger, 2008). Specifically, PTG following emotional distress

from immigration involves the ruminative processes described earlier (Calhoun et al.,

2011). In the context of immigration, rumination involves recurrent comparisons of life before and after the transition from the country/culture of origin to the host country/culture (Weiss & Berger, 2008). The degree to which the ruminative process leads to PTG is related to the immediate and broader sociocultural contexts and the differing values related to stress, trauma and coping. Weiss and Berger (2008) note that "the greater the difference [between the two cultures], the higher the probability for culture shock (the subjective experience of immigration-related anxiety) in response to the objective culture loss" (p. 96). In other words, the more dissimilar the two cultures are in terms of their values (e.g., individualistic versus collectivistic), the higher the degree of emotional distress leading to rumination, which paves way for the possibility of PTG.

Clinical work related to immigration trauma and grief usually lasts for several years, though its intensity gradually subsides (Weiss & Berger, 2008). Weiss and Berger (2008) offer several strategies for clinicians to help facilitate PTG for clients who have experienced immigration trauma. These include: (a) validation and normalization of immigration reactions to grieve immigration-related losses and engage in productive cognitive processing; (b) psychoeducation on loss and trauma in the context of immigration to help with emotion regulation; (c) create conditions that facilitate deliberate (rather than intrusive) rumination by helping the client redefine his or her strengths and identify past successful coping efforts with traumatic events; (d) be open and attentive to indications of existential and spiritual issues and integrate these into the therapeutic dialogue; (e) avoid imposing expectations for growth and instead help the client rebuild his or her shattered worldviews that incorporate loss in a meaningful way

by listening for and highlighting client statements that indicate some positive change; and

(f) connect the client with others who have experienced immigration trauma and

perceived benefits, such as a group of other immigrants, which can create a context for

cognitive processing and emotional support that can further facilitate PTG.

An important concept related to immigration and cultural adjustments is

acculturation, which is a construct that is best understood as a complex, multidimensional

process that involves an interaction between an individual's host culture and receiving

culture (Schwartz et al., 2010). Acculturation has been defined as "changes that takes

place as a result of contact with culturally dissimilar people, groups, and social

influences" (Gibson, 2001 as cited in Schwartz et al., 2010, p. 237). The concept of

acculturation had its origins in unideminsional models that placed retention of the

heritage culture at one end of the process and acquisition of the receiving culture at the

other, with the implication that assimilating into the receiving culture was the upward

ideal in terms of positive psychosocial outcomes (Gordon, 1964 as cited in Schwartz et

al., 2010). A more categorical model of acculturation evolved (Berry, 1980 as cited in

Schwartz et al., 2010) and involved four possible types of acculturation, including

assimilation (adopting the receiving culture and rejecting the heritage culture), *separation*

(rejecting the receiving culture and retaining the heritage culture), *integration* (adopting

aspects of the receiving culture and retaining aspects of the receiving culture), and

marginalization (rejecting both the heritage and receiving cultures). This bideminsional

model of acculturation has received empirical support and is a widely used

conceptualization of acculturation (Schwartz et al., 2010).

One of the most significant sources of acculturative stress (e.g., anxiety,

depression or other mental health problems related to immigration) is referred to as an

unfavorable context of reception (Segal & Mayadas, 2005 as cited in Schwartz et al.,

2010), and includes the perception that either (a) the receiving culture scorns the

individual for not adopting enough of the receiving culture and/or (b) the heritage-culture

is upset with the individual for abandoning the heritage culture. The potential impact of

these stressors is an important consideration when working with immigrant

psychotherapy clients.

On the other hand, the most favorable psychosocial and mental health outcomes,

particularly in younger immigrants, have been associated with integration, or

biculturalism (Greenman & Xie, 2008, Schwartz et al., 2010). *Blended biculturalism*, or

keeping the identities, practices, and values of both cultures consistently available in

one's daily repertoire, has been associated with higher self-esteem, lower psychological

distress, and lower levels of acculturation-related stress than maintaining heritage and

receiving cultural streams separate (Chen et al., 2008 as cited in Schwartz et al., 2010).

Empirical research is lacking, however, regarding whether blended biculturalism

promotes other mental health outcomes as well, such as acting as a buffer against

minority discrimination (Schwartz et al., 2010). What is agreed upon by contemporary

researchers, however, is that full assimilation into the receiving culture, and complete

abandonment of the practices and values of the heritage culture, does not promote

optimal psychological functioning; rather, helping individuals integrate the values and

practices of both cultures based on individual characteristics and preferences is most

closely linked with favorable outcomes (Foster, 2001; Greenman & Xie, 2008; Schwartz et al., 2010).

Other factors associated with less acculturation challenges include (Schwartz et al., 2010): (a) having an ethnic and cultural background similar to the receiving culture, such as immigrants from England to the United States, (b) migrating as young children rather than as adolescents or older adults who are more shaped by their heritage culture and have heavier accents or a reluctance to adopt the values and practices of the receiving culture (Portes & Rumbaut, 2006, as cited in Schwartz et al., 2010; Yoo, Gee, & Takeuchi, 2009); (c) individuals who are second-generation (i.e., born in the country of settlement by migrant parents) and who are able to "pass as White" (Devos & Banaji, 2005 as cited in Schwartz et al., 2010) based on physical similarities; and (d) residing within an ethnic enclave where the majority of the residents and community members are from the same ethnic group, so the heritage culture and identity is more likely to be retained, even by the second generation (Stepick, Grenier, Castro, & Dunn, 2003). Acculturation factors and challenges as described above are likely to impact the salience and manifestation of psychological issues such as trauma and PTG and the effectiveness of related interventions that are implemented by therapists.

Autonomy and Psychotherapy in a Multicultural Context

Although it has been suggested that supporting the basic psychological need for autonomy is a beneficial aspect of psychotherapy treatment of people with trauma-related issues and fostering their psychological well-being and posttraumatic growth (Joseph & Linley, 2005; Keyes et al., 2002; Ryan & Deci, 2000), there is dispute among experts as to whether autonomy is an essential psychological need for *all* individuals, independent

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of their cultural background (e.g., Deci & Ryan, 2000, 2011; Iyengar & DeVoe, 2003; Iyengar & Lepper, 1999; Kitayama, Snibbe, Markus, & Suzuki, 2004; Kitayama & Uskul, 2011; Markus & Kitayama, 1991). Some argue that autonomy is a universal need for all humans (Deci & Ryan, 2000, 2011), whereas others disagree and posit that autonomy is a need that is only salient in cultures that emphasize independence and individualism and is therefore culturally limited (Iyengar & DeVoe, 2003; Iyengar & Lepper, 1999; Kitayama & Uskul, 2011; Markus & Kitayama, 1991). In the current study, we suggest that whether autonomy is viewed as universal or culturally specific depends on the way in which autonomy is defined, and that this difference has implications for psychotherapy aimed at posttraumatic growth. The following subsections address the overarching theory of which autonomy is a part (i.e., self-determination theory; Deci & Ryan, 1985), describe definitions of autonomy and autonomy support, and conclude with the debate regarding autonomy in the context of cross-cultural research.

Self-determination theory and the basic psychological needs. Self-determination theory (SDT; Deci & Ryan, 1985; Ryan & Deci, 2000) is a broad framework for the study of human motivation and personality that is focused on people's innate growth tendencies and the psychological needs that foster those positive processes (Deci & Ryan, 2011; Ryan & Deci, 2000; Ryan, Kuhl, & Deci, 1997). Self-determination theory is an organismic dialectical approach that suggests human beings are active organisms with innate and evolved proclivities towards growing, mastering challenges in their environment, and integrating new life experiences into a coherent sense of self (Deci & Ryan, 2011; Ryan & Deci, 2000). The ability to actualize these

innate tendencies towards growth, however, is contingent upon a social environment that provides ongoing support and nutriment for the organism; both components make up this dialectical approach (Deci & Ryan, 2011; Ryan & Deci, 2000). Empirical studies have inductively resulted in the identification of three basic psychological needs that must be fostered by the social environment: *competence* (Harter, 1978 as cited in Ryan & Deci, 2000; White, 1963 as cited in Ryan & Deci, 2000), *relatedness* (Baumeister & Leary, 1995 as cited in Ryan & Deci, 2000; Reis, 1994 as cited in Ryan & Deci, 2000), and *autonomy* (deCharms, 1968 as cited in Ryan & Deci, 2000; Deci, 1975 as cited in Ryan & Deci, 2000). Whereas certain social environments are conducive to the fulfillment of these needs and therefore the facilitating of optimal functioning and well-being, it has also been empirically concluded that other environments may thwart these three basic needs, leading to deleterious effects such as psychopathology and the overall hindering of growth (Deci & Ryan, 2011; Ryan & Deci, 2000).

Self-determination theory regards intrinsic motivation and goals as more conducive to psychological well being and optimal functioning than extrinsically motivated behavior (Deci & Ryan, 1985, 2011). Extrinsic goals (e.g., money, power, fame) are suggested to lead to psychopathology and less optimal functioning, whereas intrinsic goals (e.g., improved personal relationships, growth) are related to more positive outcomes (Deci & Ryan, 1985, 2011). People who experience thwarting of the basic psychological needs for autonomy, competence, and relatedness may develop need substitutes such as extrinsic life goals (Kasser & Ryan, 1996 as cited in Ryan & Deci, 2008) that motivate their behavior rather than being aware of the necessity of the basic needs themselves for the development of intrinsic motivation and psychological well-

being (Ryan & Deci, 2008). Emphasis is placed on the critical roles of the needs for autonomy and competence to facilitate intrinsic motivation, particularly in areas such as education, the arts, sports, and psychotherapy (Deci & Ryan, 1985, 2011; Ryan & Deci, 2000, 2008), and ways in which the social context affects individuals' intrinsic motivation such as by means of rewards or interpersonal controls.

A continuum of relative autonomy has been described that depicts motivation for behavior ranging from no autonomy on one end of the continuum to full autonomy on the other (Ryan & Deci, 2000, 2008). This continuum includes the following degrees of motivation and related self-regulatory processes: (a) *amotivation*, (b) *external regulation*, (c) *introjection*, (d) *identification*, (e) *integration*, and (f) *intrinsic motivation* (Ryan & Deci, 2000, 2008). When an individual is in a state of *amotivation*, his or her behavior is thought to be non-regulated and is usually associated with not valuing an activity (Ryan, 1995 as cited in Ryan & Deci, 2000), not feeling competent to do it (Bandura, 1986 as cited in Ryan & Deci, 2000), or not expecting it to produce a certain desired outcome (Seligman, 1975 as cited in Ryan & Deci, 2000). The middle of the continuum is comprised of extrinsically motivated behaviors, including a range of behaviors that vary in the extent to which they are autonomous in their regulation. *Intrinsic motivation*, which, is defined as "the inherent tendency to seek out novelty and challenges, to extend and exercise one's capacities, to explore, and to learn" (Ryan & Deci, 2000, p. 70) is at the optimal end of the continuum of relative autonomy, reflecting the capacity for an individual to experience interest, enjoyment, and inherent satisfaction in a behavior (Ryan & Deci, 2000). Intrinsically motivated, autonomous behavior is self-determined and is essential to cognitive and social development throughout the lifespan (Ryan &

Deci, 2000). In the context of psychotherapy, the therapist's goal should be to increase the client's intrinsic motivation for therapy, with the understanding that clients can move up and down the continuum of relative autonomy as a function of the therapeutic climate or other changes within the client's social or intrapersonal context (Ryan, R., Lynch, M., Vansteenkiste, M., & Deci, E., 2011).

The phenomenon of intrinsic motivation, which is the basis of humans' innate tendency towards posttraumatic growth as argued by organismic valuing theory (Joseph & Linley, 2005, 2008, 2011), has been studied empirically in a variety of settings, and is described by Deci and Ryan (1985) through their cognitive evaluation theory (CET), a sub-theory of SDT. Cognitive evaluation theory argues that perceived competence is required for the facilitation of intrinsic motivation, and that certain social-contextual factors (e.g., feedback, communication, or rewards) that lead to feelings of competence during a performed behavior can increase intrinsic motivation for that particular behavior (Ryan & Deci, 2000). Environmental factors such as optimal challenges, feedback that promotes competence over the environment, and lack of demeaning evaluations have all been shown to promote competence, and therefore increase intrinsic motivation (Deci, 1975 as cited in Ryan & Deci, 2000; Ryan & Deci, 2000).

Cognitive evaluation theory also posits that these feelings of competence alone are not enough to increase intrinsic motivation; rather, one must have a sense of autonomy with respect to the performed behavior (Ryan & Deci, 2000). Within CET, autonomy is defined in attributional terms, and refers to having an internal perceived locus of causality (deCharms, 1968 as cited in Ryan & Deci, 2000), rendering behavior as intentional and truly self-determined. Therefore, an individual must experience autonomy

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in addition to a sense of competence for intrinsic motivation to be apparent (Deci & Ryan, 1985; Ryan & Deci, 2000). The supports for autonomy and competence may come from internal resources that have developed from earlier experiences of perceived autonomy and competence support (Deci & Ryan, 2011; Reeve, 1996 as cited in Ryan & Deci, 2000), and/or be provided by the current and immediate social environment, such as via a psychotherapeutic relationship (Ryan & Deci, 2000; Ryan et al., 2011). The third of the basic psychological needs, relatedness, has also been shown to be important for the facilitation of intrinsic motivation, and has been supported primarily through infant attachment relationship (Bowlby, 1979 as cited in Ryan & Deci, 2000; Fridi, Bridges, & Grolnick, 1985 as cited in Ryan & Deci, 2000), as well as more recently through psychotherapy research (Ryan & Deci, 2008), demonstrating that exploratory behavior occurs most when individuals feel securely attached or trusting toward another. In summary, according to SDT, social environments have the ability to either promote or preclude intrinsic motivation, based on whether or not they support an individual's basic psychological needs for autonomy, competence, and relatedness (Ryan & Deci, 2000).

Autonomy and autonomy support defined. With respect to the effects of the environment on intrinsic motivation, autonomy is the psychological need that has been most empirically studied (Deci & Ryan, 1985; Ryan & Deci, 2000). Autonomy is further distinguished from the other two basic needs in that it is the most controversial due to debate over whether or not it is a universal construct. There has been little debate over the universality of the need for relatedness (Ryan, 1993 as cited in Chirkov et al., 2003) or for competence (Deci & Ryan, 1985), but the need for autonomy has been disputed by cross-cultural researchers. This section addresses and discusses the various definitions of

autonomy and autonomy support, and then briefly reviews research on autonomy and how it has been assessed. The next section explores how it has been found by some experts to differ cross-culturally.

Keyes and Lopez (2005), provide the following operational definition of how an individual with autonomy behaves: "self-determining, independent, and regulate[s] behavior internally; resist[s] social pressures to think and act in certain ways; evaluate[s] self by personal standards" (p. 49). Autonomy has been defined within the SDT framework as a basic psychological need, in addition to competence and relatedness, which, when supported by the social environment, leads to intrinsically motivated behavior and psychological well-being (Chirkov, Ryan, & Sheldon, 2011; Deci & Ryan, 1985; Ryan & Deci, 2000). Autonomy pertains to actions that are self-endorsed, based on one's own integrated interests and values, and which have an internal perceived locus of causality (Chirkov & Ryan, 2001). Ryan and colleagues (1997) write:

> In human personality, the construct of autonomy concerns the processes through which action and experience are initiated and governed by 'the self.' The greater one's autonomy, the more one acts in accord with self-endorsed values, needs, and intentions rather than in response to controlling forces external to the self, whether these forces are within the individual (e.g., drives or ego involvements) or from outside (e.g., social pressures). (p. 702)

Autonomy can thus be conceptualized as a key factor in one's development of competence as well as the ability for self-regulation (Deci & Ryan, 1985; Ryan & Deci, 2000; Ryan et al., 1997). As will be discussed later, autonomy has been operationally defined in varying ways by cross-cultural researchers (Iyengar & DeVoe, 2003; Iyengar & Lepper, 1999; Miller, 2003; Oishi, Koo, & Akimoto, 2008), contributing to significant debate regarding the construct.

Autonomy support has been operationally defined by Ryan and Deci (2008) as

"the attitudes and practices of a person or a broader social context that facilitate the target

individual's self-organization and self-regulation of actions and experiences" (p. 188).

Specific components of autonomy support have been identified through research and

include the following: (a) understanding and acknowledging individuals' perspectives

(Koestner, Ryan, Bernieri, & Holt, 1984 as cited in Ryan & Deci, 2008); (b) providing

unconditional regard (Assor, Roth, & Deci, 2004 as cited in Ryan & Deci, 2008); (c)

supporting choice (Moller, Deci, & Ryan, 2006 as cited in Ryan & Deci, 2008); (d)

minimizing pressure and control (Ryan, 1982 as cited in Ryan & Deci, 2008); and (e)

providing a meaningful rationale for any recommendations or requests (Deci, Eghrari,

Patrick, & Leone, 1994 as cited in Ryan & Deci, 2008).

Acknowledgement of and respect for the construct of autonomy is not new to the

field of psychology, as it has had a centuries-long tradition within philosophical discourse

(Ryan et al., 2011). In clinical research, the impact of autonomy support or lack thereof

has been studied in a variety of contexts (Ryan et al., 1997), including parenting and

teaching (e.g., Black & Deci, 2000; Chirkov & Ryan, 2001; Reeve, Bolt, & Cai, 1999),

sports and music (e.g., Frederick & Ryan, 1995 as cited in Ryan & Deci, 2000;

Hollembeak & Amorose, 2005), work (Baard, Deci, & Ryan, 2000), medical healthcare

(e.g., Williams, Freedman, & Deci, 1998), relationships (e.g., Lynch, LaGuardia, &

Ryan, 2009), and psychopathology (e.g., Sato, 2001). Reeve and colleagues (1999)

identified several autonomy-supportive behaviors that facilitate the process of

internalizing environmental demands and regulations so that they become personally

meaningful and freely chosen goals. They examined elementary and high school

teachers' motivational style as measured by their conversational and interpersonal behaviors, as well as attempts to support their students' processes of intrinsic motivation and internalization. The sample of participants was comprised of mostly Caucasian teachers (85%), with 6% African American, 5% Caucasian Hispanic, 3% Asian, and 1% Native American. The autonomy supportive behaviors were found to include the following: recognizing others' unique perspectives; acknowledging their feelings; refraining from pressuring them; providing as much choice as possible within context; and providing meaningful rationales when choice is not possible. Although the recommendations from this study are directed at teachers, the same behaviors may be adopted by therapists to support the need for autonomy for their clients.

Self-determination theory researchers have developed and implemented the *Perceived Autonomy Support* measure, which includes a family of questionnaires assessing the perceptions of individuals regarding the degree to which a particular social context is autonomy supportive as opposed to controlling (http://www.selfdeterminationtheory.org/questionnaires). The four questionnaires that comprise the *Perceived Autonomy Support* measure include the Health Care Climate Questionnaire (HCCQ), the Learning Climate Questionnaire, the Work Climate Questionnaire, and the Sport Climate Questionnaire; depending on the context of interest, one of these four questionnaires is used. Williams, Grow, Freedman, Ryan, & Deci, (1996) developed the HCCQ, which is a 15-item Likert scale used to assess the degree to which patients perceive their health-care providers to be autonomy-supportive versus controlling in providing general treatment or with respect to a specific health-care issue. The questionnaire includes items such as, (a) I feel that my physician has provided me

choices and options, (b) My physician conveys confidence in my ability to make changes, (c) My physician answers my questions fully and carefully, (d) My physician listens to how I would like to do things, and (e) My physician tries to understand how I see things before suggesting a new way to do things. The HCCQ was originally used in a study of obese patients participating in a weight-loss program (Williams et al., 1996). The questionnaire has been adapted and used to assess the levels of perceived autonomy support from professionals within various clinical as well as research contexts, including smoking cessation (Williams, Gagné, Ryan, & Deci, 2002), diabetes control (Williams et al., 1998), student learning (Black & Deci, 2000), and work performance (Baard et al., 2000). However, there are no known studies to date that have used the HCCQ as a measure of perceived autonomy support in the context of psychotherapy.

  Cultural debate regarding autonomy. In the growing context of cross-cultural awareness and research, there has been heavy debate over whether autonomy is a universal aspect of human experience, or if it is a socially constructed attribute that is culture-bound and salient only within certain types of cultures that emphasize independence and individualism (Chirkov, 2007; Chirkov & Ryan, 2001; Chirkov et al., 2003; Chirkov et al., 2011; Markus & Kitayama, 1991, 2003; Miller, 2003; Oishi et al., 1999; Oishi et al., 2008; Roth, Assor, Kanat-Maymon, & Kaplan, 2006; Rubin et al, 2006; Ryan, 1995 as cited in Ryan & Deci, 2000; Ryan & Deci, 2006). This debate is a result of differences in the conceptualization and operationalization of autonomy. Whereas certain cross-cultural researchers critique the notion that autonomy is a universal need (Iyengar & DeVoe, 2003; Iyengar & Lepper, 1999; Kitayama et al., 2009; Markus & Kitayama, 1991; Miller, 1997, 2003; Oishi et al., 1999; Oishi, et al., 2008;

Rubin et al., 2006), other researchers, particularly within the SDT framework, counter

this argument with a clarified operationalization of autonomy that emphasizes its

universal importance regardless of the cultural background of the individual (Chirkov &

Ryan, 2001; Chirkov et al., 2011; Deci & Ryan, 2011; Jang, H., Reeve, J., Ryan, R. M.,

& Kim, A., 2009; Roth et al., 2006; Ryan, 1995 as cited in Ryan & Deci, 2000; Ryan &

Deci, 2006).

Autonomy as a culture-specific need. Markus and Kitayama (1991) are among

the cross-cultural researchers who paved the way for critiques of autonomy as a construct

that is not universal, rather one that is salient only in specific cultural groups that place an

emphasis on the individual, independent self. In a seminal study examining the

differences in self-construals between varying cultural groups (i.e., collectivistic and

individualistic), Markus and Kitayama differentiated between an *independent* and

interdependent view of the self, differentiated primarily in terms of the role that the other

plays in one's definition of the self. For the interdependent self, which is a characteristic

of collectivistic cultures, one is constantly aware of where one belongs with respect to

others and assumes a receptive stance, "continually adjusting and accommodating to

these others in many aspects of behavior" (Markus & Kitayama, 1991, p. 246). In other

words, it is the others (e.g., family, community, religious group) rather than the self that

serve as the reference point for organizing one's experiences and determining one's

behaviors.

In contrast, for the independent self, which is characteristic of Western,

individualistic cultural groups, the self is considered to be "a complete, whole,

autonomous entity, without the others" (Markus & Kitayama, 1991, p. 246); therefore,

there is a sense of oneself as an agent of one's own actions, of being in control over the situation, and a need to express one's own thoughts and feelings to others as a means of intrinsic motivation. Of note, Markus and Kitayama (1991), when discussing these cultural differences, equate autonomy with individualism and separateness, as is evident by the following statement:

> Yet among those with interdependent selves, striving to excel or accomplish challenging tasks may not be in the service of achieving separateness and autonomy, as is usually assumed for those with independent selves, but instead in the service of more fully realizing one's connectedness or interdependence. (p. 240)

Sociocultural researchers also suggest that cultural values for autonomy are in opposition to those for relatedness, as their operational definition of autonomy involves making choices that are different from the reference group in order to obtain independence and separateness (Iyengar & DeVoe, 2003; Iyengar and Lepper, 1999; Rubin et al., 2006). In an empirical study examining the impact of personal choice on intrinsic motivation in a sample of Anglo American and Asian American children, Iyengar and Lepper (1999) demonstrated that personal choice generally enhanced motivation for American independent selves more than for Asian interdependent selves. They also found that Anglo American children showed less intrinsic motivation when choices were made for them by others than when they made their own choices. In contrast, Asian American children were most intrinsically motivated when choices were made for them by trusted authority figures or peers (Iyengar & Lepper, 1999).

Miller (1997, 2003), another cultural relativist arguing against the universality of autonomy, defined autonomy as the absence of all external social influences. Based on this perspective, it is suggested that autonomy is a Western notion of internalization in

which one gains autonomy "from social expectations" (Miller, 1997, p. 184).

Accordingly, it is argued that adherence to controlling external pressures by people from

some cultures actually leads to greater satisfaction and well being than does autonomy

(Miller, 1997, 2003; Miller, Das, & Chakravarthy, 2011).

Finally, Oishi and colleagues (1999, 2008) contrast autonomy with

interdependence, implying that autonomy is synonymous with independence and

separateness. In a study which tested for cross-cultural differences in predictors of life

satisfaction using 6,782 individuals from 39 countries, they found that satisfaction with

esteem needs (e.g., self, freedom) predicted global life satisfaction more strongly among

individualistic than collectivistic individuals (Oishi et al., 1999). Accordingly, they

proposed a values-as-moderator model of subjective well being, in which well being

varies because of cross-cultural differences in values (Oishi et al., 1999; Oishi et al.,

2008).

Autonomy as a universal need. In response to these criticisms of autonomy as a

universal construct, SDT researchers (Lynch, Vansteenkiste, Deci, & Ryan, 2011; Ryan

and Deci; 2006) call attention to the original operational definition of autonomy that was

suggested within the framework of SDT (Deci & Ryan, 1985; Ryan & Deci, 2000, 2006).

The following clarification was provided:

> These popular, and sometimes sophisticated, critiques of autonomy require
> scrutiny, both with respect to their definitions and conceptual treatment of
> autonomy and the growing body of evidence suggesting that autonomy, when
> accurately defined, is essential to the full functioning and mental health of
> individuals and optimal functioning of organizations and cultures. (Ryan &
> Deci, 2006; p. 1559)

According to SDT, a person is autonomous when (a) his or her behavior is

experienced as willingly enacted, and (b) when he or she fully endorses the actions in

which he or she is engaged and/or the values expressed by them (Chirkov et al., 2003, p.98). Ryan and Deci (2006) reiterated and clarified that autonomy is not equivalent to independence. They stressed that autonomy is not defined by the absence of external influences; rather, as long as one is in agreement with those external influences, then autonomy exists (Ryan & Deci, 2006). Based on this view, people would be autonomous with respect to a behavior or belief if they assent to it, even if the behavior or belief ultimately originates from an authority outside of him- or herself. As such, "one can understand the importance of distinguishing between the idea of autonomy as it is embodied in the continuum of motivation and the idea of independence that is implicit in cultural worldviews such as individualism" (Lynch et al., 2011, p. 289). The opposite of autonomy is defined as heteronomy, which is "regulation from outside the phenomenal self, by forces experienced as alien or pressuring" (Ryan & Deci, 2006, p. 1562); these forces include both internal impulses and demands as well as external contingencies. Thus, SDT distinguishes autonomy from independence, noting that one can be autonomously dependent (e.g., a daughter who willingly chooses to follow her parents' demand of marrying within the culture) or can be forced into independence (e.g., a homeless man who is estranged of all his family, Ryan & Deci, 2006). In sum, it is important to differentiate dependence or interdependence from the experience of autonomy versus heteronomy associated with it (Chirkov et al., 2003; Deci & Ryan, 2011).

Self-determination theorists (Deci & Ryan, 2011; Ryan & Deci, 2000) have argued that autonomy is a universal need that must be satisfied across the life span as well as in all cultural groups in order for an individual to experience an ongoing sense of

integrity and psychological well being. Notably, they make an important distinction in their response to critiques on autonomy from cross-cultural researchers, clarifying that the notion that basic psychological needs are universal and developmentally persistent does not imply that the means for their satisfaction are the same across the developmental lifespan, or that their manifestations are the same in all cultures (Ryan & Deci, 2000; Deci and Ryan, 2011).

There have been a number of empirical studies that have supported the assertion that autonomy is a universal need that must be supported in all cultures in order to facilitate optimal functioning and well-being. In a series of studies, Jang and colleagues (2009) found that high experiences of autonomy led to Korean students' most satisfying learning experiences, and that psychological need satisfaction experiences were associated with productive and satisfying student outcomes, after controlling for cultural and parental influences. Perceived autonomy support from parents and teachers has also been found to predict positive student learning outcomes and psychological well being in Israeli (Roth et al., 2006), Russian (Chirkov & Ryan, 2001; Lynch et al., 2009; Ryan et al., 1999), Chinese (Chirkov, Vansteenkiste, Tao, & Lynch, 2007; Downie et al., 2007; Lynch et al., 2009; Vansteenkiste, Zhou, Lens, & Soenens, 2005), Korean (Chirkov et al., 2003), and Turkish samples (Chirkov et al., 2003).

Autonomy support has also been found to be an important factor in satisfying romantic relationships (La Guardia, Ryan, Couchman, & Deci, 2000; Ryan & Deci, 2006). Lynch and colleagues (2009) studied samples of romantic partners in the United States, Russia, and China, and found that in all three countries and cultural orientations,

autonomy supportive partners were ones whose actual and ideal self concepts were more aligned, suggesting greater psychological well-being.

In a study on how autonomy support relates to psychopathology, Sato (2001) argued that autonomy is indeed a universal need; however, the degree to which autonomy must be emphasized and supported depends on whether or not the individual is from a collectivistic or individualistic cultural background. Thus, clients from an individualistic background benefit from and need greater supports for the need for autonomy, whereas clients from collectivistic cultural backgrounds require a greater support for the need for relatedness (Sato, 2001).

It is reasonable, then, to state that the way in which researchers and practitioners define and conceptualize autonomy – whether as a universal or socially constructed phenomenon – has implications for the delivery of psychological treatment. Ryan (1995) emphasizes the salience of the different conceptualizations of autonomy on the nature and effectiveness of psychological interventions. He writes:

> Insofar as one believes that nature supplies us with an integrative thrust to exercise our competencies, assimilate new experiences, and unify our understandings and behavior into a coherent agency, then psychological interventions will tend to take the forms of facilitating, conducing, supporting, or nurturing such tendencies. Alternatively, if one doubts the existence or robustness of spontaneous integrative trends in the psyche, then interventions will more likely be oriented toward training, shaping, directing, programming, and controlling, Not only is our interpretive language of change affected, but the very nature of social practice. (p. 399)

The implications of the differential definition of autonomy for psychological interventions leads to this study's goal of examining whether and/or how the basic psychological need for autonomy is or should be supported for clients, particularly those who have experienced a traumatic event. The following section discusses ways in which

therapists can implement autonomy support in treatment, based on the concept of common factors in therapy.

  Considerations for trainee therapists for promoting autonomy. Therapists can serve as significant members of clients' social environment with respect to supporting the basic psychological need for autonomy, independent of the theoretical orientation that is preferred or practiced (Lynch et al., 2011; Ryan & Deci, 2008; Ryan et al., 2011; Scheel, 2011). As such, autonomy support may be implemented by trainee therapists who have not yet acquired a solid knowledge base in terms of theoretical orientation (e.g., cognitive-behavioral, psychodynamic) or therapeutic techniques grounded in such theories. In addition, autonomy support is applicable to a variety of populations and presenting issues (Lynch et al., 2011; Ryan & Deci, 2008). The concept of common factors and its significance in psychotherapy effectiveness (Lambert, 1992 as cited in Lambert & Ogles, 2004; Lambert & Ogles, 2004; Miller, Duncan, & Hubble, 2005; Rosenzweig, 1936 as cited in Hubble, Duncan, & Miller, 1999) is helpful for conceptualizing autonomy support as an aspect of psychotherapy that is important and useful across all levels of therapist training, theoretical orientation, and treatment focus. The following sections discuss the importance of common factors in psychotherapy and review literature that suggests autonomy support may be one such common factor that is important across all forms of therapy, based on the assumption that autonomy and the necessity for its support are universal phenomena. The concept of autonomy need satisfaction has been studied within various domains such as student learning, work performance, sports, close relationships, and health care, and a few recent publications have begun to theoretically discuss the application of autonomy support to psychotherapy

(Ryan & Deci, 2008; Ryan et al., 2011; Scheel, 2011; Zuroff, et al., 2007). Thus, there are no studies to date that examine ways in which trainee therapists can learn to provide this autonomy support, particularly in a population of culturally diverse clients who are dealing with trauma-related issues.

The importance of common factors in psychotherapy effectiveness. *Common* or *nonspecific factors* refer to elements that are similar across all types of psychotherapy interventions (Lambert, 1992 as cited in Lambert & Ogles, 2004; Lambert & Bergin, 2003 as cited in Lambert & Ogles, 2004; Miller et al., 2005; Rosenzweig, 1936 as cited in Hubble et al., 1999). Saul Rosenzweig (1936, as cited in Hubble et al., 1999) is attributed as the first researcher to suggest that therapies have more in common than less, arguing that the effectiveness of different therapeutic approaches has more to do with their common elements than with their varying theoretical bases. Since the 1980s, there has been an outpouring of research on common factors (Hubble et al., 1999; Miller et al., 2005; Weinberger, 1995 as cited in Hubble et al., 1999), which shows that these nonspecific factors have been found to contribute to a substantial portion of positive therapeutic outcomes. Also, experts in the field of psychotherapy outcomes are agreeing that therapy in its various forms (e.g., theoretical orientation, modality) should be considered a single entity rather than distinct forms of treatment that can be compared in terms of which is most effective (Miller et al., 2005; Frank, 1973 as cited in Hubble et al., 1999). Further, Norcross (2005) emphasized the importance of identifying common factors in psychotherapy outcome research, noting that an awareness of and focus on these elements can help identify the core elements of psychotherapeutic interventions that

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have been beneficial and salient across time and cultures (Lynch et al., 2011; Ryan et al., 2011).

Different researchers studying these elements that are common across all forms of psychotherapy have identified various clusters of common factors. Lambert and Ogles (2004) compiled a list of common factors and grouped them into support, learning, and action factors in an attempt to reflect a developmental sequence that is presumed to underlie many psychotherapy treatments. Common factors in the *support* category include: catharsis, identification with therapist, mitigation of isolation, positive relationship, reassurance, release of tension, structure, therapeutic alliance, therapist/client active participation, therapist expertness, therapist warmth/respect/empathy/acceptance/genuineness, and trust. Common factors in the *learning* category include the following: advice, affective experiencing, assimilation of problematic experiences, changing expectations for personal effectiveness, cognitive learning, corrective emotional experience, exploration of internal frame of reference, feedback, insight, and rationale. Lastly, common factors in the *action* category include the following: behavioral regulation, cognitive mastery, encouragement of facing fears, taking risks, mastery efforts, modeling, practice, reality testing, success experience, and working through (Lambert & Ogles, 2004). Of these factors, and based on literature grounded in SDT (Lynch et al., 2011; Ryan & Deci, 2008), the ones this researcher feels are connected to autonomy include therapist/client active participation, therapist warmth/respect/empathy/acceptance/genuineness, changing expectations for personal effectiveness, exploration of internal frame of reference, feedback, rationale, and mastery efforts.

Several nonspecific factors were identified by the American Psychological

Association (APA) Division 29 Task Force (Ackerman et al., 2001 as cited in Ryan et al.,

2011) and were related to issues of autonomy, motivation, and client engagement in the

therapy process (Ryan et al., 2011). These common factors included the following: the

therapeutic relationship (foremost in the APA list), *empathy* (consideration and respect

for the client's perspective), and *goal consensus and collaboration* (intended to support

autonomy and self-motivation, Ryan et al., 2011, p. 45).

Accordingly, it has been argued that the common factor most shared by therapies

is the relationship between the clinician and the client (Miller et al., 2005; Rosenzweig,

as cited in Hubble et al., 1999; Tallman & Bohart, 1999, as cited in Hubble et al., 1999).

Hubble and colleagues (1999) emphasize this important tenet of common factors by

noting that "clients' own generative, self-healing capacities allow them to take what

different therapies have to offer and use them to self-heal" (p. 14). This notion is in line

with the concept of the organismic valuing theory of posttraumatic growth (Joseph &

Linley, 2005) described earlier, which suggests an innate ability for individuals to choose

their best pathway toward well-being and fulfillment in life, facilitated by various

behaviors of the therapist that will be discussed in the next section. Therefore, the

common factor of the therapeutic relationship, and more specifically the factor of

autonomy support in the context of that relationship, may be a key element in the

facilitation of posttraumatic growth and will be examined in the current study.

Autonomy support as a common factor in therapy. Ryan and colleagues (2011),

in their recent review article, suggest that embedded in all of the various identified

nonspecific factors in therapy are elements of support for client autonomy and volition. In

their article, they offer an approach to psychotherapy that is embedded in self-determination theory (SDT; Deci & Ryan, 1985; Ryan & Deci, 2000), which emphasizes the importance of autonomy support as a common factor across all forms of psychotherapy. They posit that the principles of SDT may be applied across various psychological interventions and techniques give that the issues of motivation and of creating a climate conducive to volitional and lasting change are central to all psychotherapies (Lynch, et al., 2011; Ryan et al., 2011).

According to SDT, clients seek treatment based on different types of motives, which vary along a continuum of relative autonomy that was described earlier (Ryan & Deci, 2000, 2008). These different processes, listed in order from controlled motivation to autonomous motivation, include *external regulation*, *introjection* (both forms of controlled motivation), *identification, integrated regulation,* and *intrinsic motivation* (all forms of autonomous motivation, Ryan & Deci, 2008; Ryan et al., 2011). Clients may present to therapy with *externally regulated* motives through coercion or pressure from external forces to seek treatment (e.g., therapies mandated by the legal system). Next, people who seek treatment because of guilt or social approval are driven by an *introjection* type of motive and pressure themselves to change (e.g., *I should go to therapy, otherwise my girlfriend will break up with me.*). Next along the continuum, clients may have a more autonomous experience of *identifying* with the goals of therapy and volitionally pursuing change, which then evolves into *integrated regulation* when the motives for change become congruent with the individual's own personal values. Finally, clients may even present to treatment with *intrinsic motivation*, reflected in an open curiosity and interest in the types of changes that can result from therapy. In sum, SDT

predicts a direct relationship between the level of motivation for therapy along the continuum of relative autonomy and the client's engagement in therapy and long-term outcomes (Ryan & Deci, 2008; Ryan et al., 2011).

Self-determination theory predicts that the less autonomous the client's motive is for seeking psychotherapy treatment, the poorer the client's engagement will be in the therapeutic process, and thus the lower the long-term and maintained success (Lynch et al., 2011; Ryan & Deci, 2008; Ryan et al., 2011). Consequently, a priority and focus for psychotherapists should be to facilitate the client's internalization of his or her responsibility and willingness for the process of change – in other words, to provide support for the basic psychological need for autonomy. Self-determination theory posits that autonomous, or intrinsic, motivation can be promoted by autonomy support from the social context, in which significant others in the social environment engage in perspective-taking of the individual, support his or her choices, and minimize pressure and control (Ryan & Deci, 2008; Ryan et al., 2011). Autonomy support in therapy follows from the assumption that autonomy is an important element in the treatment of clients who present with a variety of issues (Lynch, et al., 2011; Ryan et al., 2011).

Autonomy support as a common factor has begun to receive an evidence-base in clinical research. In a study by Zuroff and colleagues (2007) on factors contributing to the effective treatment of depression, autonomy support was found to be a common factor across three different treatment groups (i.e., manualized interpersonal therapy, cognitive-behavioral therapy, and pharmacotherapy) that accounted for acute and maintained positive outcomes in a sample of depressed outpatients predominantly of European descent. Autonomy support was found to be strongly associated with therapeutic alliance

(Zuroff et al., 2007), corroborating SDT theory's postulation that autonomy is best

supported by *significant* others in the individual's social context (Ryan & Deci, 2000).

Patients who were more autonomously motivated for treatment, as facilitated by

perceived therapists' autonomy support, experienced better outcomes on symptom

reduction and remission measures, and were able to internalize and thus maintain

therapeutic gains (Zuroff et al., 2007). These findings may be helpful in informing

therapist treatment of other types of disorders and presenting issues, particularly trauma.

Suggestions have been provided by SDT researchers with respect to how

therapists can support their clients' need for autonomy (Ryan & Deci, 2008; Ryan et al.,

2011). **A**utonomy support should begin with understanding and validating the client's

internal frame of reference, or how the client sees a situation both internally and

externally (Ryan & Deci, 2008). The therapist should help the client articulate and

express his or her experiences and conflicts, while attending to the client with interested

attention and mindfulness (Brown & Ryan, 2003 as cited in Ryan & Deci, 2008), thus

facilitating the process of organizing and self-regulating behaviors. The therapist should

refrain from imposing his or her own agenda or values on the client, and rather should

help the client understand his or her experiences and take ownership of new behaviors

(Ryan & Deci, 2008). According to SDT, autonomy support occurs within a therapeutic

environment that is consistent with Roger's (1961) nonspecific factors of genuineness,

empathy, and unconditional positive regard, which are the facilitating conditions for

motivation in the direction of actualization and positive and lasting therapeutic change

(Ryan et al., 2011). In sum, autonomy support operates in a nonjudgmental and non-

controlling environment, one that is conducive for clients to make choices and changes in the direction of health (Ryan, 1995; Ryan & Deci, 2008; Ryan et al., 2011).

Autonomy support also appears to play a role in acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 1999), a branch of cognitive-behavioral psychology used to treat people with various disorders, including PTSD. Specifically, two of the six core principles of the ACT model – *identifying and clarifying personal values*, and *committed action* – focus on the client experiencing valued living that is consistent with his or her own personal goals. Specifically, *identifying and clarifying personal values* refers to the therapist helping the client explore what is significant and meaningful for him or her. *Committed action* describes the attempts made by the therapist to help the client to set goals that are guided by those values and take effective action to achieve them (Hayes et al., 1999). Therapists can support the client's need for autonomy and facilitate intrinsic motivation for behavior by integrating interventions consistent with these values-based core principles of the ACT model.

The importance of autonomy for an individual's psychological well being has been well-established within the framework of positive psychology (Deci & Ryan, 1985; Keyes & Lopez, 2005; Ryan & Deci, 2000). Autonomy has been suggested as one of six dimensions of psychological well being (Ryff & Keyes, 1995 as cited in Keyes & Lopez, 2005), which serve as the basis of a psychotherapeutic treatment referred to as well-being therapy (Fava, 1999; Fava & Tomba, 2009). Within well-being therapy, the therapist's primary responsibility is to help the client cognitively restructure his or views on concepts central to well being, including environmental mastery, personal growth, purpose in life, autonomy, self-acceptance, and positive relations with others. The client's

awareness of psychological health is raised, and occurrences of well being are identified and highlighted by the therapist. Once the client learns to hone in on mastery, growth, and positive relationships, sessions then focus on the processes that interfere with well being, with later sessions intended to promote progression beyond the baseline and induce greater psychological well being (Fava, 1999; Fava & Tomba, 2009; Keyes & Lopez, 2005). Thus, autonomy is a key element that is examined and supported by the therapist in an attempt to increase the client's psychological well being and optimal functioning. Empirical studies have shown a decreased vulnerability to depression and anxiety after treatment with autonomy-supportive well-being therapy (e.g., Fava & Tomba, 2009).

Cultural critique of autonomy supportive psychotherapy. The ideal standard for culturally sensitive psychotherapy would be for therapists to have a deep and comprehensive understanding of each diverse client's unique perspective and worldview (Baluch et al., 2004 as cited in Ryan et al., 2011). However, since there are usually economic and cultural barriers to achieving this ideal, Ryan and colleagues (2011) argue that the value of supporting autonomy and appreciating the client's internal frame of reference and value system becomes a vital therapeutic consideration.

From the standpoint of cross-cultural applicability, it has been questioned whether autonomy support is of value across cultures or whether it is itself a culturally specific value. As described earlier, the psychological need of autonomy and its importance for the psychological well being of individuals has been widely debated on the basis of varying definitions and conceptualizations of the construct (Chirkov, 2007; Chirkov & Ryan, 2001; Chirkov et al., 2003; Kim, 2011; Kitayama & Uskul, 2011; Markus &

Kitayama, 1991, 2003; Miller, 2003; Oishi et al., 1999; Oishi et al., 2008; Roth et al.,

2006; Ryan, 1995 as cited in Ryan & Deci, 2000; Ryan et al., 2011; Ryan & Deci, 2006).

For those who argue that autonomy is important only within those sociocultural contexts

that explicitly value autonomy (e.g., Kim, 2011; Markus & Kitayama, 1991, 2003;

Miller, 2003; Oishi et al., 2008), then it would follow that autonomy support would not

be an important element in the delivery of all psychotherapy services. However, the

meaning of autonomy in this regard would be based on the view that development and

positive change through therapy are primarily achieved via individuation and

independence; accordingly, autonomy support may not be as appropriate for individuals

from cultural groups that do not value such individualistic goals (Ryan et al., 2011). On

the other hand, when autonomy is defined in terms of facilitating volition, choice, and

self-regulation of experiences and behaviors (Ryan & Deci, 2000, 2008; Ryan et al.,

2011), then its support from the social environment is not only relevant but also crucial

for clients from all cultural backgrounds, whether individualistic or collectivistic (Ryan et

al., 2011). As Ryan and colleagues (2011) note:

> When autonomy is defined in terms of the person's endorsement of her or his own actions, rather than in terms of individualistic definitions of autonomy as self-sufficiency or independence, autonomy can encompass relational and cultural concerns and, in fact, is the basis of enacting them. (p. 48)

Research in SDT suggests that autonomy support is beneficial across all cultures

given that autonomy support is a common, nonspecific factor that concerns the extent to

which an individual can act on one's own values, and does not relate to the specific and

diverse values that are embraced by an individual (Chirkov & Ryan, 2001; Chirkov et al.,

2003; Jang et al., 2009; Ryan et al., 2011; Vansteenkiste et al., 2005). Thus, whether one

autonomously pursues independent or interdependent goals and values, it would be

equally important for members of the social context (e.g., therapist) to support the innate

and universal need for autonomy in order to facilitate the individual's optimal functioning

and psychological well-being.

Moreover, research suggests that the interpersonal autonomy support within the

dyadic relationship between therapist and client may be associated with greater

authenticity and relationship satisfaction across cultures (Ryan et al., 2011). For example,

Lynch and colleagues (2009) tested Roger's (1961) prediction that discrepancies between

individuals' ideal and actual self-concept would be negatively associated with well-being,

and confirmed this hypothesis for ethnically diverse samples of college students from the

United States, Russia, and China. Further, participants' actual self concept was found to

be closer to their ideal when perceived autonomy support from partners within six target

relationships (i.e., Mother, Father, Best Friend, Romantic Partner, Roommate, and a self-

selected Teacher) was high. These findings are promising for the importance of the need

for autonomy support across cultures, though the study is limited to college students and

did not include the relationship between therapist and client. Lynch and colleagues

(2011) asserted:

> Indeed, to the extent that support for autonomy represents a universal ethical
> imperative to respect the person, values, and beliefs of each client – beliefs and
> values that may fall anywhere along the spectrum from individualistic to
> collectivistic and from horizontal to vertical – we believe that an autonomy
> supportive attitude on the part of the counselor may be the best safeguard against
> cultural insensitivity. (p. 291)

Although it has been argued for many years that autonomy support is a universal

need that is important for clients from diverse cultural backgrounds, and that the concept

may be applied to all forms and types of therapies, there is very limited research

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examining the impact of autonomy support on psychotherapy clients' motivation, self-concept, and sense of psychological well-being.

Summary and Purpose of Study

This literature review has presented a description of trauma and its effects from the perspective of positive psychology, which acknowledges both the negative and positive aspects of human experience. Several definitions of trauma have been described, including a differentiation between physical and psychological effects, isolated and multiple incidents, and event-based and perception-based traumas. Trauma may be understood broadly as events, or experiences of events, that have an impact on the physical as well as psychological well-being of individuals.

The various adverse effects of trauma on survivors' cognitive, emotional, and physical functioning have been reviewed. However, in the tradition and viewpoint of positive psychology, it is emphasized that growth following trauma is a phenomenon that many survivors experience. Various growth models have been identified and described, and the organismic valuing theory of posttraumatic growth (PTG) has been reviewed in more detail. This organismic valuing theory of PTG posits that humans have an innate tendency toward growth and self-actualization, to the extent that their social environment supports this growth tendency. More specifically, self-determination theory (SDT) describes the process by which the social environment may facilitate individuals' innate tendencies toward growth, which includes the satisfaction of the basic psychological needs for autonomy, competence, and relatedness. Of these three needs, autonomy has been the most controversial, particularly due to cross-cultural debate over whether autonomy is a universal need or is specific to certain types of cultures. However, this

debate may be null depending on how autonomy is defined. In other words, if autonomy is defined as actions that are self-endorsed, based on one's own integrated interests and values, and which have an internal perceived locus of causality (according to SDT), then it is a construct that can be argued to be of importance whether the cultural group values independence or interdependence.

Assuming, then, that autonomy is a universal construct and, as such, is important for all individuals independent of their cultural background, it is argued that autonomy support is an important factor in the context of psychotherapy. Therapists can serve as important figures in the social environment that support the need for autonomy for survivors of trauma, thus facilitating self-determination and growth. Research that argues for the element of autonomy support being a factor that is nonspecific to different forms of therapy has been presented, in the context of the phenomenon of common factors from psychotherapy effectiveness research. Autonomy support has been studied in a variety of settings, including education, sports, work performance, and health care, and psychotherapy, and suggestions for how to provide autonomy support are offered and included in the current study.

Whereas autonomy support has been argued to be an important element in different domains of human functioning, including psychotherapy, research on how to support autonomy for therapy clients is limited. Moreover, there are no empirical studies that examine these suggested autonomy supportive factors for survivors of trauma who are from diverse cultural backgrounds. The purpose of this study, then, was to explore whether and/or how trainee therapists address the basic psychological need for autonomy when treating culturally diverse clients with trauma related issues. The research question

to be asked in this study was: In what ways do trainee therapists address the need for

autonomy when working with culturally diverse clients who have experienced trauma?

Chapter 2. Method

The purpose of this chapter is to provide a description of the methods used during

the course of the study. It includes a description of the study's research design,

participants, and instrumentation. There is also a discussion of the data coding system,

human subjects considerations, and the data analysis using conventional content analysis

procedures.

Research Design

The study engaged in qualitative inquiry, an approach commonly used in clinical

and counseling psychology research (Morrow, 2007). Within this kind of study, "the

investigator is intrinsically linked to the process that parallels the role of therapist in the

therapeutic process" (Glazer & Stein, 2010, p. 56). The researcher must be aware of

his/her own assumptions and values as they may influence the findings and conclusions

that are drawn from the data (Glazer & Stein, 2010). Qualitative research is useful for

exploring and understanding the complex meanings that individuals or groups attribute to

an experience (Creswell, 2009; Glazer & Stein, 2010). Particularly, it is suitable when

there is inadequate research on the question of interest (Creswell, 2009). The present

study aimed to investigate ways in which trainee therapists support autonomy for clients

of diverse cultural backgrounds who had experienced trauma, which has not been

sufficiently studied by prior research.

More specifically, the study used a clinical research design that was developed to

assist researchers in trying to understand a problem within a clinical context (Mertens,

2005). This method of inquiry can also be used to better understand the multiple forces that influence the effectiveness of different types of therapy (Mertens, 2005). Thus, the present study used a clinical research design as the method of inquiry to explore the ways in which trainee therapists use autonomy supportive behaviors in psychotherapy sessions.

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

and self-disclosures), and *paralinguistic measures* which describe behaviors that are not verbal but accompany speech (e.g., hesitations and tonal qualities). The choice of measure used in the treatment process approach is based on the specific question or topic being investigated (Stiles et al., 1999).

The researcher can report measures directly through case studies or analyses of brief segments after he or she applies some of these categories describing the treatment process approach. Typically, however, measures are aggregated across some stretch of treatment or summarizing unit (Stiles et al., 1999). As such, the frequency of a category in each session may be described, or the average of a rating across a whole treatment (Stiles et al., 1999). A description of how the treatment process approach was applied in this study, including descriptions of the derived categories and how they were applied and reported is provided in the following sections of this chapter.

Participants

Five psychotherapy cases were selected from an archival database of video-recorded psychotherapy sessions from a university's community counseling centers in Southern California. Random purposeful sampling was used to select the participants based on general guidelines for qualitative research (Patton, 1990; Creswell, 2009).

In order to be included in the study, the participants had to meet certain inclusion and exclusion criteria. The participants were adult clients at least 18 years of age at the time of intake, English-speaking, and had given written consent for written records and videotaping to be included in the research database. The therapist also had given written consent for written and videotaped records to be included in the database. There were certain specifications for the participants with regards to age, gender, race/ethnicity,

religious orientation, socioeconomic status, and presenting problem (see Sampling procedure on p. 101). The participants were self-identified as having a specific ethnic cultural background, which was classified as either individualistic or collectivistic for the purposes of this study (see Instrumentation on p. 92). Only cases with sufficient data were included in this study. Sufficient data was defined as participants who had at least one videotaped recording available of a session in which a traumatic event or experience was discussed (see Instrumentation on p. 92) Given that each of the participants had more than one videotaped session in which trauma was discussed, the session from latest into the course of treatment was chosen. The rationale for this selection criterion was based on the idea that autonomy support occurs in the context of a significant social relationship (Ryan et al., 2011; Ryan & Deci, 2000), and this relationship between therapist and client is more likely to have developed and strengthened over time.

There were two exclusion criteria. The therapist could not be someone whom the researchers knew well personally in order to preserve the confidentiality of the therapist as well as to reduce possible research bias during the coding process. Also, persons who were seeking therapy in a modality other than individual (e.g., couples, child/adolescent, family) were not included in the sample.

The following is a description of information regarding the demographics, presenting issues, and type of trauma experienced specific to each participant, based on information provided in the clinic Intake Evaluation, Client Information Adult Form, and/or Treatment Summary. For each of the participants, the researcher selected the latest session in the course of treatment in which trauma was discussed, given that autonomy support has been shown to occur in the context of a significant social relationship (Ryan

et al., 2011; Ryan & Deci, 2000), and it is presumed that this relationship between therapist and client is more likely to have developed and strengthened over time and course of therapy. Table 2 outlines the participant demographic information that is described in the following paragraphs. All quotes provided within the descriptions that follow are directly from the participants.

Participant 1. Participant 1 was a 33-year old single, heterosexual, Caucasian male who did not have children and who was in a relationship during therapy. Participant 1 was a high school graduate and was unemployed at the time of treatment, though his occupation was described as cinematographer. Presenting issues for treatment included symptoms of trauma and relational problems with his girlfriend, both of which stemmed from an incident where he and girlfriend were robbed at gunpoint while at home approximately two years prior to treatment. These symptoms were exacerbated by the suicide of his half-brother shortly after Participant 1 initiated treatment. Specific symptoms included panic (racing heart, sweating, shortness of breath, lightheadedness), hypervigilance, avoidance of thoughts/feelings/places that are reminders of the traumatic events, difficulty concentrating, sleep difficulties, social withdrawal, and loss of motivation and interest in previously pleasurable activities. He also was experiencing significant interpersonal conflict with his live-in ex-girlfriend based on assuming responsibility for his girlfriend's significant psychological distress following the robbery. These presenting issues occurred in the context of prior history of traumatic events (e.g., his younger brother being killed in a farm accident, accidental death of another brother while Participant 1 was in college). Additional concerns included substance use (i.e.,

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smoking marijuana 2-3 times per week) and somatic complaints (i.e., back and shoulder pain).

Participant 1 was given a diagnosis of PTSD by his clinic therapist. According to the Termination Summary, CBT-informed interventions were used to help Participant 1 address feelings of guilt and other relational issues with his ex-girlfriend, as well as his PTSD symptoms. Treatment also included a mindfulness component to help with anxiety management. Treatment terminated prematurely as result of the client-participant not scheduling follow-up therapy sessions. Participant 1 was seen for a total of 15 sessions. The psychotherapy session selected and transcribed for analysis was session number 12 (6/9/2009). Based on his self-identification as "Caucasian" on relevant clinic forms, he was categorized as having an *individualistic* cultural background for the purposes of this study.

Participant 2. Participant 2 was a 21-year old married, heterosexual, Hispanic (El Salvadorian) female who did not have children at the time of participating in therapy. Participant 2 immigrated to the United States prior to the start of therapy, and was employed as a housekeeper. She initially presented to treatment with onset of depressive symptoms (e.g., sadness, anhedonia, guilt/worthlessness, poor concentration, loss of energy, irritability) 6 months prior, and suicidal ideation multiple days per week for the 5 weeks before start of therapy. Other issues included relational conflict with her husband, impulsivity and difficulty with regulating anger, and a lack of friends or other meaningful interpersonal relationships. Per self-report, Participant 2 was adopted by a maternal aunt at 2 years of age due to her biological mother not wanting to be her primary caregiver. She presented with depressive symptoms in the context of history of multiple abuses.

These included severe physical and verbal abuse between the ages 11 and 17 perpetrated by her biological mother, her aunt (different from her adopted one), and maternal grandmother; of note, reported physical abuse included beatings with use of cords and multiple murder attempts (trying to stab her with a knife) by her mother. Further, her history was significant for two incidents of sexual abuse at the age of 11 perpetrated by a cousin. Participant 2 was diagnosed with Borderline Personality Disorder by her therapist during the course of treatment. She was also given rule out diagnoses of PTSD and Dysthymic Disorder therapy. According to the Termination Summary, interventions guided by Dialectical-Behavioral Therapy were used to help Participant 2 build skills related to emotion regulation, distress tolerance, and communication, and reduce suicidal ideation. Treatment terminated prematurely as result of Participant 2's "choice to refuse to attend two [therapy] sessions per week as required by the therapist to meet the standard of care"; she was referred to another mental health services provider. Participant 2 was seen for a total of 31 sessions. The psychotherapy session selected and transcribed for analysis was session dated 4/3/08 (specific session number not documented by clinic therapist). Given her self-reported ethnic background as Hispanic, Participant 2 was categorized as having a *collectivistic* cultural background.

Participant 3. Participant 3 was a 31-year old single, heterosexual, Turkish male who did not have any children and was not in a relationship at the time of treatment. He immigrated to the United States from Turkey 10 years prior to the start of treatment, with the reported reason for immigration as intent to attend "occupational school." Participant 3 was a college student during the time of treatment. He presented to therapy with symptoms associated with his immigration the, including acculturation difficulty,

depressive feelings, loneliness, anxiety, and familial conflict related to his decision to live in the United States rather than in Turkey. Specific symptoms at intake included diminished interest in pleasurable activities, difficulty sleeping, fatigue, guilt, poor concentration, and an inability to stop worrying about multiple problems. Over the course of therapy, Participant 3 discussed his difficulty managing the conflicting expectations and demands of his family's Turkish culture and those he experienced living in the United States. Specifically, these included feelings of guilt about not "being there" for his mother and sister (especially after the death of his father shortly after he immigrated to the United States) and frustrations related to difficulty establishing a social support system of individuals with similar values as him. Per the therapist's report, Participant 3 also struggled with perfectionism and feelings of anxiety related to significant pressures to succeed academically because this was the impetus for his immigration.

Participant 3 was given the diagnoses of Major Depressive Disorder and Generalized Anxiety Disorder by his clinic therapist. According to the Termination Summary for this client-participant, the therapist-participant reported using CBT-informed interventions to help Participant 3 address his tendency "to jump to negative conclusions about himself," to address his firm beliefs about how he believes he and others should act, and perfectionism stemming from beliefs that he is inadequate. The focus of treatment was predominantly on Participant 3's conflict about whether to stay in the United States or return to Turkey. Treatment terminated prematurely due numerous cancellations and because Participant 3 was resistant in making a weekly commitment to therapy. Participant 3 was seen for a total of nine sessions. The psychotherapy session

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selected and transcribed for analysis was session number six (2/1/08). In terms of cultural background categories, Participant 3's self-report of being of a Turkish ethnic background classified him as having a *collectivistic* cultural background for the purposes of this study.

Participant 4. Participant 4 was a 47-year old, single, heterosexual, British-American female who did not have any children. At the time of treatment, Participant 4 was unemployed and waiting to acquire disability benefits. Presenting issues for therapy included distress related to progressive loss of her vision secondary to a stroke she suffered a year prior to the start of therapy. Specific symptoms included being easily and frequently moved to tears and skin scratching, both of which began immediately following her progressing loss of vision 6 weeks prior to the intake. She also had additional medical complications related to diabetes, including neuropathy of her bilateral lower extremities and right-sided numbness; she reported feelings of fear related to losing her legs throughout the course of therapy. Her loss of vision and resulting increased dependence on others was connected in therapy to feelings of abandonment rooted in her childhood relationships with her father, aunt, and uncle, which were notable for emotional abuse and neglect.

Participant 4 was not given an Axis I or II diagnosis by her clinician. The focus of the therapy was on how her stroke and associated blindness brought up thoughts and feelings related to her history of emotional abuse/neglect, and themes around abandonment and becoming dependent on others again. Participant 4 was seen for a total of approximately 12 sessions (exact number of total sessions was unclear from clinic documentation). The psychotherapy session selected and transcribed for analysis was

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session dated 5/1/07 (specific session number not documented by clinic therapist; another session containing a trauma discussion and noted as an earlier session was dated 1/23/07). In terms of ethnic background, Participant 4 self-identified as a Caucasian, and was thus classified as having an *individualistic* cultural background.

Participant 5. Participant 5 was a 29-year old, single, heterosexual, Korean male who did not have any children. He immigrated to the United States from South Korea at 4 years of age. He was a college graduate and was employed in the computer industry. Participant 5 presented to therapy 2 months following the accidental death of his close friend, and had complaints of anxiety and difficulty adjusting to the unexpected death of his friend. Participant 5's current symptoms and traumatic stressor (i.e., death of his friend) occurred in the context of longstanding anxiety with onset in childhood. In addition, his concerns included more recent worrying about dating, relationships, and social interactions, which were reportedly exacerbated by the additional stressor of his friend's death. Other presenting issues included: problems associated with sexual orientation; feelings of loneliness and guilt, difficulty with decision-making; feeling controlled by others and familial conflict; and existential issues (e.g., wondering "Who am I"). Participant 5 reported significant difficulties at work related to poor concentration, negative thinking, low self-esteem, and excessive worrying about issues of dating and other social situations, which contributed to feelings of low self-esteem. He also reported history of possible drug and alcohol abuse, emotional abuse, and immigration stress/trauma (e.g., discrimination including insults and hate crimes).

Participant 5 was given a diagnosis of Social Phobia by his clinic therapist. According to the Termination Summary, CBT-informed interventions were used to

facilitate Participant 5's understanding of the connection between thoughts, feelings, and behaviors, to provide psychoeducation regarding social anxiety, teach relaxation strategies, increase assertiveness, and reduce negative thinking. Treatment terminated prematurely due to issues with rapport, miscommunication, and an overall weak therapeutic relationship. Participant 5 was seen for a total of 15 sessions. The psychotherapy session selected and transcribed for analysis was session number 10 (9/13/07). In terms of cultural background, Participant 5 self-identified as Korean, and was thus classified as having a *collectivistic* cultural background.

Table 2

Participant Demographic Information

Participant	Age	Gender	Ethnicity; Cultural Background	Trauma Type	Diagnoses
1	34	M	Caucasian; IND	Brother's suicide; robbery	PTSD, Partner Relational Problem
2	21	F	Hispanic; COL	Childhood physical, emotional, sexual abuse	MDD, BPD; R/O PTSD; R/O DD
3	31	M	Turkish; COL	Immigration	No diagnosis
4	47	F	British; IND	Stroke; blindness	Social Phobia
5	29	M	Korean; COL	Sudden death of friend	PTSD

Note. Definitions of abbreviations are as follows IND = individualistic; COL = collectivistic; PTSD = Posttraumatic Stress Disorder; MDD =Major Depressive Disorder; BPD = Borderline Personality Disorder; GAD = Generalized Anxiety Disorder; DD = Dysthymic Disorder.

Researchers. The researchers of this study consisted of a team of three clinical psychology doctoral students who served as coders for the data collected (Coders 1, 2, and 3). The auditor for the study was a clinical psychologist who supervised the research

team throughout the data collection and coding process. Each of the coders and the auditor provided a personal description of themselves, including their personal background, and clinical perspectives, in an attempt to identify and acknowledge potential areas of bias.

Coder 1, the primary researcher and author of this dissertation, is a 31-year old, first-generation Armenian-American female doctoral student in clinical psychology whose parents immigrated to the United States over 30 years ago. Coder 1 generally conceptualizes clients and conducts psychotherapy from a psychodynamic perspective. Through her training and experience in this theoretical orientation, she has come to believe in the importance of significant human relationships and the effects they have on individuals' view of themselves and of the world. For individuals who have experienced a traumatic event, the importance of this interpersonal connection and relationship is heightened, and the extent to which significant others in the individuals' lives support their need for autonomy and personal competence determines the degree of growth that can be experienced by the individual. The therapeutic relationship is an essential medium of autonomy support for clients who have experienced trauma. Therefore, Coder 1 believes that, independent of ethnic cultural background, all clients would benefit from therapy that would support the universal need for autonomy, facilitating the human tendency towards posttraumatic growth following an adverse event.

Coder 2 is a 29 year-old female of Russian and Native American descent who is a doctoral student in clinical psychology. She generally conceptualizes clients and conducts psychotherapy from a cognitive behavioral perspective. Through her training and experience in this theoretical orientation, Coder 2 believes that one's interpretation of a

situation often expressed in automatic thoughts, influences one's subsequent emotions, behaviors, and physiological responses. Consistent with the cognitive model, she believes that enduring improvement results from realistically evaluating and modifying biased thinking in one's automatic thoughts, rules, assumptions, attitudes, and underlying dysfunctional core beliefs about oneself, the world, and others. Coder 2 is also a proponent of eastern philosophy principles such as Mindfulness practices that have been integrated into cognitive-behavioral-oriented psychotherapeutic treatments such as Dialectical Behavior Therapy. She is supportive of evidence-based treatments and has a general interest in assessing and treating traumatic stress disorders in children and adults. Coder 2 believes that, while not experienced by everyone, many individuals can benefit from psychotherapy as a means to cognitively reevaluate their schemas that have been challenged by traumatic stress, and subsequently experience PTG in the process as they struggle to understand and create new meaning in their lives.

Coder 3 is a 31 year-old, Caucasian Welsh/German male doctoral student in clinical psychology. His family has lived in the United States for over two hundred years, he has been brought up in the upper middle class, and he generally conceptualizes clients and conducts psychotherapy from a psychodynamic perspective, incorporating elements from cognitive and strength-based models of treatment. He believes that many clients present to treatment due to difficulties that occur as a result of a combination of problems in early relationships, the manner in which they relate to and manage internal and external conflict, and having subjectively stressful and traumatic experiences throughout their lives. He believes that self-awareness and the ability to relate to difficult psychological material, both occurring within the therapeutic relationship, are core

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

The auditor of the study, the dissertation chairperson, is a 44 year-old, European-American, progressive, Christian, 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. The auditor 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 hoped that therapists working with culturally diverse clients who have experienced trauma and discuss it in therapy would support the clients' need for autonomy.

Instrumentation

This section describes the instruments that were used by the researchers to select the participants of the study, and the codes created by the researcher and used for identifying autonomy supportive factors.

Instruments for selecting participants. The researcher used three steps to choose cases involving discussions of trauma with culturally diverse clients: (a) determining whether the experience of trauma was reported in written files, (b) noting the participant's ethnic cultural background, and (c) locating a discussion of the trauma in the videotapes. During these steps, several instruments were used to determine which potential participants and which of their sessions would be selected for the study. The data was obtained from an archival research database at the Pepperdine University Graduate School of Education and Psychology community counseling clinics that includes the therapists' written material about their clients, measures completed by all clients at the clinics at intake and follow-up intervals, and videotapes of sessions, which are used to determine the needs and strengths of clients, and to monitor their progress and satisfaction with the psychotherapy services being provided.

Step 1: Determining experience of trauma. For the purposes of the current study, *trauma* is defined in terms of threats to *physical* and/or *psychological* integrity, including (a) exposure to a negative event or experience, and (b) the distress or psychological reaction to the exposure (Briere & Scott, 2006; Hall & Sales, 2008). In

other words, trauma refers to the nature of the event or experience of the client as well as the client's perception of an event or experience(s) as being traumatic or "extremely upsetting and at least temporarily overwhelm[ing] the individual's resources" (Briere & Scott, 2006, p. 4). In some trauma cases, as described earlier in the literature review, the event meets the *DSM-IV-TR* (APA, 2000) criteria of "threatened death or serious injury, or other threat to one's physical integrity" (p. 467). Events that are listed as traumatic in the *DSM-IV-TR* include: combat; sexual and physical assault; robbery; being kidnapped; being taken hostage; terrorist attacks; torture; disasters; severe automobile accidents; life-threatening illnesses; witnessing death or serious injury by violent assaults, accidents, war, or disaster; and childhood sexual abuse with or without threatened or actual violence or injury. *Trauma* also refers to complex psychological trauma resulting from exposure to severe stressors that (a) are chronic and repetitive, (b) involve harm or abandonment by caregivers or other responsible adults, and (c) occur at developmentally vulnerable times in the victim's life, such as early childhood or adolescence (Ford & Courtois, 2009).

In order to select cases that involved the experience of trauma, the researchers started by identifying research files of clients. To determine which clients had reported experiencing a trauma in his/her life, the following four written materials were reviewed; if trauma was indicated in any of the following materials, the case proceeded to Step 2.

(a) Client Information Adult Form (Appendix A). In the Family Data Section of this form, the client would have met criteria if s/he indicated "Yes – This Happened" in the "Self" column under the question, "Which of the following have family members, including yourself, struggled with" for at least one of the following: separation/divorce;

frequent re-location; extended unemployment; adoption; foster care; miscarriage or fertility difficulties; financial strain or instability; inadequate access to healthcare or other services; discrimination (insults, hate crimes, etc.); death and loss; alcohol use or abuse; drug use or abuse; addictions; sexual abuse; physical abuse; emotional abuse; rape/sexual assault; hospitalization for medical problems; hospitalization for emotional/psychiatric problems; diagnosed or suspected mental illness; suicidal thoughts or attempts; self harm (cutting, burning); debilitating illness, injury, or disability; problems with learning; academic problems (drop-out, truancy); frequent fights and arguments; involvement in legal system; criminal activity; incarceration. For 4 of the 5 participants, at least one of the following items was indicated: death and loss, physical abuse, or debilitating illness/injury/disability. If the client indicated "yes this happened" in the Family or Other column, information from the other instruments were used to corroborate this information to determine if it impacted the client's presenting experience of trauma(s).

(b) Intake Evaluation Summary (Appendix B). This document was reviewed to see if the therapist indicated that the client discussed a traumatic experience in at least one of the following sections of the Intake Evaluation Summary: Presenting Problems (section 2), History of Presenting Problems (section 3), and/or Psychosocial History (section 4).

(c) Telephone Intake Form (Appendix C). On the Telephone Intake Form, the Reason for Referral section was examined and the clients who reported that one of the reasons for calling to schedule a psychotherapy session was due to some experience of trauma were selected as potential participants.

(d) Treatment Summary (Appendix D). The Treatment Summary was examined to see whether or not the therapy addressed any experiences of trauma as defined above.

Throughout the process of examining various instruments to determine the experience of trauma, the *Participant Selection Data Sheet,* an Excel document, was used to track and identify clinic forms indicating experiences of trauma (see Appendix E). A case proceeded to step 2 if an experience of trauma was indicated in at least one of the instruments indicated above.

Step 2: Noting participant cultural background. For those clients who were selected as participants based on experiences of trauma (Step 1), the Client Information Adult Form (Appendix A)'s optional Social/Cultural section was examined to see whether and how the client responded to the item "Ethnicity or Race." In addition, the Intake Evaluation Summary's (Appendix B) section entitled Cultural Factors and Role of Religion in the Client's Life that includes a brief description of the client's cultural self-identification was reviewed. For the purposes of this study, cultural background was identified as either *individualistic* or *collectivistic*. Participants that were considered *individualistic* were those from the following countries/regions: United States, Canada, Australia, New Zealand, Western Europe (e.g., France, Netherlands, United Kingdom) or the Pacific Islands (Schwartz et al., 2010). Participants from the following countries/regions were identified as *collectivistic*: Latin America, Asia, Africa, Caribbean, or Middle East (Schwartz et al., 2010; Triandis, 2002).

Only those clients who responded to these items were selected as potential participants. These participants were then categorized based on individualistic or

collectivistic cultural background, and the information was added to the *Participant*

Selection Data Sheet.

Step 3: Identifying a discussion of trauma. The videotapes of clients who met the

requirements for Steps 1 and Step 2 were reviewed. If there was a discussion of trauma in

any of the tapes, then that information was recorded in the Data Tracking Form, and that

client was selected as a potential participant. "Discussions of trauma" was defined as

verbalizations consisting of (a) descriptions of the traumatic event or life experience, (b)

evaluative content such as thoughts, beliefs, and attitudes about the traumatic event or life

experience, and (c) affective content such as one's feelings and emotions about the event

or experience (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker,

Zech, & Rime, 2001). As mentioned earlier based on Briere and Scott's (2006) definition,

in order for a discussion of material to be defined as traumatic, the client had to convey

some distress or psychological struggle around the event or life experience. For example,

in the following discussion, *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, the client describes the event (i.e., mother threatening to stab

her), as well as her thoughts and upsetting feelings about it (i.e., fear). Additional

examples of these verbalizations may be found in the coding manual (Appendix F).

Coding autonomy support. In order to determine the use of autonomy-

supportive behaviors by the therapist, the researcher created a directed coding system that

consisted of six categories derived from various sources, including literature related to

humanistic and motivational interviewing interventions (Bylund & Makoul, 2005; Miller,

Moyers, Ernst, & Amrhein, 2008), feminist trauma treatment perspectives (Brown, 2004),

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ACT and its core-values centered interventions (Hayes et al., 1999), autonomy-supportive factors in various contexts (Reeve et al., 1999; Ryan & Deci, 2008; Williams et al., 1996) and common factors (Lambert & Ogles, 2004). These categories included: (a) *Unconditional Positive Regard;* (b) *Empathy*; (c) *Egalitarianism/Providing Choices*; (d) *Psychoeducation*; (e) *Empowerment*; and (f) *Listening for Core Values*.

Individual codes were created and operationally defined for each of the coding categories. Consistent with our qualitative approach, the initial coding system was revised throughout the coding process to better capture the autonomy supportive factors, and to increase the coding reliability within and across raters; code modifications are detailed in the sections that follow for each of the coding categories, and inter-rater reliability is discussed in the data analysis section below. The following codes and their operational definitions were used to identify and analyze therapist responses that were autonomy supportive (see coding manual in Appendix F for explicit examples of each code). Data that fit the coding categories were labeled with the appropriate code(s) in a column next to the transcribed trauma discussion in Word document stored for the researchers' confidential use on *Google Docs*.

Unconditional Positive Regard. Based on person-centered therapy, the autonomy supportive factor *Unconditional Positive Regard* (UPR) was operationally defined as when the therapist accepts the client unconditionally, without judgment, disapproval, or approval (Rogers, 1961), and when the therapist conveys blanket acceptance and support of a client regardless of what the client says or does (Standal, 1954 as cited in Rogers, 1961; Miller et al., 2008). The code UPR was thus defined to include statements conveying acceptance, respect, support, and validation.

The initial coding system included four separate UPR codes defined as *acceptance* (UPR1), *respect* (UPR2), *support* (UPR3), and *validation* (UPR4). However, due to a high degree of overlap among these four separate codes, the four codes were collapsed and relabeled as *Validation*; the new code was defined as therapist responses that explicitly state the client is entitled to think, feel, and/or behave in the way that he or she is or wants to.

Empathy. The second autonomy supportive category, *Empathy*, was operationally defined as "accurately understanding the client's perspective" (Miller et al., 2008, p. 4), and focused on the extent to which the therapist understood the client's point of view while discussing trauma-related information and content. This category included the following codes: *reflecting fact* (EMP1a), *reflecting emotion* (EMP1b), *reflecting ambiguous fact/feeling* (EMP1c), *nonverbal referent* (EMP2), *shared feeling or experience* (EMP3), *understanding of content – cognitive* (EMP4a), *understanding of content – affective* (EMP4b), and *understanding of content – ambiguous fact/feeling* (EMP4c).

Several changes were made to the *Empathy* codes throughout the data analysis process. The initial coding system included the following codes: *reflecting fact* (EMP1a), *reflecting emotion* (EMP1b), *nonverbal referent – statement* (EMP2a), *nonverbal referent – tone* (EMP2b), *summarizing series of related statements* (EMP3), *shared feeling or experience* (EMP4), *understanding of content – cognitive* (EMP5a), *understanding of meaning – affective* (EMP5b), and *nonverbal understanding of experience* (EMP6). The code *reflecting ambiguous fact/feeling* (EMP1c) was created to capture therapist responses that reflected content that was not clearly either a fact or an emotion. Similarly,

for the understanding group of codes (EMP5a and EMP5b), the code *understanding of content – ambiguous fact/feeling* was added. The EMP2b (*nonverbal referent – tone*) and EMP6 (*nonverbal understanding of experience*) codes were removed given the subjective nature inherent in tone and nonverbal interpretations, precluding reliable usage of these codes. The original EMP3 code (*summarizing series of related statements*) was also removed on the basis that these responses would be best captured by the reflecting fact/emotion/ambiguous codes; it was difficult to consistently determine how many responses would be considered a summary.

    Egalitarianism/Providing Choices. This third category of autonomy support included two combined factors. *Egalitarianism* referred to the therapist treating the client as an equal within the relationship rather than acting as an authoritarian, thus emphasizing the client's personal choice, autonomy, and responsibility (Miller et al., 2008). *Providing Choices* was defined as the therapist allowing the client to have options in matters, when appropriate, that were both therapeutically related (e.g., ways to respond in a given relational situation), as well as administrative issues (e.g., frequency of sessions, Williams et al., 1996). Codes for this category included *providing choices – therapeutic material* (EgPc1), and *providing choices – administrative* (EgPc2).

    Initial codes for this category included *emphasizing the client's responsibility* (EgPc1), *providing choices – therapeutic material* (EgPc2a), and *providing choices – administrative* (EgPc2b). The code emphasizing client responsibility was removed because it was determined to be better captured by one of the *Empowerment* codes (as described below). Therefore, only the two providing choices codes were maintained.

Psychoeducation. The fourth category, *Psychoeducation*, was operationally

defined as providing information about the cause and effect of psychological issues and

explaining aspects of treatment to the client (Deci, Connell, & Ryan, 1989; Lambert &

Ogles, 2004). The code for this autonomy supportive factor was labeled as *providing*

information – symptoms, theory, and treatment (PSY).

Originally, the codes for this autonomy supportive factor included *providing*

information – symptoms (PSY1) and *providing information – treatment* (PSY2). During

data analysis, it was decided that collapsing the two codes into one and relabeling it

providing information – symptoms, theory, and treatment proved more reliable in terms

of coding therapist responses characterized as providing psychoeducation.

Empowerment. The autonomy supportive category of *Empowerment* was

operationally defined, based on feminist theory, as "encouraging clients to become more

capable of believing in themselves and seeing themselves as a source of authority about

their life narratives" (Brown, 2004, p. 468); it was also defined as expressing belief in the

client's ability to makes changes in a positive direction and to self-regulate his or her own

behaviors (Williams et al., 1996).   It was captured by the following codes: *conveying*

confidence in ability to make changes – competence (EPW1) and *emphasizing control*

(EPW2).

In the initial coding system, *Empowerment* was defined using the following

codes: *conveying confidence in ability to make changes – competence* (EPW1) and

encouraging client to see his or herself as a source of authority over his/her life decisions

– self-regulation (EPW2). To better capture the purpose of EPW2 and distinguish it from

EPW1, EPW2 was relabeled as emphasizing control, and was redefined to capture

statements that reflected the therapist's encouragement of the client to take control of decision-making processes as they relate to his or her own life. .

Listening for Core Values. The sixth autonomy supportive category, *Listening for Core Values*, was adapted from two of the core principles of the ACT model that focus on valued living (Hayes et al., 1999). It was operationally defined as helping a client articulate and behave in line with personal values, and included *identifying and clarifying personal values* (CV1) and *committed action* (CV2a and CV2b). The first code, *identifying and clarifying personal values*, referred to the therapist helping the client explore what is significant and meaningful for him or her (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes et al., 1999). The second code, *committed action*, described the therapist helping the client *set goals* that are guided by those values (CV2a) and take *effective action* to achieve them (CV2b, Hayes et al., 1999; Hayes et al., 2006). No changes were made to this coding category from the initial coding system during the data analysis process.

Procedures

Sampling procedure. An archival database was used to obtain the research data for the study. Each participant completed a written consent form to include his/her written and video materials in the research database. This study used purposive sampling in order to capture the specific phenomenon being examined. The following steps outline and describe the purposive sampling procedure.

Step 1. A list of research record numbers was obtained for de-identified clients.

Step 2. English-speaking adults over the age of 18 who partook in individual therapy were identified.

Step 3. The potential sample was narrowed to include only clients who had reported experiencing trauma (see Instrumentation section for operational definition of trauma).

Step 4. The potential sample was narrowed to include only participants who self-identified as having a specific ethnic cultural background, which was classified as either *individualistic* or *collectivistic* (see Instrumentation section and Data Tracking Sheet). The total number of therapy sessions for each client, as indicated on the Treatment Summary Form, was recorded on the Data Tracking Sheet.

Step 5. The sample was further narrowed to clients who had at least one videotaped session in which there was a discussion of trauma (see Instrumentation section and Data Tracking Sheet). Videotapes were viewed from latest to earliest in the course of therapy; in the event that more than one session included a trauma discussion, the later of the two sessions was selected. The researcher selected a relatively equal number of participants from each of the two ethnic cultural background groups. This was done by alternating between an *individualistic* client and a *collectivistic* client when viewing videotapes for and identifying trauma discussions.

Step 6. Of the remaining potential participants, 5 were selected based on specific client characteristics and demographics of age, gender, race/ethnicity, religious orientation, socioeconomic status, and presenting issues. These variables were considered to make sure that a representative sample of the counseling centers' population was obtained. The researchers consulted with the clinic directors of each counseling center to obtain estimates for each of the specified demographic variables of the community counseling clinic population.

Transcription. A total of seven master's level psychology graduate students were hired to transcribe the entire videotaped therapy session that included a discussion of a traumatic event/stressful life experience for each participant. The students were trained to transcribe therapy sessions verbatim. The doctoral student researchers reviewed the transcripts from each participant for accuracy and then coded them for autonomy support.

Coding. Three doctoral level psychology graduate students served as the coders for this study, and their research supervisor served as the auditor. The coders were trained to understand the essential concepts, terms, and issues that were relevant to the study (Hsieh-Fang & Shannon, 2005; Ryan & Bernard, 2003), including how to accurately identify and code occurrences of discussions of trauma and autonomy-supportive statements. Before coding the videotapes, coders practiced coding until they reached 66% agreement on practice cases.

After training was completed, and after the research assistants completed transcribing one session, each participant's session transcription was reviewed by the coders. The coders used the Coding Manual (Appendix G) to identify autonomy-supportive behaviors of therapists during the trauma discussions in the following five categories: (a) *Unconditional Positive Regard*; (b) *Empathy*; (c) *Egalitarianism/Providing Choices*; (d) *Psychoeducation*; (e) *Empowerment*; and (f) *Core Values* (see Instrumentation section for descriptions and definitions).

The coders met weekly or biweekly over 5 months to discuss their individual codes and come to a consensus about the coding of the data. After completing each session, they shared the coded transcription with the auditor, who then reviewed the

transcripts and the audit trail to determine whether all of the data reflective of the codes had been captured and to address coders' questions or issues (e.g., inter-rater reliability). The auditor provided her feedback and suggestions to the team of coders to discuss together and reach a consensus. In some cases, there were several discussions back and forth between the coders and the auditor related to coding decisions, which were eventually agreed upon by the team of coders.

Human Subjects/Ethical Considerations

All participants included in the study provided informed consent to have their records included in the research database prior to the intake interview at the community clinic (Appendix I). In addition, all therapists in the study gave consent to allow their psychotherapy tapes and client records to be part of the research database (Appendix J). Limits of confidentiality were reviewed with the client during the intake procedure. To protect participant confidentiality, all identifying information was redacted from the clients' written documents and a research number was given to each participant in order to de-identify his/her information.

Each researcher/coder and transcriber completed an IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to enhance understanding and adherence to ethical subject research. All researchers signed a confidentiality statement indicating they will keep all sensitive information confidential. Furthermore, steps were taken to ensure that research coders did not know the client-participant or did not have a social relationship with the therapist-participant on the videotapes in order to maintain confidentiality.

Data Analysis

The research design of the present study was a naturalistic, directed content analysis (Hsieh-Fang & Shannon, 2005; Schilling, 2006). Directed content analysis is based on a deductive category system in which the goal is "to validate or extend conceptually a theoretical framework or theory" (Hsieh-Fang & Shannon, 2005, p. 1281). Researchers from the SDT framework have identified certain elements that support autonomy for individuals. These include: (a) understanding and acknowledging individuals' perspectives (Koestner, Ryan, Bernieri, & Holt, 1984 as cited in Ryan & Deci, 2008); (b) providing unconditional regard (Assor, Roth, & Deci, 2004 as cited in Ryan & Deci, 2008); (c) supporting choice (Moller, Deci, & Ryan, 2006 as cited in Ryan & Deci, 2008); (d) minimizing pressure and control (Ryan, 1982 as cited in Ryan & Deci, 2008); and (e) providing a meaningful rationale for any recommendations or requests (Deci, Eghrari, Patrick, & Leone, 1994 as cited in Ryan & Deci, 2008). A deductive category system, based on these suggestions, was utilized in the current study in an attempt to extend the SDT-based framework of supporting autonomy, specifically in the context of psychotherapy for survivors of trauma.

Data analysis steps. The researcher identified key concepts as coding categories and determined operational definitions for each category (see Instrumentation section) based on prior research related to self-determination theory (SDT) and its predictions about the relationship between autonomy support and psychological well-being. While analyzing the data, the researchers adhered to the guidelines summarized by Hsieh-Fang and Shannon (2005) for a directed content analytic approach. The following outlines the steps taken during the data analysis process.

Step 1: Research assistants transcribed entire videotaped psychotherapy sessions of selected tapes that included some discussion of trauma. These transcriptions were uploaded into a *Google Docs* document as a Word data sheet, with an additional column for indicating presence of autonomy-supportive codes where appropriate. The researcher-participants then determined the *Start* and *Stop* points indicating when the trauma discussion for that session began and ended. These *Start* and *Stop* points were shared with the auditor, and final trauma discussion *Start* and *Stop* points were agreed upon collaboratively and indicated on the transcript.

Step 2: The researchers then read the transcripts of trauma discussions and highlighted all text that, on first impression, appeared to represent the concept of autonomy support.

Step 3: The researchers coded all highlighted passages using the following codes: UPR, EMP1a, EMP1b, EMP1c, EMP2, EMP3, EMP4a, EMP4b, EMP4c, EgPc1, EgPc2, PSY, EPW1, EPW2, CV1, CV2a, and CV2b (see Instrumentation section for code modifications made during data analysis). All of the highlighted passages were coded using at least one of these autonomy-supportive codes; no data required further analysis to determine if a new category or a subcategory of an existing code was represented (Hsieh-Fang & Shannon, 2005).

Coders 1, 2, and 3 independently examined the data prior to meeting together as a group to discuss each other's codes and come to a consensus. The advantages of using multiple researchers include the opportunity for diverse perspective and opinions, circumventing individual biases, and capturing the complexity of the data (Hill, Thompson, & Williams, 1997). To avoid potential group bias in the coding process or

consensual observer drift (i.e., coders altering or modifying their recordings to be consistent with another coder's with whom they previously compared ratings; Harris & Lahey, 1982 as cited in Hill et al., 1997), each coder maintained a copy of his or her initial codes that were independently derived, as well as those codes agreed upon after the group meeting. In cases of inter-rater disagreement during the group discussions, coders documented the rationale for each judgment call made in an audit trail so that the auditor could have an understanding of the coder judgment process (Orwin, 1994, as cited in Hill et al., 1997).

Inter-rater reliability among the three coders prior to group discussion was calculated using Fleiss' kappa coefficient (K; Fleiss, 1971). Table x outlines the K scores obtained for each code as well as the average for each code across participants. This coefficient was computed in order to test whether the agreement among coders exceeded what would be expected if all coders made their ratings completely randomly (Gwet, 2010). Fleiss's kappa is used with nominal-scale ratings to assess the reliability of agreement between a fixed numbers of raters; the advantage over Cohen's kappa is that it can be used when assessing the agreement between more than two raters, as was the case for the current study (Fleiss, Cohen, & Everitt, 1969).

Although there is no generally agreed upon measure of significance for K values, guidelines outlined by Landis and Koch (1977) indicate the following interpretations of K: $K < 0$ is poor agreement; $0.01 < K < 0.20$ is slight agreement; $0.21 < K < 0.40$ is fair agreement; $0.41 < 0.60 <$ is moderate agreement; $0.61 < 0.80$ is substantial agreement; and $0.81 < K < 1.00$ is considered almost perfect agreement. A negative K value indicates that the agreement is worse than that expected by chance.

As shown below, coders had an average pre-group discussion agreement of 0.60

for UPR (moderate), 0.77 for EMP1a (substantial), 0.80 for EMP1b (substantial), 0.31 for

EMP1c (fair), 0.56 for EMP4a (moderate), 0.37 for EMP4b (fair), 1.00 for EMP4c

(almost perfect), -0.01 for EgPc1, 0.72 for EgPc2 (substantial), 0.64 for PSY

(substantial), 0.23 for EPW1 (fair), 0.43 for EPW2 (moderate), 0.63 for CV1

(substantial), 0.12 for CV2a (slight), and 0.18 for CV2b (slight). The average agreement

for codes EMP2 and EMP3 were undefined since these codes were not used in any of the

coded sessions.

Table 3

Inter-rater Reliability Coefficients Among Three Coders (Pre-Group Discussions)

	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.		Fleiss' Kappa	Observed Agrmt.	Expected Agmt.
UPR				EgPc1			
1	0.45	0.964	0.934	1	-0.008	0.984	0.984
2	0.86	0.987	0.908	2	-0.006	0.987	0.987
3	0.692	0.984	0.947	3	N/A	1	1
4	-0.008	0.984	0.985	4	N/A	1	1
5	1	0.984	0.805	5	N/A	1	1
Avg.	0.599	0.981	0.916	Avg.	-0.007*	0.994	0.994
EMP1a				EgPc2			
1	0.453	0.952	0.912	1	0.496	0.992	0.984
2	0.77	0.917	0.638	2	0.497	0.994	0.987
3	0.938	0.984	0.734	3	0.886	0.995	0.952
4	0.8	0.977	0.884	4	1	1	0.977
5	0.89	0.982	0.834	5	N/A	1	1
Avg.	0.770	0.962	0.800	Avg.	0.720*	0.996	0.980
EMP1				PSY			
1	-0.012	0.976	0.976	1	0.726	0.98	0.927
2	0.587	0.955	0.891	2	-0.006	0.987	0.987
3	0.796	0.992	0.96	3	0.927	0.997	0.962
4	0.757	0.977	0.904	4	0.77	0.984	0.933
5	0.481	0.963	0.930	5	0.768	0.982	0.921
Avg.	0.522	0.973	0.932	Avg.	0.637	0.986	0.946

(continued)

	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.		Fleiss' Kappa	Observed Agrmt.	Expected Agmt.
EMP1c				EPW1			
1	0.498	0.996	0.992	1	-0.004	0.992	0.992
2	-0.003	0.994	0.994	2	0.594	0.942	0.858
3	0.331	0.995	0.992	3	0.337	0.956	0.934
4	-0.016	0.969	0.969	4	-0.008	0.984	0.985
5	0.757	0.954	0.812	5	N/A	1	1
Avg.	0.313	0.982	0.952	Avg.	0.230*	0.975	0.954
EMP2				EPW2			
1	N/A	1	1	1	-0.01	0.98	0.98
2	N/A	1	1	2	0.701	0.974	0.914
3	N/A	1	1	3	0.538	0.986	0.97
4	N/A	1	1	4	0.492	0.984	0.969
5	N/A	1	1	5	N/A	1	1
Avg.	N/A	1.000	1.000	Avg.	0.430*	0.985	0.967
EMP3				CV1			
1	N/A	1	1	1	0.082	0.964	0.961
2	N/A	1	1	2	0.657	0.981	0.944
3	N/A	1	1	3	0.387	0.975	0.96
4	N/A	1	1	4	1	1	0.955
5	N/A	1	1	5	1	1	0.973
Avg.	N/A	1.000	1.000	Avg.	0.625	0.984	0.959
EMP4a				CV2a			
1	0.483	0.968	0.938	1	0.498	0.996	0.992
2	0.56	0.942	0.869	2	-0.003	0.994	0.994
3	0.499	0.997	0.995	3	0.499	0.997	0.995
4	0.698	0.969	0.897	4	N/A	1	1
5	N/A	1	1	5	N/A	1	1
Avg.	0.560*	0.975	0.940	Avg.	0.331*	0.997	0.996
EMP4				CV2			
1	0.694	0.988	0.961	1	N/A	1	1
2	0.428	0.968	0.944	2	0.359	0.968	0.95
3	-0.003	0.995	0.995	3	-0.001	0.997	0.997
4	N/A	1	1	4	N/A	1	1
5	N/A	1	1	5	N/A	1	1
Avg.	0.373*	0.990	0.980	Avg.	0.179*	0.993	0.989
EMP4c							
1	1	1	0.988				
2	N/A	1	1				
3	N/A	1	1				
4	N/A	1	1				
5	N/A	1	1				
Avg.	1.000*	1.000	0.998				

Note. Coefficients marked with an asterisk (*) indicate average inter-rater reliability values across those sessions that included the code. Definitions of abbreviations are as follows: Agrmt. = Agreement; Avg. = Average.

Step 4: Once the researchers independently coded the transcripts, they met as a group to reach a consensus for final codes prior to submitting their findings to the auditor of the study. During these meetings, the coders discussed how each of their biases may have potentially impacted their process of coding.

Step 5: Codes were then submitted to the auditor. In order for the data collected by the researchers to be audited accurately and effectively, the researcher provided a clear and full account of the research process so that the reader may be able to judge the reliability of the study (Lincoln & Guba, 1985). This clear description of the research process, or audit trail, included information such as decisions regarding research design and data collection, and the steps taken to analyze and report the data. Based on recommendations for an audit trail (Halpern, 1983, as cited in Lincoln & Guba, 1985), the following information was tracked: (a) raw data, (b) data reduction and analysis products including quantitative summaries and theoretical notes, (c) data reconstruction and synthesis notes such as the structure of categories (themes, definitions, and relationships) and connections to existing literatures, (d) process notes including methodological notes (procedures, designs, strategies, rationales) and trustworthiness notes, (e) instrument (coding) development information, and (f) materials related to intentions and dispositions such as personal notes and expectations. Information regarding the personal expectations of each of the researchers was recorded using the technique of bracketing. Bracketing is a means by which researchers demonstrate the validity of the data collection and analytic process by attempting to not allow their

assumptions to shape and impose on the data collection process (Ahern, 1999).

Researchers recorded various issues in a reflexive journal, including the following: (a)

assumptions associated with gender, race, and where one belongs in the power hierarchy

in relation to the research study; (b) one's personal value system and areas in which one

knows he or she is subjective; (c) possible areas of potential role conflict; (d)

gatekeepers' interests and the extent to which they are disposed favorable toward the

study; and (e) feelings that may indicate a lack of neutrality (Ahern, 1999). Thus, during

group discussions, each of the researchers in the current study, as well as the auditor,

shared his or her thoughts related to personal biases as well as conflicts that arose

regarding coding decisions based on differences in individual perspectives. Prior to

beginning the coding process, the coders and auditor each kept a reflexivity journal

regarding initial thoughts and biases; although the intent was to keep the reflexivity

journal throughout the coding process, information regarding thoughts and biases were

limited to oral discussions once the coding process was initiated (see Limitations section

on p. 193). Information regarding thoughts and biases specific to the researcher of this

study is described in the Researcher Bias section below.

Step 6: After submitting the codes to the auditor, the coders communicated with

the auditor via the audit trail in the form of a *Google Docs* Word document, which

indicated both the coders' and the auditor's rationale for coding decisions. The auditor

served as an additional check of the team's judgments and decisions. The group decided

on the final codes.

Table 4 outlines the post-group discussion Kappa (K) scores across participants

for each code, including the average for each code across participants. As depicted

below, the average post-group discussion agreements were almost perfect for the majority

of the codes, with K = 1.00 for EMP1b, EMP1c, EMP4b, EMP4c, EgPc1, EgPc2, PSY,

and CV2a; K = 0.99 for EMP1a, EMP4a, EPW1, EPW2, and CV1; and K = 0.97 for

CV2b. As with the pre-discussion coefficients, inter-rater agreement was unable to be

calculated for EMP2 and EMP3 since these codes were not used for any of the

participants.

Table 4

Inter-rater Reliability Coefficients Among Coders (Post-Group Discussions)

	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.		Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
UPR				EgPc1			
1	1	1	0.93	1	1	1	0.93
2	1	1	0.93	2	1	1	0.93
3	1	1	0.93	3	N/A	1	1
4	1	1	0.93	4	N/A	1	1
5	1	1	0.93	5	N/A	1	1
Avg.	1	1	0.93	Avg.	1.000*	1.000	0.972
EMP1a				EgPc2			
1	1	1	0.93	1	1	1	0.93
2	1	1	0.93	2	1	1	0.93
3	0.97	0.992	0.733	3	1	1	0.93
4	1	1	0.93	4	1	1	0.93
5	1	1	0.93	5	N/A	1	1
Avg.	0.994	0.998	0.891	Avg.	1.000*	1.000	0.944
EMP1b				PSY			
1	1	1	0.93	1	1	1	0.93
2	1	1	0.93	2	1	1	0.93
3	1	1	0.93	3	1	1	0.93
4	1	1	0.93	4	1	1	0.93
5	1	1	0.93	5	1	1	0.93
Avg.	1	1	0.93	Avg.	1.000	1.000	0.930
EMP1c				EPW1			
1	1	1	0.93	1	1	1	0.93
2	1	1	0.93	2	1	1	0.93
3	1	1	0.93	3	0.97	0.992	0.733

(continued)

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	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.		Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
4	1	1	0.93	4	1	1	0.93
5	1	1	0.93	5	N/A	1	1
Avg.	1	1	0.93	Avg.	0.993*	0.998	0.905
EMP2				EPW2			
1	N/A	1	1	1	0.97	0.992	0.733
2	N/A	1	1	2	1	1	0.93
3	N/A	1	1	3	1	1	0.93
4	N/A	1	1	4	1	1	0.93
5	N/A	1	1	5	N/A	1	1
Avg.	N/A	1	1	Avg.	0.993*	0.998	0.905
EMP3				CV1			
1	N/A	1	1	1	0.97	0.992	0.733
2	N/A	1	1	2	0.97	0.992	0.733
3	N/A	1	1	3	1	1	0.93
4	N/A	1	1	4	1	1	0.93
5	N/A	1	1	5	1	1	0.93
Avg.	N/A	1	1	Avg.	0.988	0.997	0.851
EMP4a				CV2a			
1	1	1	0.93	1	1	1	0.93
2	0.97	0.992	0.733	2	1	1	0.93
3	1	1	0.93	3	1	1	0.93
4	1	1	0.93	4	N/A	1	1
5	N/A	1	1	5	N/A	1	1
Avg.	0.993*	0.998	0.905	Avg.	1.000*	1.000	0.958
EMP4b				CV2b			
1	1	1	0.93	1	N/A	1	1
2	1	1	0.93	2	0.97	0.992	0.733
3	1	1	0.93	3	N/A	1	1
4	N/A	1	1	4	N/A	1	1
5	N/A	1	1	5	N/A	1	1
Avg.	1.000*	1.000	0.958	Avg.	0.970	0.998	0.933
EMP4c							
1	1	1	0.93				
2	N/A	1	1				
3	N/A	1	1				
4	N/A	1	1				
5	N/A	1	1				
Avg.	1.000*	1.000	0.986				

Note. Coefficients marked with an asterisk (*) indicate average inter-rater reliability values across those sessions that included the code. Definitions of abbreviations are as follows: Agrmt. = Agreement; Avg. = Average.

Step 7: After the coding was completed, audited, and final codes were decided upon, the data were entered into a frequency table that included the session identification number (i.e., 1 through 5), ethnic background of the participant, and frequency counts for each of the autonomy supportive codes. The researcher presented findings by rank ordering frequencies to compare the coded data. The data was compared across all 5 participants, as well as across participant cultural background groups (i.e., individualistic and collectivistic). In addition, within-participant frequencies of data were presented and compared. For each of these groups of findings, qualitative data was also provided, including direct quotes from the trauma discussions that were considered to capture the codes

Step 8: Finally, the researcher evaluated the data for patterns based on variables including specific autonomy supportive behaviors and ethnic background of participant (see Appendix J).

Researcher bias. The primary researcher observed her own biases that potentially impacted coding decisions made throughout the data analysis process. For example, the primary researcher identifies as a first-generation Armenian-American, with a combination of both individualistic and collectivistic values, though slightly more collectivistic in her view of the degree of relatedness between self and others. As such, one ongoing assumption that was constantly monitored was that clients from individualistic backgrounds would value independence, whereas clients from collectivistic backgrounds would lean towards dependence and interconnectedness. This resulted in initially neglecting to notice some of the individualistic statements made by clients who were categorized as having a collectivistic cultural background, and vice

versa. The same assumption applied for the therapist-participants; although information was not available with respect to the cultural background of the therapist-participants, assumptions were made based on physical appearance and, accordingly, assumptions were made as to the emphasis that the therapist-participant placed on independence versus dependence on others.

Another bias that was observed within the primary researcher coding for autonomy-supportive codes was a tendency to view more statements than the other coders as representative of autonomy support in the first two to three sessions. This was particularly the case for the codes EMP4a and EMP4b, EPW1, and CV1. Upon reflection, this was attributed to a possible desire for therapist-participants to more frequently demonstrate empathy, empowerment, and encouraging exploration of core values for diverse clients who have experienced a trauma, especially since based on the review of literature on posttraumatic growth, these types of responses would help clients overcome and grow from their aversive experiences. Given these biases and assumptions, four different perspectives through group discussions and reliability checks helped maintain a more diverse and balanced view of the construct of autonomy support.

Chapter 3. Results

This chapter presents results from the qualitative and quantitative content analysis of psychotherapy sessions with culturally diverse survivors of trauma involving the autonomy supportive codes developed by the researcher based on existing literature on self-determination theory (SDT; Deci & Ryan, 1985; Ryan & Deci, 2000), operationally defined in the method section and located in the coding manual (Appendix F): (a) *Unconditional Positive Regard* (UPR); (b) *Empathy* (EMP1a, EMP1b, EMP1c, EMP2,

EMP3, EMP4a, EMP4b); (c) *Egalitarianism/Providing Choices* (EgPc1, EgPc2); (d)

Psychoeducation (PSY); (e) *Empowerment* (EPW1, EPW2); and (f) Core Values (CV1,

CV2a, CV2b). The goal of the analyses was to extend the SDT-based framework of

supporting autonomy by elucidating whether and/or how trainee therapists address the

basic psychological need for autonomy when treating culturally diverse clients with

trauma related issues. This chapter reviews findings from the content analysis based on

data gathered across sessions, data across cultural background, and finally, data within

participants. All quotes within the content analyses are directly from the participants,

unless cited otherwise.

Content Analysis

As outlined in Table 5, the content analysis of therapists' use of autonomy

supportive responses in transcribed psychotherapy sessions yielded a total of 258 codes

within the 672 possible transcribed therapist talk-turns. The total number of codes within

each session ranged from 25 to 97, with an average number of codes equaling 51.6 (SD =

32.16). The total number of talk turns comprising the trauma discussion for each session

ranged from 73 to 243, with an average number of talk turns equaling 134.4 (SD =

70.41). Put another way, autonomy supportive responses occurred in 38% of the therapist

talk-turns in response to client trauma discussions. Table 5 below depicts the

abovementioned totals for each session.

Table 5

Total Number of Codes and Talk-Turns

	1	2	3	4	5	1-5
Total Codes	34	74	97	25	28	258
# Talk Turns	166	104	243	86	73	672

Of the 258 autonomy-supportive codes, 141 (55%) were coded as an *Empathy* code (87 EMP1a, 18 EMP1c, 18 EMP4a, 12 EMP1b, 5 EMP4b, and 1 EMP4c); 38 (15%) as an *Empowerment* code (22 EPW1, 16 EPW2); 24 (9%) as a *Listening for Core Values* code (21 CV1, 2 CV2a, and 1 CV2b); 24 (9%) were coded as *Unconditional Positive Regard*; 20 (8%) as *Psychoeducation* (PSY); and 11 (4%) as an *Egalitarianism/Providing Choices* code (10 EgPc2, 1 EgPc1). Table 6 depicts the frequencies of coded responses by participant (session) as well as by code (both broader coding categories and specific individual codes).

Table 6

Frequency Data for Autonomy-Supportive Codes Within and Across Sessions

| Participant ID | 1 | 2 | 3 | 4 | 5 | Total |
Culture	IND	COL	COL	IND	COL	(across)
Unconditional Positive Regard						
UPR	2	5	7	2	8	24
Empathy						
EMP1a	7	29	41	4	6	87
EMP1b	1	4	2	3	2	12
EMP1c	1	1	4	3	9	18
EMP2	0	0	0	0	0	0
EMP3	0	0	0	0	0	0
EMP4a	2	10	1	5	0	18
EMP4b	1	3	1	0	0	5
EMP4c	1	0	0	0	0	1
Total EMP Codes	13	47	49	15	17	141
Egalitarianism/ Providing Choices						
EgPc1	1	0	0	0	0	1
EgPc2	1	1	7	1	0	10
Total EgPc Codes	2	1	7	1	0	11
Psychoeducation						
PSY	6	2	6	4	2	20
Empowerment						

(continued)

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| Participant ID | 1 | 2 | 3 | 4 | 5 | Total |
Culture	IND	COL	COL	IND	COL	(across)
EPW1	0	9	12	1	0	22
EPW2	3	5	7	1	0	16
Total EPW Codes	3	14	19	2	0	38
Core Values						
CV1	7	4	8	1	1	21
CV2a	1	0	1	0	0	2
CV2b	0	1	0	0	0	1
Total CV Codes	8	5	9	1	1	24
Total Codes	34	74	97	25	28	258
# Talk Turns	166	104	243	86	73	672

Note. IND is an abbreviation for individualistic; and COL is an abbreviation for collectivistic.

Findings across participants. Across all 5 participants, the autonomy-supportive category that was most frequently coded was *Empathy* (141 codes; 55%). Within the *Empathy* coding category, the vast majority of the responses were coded as *reflecting fact* (EMP1a, 87 codes). As described in the method section and coding manual, EMP1a was defined as therapist responses that reflect/rephrase/restate the client's content-related, factual verbalizations. For example, in the trauma discussion for Participant 2, the therapist responded, "People are complicated, that's true" (T94) to the client's preceding statement of "Right. Yeah, I don't know, people is complicated" (C93). In this case, the therapist reflected the client's response using verbatim terminology (i.e., "people are [/is] complicated"). Another example of EMP1a is found in session 5, in which the client stated, "He was one of those guys I'd waste – waste time with during the three years that I did nothing [...]" (C226); the therapist responded by rephrasing the

client's statement in a reflective manner, stating, "So you spent a lot of time with him" (T228).

Code EMP1c and EMP4a represented the second most frequent *Empathy* codes (18 codes each). The EMP1c code included statements such as "[...] It must have been really hard to hear" (Session 5, T231), which were therapist responses that reflected an ambiguous client statement with respect to whether it was a thought or an emotion. The code EMP4a, defined as therapist questions that attempted to understand more fully the client's thoughts or situation, followed by a response that reflected verbal understanding back to the client, was exemplified by the following series of verbalizations in session 2: "What are you thinking about right now?" (T112); "I don't know. I'm just listening to you" (C112); "You're just listening? Okay [...]" (T113).

The *Empathy* code that represented the least number of coded responses was EMP4c, which included responses that questioned the client regarding an ambiguous thought or feeling (e.g., "That's a great unknown, is that hard?" Session 1, T76). Notably, the codes *nonverbal referent* (EMP2) and *shared feeling or experience* (EMP3) were not coded for any of the participants.

The second most frequently used coding category was *Empowerment,* representing 14% of the total codes (37 codes). These codes included EPW1 (conveying confidence in the ability to make changes – competence) and EPW2 (emphasizing control). Within the *Empowerment* category, EPW1 was more frequently coded than EPW2 (22 versus 16). EPW1 was captured by statements such as "[...] you've assimilated into Western American culture, you know, whereas your community kind of just still has their community [...]" (Session 3, T110), in which the therapist highlighted a change that

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the client already made in a positive direction (i.e., assimilation into a new culture). The EPW2 code was captured by therapist responses that suggested the client was in control of his or her own situation; for example, in session 2, the therapist states, "If that's something you want to do" (T144) in response to the client's debate of whether or not she should contact her younger sister to wish her a happy birthday, which the client discussed as a difficult decision for her to make.

The next most frequently coded categories were *Unconditional Positive Regard* (24 codes) and *Listening for Core Values* (24 codes), with each representing 9% of the total codes. In terms of *Unconditional Positive Regard*, the code was defined as "validation" and captured therapist statements that suggested the client was entitled to think, feel, and/or behave in the way that he or she is or wants to. For instance, in session 5, the therapist made several validating statements, including "[...] It must have been really hard to hear" (T231), and "[...] but thank you for sharing that with me because I – I know, I can only imagine how hard it is to talk about it" (T274). In session 5, the therapist's brief statements of "It is" (T69) and "Yeah, it's tough" (T71) were also made in response to the client discussing her health-related difficulties and challenges.

Listening for Core Values was defined by statements that helped the client explore what is meaningful to him or her (CV1), helped the client set behavioral goals consistent with those values (CV2a), and helped the client articulate how to take effective action towards those goals (CV2b). For example, in Session 3, the therapist statement, "[...] you have very strong morals and values [...] that you, you know, hold up to yourself and to [...] other people which has served you well [...]" (T89), in a discussion related to his values stemming from his culture and family of origin, was given a code of CV1.

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The coding category *Psychoeducation* comprised 8% of the total codes across sessions, and included 33 statements that the therapists made in an effort to provide their clients with information regarding their reported symptoms as they might relate to their clients' psychological functioning, psychological theory, or treatment-related issues. In session 1, for example, the therapist provided information regarding mindfulness as a psychological theory and treatment, stating:

> Um, so a couple of, [T grabs book] or last week and few other times we've talked about um, mindfulness stuff. And this is, um, it's my book actually [T looks at book], but this is uh, one of the big books that is about doing mindfulness and mediation in everyday life. Um, and you still have a lot of exercises about how to try and bring it into your daily practice and stuff like that [...] and it's a lot about you know in day to day life [T wipes eyes] how to really take the time to be in the moment and reflect on what's going on around you, and different little exercises about how to do that. (T93)

A few talk-turns later in the session, the therapist offered an additional recommendation as far as a resource, stating, "Actually if you enjoy this I also have a book on grieving mindfully. That might be something to think about with all the losses that have gone on for you" (T103). Another example of a PSY code was found in session 3, where the therapist explained concepts of cognitive-behavioral therapy as they related to the client's described experience. The therapist stated, "[...] when you were talking and telling me some of you know the stories and things happening, you, you know, named some of the automatic thoughts when you were thinking, and so you were just more aware of those, and able to kind of deal with them" (T172).

Finally, the least frequently coded category across all 5 sessions was *Egalitarianism/Providing Choices*, with 11 codes total (4%) between the two separate codes (EgPc2, 10 codes; EgPc1, 1 code). The code EgPc2 was defined as providing the client with choices concerning administrative decisions. Session 3 had the most EgPc2

codes among sessions; the therapist was noted to give the client the opportunity to make a choice regarding the frequency of sessions and when the next session would be scheduled for. For example, the client asked the therapist, "Um, should I just call you when I..." (C174) to find out when the next session should be, and the therapist responded with, "When you want – so are you thinking of anything specific? Or, just when you want to kind of come in? Or are you thinking every other Friday or?" (T175); this response suggested that the client had the choice in the administrative decision. The code EgPc1, which was defined as providing the client with choices regarding the therapeutic material discussed in session, was found only in Session 1. The therapist was noted to give the client an additional resource option to consider in light of the client's recent loss of a family member: "[...] I also have a book on grieving mindfully. That might be something to think about with all the losses that have gone on for you" (T103).

Patterns across cultural background. This section compares findings of autonomy support coding categories across the two cultural background groups. Because the numbers of participants classified as collectivistic (n = 3) and individualistic (n = 2) were not equal, average frequency of each coding category was calculated and is reported next. Table 7 outlines simple descriptive statistics in terms of frequencies for each coding category by client-participant cultural background category.

Table 7

Descriptive Statistics for Coding Categories by Participant Cultural Background

	Collectivistic (n=3)			Individualistic (n=2)		
	Total	Mean	SD	Total	Mean	SD
UPR	20	6.67	1.53	4	2.00	0.00
EMP	113	37.67	17.93	28	14.00	1.41
EgPc	8	2.67	3.79	3	1.50	0.71

(continued)

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	Collectivistic (n=3)			Individualistic (n=2)		
	Total	Mean	SD	Total	Mean	SD
PSY	10	3.33	2.31	10	5.00	1.41
EPW	33	11.00	9.85	5	2.50	0.71
CV	15	5.00	4.00	9	4.50	4.95
Total	199	66.33	35.13	59	29.50	6.36

The content analysis revealed a mean total of 66.33 (SD=35.13; range = 2.67 to 37.67) codes for collectivistic participants, compared to a mean total of 29.50 (SD=6.36; range = 1.5 to 14.00) codes for clients classified as individualistic; the trauma discussions for the collectivistic clients contained more than double the total autonomy-supportive codes as compared to the trauma discussions for the individualistic clients. The hierarchy of frequently coded categories with respect to the mean totals for collectivistic clients was as follows: *Empathy* (37.67), *Empowerment* (11.00), *Unconditional Positive Regard* (6.67), *Listening for Core Values* (5.00), *Psychoeducation* (3.33), and *Egalitarianism/Providing Choices* (2.67). Comparatively, the hierarchy for the mean totals for individualistic clients differed somewhat: *Empathy* (14.00), *Psychoeducation* (5.00), *Listening for Core Values* (4.50), *Empowerment* (2.50), *Unconditional Positive Regard* (2.00), and *Egalitarianism/Providing Choices* (1.50). The coding categories of *Egalitarianism/Providing Choices*, *Psychoeducation*, and *Listening for Core Values* were similar with respect to mean totals between the two cultural background groups, whereas *Unconditional Positive Regard*, *Empathy*, and *Empowerment* more often occurred in the collectivistic group. Also, both groups similarly had *Empathy* as the most frequently coded category, and *Egalitarianism/Providing Choices* as the least frequently coded category; notably, this pattern was consistent with the overall findings across all 5 participants.

In terms of the *Unconditional Positive Regard* (UPR) category, the collectivistic group had a mean of 6.67 codes, ranging from 5-8; the individualistic group had a mean of 2.00 codes (Range = 0). The collectivistic group had more than triple the frequency of UPR codes when compared to the individualistic group. In Session 2, as the collectivistic client discussed her desire for friends in the context of a history of childhood complex trauma and not having had many friends, the therapist stated, "[...] I understand, I mean, it makes sense that it's confusing, you know, because like you said, you have had bad experiences with people before, right?" (T86). Another example of a UPR code used with a collectivistic client was found in Session 3, in which the therapist was noted to validate the client's dilemma related to assimilating into American culture while adhering to his Turkish culture of origin; the therapist responded with the statement, "[...] I could see how that might cause, you know, conflict between how you feel, you know, and your community and how your relationship with your community is" (T112). In contrast, a therapist statement coded as UPR in Session 1 (individualistic) was a validating response related to the client's experience of distress related to his brother's suicide, and his difficulty managing his own stress related to it; the therapist states, "[...] it's hard to ignore the chaos and emotions of a moment in order to [T laughs], you know, of the overwhelmingness of everything about the future in order to focus on one particular moment" (T98).

The total mean frequency for the coding category of *Empathy* (EMP) was more than double for the collectivistic compared to the individualistic group. Specifically, the mean frequency for EMP in the collectivistic group was 37.67 (range = 17 to 49), whereas the total mean frequency for the individualistic group was 14.00 (range = 13 to

15). Qualitatively, examples of therapist responses coded as an EMP code from sessions 1 (individualistic) and 5 (collectivistic) highlight the different emphases placed on independence versus interdependence by each of the therapists, respectively. The reflective responses in session 1 emphasized the therapist hearing that the client wanted to prioritize himself over others, whereas the reflective statements in session 5 focused on the client's difficult cognitions and emotions related to the loss of a relationship due to his friend's unexpected death. In session 1, the therapist responded, "I mean to a certain extent you have to be selfish to live a happy life" (T157) to reflect the client's discussion regarding dealing with family stressors while attempting to cope with his traumatic experiences (brother's suicide and robbery). In session 5, on the other hand, the client is discussing his difficulty coping with the death of his friend, and the therapist reflects this difficulty by affirming the importance of relationships and connectedness, stating, "[...] Yeah, it's really hard to deal with that, especially someone you knew so well and..." (T270).

The total mean frequencies for the coding category of *Egalitarianism/ Providing Choices* (EgPc) were roughly equivalent between the collectivistic group (2.67; range = 0-7) and the individualistic group (1.50; range = 1-2). Qualitatively, the following examples show similar EgPc approaches between the two therapists. An example of a therapist response coded as an EgPc code for a collectivistic participant included, "[...] I respect whatever decision about how often you want to come in..." (Session 3, T222). As far as an individualistic participant, Session 4 contained a therapist response coded as EgPc; the therapist stated, "Is that something [therapist using hands pointing to herself and client] that you would maybe like to do together with me maybe?" (T12), referring to

the choice she gave the client as to whether or not the client wanted to enlist the help of the therapist during a session to search for an assisted living residence for individuals who are blind.

Similarly, in terms of the *Psychoeducation* (PSY) coding category, the collectivistic group contained a mean frequency of 3.33 codes (range = 2-6), and the individualistic group contained a mean frequency of 5.00 codes (range = 4-6). The PSY code was evident in Session 3 (collectivistic), in which the therapist stated, "[...] Like some of those, you know, chapters that I gave you were a lot, you know, of things about this. About kind of having a rigid belief like I need to do this perfectly" (T217). The client was discussing his dilemma of whether or not to enroll in a university and the challenges he foresaw as doing well at the school, and the therapist had recommended a book for him to read that addressed core beliefs. Likewise, in a session for an individualistic client (Participant 4), the therapist referred to the client's core beliefs and the way in which they may be contributing to her current distress; the therapist stated, "Whereas that's probably not completely accurate but sort of your vision of what would happen. But looking at what, what, what your own core beliefs are, that would be the case" (T62).

The frequency of the *Empowerment* (EPW) coding category appeared to differ with respect to cultural background, as the collectivist group contained a mean frequency of 10.67 codes (range = 0-19) and the individualistic group had a mean frequency of 2.50 (range = 2-3). However, the use of this code for both groups reflected the same theme, that is, personal control. An example of an EPW code was found in Session 2 (collectivistic), in which the therapist attempted to emphasize the client's control over her

situation by stating, "But you're, like you said, you're not letting it affect your own life [T points toward self] in terms of wanting to hurt yourself" (T131). Similarly in the same session, the therapist responds, "Well do you think you could still send if you want?" (T138) to the client's debate of whether or not to send her sister a birthday card, suggesting that the client should choose for herself whether or not she will send the card. In an earlier portion of the trauma discussion, the therapist highlights strengths and positive changes in the client, stating "[...] you've changed so much since I first saw you [...]" (T81) and "[...] you've really learned, but you've learned the ability to allow yourself to change, right?" (T83). Examples of EPW codes found in an individualistic participant's session are found in session 1, in which the therapist states, "I mean to a certain extent you have to go 'Okay, I have to take care of myself' " (T158), and "At a certain point, I think you have to take ownership of your own problems though [...]" (T175), both of which represent the therapist's attempt to encourage the client to take control of his life and personal choices.

Finally, the coding category of *Listening for Core Values* (CV) appeared to be roughly equivalent between the two groups (collectivistic = 5.00, range = 1-9; individualistic = 4.50, range = 1-8). In session 3, the client was discussing his decision-making process related to pursuing a career in the context of his assimilation challenges. The therapist responded with a statement reflecting an attempt to help the client identify and clarify his personal, core values and compare them to those of his family and community:

> You know they're good values to have [...] you've reached a point where it's you know, 'I think this way and it's okay to think this way and this is what I'm going to do, you know [...] How does it feel being, um, from the community, from that community pursuing your own, you know, individual career, you know, going to

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school and your career kind of, you know, being different from the community? (T90)

In terms of an individualistic participant and an example of a therapist response coded as CV, the therapist stated, "[...] Have you never really wanted children or have you never really allowed yourself to want children?" (T37) in response to the client stating that she has never wanted children; the therapist's response is an example of an attempt to help the client clarify what her values are with respect to having a family and children of her own.

Patterns within participants. This section provides both quantitative data and qualitative descriptions of coded responses within each participant session, including code frequency data and examples of specific statements that were considered to capture the code. A brief synopsis of the trauma discussion is provided in the beginning of each participant's results discussion in order to provide context for the description of the frequencies of the assigned autonomy-supportive codes that follows.

Participant 1. As described in the method section, Participant 1 was a 33-year old single, heterosexual, Caucasian (individualistic) male, whose traumatic events consisted of his brother's suicide, and a robbery he and his girlfriend had survived. Participant 1's trauma discussion consisted of 166 therapist talk turns that were reviewed for relevant autonomy-supportive responses. A total of 34 codes were assigned, comprising 20% of the total talk turns within the session. The autonomy supportive codes appeared to occur in clusters intermittently throughout the trauma discussion. The first group of codes did not occur until 50 therapist responses into the trauma discussion (most of the therapist responses up to that point were "mm-hmm"). A pattern throughout

the trauma discussion was noted in that statements coded as *Empathy* led to responses

coded as either *Psychoeducation* or *Listening for Core Values*.

The trauma discussion began with the client describing his positive feelings

related to his girlfriend's new job and move, noting that these changes should help

mitigate her distress related to their recent robbery, and therefore improve their

relationship and the distress that the relationship has been causing for the client. The

therapist asked a few questions to engage the client in a discussion of how he would feel

if he and his girlfriend ended their relationship, and whether this would negatively impact

his reported feelings of worry about her. The client reported that he would feel

comfortable with the changes, and his verbalizations reflected a feeling of either

acceptance or apathy, which was difficult to distinguish without making assumptions.

Notably, the client abruptly switched the focus of the conversation to the numbness in his

hands that had been a recent concern, and expressed his worries about the unknown

etiology of this symptom. The therapist listened to the client and responded with "mm-

hmm" throughout, until the first autonomy-supportive statement (reflection of fact) was

made, followed by a question to explore the client's feelings related to this unexplained

physical symptom, which led to a discussion regarding the client's feelings of

hopelessness. The therapist eventually transitioned the discussion to recommending a

book on mindfulness, which appeared to lack a clearly or explicitly articulated

connection to the client's discussion of the numbness in his hands. The client appeared to

be interested in this resource, and the therapist eventually made a validating statement

regarding the distress the client had been experiencing with the multiple stressors in his

life (e.g., robbery, brother's suicide, relational difficulties, numbness in his hands), and the potential benefit of mindfulness skills to help him cope with this stress.

Shortly after, the client resumed the discussion regarding his hand numbness, and he himself commented that the numbness might be a symptom of the stress he was experiencing. The discussion transitioned again to a conversation regarding the client's use of marijuana for his pain that the therapist initiated. The therapist made a confrontational response regarding the client's increased use of marijuana, which the client relatively quickly avoided and transitioned into a discussion wondering why he "doesn't do things faster when it has to do with [him]." The therapist responded by suggesting, "You don't make yourself a priority?", which the client then agreed with and led to an exploration of this core value. The therapist brought back the client's use of marijuana in a questioning form, and attempted to use this discussion as a further exploration of the client's values and behaviors that have thus far been inconsistent with the value of prioritizing himself. Interestingly, this led to client-initiated discussion characterized by positive and hopeful statements (e.g., "Like my hands are going to be fine"), which were opportunities for the therapist to reflect, validate, empower, or otherwise emphasize the client's positive self-statements by her responses, which was not done; this pattern of client-initiated positive statements, without relevant autonomy-supportive therapist responses lasted for 25 client talk-turns (C132 to C157). The therapist eventually made a reflective statement noting that one must be selfish in order to be happy, which is followed by several responses that were empowering as well as encouraging the client to explore his personal values. These subsequent therapist responses (which occurred throughout the rest of the trauma discussion) and their

individualistic emphasis were exemplified by the statement, "[...] I have to take care of myself" (T158); focus was placed on the individual taking care of himself rather than possibly depending on others to help and support him through this difficult time.

Next, specific frequency data is provided. The frequency hierarchy for Participant 1's coded categories was as follows: *Empathy* (13 codes; 38% of total codes); *Listening for Core Values* (eight codes, 24% of total codes); *Psychoeducation* (six codes, 18% of total codes); *Empowerment* (three codes, 9% of total codes); *Unconditional Positive Regard* (two codes, 6% of total codes); and *Egalitarianism/Providing Choices* (two codes, 6% of total codes).

In terms of *Empathy*, the most frequently used code was EMP1a, with a total of seven codes. An example of EMP1a is represented by the statement, "[...] And it seems like for you there's a lot of, you can't let go, or ignore of anything that's going on with [client's girlfriend]. And then your hands are numb, and you have all this work stuff. And..." (T98). In this example, the therapist reflected factual content related to the client's described stressors related to his relationship with his girlfriend as well as the somatic complaints he discussed. In another example, the therapist responded, "[T nods] To a certain extent you have to be selfish to live a happy life" (T157) to the client's discussion of his mother having negative personal effects related to not taking care of herself because she was so busy taking care of multiple others; the client had previously stated, "[...] So watching that example [his mother], I need to learn from that. And it's like I'm not trying to be like perfect person, or like Zen master whatever you know what I mean, I'm just trying to live a happy life [...]" (C156). For the remainder of the *Empathy* codes, the next most frequently used code was EMP4a (two codes), followed by EMP1b

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(one code), EMP1c (one code), EMP4b (one code), and EMP4c (one code). The codes EMP2 and EMP3 were not used for this participant's trauma discussion.

Following *Empathy*, the next most frequently coded category was *Listening for Core Values*, of which CV1 was the most frequent (seven codes). In attempting to help guide the client through identifying and clarifying his personal values, the therapist responded with verbalizations such as, "You don't make yourself a priority?" (T123) and "I mean, to a certain extent you have to go 'Okay, I have to take care of myself'" (T158). In addition, one of the CV1 examples included the statement, "Well in order to have the strength to be able to give to others and to help others, you have to be somewhere yourself where you're centered [...] – I mean you don't have to be the perfect person [...], but you do have to have room for someone else" (T161). Similarly, the therapist was noted to respond, "And if you're so caught up in your own turmoil, your own pain that you're not dealing with, you don't have room for other people, and for helping others" (T162). These therapist responses were all similar in that they placed an emphasis on the client's own individual needs, and putting himself first before others. Of note, the therapist did indicate that the client should prioritize himself with the goal of being able to help and be available for the others in his life, which reflects both individualistic values of prioritizing the self but also collectivistic values of honoring his mother's legacy.

The CV1 code was followed by CV2a in terms of frequency (1 code). The therapist's response, "[...] How do you envision getting through your issues with [client's girlfriend]" (T140) was an example of helping the client set goals of how he will go about behaving consistently with what he has identified as being important to him –

determining which direction he wants his current relationship to head (i.e., toward

friendship or long-lasting romantic relationship). The CV2b code was not used in this

trauma discussion.

The third most frequently coded category/code was *Psychoeducation* (PSY, six

codes). The statements coded as PSY in this trauma discussion related to different

resources or treatment options for the participant's traumatic experiences and related

distress. As mentioned earlier, the therapist introduced these resources without a clear or

explicit initial connection to how the resources related to the client's discussion. For

example, the therapist introduced a resource on mindfulness rather abruptly following the

client's relatively long discussion of the numbness in his hands, but eventually made the

connection of using mindfulness as a skill to deal with the multiple stressors the client

was experiencing, including his somatic complaints. In describing mindfulness as a

treatment, the therapist stated, "[...] it's a very difficult thing to actually stay in the

moment [...], and so mindfulness practice, the idea is to learn to bring yourself in the

present, and enjoy the present moment and focus on the present moment, but it's not an

easy skill to have [...]" (T95). The therapist also stated, "Actually if you enjoy this I also

have a book on grieving mindfully. That might be something to think about with all the

losses that have gone on for you (T103)" to suggest an additional resource for the client

to consider given his losses. The PSY responses represented in this trauma discussion

were related in that they focused on ways in which the client can help himself as he deals

with the impact of the traumatic experiences he has had.

The *Empowerment* category was the fourth most frequently used set of codes,

with three EPW2 codes found throughout the trauma discussion; the EPW1 code was not

used. Examples of the EPW2 codes included therapist responses that emphasized the client's and/or others' control over his/their own situation. For instance, the therapist stated, "I mean, to a certain extent, you have to go 'Okay, I have to take care of myself'" (T158) in order to convey the decision-making abilities of the client with regards to his own life choices related to prioritizing himself. Additionally, the therapist made statements in response to the client's discussion of his girlfriend's stressors and difficulties managing them; the therapist stated, "At a certain point, you have to take ownership of your own problems though" (T175), and "At a certain point, you have to accept that you're making those choices..." (T178), emphasizing the individual's freedom of choice over his or her decisions.

Lastly, the two least frequently coded categories in this trauma discussion included *Unconditional Positive Regard* and *Egalitarianism/Providing Choices*. In terms of the former, the UPR code was used 2 times throughout the trauma discussion. These statements included, "Mm-hmm [T nods], it'd be hard to work that way" (T78)", and "[...] it's hard to ignore the chaos and emotions of a moment in order to [...] focus on one particular moment" (T98). These responses were both related to the client's own struggle with the traumatic experiences and the resulting somatic complaints and impact on his ability to handle daily life. The *Egalitarianism/Providing Choices* category was represented equally by the EgPc1 and EgPc2 codes (one code each). The EgPc1 statement, "Actually if you enjoy this book I also have a book on grieving mindfully. That might be something to think about with all the losses that have gone on for you" (T103) reflected the therapist providing the client with the choice over the content to be discussed or worked on in their course of therapy. The EgPc2 statement, "Um, I can let

you borrow it [...], or you can buy your own [...]" (T100) represented a choice provided to the client with respect to an administrative-related decision in the therapeutic relationship.

 Participant 2. Participant 2 was a 21-year old married, heterosexual, Hispanic (collectivistic) female, whose traumatic events discussed in the session were a history of multiple incidents of physical, verbal, and emotional abuse during childhood. The trauma discussion consisted of 104 therapist talk turns. A total of 75 codes were assigned to the trauma discussion, comprising 72% of the total talk turns within the session. Autonomy-supportive codes were identified from the beginning (the second therapist response) of the trauma discussion, and continued throughout it (T81 to T183). More specifically, *Empathy*, *Empowerment* and *Unconditional Positive Regard* were found throughout the discussion *and Listening for Core Values* responses were used in the first half (approximately) of the trauma discussion. Also, autonomy-supportive statements appeared to follow a circular pattern, in which empathic responses (EMP codes) led to responses coded as *Empowerment*, *Listening for Core Values*, and/or *Unconditional Positive Regard*, which then in all cases led back to *Empathy codes*.

 The trauma discussion began with an exploration of the client's progress towards becoming more trusting towards others and considering developing friendships, in the context of a history of childhood abuse and longstanding distrust of others. Although the client introduced the discussion with the statement, "I'm still don't change about the friends thing, though [sic]" (C79), suggesting that she is still distrustful of others, the therapist responded in a nonjudgmental way (i.e., "That's okay"), which then led to the client stating "But I'm working on it." This exchange progressed into a long discussion of

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the evolution of the client's attitude towards others and friendships, with an emphasis placed by the therapist on validating and empowering the client, as well as encouraging an exploration of her values regarding relationships; the therapist appeared to encourage the client in a direction towards building relationships, as is consistent with the values inherent in the client's collectivistic cultural background. The therapist explained the therapeutic relationship with the client as an example of a positive relationship that evolved from initially being strangers.

The trauma discussion progressed to the client discussing her distressing feelings related to her family of origin and their ongoing negative interactions and threats made by her mother towards others in the family. The client stated that she is "not letting it affect [her] [...] like it did before" (C129), and the therapist immediately responded with a series of empathic and empowering statements highlighting the description of positive changes initiated by the client. Throughout the remainder of the trauma discussion, the therapist guided the client through exploring her feelings related to her family and their ongoing stressors, and ways in which she can maintain her closeness to her sister, including deciding not to commit suicide as she had previously considered. The end of the trauma discussion included a choice provided by the therapist as to whether the client wanted to engage in a relaxation exercise.

The frequency hierarchy for Participant 2's coded categories was as follows: *Empathy* (48 codes; 64% of total codes); *Empowerment* (14 codes, 19% of total codes); *Unconditional Positive Regard* (five codes, 7% of total codes); *Listening for Core Values* (five codes, 7% of total codes); *Psychoeducation* (two codes, 0.03% of total codes); and *Egalitarianism/Providing Choices* (two codes, 0.03% of total codes).

With respect to *Empathy*, the most frequently used code was EMP1a, comprising 48 out of the 75 codes within this category. Many of the EMP1a codes in the trauma discussion reflected factual, content-related verbalizations made by the client regarding her relationship with close family members. For example, the therapist stated, "[...] you said you, um, you were thinking about your little sister cause it was her birthday [...]" (T136), and shortly after, "[...] I like the idea of calling your sister or sending her a watch, something that she's been wanting cause it's like when you are feeling that she is so far away it's hard not to be with her on her birthday, I'm sure she misses you a lot too [...]" (T145). The therapist's reflections pertained to the client's desire to connect with her sister. In addition, several of the EMP1a responses related to the client's progress in her indecision about whether or not she wants to develop friendships, given her history of chronic physical abuse and related distrust of others. The therapist responded, for example, by stating, "[...] I'm very excited to hear you say that because [...] it shows that, like I said that you're learning, like you're learning to do, be comfortable with yourself and to trust other people [...]" (T97). These reflective responses were all similar in that they pertained to the client's discussion of her relationships with other people; further, the therapist responses appeared to promote the client's relatedness with others.

The next most frequently used code within the *Empathy* category was EMP4a, with a total of 10 codes. Similar to the EMP1a examples, therapist responses coded as EMP4a were questions that attempted to gain an understanding of the client's perception of and experiences with relationships. For example, the therapist stated, "[...] But we know each other now, right?" (T109), and "[...] But we have a trusting relationship, right?" (T110) in an effort to help promote the client's trust in the therapeutic

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relationship. The code EMP1b represented four of the *Empathy* codes in this trauma

discussion; an example of this *reflecting emotion* code was found when the therapist

stated, "[...] I know sometimes when you talk to [client's husband] about friends, he

kinda makes you upset right? [...]" (T118). Similarly, the code EMP4b (three codes) was

captured by the therapist's question of "Are you feeling upset right now thinking about

everything or..." (T169), as the therapist attempted to gain an understanding of the

client's feelings regarding her abusive family of origin and her related stressors. Lastly,

the code EMP1c was used one time throughout the trauma discussion.

The next most frequently represented coding category for Participant 2 was

Empowerment, comprising 19% (14 codes) of the total codes found in the trauma

discussion. The code EPW1 (nine codes) was found throughout the trauma discussion,

and was captured by statements such as, "And you've really learned [...] the ability to

allow yourself to change, right?" (T83), and "[...] I have to say I'm very excited to hear

you say that because I think it's a very, it shows that, like I said that you're leaning [...] to

do, be comfortable with yourself and to trust other people [...]" (T97). The therapist

highlighted multiple times the positive changes that the client has made with respect to

allowing herself to trust others and build relationships with people. The code EPW2 (five

codes) was exemplified by statements that emphasized the client's control over her life

and choices, such as, "[...] you're not letting it affect your own life in terms of wanting to

hurt yourself" (T131) and "If that' something you want to do" (T144).

The *Unconditional Positive Regard* and *Listening for Core Values* coding

categories each comprised 7% (five codes) of the total codes. In terms of UPR, the code

was captured by statements such as, "[...] I understand, I mean it makes sense that it's

confusing" (T86), and "No. It's not fair at all" (T170); the therapist responded with such

statements in an attempt to validate the client's expressed distress (including suicidal

ideation) regarding her history of physical abuse perpetrated by family members.   As far

as *Listening for Core Values*, CV1 (four codes) and CV 2b (one code) captured the

therapist's attempt to help the client identify personal values and behave according to

them. For example, the therapist stated, "[...] when you're saying I'm working on the

friends thing, have you been thinking about that lately or – " (T84) in order to help guide

the client throughout her process of determining the importance of friendships in her life.

 Psychoeducation comprised 0.03% (two codes) of the total codes for the trauma

discussion. An example of the PSY code was found when the therapist stated, "But it's

something that once you try, you know, you build slowly, then, you know your brain gets

to learn, 'Hey I can do this.' Just like therapy" (T107), as the therapist was promoting the

idea of the client developing relationships with friends. The *Egalitarianism/Providing*

Choices coding category was the least frequently coded category, representing 0.01% (1

code) of the total codes; the code was EgPc2, and EgPc1 was not coded. The therapist

provided the client with a choice in terms of the content/process of the remainder of the

session, stating "[...] would you like to do a deep breathing exercise before we leave? We

haven't done that in a while. You can say no if you don't wanna do it" (T183); the client

declined the option.

 Participant 3. Participant 3 was a 31-year old single, heterosexual, Turkish

(collectivistic) male, whose traumatic experience discussed in the session was difficulty

related to immigration and acculturation.   The trauma discussion consisted of 243

therapist talk turns. A total of 97 codes were assigned to the trauma discussion, comprising 40% of the total talk turns within the session.

The therapist used autonomy-supportive statements sporadically throughout the first half (approximately) of the trauma discussion. The majority of these early therapist responses were not coded because, it appeared as though she was listening to the client's discussion regarding relational stressors (e.g., with his mother, with a romantic interest), given her use of attending responses (e.g., "mm-hmm," "yeah"). She then followed a period of listening with empathic, reflective responses that led to responses that were coded as *Empowerment* or *Listening for Core Values*. For example, the therapist did not respond with any autonomy-supportive statements from C17 to C43, but then made a reflective statement: ["It sounds like in that situation [...] you kind of put your worries aside [...]" (T44),] followed by a CV1 statement: "Right, and it comes down to your strong values" (T48). This pattern of listening to the client and then summing up his culture-related dilemmas with an autonomy-supportive statement was later exemplified with the following therapist response: "[...] well it sounds like, you know, the past couple of weeks you've really been asking yourself a lot of questions, when you're in these situations, and focusing on what, you know really just focusing on just what you want" (T69). This response captured the therapist's empowering the client to reflect on his values and life choices in the context of assimilation from a Turkish to an American society and culture, reinforcing and emphasizing the client's personal control.

In terms of content, the trauma discussion began with the client stating his decision to stay in the United States rather than go back to Turkey, with the goal of attending graduate school and eventually bringing his mother and sister to the United

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States. The client expressed the reason for his decision, stating, " I don't feel like if I go back I will fit in again. Because it's, I'm used to this [American] system" (C14). The therapist responded with a question to explore the client's feelings, asking, "So how do you feel after you made that decision?" (T16), leading to an exploration of the client's struggle and feelings related to the difficult choice he had to make in terms of where to live.

The next discussion concerned a female from his community that he mentioned to his mother as a potential romantic interest, and how he was refusing to base his decision on whether she is a good match for him solely on the fact that she is from the same community of Turkish immigrants. What ensued was a discussion about the client's beliefs and perspectives towards people and relationships that are different from the dominant belief within his culture of origin; the client's responses alternated between his Westernized values and those of his Turkish culture of origin as he described the woman and his interactions with her. The therapist's responses during this discussion were focused on highlighting the client's "strong values" (T48).

The discussion progressed to content related to the client's struggle with friends and acquaintances in the Turkish community with whom he disagrees in terms of worldview and beliefs and suggested that the community in which they live and associate "have their own beliefs" (C87). The client and therapist discussed the client's difficulty with the changes in values he has undergone via assimilation, and how his values conflicted with those of his peers from the community. The discussion included the client's thoughts regarding ending those relationships and finding new friends who have similar beliefs as his. The therapist responded with an empowering statement, "you're

able to change you know some of the values of your community or culture" (T145),

highlighting the assimilative progress of the client with which he has been struggling.

Finally, the discussion turned to the client's success and performance in school,

with the therapist emphasizing the positive changes that the client has made in

recognizing his automatic thoughts, relating them to his core beliefs, and moving forward

with pursuing graduate school and a desired career despite the cultural challenges

inherent in his recent immigration, including English as a second language.

In sum, the content of each of the discussions concerned stressors related to his

immigration and assimilation process. Perhaps the best depiction of the client's struggle

related to his immigrating and assimilating to the American culture, and the therapists'

empathic and empowering responses was captured by the following exchange that

occurred approximately halfway through the trauma discussion:

> C107: Cuz I always feel pressured and controlled and I feel it from the beginning, you know, I'm not really like our culture [...].
>
> T108: Right.
>
> C108: And because I'm pretty much not, just pretty much more, you know just I like things direct and honest and you know, I just have a different perspective [...] There is a lot of stuff that's embedded already in me and it's really, some of the stuff is really hard to change but, um, I'm working on it, I don't know where it will take me. I'm not even sure if I will make that transformation, stay where I am [in the United States] and work something out but I'm just kind of still questioning stuff.
>
> T109: Mm-hmm. It sounds, you know, like a process. You're trying to, you're trying new things, going to a different place, and seeing where it takes you and, you know, no one has the answers for what something is going to be like in one week, let alone five years, you know.
>
> C109: Right.

T110: And it sounds, and you, you've assimilated to Western American culture, you know, whereas your community kind of just still has their community, you know."

C110: Yes.

The frequency hierarchy for Participant 3's coded categories was as follows: *Empathy* (49 codes; 51% of total codes); *Empowerment* (19 codes, 20% of total codes); *Listening for Core Values* (nine codes, 9% of total codes); *Unconditional Positive Regard* (seven codes, 7% of total codes); *Egalitarianism/Providing Choices* (seven codes, 7% of total codes), and *Psychoeducation* (six codes, 6% of total codes).

With respect to *Empathy*, the most frequently used code was EMP1a, comprising 41 out of the 97 codes within this category. The EMP1a codes in the trauma discussion typically occurred in the context of the client's statements related to his conflict in values between his collectivistic culture of origin and the individualistic culture of the Unites States. For example, the therapist responded, "It sounds like in that situation, you kind of put your worries aside and just was like, okay I'll just give it a chance and see if I meet this girl. If it doesn't work out…" (T44); the therapist's statement reflected the client's discussion related to whether a woman from his community is someone he would be interested in having a romantic relationship with, based on her own level of acculturation.

The next most frequently used code within the *Empathy* category was EMP1c, with a total of four codes. Similar to the EMP1a example above, therapist responses coded as EMP1c were responses that attempted to reflect the client's statements related to his struggle with assimilation into Western culture and having to navigate relational choices in the process. For instance, the therapist responded, "[...] it sounds like hanging out with some of those guys makes you really uncomfortable" (T141), to reflect the

client's thoughts/feelings related to associating with friends from his community whose values differ from his. The code EMP1b represented two of the *Empathy* codes in this trauma discussion. This *reflecting emotion* code was found when the therapist stated, "[...] it must have been somewhat of you know, of relief to make that decision" (T17), in response to the client's decision to stay in the United States despite his mother's initial discontent with his decision not to return to live in Turkey. Likewise, the code EMP4b (one codes) was captured by the therapist's question of "So how did you feel after you made that decision" (T16), as the therapist attempted to gain an understanding of the client's feelings regarding his decision to remain in the United States. Lastly, the code EMP4a was coded one time in the trauma discussion, and the codes EMP2, EMP3, and EMP4c were not coded at all.

The second most frequently represented coding category for Participant 3 was *Empowerment*, comprising 20% (19 codes) of the total codes found in the trauma discussion. The code EPW1 (12 codes) was exemplified by statements such as, "[...] you've assimilated to Western American culture, you know, whereas your community kind of just still has their community, you know..." (T110), and "[...] their location might have changed but they're still in this community-oriented culture, whereas you know you're wanting to you know explore and break away and become more you know in this individualized, Western you know culture" (T111). These statements captured the therapist's attempt to highlight and emphasize the client's competence and ability to make changes for himself in a way they both considered to be in a positive direction – in this case, towards assimilation into the more individualistic culture. The code EPW2 (seven codes) was exemplified by the therapist's statement, "[...] you decided 'you know,

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I want to be happy, and being happy means I want you know, to take care of myself'"
(T161). Of note, this latter response placed an independent emphasis on the client taking
care of *himself*, which is not congruent with the collectivistic emphasis on depending on
others.

The *Listening for Core Values* coding category comprised 9% (nine codes) of the
total codes in the trauma discussion (CV1, eight codes; CV2a, one code; CV2b, zero
codes). In terms of CV1, the code was captured by therapist responses such as, "[...] and
what is it like for you thinking that, and realizing you know, you kind of want to separate
yourself from you know the community and some of those people?" (T153), with which
the therapist is encouraging the client to explore his personal, core values and what his
experience is in terms of how those are separate form his culture of origin's values.

The second to last most frequently coded categories were *Unconditional Positive
Regard* (UPR) and *Egalitarianism/Providing Choices*, each representing 7% (seven
codes) of the total codes. UPR was used when the therapist responded with statements
validating the client's struggle with assimilation, such as, "[...] I could see how that might
cause you know conflict between how you feel you know and your community and how
your relationship with your community is" (T112). The EgPc2 code was captured by
therapist statements providing the client with the decision-making role in terms of the
frequency of his therapy session. The EgPc1 code was not used.

Lastly, *Psychoeducation* comprised 6% (six codes) of the total codes in the
trauma discussion for Participant 3. An example of the PSY code was found when the
therapist stated, "[...] when you were talking and telling me some of you know the stories
and things happening, you [...] named some of the automatic thoughts when you were

thinking, and so you were just more aware of those, and able to kind of deal with them"
(T172); the therapist pointed out, from a cognitive-behavioral perspective, the client's
increased awareness of the thoughts he was experiencing led to improved ability to
manage the emotions and behaviors related to his thoughts.

   Participant 4. Participant 4 was a 47-year old, single, heterosexual, Caucasian-
British (individualistic) female, whose traumatic experience discussed in the session was
a stroke and secondary medical conditions including blindness. The trauma discussion
consisted of 86 therapist talk turns; a total of 25 codes were assigned to the trauma
discussion, comprising 29% of the total talk turns within the session. The discussion
began with the client explaining how overwhelmed she felt with her current stressors.
The therapist asked both content- and emotion-related questions to encourage dialogue
regarding the client's day-to-day functioning with blindness. The client initiated a
conversation about her upset feelings related to her friend's son's "detachment" from her.
The client's language was notable for the struggle with cognitively understanding the
teenager's developmentally appropriate desire for independence, yet emotionally being
"dumbfounded" (C31) by it and having it "pull at [her] heart-strings" (C23). The therapist
responded with a very empowering statement that conveyed the message to the client that
she had "a very good handle on what it is" (T32) despite her expressed confusion. The
client responded, "Well I have to thank you for that because I did go back and use some
of the tools you've asked me to think about [...]" (C33); although this suggests the client
had found the therapists' interventions as useful, her comment in some ways deflected the
empowering intent of the therapist's previous response coded as EPW2.

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This *Empowerment* statement led to further processing of the client's thoughts and feelings related her friend's son's "detachment." The client responded, following the therapist's suggestion of "sharing[ing] some of [her] thoughts with him" (T33), that she had begun to express her feelings to her friend's son, but that this was followed by an additional perceived rejection when he did not listen to all she had to explain: "[...] He said 'Okay fine,' and went back to his room and closed the door. So it was uh, it was quite a little moment for me" (C36). This led to a discussion about the client stating she never wanted children of her own, and the therapist engaging her in a discussion about whether this was truly what the client wanted and what would make her happy. Interestingly, the client expressed uncertainty regarding her capability to "raise a child that could be accepted" (C46) following a discussion about her feelings of rejection and not being wanted or needed. The therapist guided the client through a discussion regarding these feelings that stemmed from an early childhood that the client described as one of "trauma" (C48), and how her current beliefs of not being able to raise a child adequately were connected to her low self-esteem due to her childhood. The therapist responded with empowering statements to counter these beliefs, stating that the client was "a good person" with "a lot of good values" (T59) that she instilled in the children she cared for as a nanny.

The client then initiated a conversation regarding her improvement in emotional and psychological well being since starting therapy and confronting her issues, which the therapist used as an opportunity to resume the discussion regarding the client's current health issues. The client made statements regarding the barriers and difficulties posed by her health conditions (e.g., vision loss, motor limitations, transportation issues) for the

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remainder of the session (C72 to C88), noting, "[...] it's been a very difficult [time]" (C81). As she mentioned these difficulties, she appeared to be using humor as a defense mechanism (was noted to be smiling and laughing).

None of the therapist's responses during this later portion of the trauma discussion (e.g., "Wow, that's really interesting," "Okay, that's good") were considered to capture any of the autonomy-supportive codes. Further, there were opportunities during the latter part of the trauma discussion for the therapist to reinforce or otherwise highlight the client's positive statements and reframes made related to these barriers. For example, the client stated that she will be returning to work for 2 days a week upon her request, and that this "[...] makes [her] feel as if [she's] doing stuff, as if [she's] part of something" (C84). These opportunities were not responded to with autonomy-supportive statements. The client's last statement, "And my friends have all been just so supportive and so wonderful" (C88) was responded to with, "Ok, we have to stop" (T88). [nor did they point out the incongruence of content and affect – unless was more negative affect around struggles an improvement over previous sessions? I could be reaching there!]

The frequency hierarchy for Participant 4's coded categories was as follows: *Empathy* (15 codes; 60% of total codes); *Psychoeducation* (four codes, 16% of total codes); *Unconditional Positive Regard* (two codes, 8% of total codes); *Empowerment* (two codes, 8% of total codes); *Egalitarianism/Providing Choices* (one code, 4% of total codes), and *Listening for Core Values* (one code, 4% of total codes).

In terms of *Empathy*, the most frequently used code was EMP4a, comprising five out of the 15 codes within this category. Most of the EMP4a codes were questions posed by the therapist in an attempt to gain an understanding regarding statements made by the

client about her illness, blindness, and the related struggles with her increased need for dependence on others. The client also discussed her difficulty with the fact that her friend's son (a son-figure for the client) is reaching an age of increased independence and no longer needs or wants to need the client, in the context of the client's fear of potentially having to depend more on him and others given her health issues. For example, the therapist asked, "He won't want you anymore because he doesn't need you?" (T27), in order to clarify and gain an understating of her expressed concerns. There appeared to be a struggle between independence and inter-dependence with this client, and the therapist's responses coded as EMP4a appeared to be attempts to elucidate this conflict for the client.

The second most frequently used code within the *Empathy* category was EMP1a, with a total of four codes. Therapist responses coded as EMP1a were statements that attempted to reflect the client's perception of herself as incapable of being a good mother because of "skills" she is lacking from her upbringing, and her fears of not being able to raise a child as well as she would like. An example of this reflective response was captured by the statement, " [...] But I think that the feeling that you could [not] raise somebody as good or better than you, it comes from a place in deep inside, that you don't feel good about yourself [...]" (T59); this was a response to several earlier statements made by the client regarding her perceived inability to adequately raise a child, such as "[...] I just always thought I would never have the right skills to raise a child that could be independent and..." (C40). The codes EMP1b and EMP1c each represented three of the *Empathy* codes in this trauma discussion. Similarly, these codes were the therapist's reflections to comments made by the client indicative of her poor self-esteem. An

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example of EMP1b was captured by the statement, "And that goes back to what we were

sort of, what I mentioned before about the low self-esteem. The way you feel about

yourself, makes you feel that you couldn't raise someone as good or better than yourself"

(T58). The *Empathy* codes EMP2, EMP3, EMP4b, and EMP4c were not used in this

trauma discussion.

The next most frequently represented coding category for Participant 4 was

Psychoeducation (PSY), comprising 16% (four codes) of the total codes found in the

trauma discussion. The PSY codes were statements made by the therapist to provide

information regarding the client's core beliefs related to her low self-esteem and resulting

current distress. For example, the therapist stated, "Whereas that's not completely

accurate but sort of your vision of what would happen. But looking at what your own

core beliefs are, that would be the case [...]" (T62).

The *Unconditional Positive Regard* and *Empowerment* coding categories each

comprised 8% (two codes) of the total codes. In terms of UPR, the code was captured by

statements such as, "Yea, it's tough" (T71), to reflect the struggle and difficulty the client

is experiencing due to her health problems. As far as *Empowerment* (EPW1, one code;

EPW2, one code), these therapist responses were statements that pointed out the client's

awareness of how her current thoughts, feelings, and distress are related to her past

experiences. The therapist responded, "It sounds like you have a very good handle on

what it is" (T32), referring to this awareness. In addition, the therapist highlighted the

client's strengths and values by noting evidence contrary to her negative thoughts/beliefs,

stating, "[...] there's no reason why your child would have those problems because you

are a good person, looking at it from the outside, and you do have a lot of good values and you brought up many children with good values and everything [...]" (T59).

Lastly, the coding categories *Egalitarianism/Providing Choices* and *Listening for Core Values* each represented 4% (one code) of the total codes in the trauma discussion for Participant 4. The therapist's question, "Is that something that you would maybe like to do together with me maybe?" (T12) was coded as EgPc2 as the therapist provided the client with the option of spending time during sessions looking for assisted living facilities together. In terms of *Listening for Core Values*, the CV1 code was captured by the question, "Have you never really wanted children or have you never really allowed yourself to want children?" (T37), as the therapist attempted to help the client explore her values and core beliefs related to raising children of her own (which later led to a discussion about her underlying negative core beliefs).

Participant 5. Participant 5 was a 21-year old, single, heterosexual, Korean (collectivistic) male, whose traumatic experience discussed in the session was consistent the unexpected death of his close friend. The trauma discussion consisted of 73 therapist talk turns; a total of 28 codes were assigned to the trauma discussion, comprising 38% of the total talk turns within the session.

The autonomy-supportive codes occurred throughout the entire trauma discussion, though they appeared to consist mostly of simple reflecting statements and a few short validating statements. The discussion began from the first client talk-turn and was about his friend's unexpected death, which he described as "traumatic" (C222). The therapist attempted to support the client through intermittent *Unconditional Positive Regard* statements in the context of several short *Empathy* statements throughout the discussion.

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The discussion was notable throughout for frequent laughter and avoidance of feelings on the part of both the client and therapist. Towards the end of the discussion, the client disclosed that he had a tendency to avoid the feelings related to his friend's death, which led to a brief client-initiated discussion about those feelings. Rather than processing that statement or the avoided feelings, the therapist transitioned away from this affective discussion, responding, "Right. So those are a lot of powerful reasons for coming to therapy" (T275) after the client stated, "Yeah it was, yeah. It was, uh, it was traumatic I gotta admit [chuckles]" (C274). The rest of the session then involved a discussion regarding the client's cognitions related to various realizations resulting from his friend's death. Although the therapist made the above empathic and validating statements throughout the trauma discussion, she did not take opportunities to empower the client, reinforce his discussion of the trauma and related feelings, or engage him in a discussion regarding his values, beliefs, and what is meaningful for him (particularly given his expressed realization and distress that time moves fast after a death); thus, those autonomy-supportive codes were not used. For example, the client initiated a conversation regarding his parents' eventual death, and how that would be difficult. Given his collectivistic cultural background, an opportunity to explore the meaning and impact that their passing would have on the client was not pursued. Instead the therapist, responded with a series of brief statements (e.g., "Right," "Yeah," "Mm-hmm") for the next five consecutive talk turns (T283-T287), and ended with several repetitive responses that reflected that the client was "woke[n] up in some ways" (T291), ways that were not elaborated on by either the therapist or client.

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The frequency hierarchy for Participant 5's coded categories was as follows: *Empathy* (17 codes; 61% of total codes); *Unconditional Positive Regard* (eight codes, 29% of total codes); *Psychoeducation* (two codes, 7% of total codes); and *Listening for Core Values* (one code, 4% of total codes). The *Egalitarianism/Providing Choices* and *Empowerment* categories were not found in Participant 4's trauma discussion.

The most frequently used *Empathy* code was EMP1c, comprising nine out of the 17 codes within this category. Most of the EMP1c codes were reflective statements made by the therapist regarding the client's discussions regarding his thoughts/feelings surrounding his friend's death. For example, the therapist stated, "[...] It must have been really hard to hear" (T231), and "[...] Yea, it's really hard to deal with that, especially someone you knew so well, and..." (T270).

The next most frequently used codes within the *Empathy* category were EMP1a, with a total of six codes, and EMP1b, with a total of 2 codes. The code EMP1b was captured by the statement, "It's all rushing up [waving hands near head to gesture rush of emotions]" (T267), as an attempt by the therapist to reflect the negative and difficult affects experienced and expressed by the client in response to his friend's death. The codes EMP2, EMP3, EMP4a, EMP4b, and EMP4c were not used in this trauma discussion.

The second most frequently coded category was *Unconditional Positive Regard* (UPR), which represented 29% (eight codes) of the total codes. These validating statements made by the therapist included responses such as, "[...] It must have been really hard to hear" (T231) and "[...] It must be hard even talking about it now" (T264),

referring to the struggle experienced by the client with his friend's death as well as bringing up the traumatic experience during the therapy session.

Psychoeducation (PSY) was the third most frequently coded category, with a total of 2 codes that comprised 7% of the total codes in the trauma discussion. The code was exemplified by a statement made by the therapist to explain the impact that death and loss may have on individuals; the therapist stated, "[...] it's very normal when we, someone close to us passes away, to start thinking about all these things. I mean, people think about it from time to time anyways, but when these kind of things happen it kind of wakes us up" (T288). The trauma discussion ended here, as the therapist transitioned the discussion away from the client's friend's death and related thoughts/feelings, and back to a previous discussion about an ex-girlfriend of the client in order to explore his previously reported anxiety related to developing intimate relationships.

The *Listening for Core Values* category represented 4% (one code) of the total codes in the trauma discussion for Participant 4. The therapist's response, "[...] not only are we like upset about our friend passing away, but you know it kinda, it makes you think more about yourself" (T272) captured this code in that the therapist's statement attempted to guide the client through the process of exploring his values, which was a process reportedly initiated by the loss he experienced. Of note, the client's response immediately proceeding this statement was, "Yea it was, yeah. It was, uh, it was traumatic I gotta admit" (C274), indicating that the client's own perception of his friend's death was indeed that of a traumatic event.

Chapter 4. Discussion

Because the construct of autonomy support in the context of psychotherapy for trauma-related issues has not been sufficiently studied by prior research, the purpose of this study was to explore ways in which trainee therapists support the basic psychological need of autonomy for clients from diverse cultural backgrounds who have experienced various types of trauma. In order to address this question, the study created a autonomy support coding system that integrated humanistic, feminist, motivational interviewing, ACT and common factors approaches, and employed a qualitative deductive content analysis to examine autonomy supportive therapist responses using our codes during discussions of trauma. Findings indicated that although therapists generally provided autonomy supportive responses that appeared to be consistent with clients' cultural backgrounds, autonomy supportive responses were not used as often as possible or expected given the humanistic and clinically foundational basis of many of the codes. This finding has implications for clinical training related to the role of the therapeutic relationship and posttraumatic growth in working with trauma survivors. It is hoped that our study will enhance clinical awareness of autonomy and its applicability for trainee therapists who are working with clients who have experienced trauma, particularly from a culturally informed standpoint.

This chapter first describes the varied experiences of trauma and PTG in the study's sample of participants as related to current literature on those topics. Next, autonomy codes that were observed across and within participants, and the themes that emerged during coding, are discussed in the context of relevant literature, including participant cultural backgrounds. The study's limitations are then discussed followed by

suggested directions for future research. This chapter concludes with our study's

proposed contributions.

 Findings Related to Client Experiences of Trauma and PTG

The participants from our study comprised a group of psychotherapy clients who

had experienced a wide variety of types of traumas. These included traumas that posed a

threat to one's physical integrity, consistent with the *DSM-IV-TR* criterion A1 for PTSD

(APA, 2000), as well as stressful life experiences that adversely impacted the individual's

psychological well-being only, consistent with a broader definition of trauma proposed

by some trauma researchers (e.g., Briere & Scott, 2006; Hall & Sales, 2008; Weathers &

Keane, 2007). Specifically, 3 of the 5 participants presented to therapy having

experienced one or more criterion A1 traumas, including a robbery at gunpoint and

brother's suicide (Participant 1), chronic, complex trauma involving childhood physical,

sexual, and emotional abuse (Participant 2), and experiencing the sudden and unexpected

death of a close friend (Participant 5). On the other hand, 2 of the 5 participants

presented to therapy with highly stressful experiences leading to psychological trauma,

including immigration and acculturation difficulties (Participant 3) and chronic,

debilitating medical conditions (Participant 4). These 2 latter participants had

experiences that, although were perceived to be traumatic and were extremely upsetting

and overwhelming to the participant's psychological resources, would not meet the

current diagnostic standards for the definition of a traumatic event (APA, 2000; Briere &

Scott, 2006; Weathers & Keane, 2007). Nonetheless, they were included in our sample

of trauma survivors based on prior research suggesting a broader definition of trauma.

The definition of trauma has been a source of debate within the field of clinical psychology, the most prominent argument of which has been limiting traumatic events to those that threaten one's physical integrity (consistent with *DSM-IV-TR*), or broadening the definition of the term trauma to also include events and experiences that threaten one's psychological integrity (Briere & Scott, 2006). To examine whether and how trainee therapists provide autonomy supportive responses to clients who have experienced a trauma, our study adopted this latter definition, based on previous literature suggesting that psychological effects of trauma may be just as debilitating as physical effects, and that these conditions and issues may be equally responsive to trauma-focused therapies (e.g., Briere & Scott, 2006). Accordingly, threats to both physical integrity and psychological integrity were defined as including (a) exposure to a negative event (event-based definition), and (b) the distress or psychological reaction to the exposure (perception-based definition, Briere & Scott, 2006; Hall & Sales, 2008). Further, an event or experience was considered to be traumatic "if it [was] extremely upsetting and at least temporarily overwhelm[ed] the individual's internal resources" (Briere & Scott, 2006, p. 4).

If the definition of a trauma is being broadened beyond the current diagnostic standards of the *DSM-IV-TR*, how then does one conclude that an event or experience was indeed *traumatic* for an individual? According to Briere and Scott (2006), a clinician can determine whether an experience has been traumatic by subjectively observing a client's behavior for process responses that may be suggestive of psychological effects of trauma; these include (a) *negative emotions* that emerge in response to a triggering stimulus, (b) *avoidance responses* such as withdrawal from topics related to the traumatic

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stressor, (c) evidence of *affect dysregulation*, and (d) indications of *relational difficulties*. Based on these guidelines, evidence for these process responses were noted within the trauma discussions for all 5 of the participants. For example, Participant 1 presented to therapy with distress related to recent traumatic events (robbery and brother's suicide), with one of the most prominent concerns including relational difficulties he was having with his ex-girlfriend that were exacerbated by the robbery they experienced. As such, his ex-girlfriend served as a triggering stimulus throughout the trauma discussion, and avoidance of this triggering stimulus was evidenced by responses such as, "So, it's distracting, my hands are distracting me this morning. It's like I don't know how I can concentrate on anything" (C51) immediately after the therapist had asked him about his worrying thoughts about his ex-girlfriend. Evidence of affect dyregulation was apparent across all 5 participants in the therapists' documentation of clinical levels of depression, anxiety, and emotional instability across all 5 participants, and there were indications of relational difficulties during the trauma discussions for all the participants as well. As such, and in the context of literature regarding the perception-based definition of a trauma (Briere & Scott, 2006; Weathers & Keane, 2007), it was determined that all of the participants had experienced events and stressors that were perceived to be traumatic in their nature and effects on the individuals.

Given the variable definitions of trauma in the clinical literature, it is not surprising that the diagnoses assigned to our participants by their therapists were not all consistent with our findings that each had experienced trauma(s). For example, of the 3 participants who met criterion A1 for PTSD, only one was given a diagnosis of PTSD by his clinic therapist (Participant 1). Participant 2 had a rule out for PTSD, and Participant

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5 was given a diagnosis of Social Phobia based on other presenting issues, with no mention in the treatment summary of the potential contribution of the traumatic event (sudden death of his close friend) on his symptoms and distress. Also consistent with literature suggesting some common psychological reactions to trauma other than PTSD (Briere & Scott, 2006; Cloitre et al., 2009; Schore, 2003; van der Kolk et al., 1996), other diagnoses given to the participants from our study included major depressive disorder (Participants 2 and 3), generalized anxiety disorder (Participant 3), borderline personality disorder (Participant 2), and partner relational problem (Participant 1). These findings are consistent with literature that questions the validity of current diagnostic standards for PTSD, highlighting that trauma and PTSD are conceptualized and operationalized in varying ways, presenting a challenge in the field (Briere & Scott, 2006; Davidson & Foa, 1991; Rosen, 2004). In addition, the early level of training of the therapists in the current study could have affected the different conceptualization of traumatic events or experiences of their clients. Either way, diagnostic and conceptual inconsistency is an inherent, universal, and problematic side effect of the variability across researchers and clinicians in their understanding and application of the definition of trauma and its related disorders.

Further, it has been well established that the ways in which the effects of trauma manifest are multifaceted and impact cognitive, emotional/psychological, and physical functioning (Briere & Scott, 2006; Cook et al., 2003; Herman, 1992; Schore, 2003, 2008; van der Kolk et al., 1996). Accordingly, the presenting issues and complaints for our study's participants spanned all of these domains. Cognitive symptoms are described by the literature as the shattering of core assumptions and beliefs about oneself and the

world (Janoff-Bulman, 2002; Joseph & Linley 2005, 2008), and the processing of new trauma-related information via assimilation, negative accommodation, or positive accommodation (Joseph & Linley, 2005, 2008). Positive accommodation, which is suggestive of posttraumatic growth (Joseph & Linley, 2005, 2008), was evident in Participant 1's discussion regarding his goal to make himself more of a priority following his experience of traumatic events; in other words, Participant 1's discussion was indicative of his cognitive process of changing his worldview to better fit the new trauma-related information in a positive direction (Janoff-Bulman, 2002; Joseph & Linley, 2005, 2008). In discussing the difficulty of his current situation and his choice to re-establish his basic beliefs about himself and others, he stated, "[...] I've had routine, I've had years of things where life was great [...] just things have to change. That's why, you know, like I've learned to come [to therapy] and do this, and that's hard" (C133). Another example of the cognitive effects of trauma was evident in the trauma discussion for Participant 5, with the therapist's paraphrasing of the client's expressed struggle with his friend's death: "It's hard, it makes us – I mean not only are we like upset about our friend passing away, but you know, it kinda – it makes you think more about yourself" (T272).

In terms of physical and biological effects of trauma, client-participants in our sample presented with symptoms including: somatic complaints, such as back pain and hand numbness (Participant 1) and persistent itching (Participant 4); alcohol and marijuana use/abuse (Participants 1 and 5); and evidence of potential early effects on right brain development from complex trauma, including affect dysregulation and difficulty building trusting relationships (Participant 2). Some researchers suggest that

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poor physical and health outcomes in adult survivors of childhood trauma may be due either to the impact early life stress has on the immune system, or to the greater tendency for adult survivors to engage in high-risk behaviors such as promiscuity or drug abuse (Sachs-Ericsson et al., 2009).

The psychological and emotional effects of trauma were clearly apparent across all five participants, and included symptoms such as helplessness, shame, grief, loss of connection with one's spirituality, and disruption of one's ability to hope and trust (Briere & Scott, 2006; Cook et al., 2003; Hall & Sales, 2008). Participant 2, whose trauma history was the most involved and chronic, presented with significant issues related to her self-concept and "chronic feelings of emptiness" as conceptualized by her diagnosis of BPD; this is consistent with literature on the psychological impact of the horror and threat related to some traumatic events on an individual's sense of self (van der Kolk, 2003).

More specifically, Participant 2 presented to therapy with a history of multiple occurrences of physical, emotional, and sexual abuse during her childhood. Her symptoms included affect dysregulation (including difficulty controlling sadness and anger), feelings of worthlessness, suicidal ideation, impulsivity, and difficulty forming and maintaining meaningful interpersonal relationships. Although it is clear that the therapist conceptualized Participant 2's history of chronic abuse as traumatic and having a pervasive negative impact on her overall functioning, PTSD as a diagnosis was ruled out. This history of complex, chronic traumas occurring at developmentally vulnerable periods of Participant 2's life would have been better captured by the diagnosis of developmental trauma disorder (DTD; van der Kolk, 2005) proposed for *DSM-V*. This is particularly true given the dual nature of the impact of the traumas (Cook et al., 2003;

Ford & Courtois, 2009), as evidenced by the immediate effects of the abuse (e.g., Intake Evaluation indicating acute feelings of anxiety and depression between the ages of 11 and 17, the years the abuse occurred), as well as the long-term impact (e.g., ongoing difficulty trusting others and developing friendships). It has been suggested that DTD, or Complex Trauma Disorder, would be an invaluable diagnostic addition with important clinical implications because individuals with histories of multiple traumas typically do not respond to conventional trauma-related treatment (Briere & Scott, 2006; Ford & Kidd, 1998 as cited in Briere & Scott, 2006). Indeed, although Participant 2 was seen for over 30 sessions, described to have established a strong therapeutic alliance, and made progress in treatment, the Treatment Summary indicated that treatment terminated prematurely as a result of Participant 2's resistance to "wholly committing to the therapist's treatment plan," precluding the ability of the therapist to adequately monitor safety issues related to ongoing suicidal ideation. The decision of the therapist to refer Participant 2 elsewhere due to these unmitigated safety concerns is consistent with recommendations from researchers that individuals with complex trauma histories often present with safety concerns that need to be the primary focus of treatment (Ford et al., 2005). Nonetheless, the premature termination and ongoing suicidal ideation suggests that the conventional interventions (e.g., aspects of CBT, DBT, mindfulness) that the trainee therapist attempted to use to treat the client's trauma-related conditions were likely not effective in treating the complex trauma symptoms and issues. As such, it seems to be important to differentiate clients who are seeking treatment for an isolated traumatic event from those whose abusive histories are more appropriately

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conceptualized through a complex PTSD framework in order for trauma treatment to be most effective (Briere & Scott, 2006).

Another important consideration suggested in the literature is the role that culture plays in the experience and manifestation of trauma (Briere, 2004; Calhoun et al., 2011; Pole et al., 2008; Pole & Triffleman, 2010; Weiss & Berger, 2008). Our sample comprised participants from different cultural backgrounds, with 3 of the 5 participants categorized as *collectivistic* (Participants 2, 3, and 5), and the other 2 as *individualistic* (Participants 1 and 4), based on a conceptualization of culture that has been widely used in the literature to differentiate between different types of cultural organizations (Triandis, 1993, 2002). Specifically, Participant 2 self-identified as Hispanic, Participant 3 as Turkish, and Participant 5 as Korean; each of these 3 participants had immigrated to the United States from his or her respective country of origin.

Immigration has been studied as a source of significant stress, and in some circumstances, immigration trauma has been thought to result from the traumatic experiences associated with the migration process (Foster, 2001; Greenman & Xie, 2008; Schwartz et al., 2010). Consistent with this literature, our participants presented with varying degrees of immigration-related distress, with Participant 3 conceptualized as having experienced immigration trauma; consequently, related issues, such as difficulty acculturating, served as the primary focus throughout treatment, indicating that his therapist's conceptualization, diagnosis, and treatment was consistent with literature on culture and trauma. Of the different stages of immigration that it has been suggested for trauma to occur (Foster, 2001; Weiss & Berger, 2008), Participant 3's experience of trauma seemed most consistent with the *settlement in the host country* stage, due to

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reported inadequate social supports as well as minority discrimination. While the Intake Summary notes that Participant 3 "identifies having a 'community' in [city] mostly comprising individuals of mid-Eastern culture," the trauma discussion is notable for growing conflict and dissent with these individuals with respect to values and beliefs, and for a perception of a weakening social support system, as reflected by the therapist's response, "[...] it really does come up in your conversations and how you act, you know, so it's hard to be friends with you know and feel like you fit in when you really have, you know, different beliefs" (T143). Further, according to the Intake Summary, Participant 3 "reports having friends, but comments that he sustains superficial relationships, withholding personal information from others [...] He attributes this to a cultural difference, stating that culturally, he does not know what to say when first meeting people and to engage in 'small-talk.'" The emotional distress for immigrants has been suggested to follow a variable course, with a peak during the settlement phase when an intense sense of loss emerges after several months of initial euphoria (Weiss & Berger, 2008). Indeed, the clinical symptoms of anxiety and depression of Participant 3 had onset shortly after he moved to the Unites States 10 years ago, and are conceptualized as being related to his difficulty with acculturation to Western society, and internalized conflict related to his family pressuring him to return to Turkey, in the context of his own intrinsic uncertainty regarding where he prefers to live and whether he aligns himself more with individualistic or collectivistic values.

Immigration stress, on the other hand, defined by researchers as the psychological state resulting from variables that are inherent in any immigration experience (Foster, 2001; Geenman & Xie, 2008; Schwartz et al., 2010), was present to some degree and

noted in clinic forms and/or the trauma discussion for all three of the collectivistic

participants; these stressors included loss of family, community, and familiar social

networks (Participants 2 and 3), lack of fluency in the host American language

(Participant 2 and 3), and actual or perceived discrimination (Participants 3 and 5).

In the context of a broader definition of trauma, as well as the cultural impact on

trauma, our study emphasized a positive psychological understanding of trauma as an

opportunity for posttraumatic growth (PTG). Our broader definition of trauma was

consistent with PTG researchers who broadly used the term *trauma* interchangeably with

crisis and *highly stressful events* to signify that these expressions represent significant

challenges to one's ability to adapt and understand the world and one's place in it, thus

providing an opportunity for growth following adversity (Tedeschi & Calhoun, 2004b).

One of the unique aspects of the PTG model as a growth theory is the idea of a qualitative

change in functioning indicative of individual development that involves surpassing one's

pre-trauma level of functioning, as opposed to simply returning to baseline functioning

(Tedeschi & Calhoun, 2004a, 2004b). Given that this pre-trauma level of functioning is

difficult to measure in individuals who have survived chronic abuse during early

childhood years (prior to or concurrent with key developmental milestones), Participant

2, whose trauma history is consistent with DTD (Ford & Courtois, 2009), would not be

easily accounted for by the PTG model that served as the basis for our examination of

therapists' autonomy support. To some extent, it can also be argued that Participant 4,

given her reported early history of emotional abuse and neglect by her father and aunt,

would also be excluded from the PTG model assumed by our study. Notwithstanding the

lack of contrast between pre- and post-trauma level of functioning, all of our participants

and their experiences of trauma fit the organismic valuing (Joseph & Linley, 2005) and self-determination theory (SDT; Deci & Ryan, 2000) models of growth emphasized by our study, which suggest that supporting one's basic psychological needs, particularly autonomy, would catalyze the self-actualizing tendency towards growth.

Culturally, our participants differed from one another in the factors and aspects of PTG that may impact the potential for and/or manifestation of PTG, including the idioms of trauma, coping, and growth within their communities and cultures and the social norms and rules about trauma, its aftermath, and views about what is helpful (Calhoun et al, 2011). For example, consistent with his individualistic background and Western ways of ruminating about trauma and one's perceived control over his or her situation, Participant 1 stated, "So I have to take accountability for [trauma-related stressors], and just live in the moment and enjoy the moments. Cause sometimes you're like, 'I created this thing and it sucks [...]'" (C148). This finding is consistent with research that suggests Westerners tend to perceive more responsibility for a traumatic event or situation so they attempt to explain the trauma based on their own actions; similarly, they assume personal responsibility for the positive changes and personal strengths that may develop in the aftermath of trauma (Calhoun et al., 2011), which was evidenced by Participant 2's discussion about prioritizing himself over others.

On the other hand, Easterners tend to seek answers and meaning in the context of the traumatic event itself (Calhoun et al., 2011), and are sensitive to their potential impact on others within their collective group as they ruminate about their trauma (Calhoun et al., 2011; Markus & Kitayama, 1991). Consistent with this literature, Participant 3's trauma discussion related in part to his dilemma regarding staying in the United States or

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returning to Turkey, mostly due to his mother's discontent with his living in the Unites States; the client's interdependent ruminative struggle was highlighted with the therapist responding, "[...] it must have been somewhat of you know, of relief to make that decision" (T17), in response to the client's decision to stay in the United States despite his mother's initial discontent with his decision. This is consistent with research that suggests that during the rumination process following a trauma, collectivistic individuals prioritize the consideration of how their reactions to the event might affect others, and any concern about the traumatic experience is filtered through a lens based on how the experience would be viewed by others within their primary references group (Cohen, et al., 2007 as cited in Calhoun et al., 2011).

Self-disclosure is the other aspect of PTG that is influenced by culture through general societal norms about what kinds of information are appropriate for disclosure, and what contexts and individuals are appropriate for disclosure (Calhoun et al., 2011). Participants 1 and 4 (individualistic) as well as Participants 2 and 3 (collectivistic) were described by their clinic therapists as open and willingly engaging in the therapeutic process. This finding is somewhat inconsistent with the literature on culture and self-disclosure, although it can't be known to what extent Participants 2 and 3 actually self-disclosed fully because the cases were closed and de-identified. Participant 5 (collectivistic), on the other hand, terminated treatment prematurely due to poor rapport and indications of not willingly participating in the process of treatment. In fact, even during the trauma discussion regarding his friend's unexpected death, minimal self-disclosure was evident regarding his feelings related to the trauma, with the few emotional self-disclosures accompanied by incongruent affect (i.e., laughter) on the part

of both client and therapist. Although this apparent avoidance of affect may have been a symptom of the trauma itself, it can also be viewed as consistent with literature on culture and trauma that suggests individuals from Asian collectivistic backgrounds tend to display more positive emotions and conceal negative emotions based on the belief that expression of the latter would disrupt the harmony of the collective group; this often leaves Asian clients alone in their intrusive ruminations following the experience of a trauma (e.g., Matsumoto et al., 1998 as cited in Calhoun et al., 2011).

Findings Related to Autonomy Support Codes

Of the total talk turns that comprised the trauma discussions across all 5 participants, 38% represented autonomy support codes from at least one of the categories created for this study (i.e., *Unconditional Positive Regard*, *Empathy*, *Egalitarianism/Providing Choices*, *Psychoeducation*, *Empowerment*, and *Listening for Core Values*). In other words, trainee therapists provided autonomy supportive responses to less than half of client discussions of trauma. This finding is not surprising given the lack of literature on the use of autonomy support in the context of psychotherapy, with no studies to date describing or discussing how trainee therapists can provide autonomy support for culturally diverse clients who have experienced trauma. The following sections present the findings across participants and their cultural backgrounds organized by the broad autonomy supportive themes/categories, connecting those findings to relevant literature.

The "humanistic" codes. The autonomy coding categories of *Unconditional Positive Regard* and *Empathy* may be collectively viewed as the basic common factors across all psychotherapies (Lambert & Ogles, 2004; Norcross, 2005; Ryan et al., 2011).

In fact, though there have been a multitude of different groupings and categorizations of common factors within the relevant literature, unconditional positive regard and empathy are among the several common factors that are present and highlighted in all of these conceptualizations. As such, it would be expected that these two autonomy supportive codes would be the most frequently occurring autonomy supportive factors characterizing therapist responses in the trauma discussions, and that the two codes would often overlap; however, this was not the case in our sample. Whereas *Empathy* was expectedly the most frequently coded category among the autonomy support codes, *Unconditional Positive Regard* was comparatively found much less frequently, and these codes were not observed to commonly overlap or co-occur with one another.

Across all 5 participants in this study, the therapists most frequently responded to participants' discussions of trauma by using the autonomy supportive category of *Empathy*. This frequency finding was true for within-participant data, as well as for data across cultural background; in other words, *Empathy* was the most frequently coded autonomy support category for each participant as well as for each of the two cultural groups (i.e., collectivistic and individualistic). The codes created for this category were operationally defined using information derived from theory and prior research related to humanistic psychotherapy, common factors of therapy, motivational interviewing, and autonomy support (e.g., Rogers, 1961; Lambert & Ogles, 2004; Miller et al., 2008; Reeve et al., 1999; Ryan & Deci, 2008). *Empathy* was defined as "accurately understanding the client's perspective" (Miller et al., 2008, p. 4), and the coding category focused on the extent to which the therapist understood the client's point of view while discussing trauma-related information and content. Thus, the data suggest that therapists were either

most well trained in and/or comfortable engaging in the psychotherapeutic process using the autonomy supportive factor of empathy, such as reflecting and questioning factual and emotional content provided by the client.

Specifically, the most frequently used *Empathy* response across participants was *reflecting fact*, followed by *questioning fact* and *reflecting ambiguous fact/feeling*. These factual reflecting and questioning responses occurred more frequently than affective reflections and questions; in fact, the frequency of *reflecting fact* was found to be more than seven times greater than that of *reflecting emotion*. In the context of definitions of trauma disclosure in the literature (e.g., Jourard, 1971; Omarzu, 2000; Pennebaker et al., 2001), these findings suggest that the therapists responded more frequently to factual, content-based descriptions of the clients' traumatic experiences as well as evaluative content such as thoughts, beliefs, and attitudes about the trauma, and less frequently to *affective* content related to the trauma.

There are several reasons why there may have been a greater emphasis on factual content over emotional processing in our study. One reason is related to the level of training of the therapists. Specifically, our study included a sample of trainee therapists in their first 1-3 years in graduate school. As such, this group of therapists was possibly more likely to rely on their inherent "helper" skills that characterize those entering helping professions such as psychotherapy. In their Competency Benchmarks document developed to outline core competencies in professional psychology across levels of professional development, Fouad and colleagues (2009) listed "basic helping skills," including empathic listening, as the required skills related to therapeutic interventions that are expected of therapists at the *Readiness for Practicum* level. Graduate-level

trainee therapists, who have not yet committed themselves to a specific theoretical orientation (e.g., psychodynamic, cognitive-behavioral) are more likely to implement interventions based on interpersonal skills such as empathy and warmth (Castonguay, 2000), as evidenced by our sample of trainee therapists in this study.

Further, in their conceptualization of common factors based on the developmental sequence of therapeutic progress, Lambert and Ogles (2004) hierarchically group common factors into a *support* category, a *learning* category, and an *action* category. The support category, which includes common factors such as the therapeutic alliance and therapist variables of warmth, respect, empathy, acceptance, and genuineness, is presumed to underlie the earlier course of psychotherapy for clients (Lambert & Ogles, 2004). Although the sessions chosen for this study were those found "later" in treatment, the median total number of sessions per client was 15 (ranging from 9-31); given that treatment for trauma-related issues usually requires more sessions than typical short-term psychotherapy (years in some cases), it is likely that the sessions for our sample were consistent with the support category of the developmental sequence of psychotherapy, in which the frequent use of the *Empathy* autonomy support code would be appropriate. Further, it is likely that graduate-level trainee therapists feel more comfortable using support category common factors (e.g., empathy) rather than common factors found later in the developmental course of psychotherapy (e.g., encouragement of facing fears).

A second reason that may explain why factual reflections were found more frequently than affective ones may be due to therapists' difficulty tolerating negative affect when working with survivors of trauma. Therapists *reflecting fact* as a form of empathy keeps them at the most superficial level of person-centeredness possible. In

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other words, remaining at the factual, non-affective level of empathic listening and reflection is "safer" than having/demonstrating an empathic understanding of the trauma survivors' painful feelings and emotions resulting from trauma and its negative effects. This is consistent with literature related to issues of countertransference and vicarious traumatization inherent in working with trauma survivors, particularly for trainee therapists (Neumannn & Gamble, 1995). When working with trauma-related issues, therapists must respond to clients' difficulty tolerating and managing negative and painful affect, which must be done so that posttraumatic growth may occur (Calhoun & Tedeschi, 1999, 2006; Joseph & Linley, 2005; Ryan & Deci, 2008). Neumannn and Gamble (1995) suggest that trainee therapists must face a double-edged sword of trauma survivors' alternating between extremely constricted affect and emotional flooding. As a result, trainee therapists in particular may on one hand experience frustration over their client's seeming lack of affect and inability to articulate his or her inner experience, and on the other hand be overwhelmed by the client's emotional and affective lability (Neumannn & Gamble, 1995). Consequently, this leads to an avoidance of affective content that is common in trauma therapy, particularly at the graduate training level, and as evidenced by our findings (Neumannn & Gamble, 1995; Zoellner, Sachs, & Foa, 2001).

One of the most salient examples of this finding of affect avoidance was found in the observed behavior and responses of the therapist for Participant 5. The therapist's responses were notable for avoidance of negative affect and display of affect inconsistent with content (e.g., laughing when discussing the friend's death), which mirrored the client's self-disclosed tendency to avoid the feelings related to his friend's death. Rather

than processing the client's statements of the avoided feelings, the therapist transitioned away from this affective discussion, responding, "Right. So those are a lot of powerful reasons for coming to therapy" (T275) after the client stated, "Yeah it was, yeah. It was, uh, it was traumatic I gotta admit [chuckles]" (C274). This therapist response abruptly ended the trauma discussion as the session progressed to a discussion of topics unrelated to the friend's death. This therapist response for Participant 5 may be consistent with vicarious trauma literature, suggesting that therapists may display restrictive defenses such as minimization or avoidance of traumatic material as a means to distance themselves from the client (Adams & Riggs, 2008). In our sample, it is possible that vicarious trauma may have contributed to the therapists avoiding discussion about the client's emotions, and focusing on factual information instead.

What was surprising in our study was the finding that although empathy and unconditional positive regard are considered to be foundational common factors across therapies, and the necessary and sufficient "essential nutrients" for psychotherapy, our sample of therapists used empathic responses much more frequently than responses that conveyed unconditional positive regard. The autonomy supportive coding category of *Unconditional Positive Regard* was defined as therapist responses that conveyed acceptance, respect, support, and validation for the client. This operational definition was based on the construct as defined in humanistic, person-centered therapy, in which the therapist accepts the client as a person unconditionally, without judgment, and when the therapist conveys blanket acceptance and support of the client regardless of what the client says or does (Rogers, 1961). The rationale for choosing this specific and separate coding category to represent autonomy support was based on the recommendations by

SDT researchers who suggest that autonomy support occurs in the context of a social environment – in this case a therapeutic relationship – that understands and acknowledges an individual's unique perspectives and provides unconditional positive regard for that person (Reeve et al., 1999; Ryan & Deci, 2008; Ryan et al., 2011). The coding category of *Unconditional Positive Regard* represented 9% of the total autonomy supportive codes across all 5 sessions; this placed it as the third most frequent coding category (along with *Listening for Core Values*) out of the six coding categories.

One possible explanation for the large difference in frequencies of these two "humanistic" codes may be found in the developmental trajectory of psychotherapy training proposed by the APA Competency Benchmarks (Fouad et al., 2009). As mentioned earlier, the first level of training in intervention skills development is comprised of basic helping skills, such as empathic listening; this is followed by the development of clinical skills, including developing rapport and the therapeutic relationship (*Readiness for Internship* level); and clinical skills and judgment, including developing relationships with a wide variety of clients and effectively delivering interventions (*Readiness for Entry to Practice* level, Fouad et al., 2009, p. S19). It can be argued that empathic listening occurs at an earlier level of psychotherapy training (or as a character trait present before any training), whereas the very humanistic, person-centered factor and skill of conveying unconditional positive regard (e.g., acceptance, validation) is related to the ability of the more seasoned trainee or practicing therapist to bring one's genuine self into the therapeutic relationship, a task that is considered to be a challenging yet forceful one for new therapists working with survivors of trauma (Neumann & Gamble, 1995).

Another explanation as to why the two humanistic codes differed with respect to frequency may be explained by the concept of therapist self-disclosure. Providing unconditional positive regard involves openness, genuineness, and validation of the client's experience. Inherent in these qualities and techniques is a degree of self-disclosure. Self-disclosure in clinical psychology has been a source of debate, ranging from the traditional psychoanalytic ideal of the therapist as a "blank screen" to other viewpoints, such as the humanistic framework, that attribute positive change and growth in therapy in part to therapist openness and self-disclosure (Henretty & Levitt, 2010). In fact, Rogerians were the first therapists to practice self-disclosure in the 1950's (Farber, 2006 as cited in Henretty & Levitt, 2010), and client-centered therapists continually have argued that by cautiously modeling responses such as openness, vulnerability, and the sharing of intense feelings, "the therapist who uses therapy-relevant self-disclosure invites the client to follow the lead and cultivates trust, perceived similarity, credibility, and empathic understanding" (Henretty & Levitt, 2010, p. 64). Moreover, therapeutic approaches grounded in feminist and multicultural theories have since placed an emphasis on therapist self-disclosure (Brown, 2004; Brown & Walker, 1990 as cited in Henretty & Levitt, 2010). Our study did not support these findings, suggesting that graduate-level trainee therapists working with diverse survivors of trauma did not feel comfortable with and/or value the therapeutic skill of openness and self-disclosure in providing validating responses consistent with the definition of *Unconditional Positive Regard*. This may also explain why the *Empathy* code of shared feeling or experience (defined as therapist self-disclosure that he or she either shares the client's emotion or has had/would have a similar experience) was not used at all in our sample.

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Our sample specifically comprised a culturally diverse group of clients, representing both individualistic and collectivistic cultural backgrounds. Findings related to the use of the "humanistic" autonomy support codes (i.e., *Unconditional Positive Regard* and *Empathy*) suggested that therapists used these skills more frequently with collectivistic clients than with individualistic ones. In light of the openness, genuineness, and authenticity that is related to empathy and unconditional positive regard, few studies have examined the use of therapist self-disclosure in cross-cultural settings. Cross-cultural counseling theorists have suggested that therapist self-disclosure can be a method to convey sensitivity to cultural and racial issues, which may lead to an increase in trust and an improved therapeutic relationship with culturally diverse clients (e.g., Sue & Sue, 2003, as cited in Burkard, Knox, Groen, Perez, & Heiss, 2006). Burkard and colleagues (2006), in an effort to contribute to the minimal literature on actual use of therapist self-disclosure in cross-cultural counseling, conducted a qualitative study examining graduate trainee therapists' use of self-disclosure. Their findings demonstrated that although provision of self-disclosure appeared to improve the therapeutic relationship as perceived by the participants, the participants reported receiving inconsistent training in use of self-disclosure, with none to minimal training on use of the technique in cross-cultural counseling, leaving them feeling unprepared to use the intervention (Burkard et al., 2006). On one hand, our findings are consistent with this literature in that relatively low frequencies of *Unconditional Positive Regard* were noted across all participants, independent of cultural background. However, when comparing frequencies between cultural groups, the collectivistic group had more than triple the frequency of *Unconditional Positive Regard* codes when compared to the individualistic group. The

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qualitative nature of the coded responses differed with respect to cultural group, which will be discussed later in this section.

     The "feminist" codes. In a review of feminist models of treatment and application of those paradigms to working with survivors of trauma, Brown (2004) highlighted three factors that were integral to feminist and relational approaches to trauma therapy – empowerment, egalitarianism, and psychoeducation. These two latter factors also map on to the SDT conceptualization of autonomy support (Ryan & Deci, 2008), such that autonomy supportive behaviors have been identified as including supporting choice (consistent with an egalitarianism perspective), minimizing pressure and control, and providing a meaningful rationale for any recommendations or requests (Reeve et al., 1999; Ryan & Deci, 2008). Further, according to Ryan and colleagues (2011) in their recent review of motivation and autonomy across various psychotherapy approaches, empowerment is an important autonomy supportive component of multicultural counseling, in which the therapist should attempt to understand the client's internal frame of reference and their perceptions of their sociocultural contexts (Ryan et al., 2011; Ryan & Deci, 2008; Scheel, 2011).

     Our findings indicated that the coding category of *Empowerment* represented the second most frequently used therapist autonomy supportive response (15%). *Empowerment* was defined as "encouraging clients to become more capable of believing in themselves and seeing themselves as a source of authority about their life narratives" (Brown, 2004, p. 468); it was also defined based on SDT framework as expressing belief in the client's ability to makes changes in a positive direction and to self-regulate his or her own behaviors (Williams et al., 1996). Specifically, across all participants, therapists

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provided responses consistent with the code *conveying confidence in ability to make changes – competence* more often than *emphasizing control*. In other words, more responses were made to emphasize or reinforce the client's strengths than to emphasize the client's role of making decisions about his or her own life. Responses such as "[...] you are a good person [....] you do have a lot of good values and you brought up many children with good values [...]" (Participant 5, T59), and "[...] you've learned the ability to allow yourself to change [...]" (Participant 2, T83) highlight this autonomy supportive factor of conveying confidence in the ability to make positive changes based on strengths that the client has demonstrated. This finding is consistent with the positive psychological approach to treatment of trauma-related issues, in that the aim of positive psychology is to identify and nurture human strengths (e.g., courage, optimism, interpersonal skills, perseverance) by focusing on systematically building individuals' competencies, rather than correcting their weaknesses (Snyder & Lopez, 2005, 2009). As such, it appears that trainee therapists working with diverse trauma survivors implemented this positive psychological approach within their treatment skills.

In our study, the use of *Empowerment* responses appeared to differ with respect to cultural background, with the collectivistic group having a mean frequency of 5 times that of the individualistic group. This is somewhat surprising given that empowerment of personal strengths, competence, and control has been argued so adamantly by cross-cultural researchers to be a uniquely individualistic construct, inapplicable for and incongruent with the interdependent values and self-construals of collectivistic individuals (e.g., Kitayama & Uskul, 2011; Markus & Kitayama, 1991; Oishi et al., 2008). In fact, Participant 3 (collectivistic) had the most *Empowerment* responses of all

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the participants, and these responses shared the common theme of empowering the client to recognize his strengths and acculturative progress, as well as emphasize his ability to make autonomous decisions about his life and where to live. For example, the therapists stated, "[...] it sounds like, you know, the past couple of weeks you've really been asking yourself a lot of questions, when you're in these situations, and focusing on what, you know really just focusing on just what you want" (T69). Although we do not know the extent to which the therapist's culture or values affected her response, the therapist did not impose her own opinion regarding what decision would be best for the client; rather, she reflected and emphasized, in an empowering way, the client's own autonomy and volition with respect to his life choices.

Although the collectivistic group had more *Empowerment* codes than the individualistic group, there was an outlier in that Participant 5 (collectivistic) had no *Empowerment* responses provided by the therapist. This may have been partly explained by the fact that, according to the treatment summary for this client, there was difficulty with "rapport," "miscommunication," and an overall weak therapeutic relationship, in addition to the client stating that he "hates women." The therapist in this context was disadvantaged on two dimensions – one in being a woman, and another in being a trainee therapist, the latter of which has been associated with a vulnerable sense of professional identity (Neumannn & Gamble, 1995). As such, it follows that this therapist, possibly feeling vulnerable and disempowered herself due to her trainee status and the nature of the therapeutic relationship, did not have the resources, desire or skills to provide empowerment for her client.

The use of *Empowerment* responses for Participant 2 most closely resonated with the key aspects of feminist paradigms of trauma treatment. Participant 2, whose diagnosis was Borderline Personality Disorder, presented with history of chronic childhood physical, sexual, and emotional abuse consistent with complex or developmental trauma. Key researchers in this niche of trauma work, such as Judith Herman and Christine Courtois, are feminist therapists whose focus on complex trauma has its roots in their engagement with early feminist practice with survivors of sexual abuse (Brown, 2004). These researchers, among other feminist trauma researchers and clinicians explicitly focus on the empowerment of the client, with emphasis placed on identifying how the trauma was disempowering for the individual and helping the client develop effective strategies for responding to the effects of trauma (Brown, 2004). This skill is captured by the following therapist response for Participant 2:

> Well I mean, I have to say I'm very excited to hear you say that [you will give trusting others a chance] because I think its' a very, it shows that, like I said that you're learning, like you're learning to do, be comfortable with yourself and to trust other people and just the thought, even though, like you're saying, it still feels confusing, you don't feel ready which is more than understandable. The fact that you're even having the thought, 'I think I might like them," I think is a huge, huge sign of how far you've come. (T97)

Embedded in this response is an emphasis on how Participant's 2's chronic abuse was disempowering for her in that it impacted her ability to trust others and maintain meaningful interpersonal relationships, as well as the therapist's emphasis on the positive changes she is making toward learning to trust others and develop friendships. The goal of empowerment is to leave the client capable of believing in him or herself and seeing him or herself as a source of authority over his or her life narrative (Brown, 2004), which

is particularly apparent in the empowering responses provided by the therapist for Participant 2.

Egalitarianism/Providing Choices was an additional autonomy support category derived from self-determination and motivational interviewing theories, and which is conceptualized as a "feminist" code for the purposes of this discussion given its emphasized role in feminist paradigms of trauma treatment. In the current study, *Egalitarianism* referred to the therapist treating the client as an equal within the relationship, thus emphasizing the client's personal choice, autonomy, and responsibility (Miller et al., 2008, p. 14); *Providing Choices* was defined as the therapist allowing the client to have options, when appropriate, with respect to therapeutic material (*providing choices – therapeutic material*) and administrative issues (*providing choices – administrative*, Ryan & Deci, 2008; Williams et al., 1996). Clients' experience of choice has been associated with facilitating the process of internalization and autonomous self-regulation (Ryan & Deci, 2008).

Although this factor has been described as one of the key elements of providing autonomy support in psychotherapy (e.g., Ryan & Deci, 2008), *Egalitarianism/Providing Choices* was the autonomy support code that was least frequently found in our study, representing only 4% of the total autonomy support codes across sessions. The same finding was true across cultural background groups (i.e., *Egalitarianism/Providing Choices* was the least frequently coded category for both groups), as well as for three out of the four participants who had *Egalitarianism/Providing Choices* codes present (Participants 1, 2, and 4); Participant 5 did not have any of these responses. This finding, though inconsistent with autonomy support and feminist trauma literature, is not

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surprising when one considers the trainee status of the therapists in our sample. Trainee therapists may be more directive and authoritarian in their approach to treatment, particularly trauma treatment, in order to compensate for the vulnerability felt because of a perceived or actual lack of knowledge, skills, and competence (Brown, 2004; Zoellner et al., 2001). As such, it is possible that our sample of trainee therapists avoided an egalitarian approach and allowing clients to make decisions with respect to therapy because they felt compelled to demonstrate their own competence and control over the therapeutic process. Researchers suggest that therapists can use language that conveys choice in order to enhance autonomous motivation for an activity or behavior; for example, using language such as "can," "may," or "could" rather than "should," "must," and "have to" minimizes control and facilities autonomy (Moller, A. C., Deci, E. L., & Ryan, R. M., 2006).

Finally, *Psychoeducation*, an autonomy supportive factor inextricably linked with egalitarianism and providing choices (Brown, 2004; Reeve et al., 1999; Ryan & Deci, 2008) represented the next to last coding category in terms of frequency across participants (8% of total codes). The *Psychoeducation* code was operationally defined as providing information about the cause and effect of psychological issues and explaining aspects of treatment to the client (Lambert & Ogles, 2004). According to SDT researchers (Reeve et al., 1999; Ryan & Deci, 2008), therapists should providing meaningful rationales when choice is not possible, suggesting that reasons should be provided for therapist-directed suggestions or interventions.

Although *Psychoeducation* represented relatively few of the autonomy support codes, the therapists for each of the participants from our sample provided such

psychoeducation regarding treatment recommendations. For example, in introducing a

mindfulness resource to target the client's anxiety and posttraumatic sequelae, the

therapist for Participant 2 stated:

> [...] Last week and a few other times we've talked about um, mindfulness stuff. And this, um, it's my book actually, but this uh, one of the books that is about doing mindfulness and meditation in everyday life [...] It's one that, uh, my supervisor recommended to me, and that I um, I've used with another client before. Um, and it's a lot about you know in day to day life how to really take the time to be in the moment and reflect on what's going on around you, and different little exercises about how to do that. Cause it's really easy to say, but then the actual practice of doing it." (T93)

Consistent with recommendations by literature on trauma treatment and autonomy

support, the therapist was clearly attempting to provide a rationale for her

recommendation of mindfulness as a skill for the client to use to alleviate his anxiety and

overall distress.

Psychoeducation is also described within the feminist relational-cultural (RC)

model of trauma treatment (Banks, 2006 as cited in Brown, 2004) as a strategy for

empowering trauma survivors.   The RC model places an emphasis on increasing the

clients' growth-fostering relationships, and suggests that the therapist share information

with the client about trauma and its impact on multiple areas of functioning (e.g.,

neurobiological, social, and existential) so as to normalize the client's experience and

facilitate cognitive appraisal of the trauma-related information, which is an integral step

towards posttraumatic growth (Joseph & Linley, 2005). Brown (2004) stresses that this is

particularly true for clients whose trauma response is in violation of previously held

norms for expression of feelings and affect. For example, Participant 5 was a Korean

male whose trauma discussion, as mentioned earlier, was notable for minimal disclosure

of affect followed by avoidance of painful affect mirrored by the therapist's avoidant

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behavior and responses.   Based on our findings, there were only two responses coded as *Psychoeducation*, neither of which pertained to the direct effects of the traumatic experience on the client's affective experience (or self-disclosed lack thereof). Whereas one of these responses did reflect the effects of trauma on existential awareness ["Yeah. It's – it's very normal when we – someone close to us passes away to start thinking about all these things" (T288)], the response was somewhat detached from the client's own personal experience and no connection was made to the client's reported struggle with affect related to the trauma.

Research on the cross-cultural variability of the effects of trauma has suggested that the emotional content of information considered when ruminating differs along the individualistic-collectivistic continuum, such that collectivistic, interdependent cultures (e.g., Asian) encourage display of positive emotions and discourage the expression of negative emotions based on the belief that expression of the latter would disrupt the harmony of the group (e.g., Matsumoto et al., 1998 as cited in Calhoun et al., 2011). Given Participant 5's background as a Korean male, the therapist could have used the trauma discussion as an opportunity to provide psychoeducation and normalize the client's experience of difficulty with affect, as well as reflect and explain his frequent laughter as he discussed difficult trauma-related content. On the other hand the client's avoidance of trauma-related material and incongruent affect may have been less a product of his cultural background and more an effect of trauma itself (i.e., avoidance symptoms). Nonetheless, this could have been an opportunity to provide relevant psychoeducation to the client, as the RC model "urges therapists working with trauma survivors to understand how clients' strategies of numbing and withdrawal are inevitable

consequences of the neurobiology of trauma that must be resisted by the therapist, rather than responded to with therapeutic distancing and detachment" (Brown, 2004, p. 470).

The "values" code. Autonomy pertains to actions that are self-endorsed, based on one's own integrated interests and values, and have an internal perceived locus of causality (Chirkov & Ryan, 2001). Based on this definition of autonomy and a strong emphasis on one's actions being based on personal values, the autonomy supportive category of *Listening for Core Values* was adapted from two of the six core principles of the ACT model that focus on valued living (Hayes et al., 1999; Hayes et al., 2006). It was operationally defined as helping a client articulate and behave in line with personal values, and included statements that helped the client explore what is meaningful to him or her, helped clients set behavioral goals consistent with those values, and helped clients articulate how to take effective action toward those goals. Across all 5 participants, *Listening for Core Values* accounted for 9% of the therapist autonomy supportive responses. Although this code was the third most frequently used autonomy supportive response (together with *Unconditional Positive Regard*), the infrequent use of this autonomy support code suggests that trainee therapists are either not well trained in and/or not comfortable helping clients explore personal, meaningful values and helping them articulate goals and plans to behave in accordance with them.

The exploration of core values and helping clients behave in accordance to them is arguably the most closely tied to the concept of autonomy support and as such should be a priority in autonomy supportive therapy for clients who have experienced trauma. Acceptance and commitment therapy (Hayes et al., 1999; Hayes et al., 2006), one of the third wave theories of CBT, focuses not on changing negative psychological events (e.g.,

posttraumatic symptoms), but on changing the *function* of those events and the individual's *relationship* to them through strategies such as mindfulness, acceptance, and cognitive defusion (Hayes et al., 2006). The primary goal of ACT is to help clients increase psychological flexibility and behave in accordance with meaningful, personal values. For clients who have experienced psychological trauma such as those in our sample, intrusive and negative ruminations and the resulting painful affect are commonly used as reasons for other, value-incongruent actions (e.g., Participant 2 rationalizing his increased use of marijuana), and this "reason-giving tends to draw the person into even more focus on the world within as the proper source of behavioral regulation, further exacerbating experiential avoidance patterns" (Hayes et al., 2006, p. 7). This experiential avoidance poses a threat to the organismic valuing process and posttraumatic growth. According to SDT, autonomy is distinguished from heteronomy, which is the regulation of behavior by forces experienced as alien or pressuring, including both internal demands as well as external contingencies (Ryan & Deci, 2006). As such, from a perspective of autonomy support, it is important for clinicians working with clients struggling with trauma to bring awareness to these negative cognitive and affective patterns, and refocus the client on his or her personal and meaningful values. Supporting clients' autonomy is dependent/contingent upon clients being aware of his or her personal values, since an autonomous individual is defined as "one who acts in accord with self-endorsed values, needs, and intentions rather than in response to controlling forces external to the self" (Ryan et al., 1997, p. 702).

Despite the lower than desired frequency of *Listening for Core Values* responses in light of the importance of values for autonomy support, the use of the code in our

sample was consistent with the general autonomy support literature in two ways. First,

therapists' responses were stated/presented in a nonjudgmental manner and did not

appear to impose the therapists' values, preferences, or beliefs on the client. For

example, the therapist for Participant 2 posed the question, "[...] and what is it like for

you thinking that, and realizing you know, you kind of want to separate yourself from

you know the community and some of those people?" (T153) in an attempt to engage the

client in an exploration of his values as they reportedly differ from his culture of origin.

This therapist response was neutral, nonjudgmental, and facilitated a discussion in which

the client was able to really explore his personal beliefs and values and how his behaviors

were an attempt to act in accordance with those values. This approach is consistent the

following recommendations of Ryan and Deci (2008) for how therapists should convey

autonomy support:

> Autonomy-support entails therapists facilitating the process of clients organizing
> and self-regulating their actions, rather than imposing the therapists' agendas or
> values on them, and it involves aiding the clients in understanding their
> experiences and taking responsibility for new behaviors. It is in such a
> nonjudgmental and noncontrolling atmosphere that SDT assumes people are most
> apt to make choices and changes in the direction of health. (p. 188)

Another way in which our sample of trainee therapists used *Listening for Core*

Values responses consistently with SDT literature is that no differences were found with

respect to the frequency of the codes between the two cultural groups. Put another way,

the trainee therapists responded in autonomy supportive ways that reflected a

conceptualization of values exploration as applicable to individuals from both

individualistic and collectivistic cultural backgrounds. Proponents for autonomy as a

universal psychological need that is important for individuals of all sociocultural

backgrounds argue that:

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When autonomy is defined in terms of the person's endorsement of her or his own actions, rather than in terms of individualistic definitions of autonomy as self-sufficiency or independence, autonomy can encompass relational and cultural concerns and, in fact, is the basis of enacting them. (Ryan et al., 2011, p. 240)

On the basis that autonomy is universal, and accordingly so is the need for identifying one's self-endorsed values, therapists should be helping clients from diverse cultural backgrounds explore their own personal values and ways to behave consistent with them, irrespective of cultural background. This approach is also consistent with recommendations for facilitating the organismic valuing process toward posttraumatic growth in that therapists are considered to help clients positively accommodate new trauma-related information by helping them more clearly articulate their own new meanings and values as they begin to emerge (Calhoun & Tedeschi, 1999; Joseph & Linley, 2005; Tedeschi & Calhoun, 2004b). Our findings suggest that trainee therapists appear to be implementing this autonomy supportive factor within a multicultural context, if at a low rate.

Themes Across Codes and Participants

There were two themes that emerged across the six autonomy support codes and their use across the sessions for all 5 participants. These themes included: (a) *independence and interdependence,* and (b) *emphasis on relationships*. The following discussion describes these two themes, highlighting the context of clients' cultural background in which the patterns were observed and were consistent with relevant literature.

The first theme was related to the cultural distinction between interdependence and independence, which has been described by cross-cultural researchers as characterizing the differing self-concepts for collectivistic and individualistic persons,

respectively (Kitayama & Uskul, 2011; Markus & Kitayama, 1991). Research has suggested that there are differences in the content of traumatic ruminations that are influenced by the broad cultural factors of individualistic and collectivistic values, norms, and views of the self and others (Calhoun et al., 2011; Markus & Kitayama, 1991). Individualistic cultural group members tend to value independence and define the self in terms of how one is different from others and prefer individual action and personal goal pursuit, whereas collectivistic individuals focus on their relationship with others, try not to stand out from the group, and are sensitive to their potential impact on others within their collective group (Calhoun et al., 2011; Markus & Kitayama, 1991).

In our sample, therapists' use of the autonomy support codes tended to reflect this construct of self-in-relation-to-others, and varied as a function of the participant's cultural background. For example, in providing the "humanistic" codes of empathy and unconditional positive regard, differences were noted in how the therapist responded, with the individualistic clients receiving responses reflecting or validating their discussions related to struggles for independence and collectivistic clients receiving responses that were reflective of the interdependent content of the trauma discussions. As an illustration, the therapists for Participants 2 and 3 (collectivistic) provided unconditional positive regard responses that validated the clients' struggle with issues related to interdependence. Participant 2 received a response of ,"[...] I understand, I mean, it makes sense that it's confusing, you know, because like you said, you have had bad experiences with people before, right?" (T86), and Participant 3, who discussed his dilemma related to assimilating into American culture while adhering to his Turkish culture of origin, received a response of, "[...] I could see how that might cause, you

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know, conflict between how you feel, you know, and your community and how your relationship with your community is" (T112). Both of these therapists provided autonomy supportive responses (i.e., *Unconditional Positive Regard)* that were congruent with the interdependent self-construal and content of their posttraumatic ruminations.

In contrast, *Empathy* and *Unconditional Positive Regard* responses provided for the individualistic clients tended to relate to the personal struggles that the clients experienced independently, without consideration necessarily for how their struggles or ruminations might impact others in their lives. For example, in the session for Participant 2, the therapist responded, "It is" (T69) and "Yea, it's tough" (T71) as a means to validate the client's discussion regarding the distress that her health issues have been causing her. Further, for Participant 1, the therapist's response of, "How do you put all that stuff aside? I mean, you go through life with a ton of worries, so how do you focus on any one thing?" (T89) was very "individualistic" in that the reflective focus was placed on the client's ruminations and struggle with the fact that he does not worry about himself enough. These responses, though similar in that they conveyed empathy and unconditional positive regard, differed from one another in that the collectivistic responses reflected and/or validated the clients' struggle with trauma-related issues in the explicit context of others (e.g., family, friends community), whereas the individualistic responses related to the clients' individual struggles without any mention of how this was relevant to important others in their lives.

The adaptation of the specific nature of the autonomy supportive responses to the clients' cultural background noted in our study is consistent with literature that suggests that although autonomy is a universal need, this does not imply that the its manifestation

or the means for the satisfaction of autonomy are the same in all cultures (Ryan & Deci, 2000; Deci & Ryan, 2011). Therapists should tailor their support for autonomy (i.e., behavior guided by self-endorsed values and beliefs) according to what those specific beliefs are in the context of culture. For some, autonomy support might include validating, empathizing with, or empowering clients to behave autonomously and consistently with culture-congruent, internalized values, such as moving in with their sick father to care for him. Although this behavior would be based on interdependent values, as long as those values are intrinsic to the client and he acts according to those values based on his own volition, that behavior is autonomous.

The second theme that was observed across codes and participants was the emphasis on relationships. Upon initial consideration, this may seem to be in conflict with the previous discussion regarding the theme of highlighting interdependence and independence based on cultural background. However, all of the participants, whether individualistic or collectivistic, discussed their relationships with important others in their lives, and these discussions were responded to by the therapists with the various autonomy support codes. For example, although emphasis was placed on supporting Participant 1's autonomy with respect to decisions to prioritize himself, the trauma discussion was initiated with the client discussing his relational distress with his ex-girlfriend since their robbery, and later in the trauma discussion, the therapist provided autonomy supportive responses such as, "How do you envision getting through your issues with [ex-girlfriend]?" (T140), which represented an attempt by the therapist to help the client articulate behavioral goals consistent with his value of resolving the distress in that relationship. Likewise, the therapist responses for Participant 4 reflected autonomy

support for decision related to the struggle with not wanting to be too dependent and burdensome on her loved ones due to her physical and medical conditions. In terms of the collectivistic clients, Participant 2's trauma discussion was centered on various relationships, including her family of origin, her husband, as well as her conflicted thoughts regarding trusting others and developing relationships. Similarly, Participant 3's trauma discussion focused primarily on his immigration and acculturation struggles impacted by pressures from his family and conflicting views with other Turkish immigrants in his community. Finally, in the session for Participant 5, the trauma discussion centered on the client's distress related to the unexpected loss of his friend, and existential ruminations regarding the mortality of his parents.

This emphasis on relationships for both the "interdependent" (collectivistic) and "independent" (individualistic) clients is consistent with the literature on the necessity for the social environment to support individuals' three basic psychological needs, including autonomy, competence, and *relatedness* (Joseph & Linley, 2005; Ryan & Deci, 2000). Further, Ryan and colleagues (2011) posit that the relationship of the therapeutic alliance can be a medium not only for the support of relatedness but for autonomy as well. It is in this relationship that the organismic valuing process inherent in humans and necessary for growth following adversity is able to actualize and facilitate the natural growth process for individuals who have experienced trauma. In our study, it was evident that the trainee therapists placed an emphasis on the various relationships in the clients' lives, including the therapeutic relationship in some cases (though not all given the high rate of premature terminations for the study's participants), albeit to varying degrees dependent upon cultural background.

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Limitations

The current study had several limitations related to its methodology, which included the following: researcher bias, small sample size, subjective definition of trauma, diagnostic profile of our sample, and methods of defining cultural background. First, although qualitative research can provide rich, in-depth information about a human phenomenon and, particularly in clinical research, provide the investigator an opportunity to immerse oneself in a process that parallels the role of therapist in the therapeutic process (Glazer & Stein, 2010; Mertens, 2005), this type of research can be time consuming and difficult to analyze and compare (Creswell, 2009; Mertens, 2005). Thus, there was an increased threat of researcher bias secondary to the time-intensive and subjective nature of the content analytic methodology used (Creswell, 2009). Evidence of bias that was noted by the primary researcher and which may have impacted the reliability of analyses included initially neglecting to notice some of the individualistic statements made by clients who were categorized as having a collectivistic cultural background (and vice versa); assuming cultural background of the therapist-participant based on physical appearance and, accordingly, making assumptions as to the emphasis placed on independence versus dependence on others; and an initial tendency to view more statements than the other coders as representative of autonomy support.

Given these biases and assumptions, multiple perspectives and reliability checks were used to help maintain a more diverse and balanced view of the construct of autonomy support, as well as increase the general reliability of the coding process. .Use of multiple researchers is recommended to enhance diversity of perspective and opinions, circumvent individual biases, and capture the complexity of the data (Hill et al., 1997);

our study included three researchers and an auditor. In addition, in order for the data collected by the researchers to be audited accurately and effectively, the researcher provided a clear and full account of the research process so that the reader may be able to judge the reliability of the study (Lincoln & Guba, 1985). Information regarding the personal expectations of each of the researchers was recorded via bracketing and use of a reflexive journal (Ahern, 1999); although the intent was to keep the reflexivity journal throughout the coding process, information regarding thoughts and biases were limited to oral discussions once the coding process was initiated, further precluding optimal mitigation of researcher bias in our study. Further, to control as much as possible for coder fatigue and subsequent coder drift given the time-intensive process, weekly and biweekly conference calls focusing on inter-rater discussions of the coded responses were limited to 2 hours; also, there were multiple comprehensive discussions of each coder's ratings for individual trauma discussion talk turns following independent coding.

Further, another source of bias was the use of the coding system to measure therapist autonomy supportive responses, which involved observing the behavior and content of therapist responses during trauma discussions. Although steps were taken to operationally define each of the codes derived from various sources, there remained a level of subjectivity and inference in the codes that were assigned by the multiple coders and auditor. This was particularly evident by the frequent overlap of several initial codes in the autonomy support coding system, leading to the modification of the codes to mitigate this observed poor initial reliability. Nonetheless, there was some disagreement among coders even after the modification of the coding system, such as with some of the *Empathy*, *Empowerment*, and *Listening for Core Values* codes for which less than

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moderate pre-group discussion inter-rater reliabilities were found. Our study did not

employ more objective measures of autonomy support, such as client self-report

measures or interviews with the client and/or therapist, which together would have likely

provided a more reliable assessment of perceived autonomy support and provision,

respectively.

Although several steps were taken to help alleviate issues related to reliabiltiy, the

study's validity may have been negatively impacted by the three different coders of the

study. For example, the use of three separate and distinct coding systems in examining

the same participant trauma discussions may have resulted in shifts over time in the

coders' perspectives of the trauma discussion, thus potentially impacting the construct

validity of the autonomy support codes. In order to help control for this issue, a broad,

open coding system developed by one of the three coders to examine general therapist

responses to client trauma discussions was initially used to examine the data; it was only

after this open coding process was completed that more specific coding systems derived

from prior theory (including the autonomy support codes) were applied to the data. As

such, coders first viewed the data from a broader lens of therapist responses to clients'

discussions of trauma, followed by using more specific coding systems to examine them.

On the other hand, using the same coders to examine the participant trauma discussions

may have benefited validity given that the data was examined via multiple, diverse

perspectives inherent in having three different coding systems. Another potential

confound to the study's validity was related to the ethnocultural backgrounds of the

researchers with respect to those of the participants. Given that the coders and auditor

were not matched with the participants in terms of cultural background, the researchers

may have been less aware of or sensitive to therapist responses that may be consistent or inconsistent with autonomy support as it relates to the participant's cultural background.

Another limitation of our study was the small sample size, which excluded children adolescents, and various ethnocultural and religious groups (e.g., Pacific Islanders, Indians, Jewish individuals). Also, due to practical reasons, only English-speaking clients were included in the sample. This criterion potentially excluded participants whose linguistic and cultural differences in the manifestation and experience of trauma and growth may have been particularly salient compared to those individuals who had assimilated more into Western society evidenced by their greater proficiency in the English language. This small and exclusive sample potentially limits the generalizability of our findings for autonomy support in culturally diverse trauma survivors. However, unlike traditional experimental designs, there are no standard guidelines in qualitative research regarding sample size, and the nature of qualitative methods naturally lend themselves to practical, generalizable results by attempting to gain a more comprehensive understanding of a specific, unique process through extensive descriptions and analysis (Creswell, 2009; Mertens, 2005). Our study employed detailed attention to the verbal content of therapist responses, the use of multiple participants from various cultural backgrounds and traumatic experiences, thereby strengthening the study's transferability (i.e., external validity).

A third limitation of our study was the broad and subjective nature of the definition of trauma. The broad definition of trauma we used included several aspects that combined various trauma definitions in the literature. This involved the inclusion threats to both physical and/or psychological integrity (Briere & Scott, 2006); an event-

based as well as perception-based definition including one's reactions and responses to the events themselves (Hall & Sales, 2008); and inclusion of isolated incidents of trauma as well as multiple, chronic traumas (Ford & Courtois, 2009). Our use of a multi-faceted and broad definition of trauma was based on the longstanding conflict and criticisms in the trauma and clinical psychology literature of the definition of trauma provided by the *DSM-IV-TR*, since many events that do not include a life threat or physical injury may lead to just as much suffering as those events that do pose a threat to life or physical integrity (Briere, 2004; Briere & Scott, 2006; Long et al., 2008). Further, in their definition of posttraumatic growth, Tedeschi and Calhoun (2004b) broadly used the term *trauma* interchangeably with *crisis* and *highly stressful events* to signify that these expressions all represent significant challenges to one's ability to adapt following various life circumstances. As such, our study included a broad definition to capture a wide range of potential traumatic reactions and possibility for growth. In doing so, however, our definition was characterized by a subjectivity that perpetuates the current problem within the field. To mitigate this limitation and capture the more conservative definition of trauma as an event that threatens one's physical integrity (Briere & Scott, 2006), traumatic events consistent with *DSM-IV-TR* criteria represented 3 of the 5 participants within our study.

A fourth limitation of our study was related to the diagnoses assigned to the participants. Our diagnostic variable of interest was trauma, and our aim was to examine the quality of interactions between client and therapist in the context of trauma. However, none of our participants had a diagnosis related to "pure" trauma (e.g., PTSD), and all of the participants either had an additional diagnosis co-morbid with PTSD (e.g.,

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Participant 1), or had been given a diagnosis that is not specifically associated with trauma (e.g., Participant 2). Thus, our findings may not have accounted for the variability with which therapists responded to trauma discussions that may have been due to the diagnostic conceptualization for each client in our sample. For example, if a client presents with diagnoses such as borderline personality disorder and social phobia, then the therapist may likely approach the client and trauma discussion differently than if that client presented with a "pure" trauma reaction like PTSD (e.g., may provide less empathy for the former client). Since the majority of the co-morbid diagnoses directly impacted interpersonal relationships (e.g., major depressive disorder, social phobia, partner relational problem, borderline personality disorder), conclusions made by our study that issues related to interpersonal interactions were due to trauma and not other disorders or issues may have been invalid. However, in the case of borderline personality disorder (Participant 2), this diagnosis and etiology of chronic childhood abuse is arguably directly connected to current interpersonal relationships and functioning given the neurobiological impact of early trauma including affect dysregulation (van der Kolk, 2003). Future studies may examine trauma discussions across sessions rather than just a single session, which may help researchers draw conclusions regarding the direct impact of trauma versus other stressors or conditions. Also, it may be beneficial to compare groups of with singular diagnoses specifically connected to trauma (e.g., PTSD) to other co-morbid groups (e.g., major depressive disorder, borderline personality disorder) in order to elucidate possible differences in use of autonomy support. However, given that our study focused on a clinical sample, and the majority of individuals presenting for therapy for trauma-related issues have experienced multiple traumatic incidents (e.g., van

der Kolk, 2003), distinguishing between diagnoses related to "pure trauma" and other co-morbid conditions may not necessarily provide an accurate understanding of the effects of traumatic experiences on many individuals' interpersonal relationships or experience of posttraumatic growth.

Finally, use of a dichotomous categorization of culture as collectivistic or individualistic was an additional limitation of our study. Using these dichotomous categories potentially limited the understanding of nuances related to cultural orientation, particularly in light of research suggesting that cultural groups are just as heterogeneous as they are homogenous (e.g., Matsumoto, 2007, Matsumoto et al., 1996). For example, Participants 2, 3, and 5 were categorized as collectivistic, but information was not available as to the extent of acculturation each participant had undergone (or not undergone), thus precluding a more accurate understanding of *how* "collectivistic" each participant was.

Further, information was not available regarding possible differences between these three collectivistic cultures (Hispanic, Turkish, Korean) in the ways in which collectivistic values were experienced and manifested. Using a more continuous system of labeling cultural background would have provided a deeper, better, and potentially more accurate understanding of each participant's cultural values, and consequently, his or her perceptions regarding the self in the context of others. Future studies should attempt to use instrumentation geared toward obtaining the participant's self-report of acculturation in order to gain a more accurate understanding of the idiosyncratic cultural attributions of the individual, thus avoiding assumptions regarding values, norms, and beliefs as they may impact the experience of trauma, growth, and autonomy. In addition,

as our study did not assess or otherwise capture each researcher's cultural background, and since the coding process is likely to have been subjected to biases related to subjective cultural attitudes, values, and opinions, future studies should incorporate a measure of the researchers' cultural background and orientation as well. In addition to objective instrumentation described above, qualitative interviews may facilitate gaining a richer understanding of an individual's own perception of subjective culture, particularly as it relates to the lens through which trauma is experienced, as traumatic experiences (e.g., ruminations) are culturally bound. Furthermore, our study did not have a means to consider or assess the therapists' cultural backgrounds, thus precluding a knowledge and understanding of the therapists' worldviews, values, and perceptions of themselves in social context, particularly as these factors relate to trauma and growth. This lack of information regarding therapists' cultural background was a limitation in that the therapists' cultural background and beliefs in the importance of autonomy would likely have influenced their responses to clients' trauma discussions.

Directions for Future Research

To redress the limitations of our study, future studies should use measures of acculturation to assess the degree to which clients and therapists align their values with individualism or collectivism, rather than just assuming this cultural orientation merely by country of origin. This is particularly important in the context of contemporary United States, where acculturation is a huge concept permeating the lives of most citizens (Schwartz et al., 2010). One way in which future studies may assess cultural values and level of acculturation is by using objective assessment measures, such as the Acculturation, Habits, and Interests Multicultural Scale for Adolescents (AHIMSA;

Unger et al., 2002). The AHIMSA is a brief, multidimensional, multicultural acculturation measure for adolescents that generates four subscores including United States Orientation (Assimilation), Other Country Orientation (Separation), Both Countries Orientation (Integration), and Neither Country Orientation (Marginalization, Unger et al., 2002). These domains are consistent with the bi-dimensional categories of acculturation proposed by Berry (1980 as cited in Schwartz et al., 2010), which have received considerable empirical support and are widely used in the conceptualization of acculturation (Schwartz et al., 2010). Although this measure was normed and validated on adolescents and thus arguably may not be generalizable to adults, it is one of very few acculturation measures in existence to date that is brief, applicable to diverse ethnic groups (rather than just one such as Mexican-Americans), and does not rely on language as an exclusive measure of acculturation. An alternative method of assessing each client's and/or therapist's cultural orientation and level of acculturation may be through the use of semi-structured interviews, with questions based on the measures such as the AHIMSA. Interviews would provide an opportunity for clients and therapists to provide their own subjective and idiosyncratic experiences related to the questions and construct of culture and acculturation. The interviews could be explored through the use of qualitative methodology to gain an in-depth, rich description of individuals' perceptions and experiences of acculturation.

Moreover, use of an acculturation measure or interview adapted from the AHIMSA may be utilized in a qualitative examination of whether and how therapists tailor the content of autonomy supportive responses to clients' varying and nuanced degrees of acculturation, based on which category of acculturation their clients present

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with. Qualitative research has been suggested as preferred over quantitative methods in culturally sensitive trauma research in that the latter may "miss the complexity of traumatic responses, especially when the precipitating stressor is ambiguous" (Mattar, 2011, p. 262). As such, future studies should emphasize qualitative approaches to the study of constructs such as autonomy support in a multicultural context in order to expand knowledge related to working with clients who present with traumatic or highly stressful experiences in the context of their cultural complexity, and enrich clinical understanding related to the intersection of culture and trauma.

Additionally, in order to address the potential confound related to researcher cultural background, future studies may attempt to match the cultural background of the researcher and client- and therapist-participants in order to increase the sensitivity of identifying autonomy support codes that may vary based on culture. Alternatively, studies may incorporate experts from different cultural groups who would evaluate the use of autonomy support codes for each participant and note any nuances that may be missed by the coder.

It is possible that other studies may use the information and findings from in-depth qualitative research to inform quantitative methods and hypotheses. For example, a regression analysis can be used to predict posttraumatic growth (e.g., using a pre- and post-treatment PTGI) based on variables of treatment (i.e., autonomy supportive versus treatment as usual) and cultural background (e.g., collectivistic or individualistic, or bi-dimensional category based on pre-treatment AHIMSA). Such studies may provide useful information regarding the relationships between client cultural variables and autonomy supportive therapy as predictors of posttraumatic growth. Alternatively, a

study may wish to use both client and therapist cultural background (e.g., using an acculturation measure for both individuals) as independent variables, predicting the relationship of the match (or mismatch) of therapist and client cultural background to use of autonomy supportive responses. Findings would be useful for elucidating patterns of responses within a multicultural context, and informing psychotherapy techniques based on predictors of posttraumatic growth as they may or may not vary by cultural background.

In order to address the current study's limitation of researcher bias, future researchers qualitatively examining clinical phenomena should maintain a reflexive journal to minimize the negative impact of researcher bias as much as possible, and then ensure that they discuss the contents of this journal with one another as a team. Researchers should be aware of and anticipate the challenges of time-intensive content analytic methodology, and take steps to ensure that the reflexive journal remains an integral part of the process throughout. Nonetheless, subjectivity bias is inherent in qualitative research, and despite its potential negative impact, the researcher's perception of complex phenomena serves as a tool for generating theory and testable hypotheses to guide further research and practice. In other words, "the human factor is the great strength and the fundamental weakness of qualitative inquiry and analysis" (Rajendran, 2001, p. 3). Overall, researchers conducting qualitative studies should maintain constant awareness that subjectivity is inherent in qualitative work in that it requires the researcher to have personal rather than detached engagement in the context of various patterns and themes in human phenomena. As such, qualitative researchers should be constantly aware and honest with themselves, regularly confronting their own opinions and judgments

about the data, as well as voicing them throughout the research process so that they may be considered openly and challenged (Rajendran, 2001).

In order to help further mitigate researcher bias related to the qualitative content analysis approach, several other steps could be taken in future studies. First, inclusion of other coders who are not connected with the study may help reduce the bias related to using the researchers who developed the coding systems as well as the auditor. Incorporating additional coders, especially those not affiliated with or invested in the research project, would help reduce or eliminate the influence of prior knowledge of autonomy support and related theories, as well as personal biases that may lead to being more sensitive to identifying desired therapists responses supportive of the author's hypotheses.

Also, prior to beginning the coding process, researchers may benefit from additional practice trials to refine and become familiarized with the coding system as applied to trauma or other therapy discussions separate from those of the study's participants. Conducting such additional practice coding sessions prior to examining the data may help enrich the coding system by obtaining a more comprehensive set of criteria for each code, and ensuring that the codes are more inclusive and clearly defined. Further, it may be beneficial for future similar studies to clarify and refine the operational definition of *fact* that was used in our study, since the term may be used to refer to situational details as well as cognitive processes (e.g., thoughts, beliefs, attitudes, and worries). Distinguishing these two constructs related to *fact* may help elucidate different trauma-related discussions and autonomy supportive codes related to each, particularly

because responding to cognitive process are more likely to lead to posttraumatic growth (e.g., Joseph & Linley, 2005).

In addition, our study did not assess the overarching outcome of interest, namely posttraumatic growth. Future studies may wish to assess whether supporting the need for clients' autonomy indeed facilitates the organismic valuing process, evidenced by the client's experience of posttraumatic growth, and how this need may differ based on the participants' unique cultural values and self-perceptions within their sociocultural contexts. When clients present with trauma-related issues (broadly defined), studies may use a baseline and post-treatment measure of PTG (e.g., PTGI; Tedeschi & Calhoun, 1996) to assess whether there truly was a progression beyond pre-trauma baseline following growth-related (e.g., autonomy supportive) therapy, since this supposition of psychological well-being greater than pre-trauma baseline is uniquely proposed by PTG theory. Future studies should attempt to assess whether this use of autonomy supportive therapy indeed leads to clients' posttraumatic growth, such as with use of a pre- and post-treatment PTGI. Experimental designs may be used in which clients are randomly assigned to two treatment groups (e.g., autonomy supportive versus directive/authoritarian), and measures of PTGI may be compared pre- and post-treatment to note any statistical differences between the two groups, and/or within-group differences in levels of posttraumatic growth before and after the treatment. Alternatively, other clinically relevant outcomes may be assessed following treatment using autonomy supportive therapy, such as reduction in symptoms of depression, anxiety, and PTSD. The relationship between symptom reduction and PTGI could also

be looked at, with example hypotheses including an inverse relationship between severity of post-traumatic symptoms and posttraumatic growth.

Finally, other studies may consider and account for the potential differences in the use of autonomy support based on therapist theoretical orientation. For example, a therapist operating from a cognitive-behavioral perspective is likely to provide more psychoeducation than a psychodynamic therapist. In the case of our study, the sample comprised trainee therapists who likely had not yet committed to any theoretical orientation. Even though some interventions were used intermittently, there was no coherent conceptualization and treatment from one theoretical orientation, consistent with proposed developmental stages of clinical competencies (Fouad et al., 2009). Future studies may want to examine how more seasoned therapists from varying theoretical orientations may use autonomy supportive responses when working with clients who have experienced trauma. This type of study may help inform ways in which different theoretical orientations and approaches incorporate strength-based approaches such as supporting autonomy.

Potential Contributions

It has been suggested that the problem with understanding trauma-related conditions, including but not limited to PTSD, and their treatments is that the sources are widely dispersed, not easily available to clinicians, tend to refer to a single theoretical orientation, focus on a single group of victims/survivors, and often do not provide adequate information on how to actually implement a given treatment approach (Briere & Scott, 2006; Davidson & Foa, 1991). Our study hopes to mitigate some of these problems by offering an autonomy-based approach to working with clients who have

experienced trauma and other distressing experiences that cuts across therapist theoretical orientations, training levels, and diverse client cultural backgrounds, and which may be integrated into empirically supported trauma treatments.

Autonomy support has been identified as a common factor in and of itself (Ryan et al., 2011; Scheel, 2011), and is beginning to receive empirical attention for its effectiveness as a nonspecific factor across therapies (e.g., Zuroff et al., 2007). Our study appears to be the first to bring together a conceptualization of autonomy support as including components integrated from humanistic, feminist, motivational interviewing, and ACT theory and research, as well as recent studies of autonomy support as a common factor itself. This demonstrated ability to bring together major psychological theories and practices to represent a single unifying construct has strong implications for the field of autonomy. We encourage the field to continue to examine our impressions that autonomy support does indeed appear to be a common factor across therapies and may be implemented by therapists to help their clients live meaningful lives that are consistent with their personal, internalized values and beliefs, regardless of whether these values are independent or interdependent in nature.

Using our autonomy support coding system, we examined whether and how autonomy support varied based on client cultural background in a sample of trainee therapists. Our findings indicated that trainee therapists appear to be incorporating some strengths-based approaches early on in their treatment for clients with trauma-related issues. Specifically, based on our integration of humanistic, feminist, motivational interviewing, ACT, and autonomy support/SDT research to derive autonomy support factors, our study demonstrated that the responses of the trainee therapists to client's

discussion of trauma-related material was characterized by autonomy supportive content during less than half of the clients' trauma discussions. Assuming providing autonomy support leads to positive outcomes (e.g., Ryan & Deci, 2000; Zuroff et al., 2007), our study indicates that trainee therapists may require further training on the use of autonomy supportive skills/factors when working with culturally diverse clients who have experienced trauma.

Our codes could be incorporated into what has been described as a much needed and slowly developing area in clinical psychology training programs (Mattar, 2011), an early focus on developing competencies in knowledge and clinical and research skills that may guide culturally-informed interventions for trauma-related issues. For example, a graduate course could be offered that integrates theory and interventions related to trauma and culture, with an emphasis on understanding the various definitions of trauma (e.g., physical and psychological), and the diverse manifestations of trauma effects, posttraumatic growth, and autonomy experiences based on clients' cultural background. This course may help set an early foundation for students and clinicians who will be working with diverse clients who present to therapy with trauma-related issues. Such a training program would be consistent with the goal set by proponents of multiculturalism in the field of trauma to start changing some of the Western philosophical underpinnings of trauma psychology in order to meet the needs of a culturally diverse population (Mattar, 2011). In addition, this information on multicultural understandings of trauma, posttraumatic growth, and the importance of and rationale behind autonomy support may be incorporated into a treatment manual given to clinicians during their first year of training. This manual would include the autonomy supportive codes as treatment

guidelines and skills to apply in their work with relevant clients. Such a manual would help facilitate the early development of culturally responsive practice, which, in the field of psychology, "should be our standard and norm and not the exception" (Gallardo, 2009, p. 429).

Also, the majority of the autonomy supportive responses found in our study were empathic reflections of primarily fact-based information, suggesting that trainee therapists appear to be more comfortable with this basic reflection skill and less equipped to explore deeper, affective process related to the experience of trauma. If this finding was found in future research to be representative of trainee therapists in general, it has several implications for training programs. First, focused education should be provided regarding the multiple facets of the humanistic skills of empathy, with an emphasis on how empathy encompasses both reflective responses related to content-related information, as well as emotional responses conveyed or experienced by the client. Also, trainees in clinical programs should be educated early on in their training regarding vicarious traumatization, and that this is a normal and expected response when working with clients presenting with trauma-related issues. Instilling awareness of this phenomenon and "side effect" of working with trauma and highly stressful experiences may help increase awareness of this response, as well as help normalize if for trainee therapists who already likely struggle with feelings of vulnerability and limited competence. In addition, supervisors should encourage an open and ongoing discussion with trainee therapists who begin working with clients presenting with trauma, in order to help minimize the effects of vicarious traumatization and allow trainee therapists an opportunity to process their distressing experiences. Lastly, supervision and training

should focus on helping trainee therapists build their skills of reflecting affect, through education, modeling, and practicing (e.g., role plays), as consistent with various theoretical approaches.

Moreover, our findings suggest that, contrary to cross-cultural research arguing that autonomy is a need only for clients from individualistic cultural backgrounds, trainee therapists overall provided *more* autonomy supportive responses to clients from collectivistic cultural backgrounds. With this finding, we emphasize that autonomy, when defined consistently with SDT, is indeed a universal psychological need that must be fulfilled by the client's social environment to help facilitate posttraumatic growth. Our study highlights the clarification repeatedly made by SDT researchers that the notion that basic psychological needs, such as autonomy, are universal and developmentally persistent does not imply that the means for their satisfaction are the same across the developmental lifespan, or that their manifestations are the same in all cultures (Ryan & Deci, 2000; Deci and Ryan, 2011). When defined as actions that are self-endorsed and based on one's own integrated values and interests, autonomous behavior is integral to the psychological well-being of all human beings. Just as the therapists in our study were observed to tailor their autonomy supportive responses based on the interdependent or independent cultural orientation of the client, autonomy, in accordance with the argument made by SDT, is manifested and experienced differently among diverse clients and the field of autonomy support should focus its efforts on further highlighted the nuances of ways to best facilitate the idiosyncratic needs of autonomy for individuals in a multicultural context.

According to Mattar (2011), evidence-based research should attempt to integrate and address cultural factors by researchers increasing knowledge in the field of trauma as well as about the diverse communities in which they work, examine their own biases in developing research questions, and understand the need to incorporate cultural context into research questions. It is our hope that the present study has accomplished each of these recommended aspects of evidence-based research in exploring use of autonomy support by trainee therapists working with trauma-related issues in a multicultural context. By considering various definitions of trauma and expanding ours to include a broad range of potentially traumatic experiences, we have increased our own knowledge in the field of trauma and hope to have contributed this understanding to the field. In examining the constructs of culture and acculturation, and the implications these factors have on individuals' experiences of trauma, growth, and autonomy, our study hopes to increase knowledge and awareness of the importance of this basic psychological need. As such, it is our hope that clinicians will support their clients' need for autonomy through what will hopefully be a healing and growth-promoting relationship and experience for culturally diverse individuals who have struggled with tremendous hardships in life.

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Appendix A

Client Information Adult Form

CLIENT INFORMATION **ADULT FORM

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

TODAY'S DATE _____

FULL NAME _____

HOW WOULD YOU PREFER TO BE ADDRESSED? _____

REFERRED BY: _____

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

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

_____

_____

Personal Data

ADDRESS: _____

_____

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

AGE: _____   DATE OF BIRTH ___ / ___ / _____

MARITAL STATUS:

☐ MARRIED   ☐ SINGLE   HOW LONG? _____

☐ DIVORCED   ☐ COHABITATING   PREVIOUS MARRIAGES? _____

☐ SEPARATED   ☐ WIDOWED   HOW LONG SINCE DIVORCE? _____

LIST BELOW THE PEOPLE LIVING WITH YOU:

NAME	RELATIONSHIP	AGE	OCCUPATION

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

REVISION DATE 5/18/2006   1

CLIENT INFORMATION **ADULT FORM

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

_____

MEDICATIONS BEING TAKEN: _____

_____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

_____

_____

_____

OTHER SERIOUS ILLNESSES

DATE

_____

_____

_____

_____

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHOLOGIST, PSYCHIATRIST, MARRIAGE COUNSELING, GROUP THERAPY, ETC.)

DATE

_____

_____

_____

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

☐ ELEMENTARY/MIDDLE SCHOOL: LIST GRADE_____   ☐ VOCATIONAL TRAINING: LIST TRADE_____

☐ HIGH SCHOOL: LIST GRADE_____   ☐ COLLEGE: LIST YEARS_____

☐ GED   ☐ GRADUATE EDUCATION: LIST YEARS OR DEGREE EARNED_____

☐ HS DIPLOMA

☐ CURRENTLY IN SCHOOL? SCHOOL/LOCATION:_____

_____

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATES/DURATION

REVISION DATE 5/18/2006

2

CLIENT INFORMATION **ADULT FORM

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, PLEASE CHECK THE "NO" BOX. IF YOU ARE UNSURE WHETHER OR NOT THE EXPERIENCE OCCURRED FOR YOU OR IN YOUR FAMILY AT

CLIENT INFORMATION **ADULT FORM

SOME TIME, PLEASE CHECK THE "UNSURE" BOX. IF THE EXPERIENCE HAPPENED TO YOU OR IN YOUR FAMILY AT ANY POINT, PLEASE CHECK THE "YES" BOX.

	SELF			FAMILY			
WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, *INCLUDING YOURSELF*, STRUGGLED WITH:	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	PLEASE INDICATE WHICH FAMILY MEMBER(S)
SEPARATION/DIVORCE	☐	☐	☐	☐	☐	☐	_____
FREQUENT RE-LOCATION	☐	☐	☐	☐	☐	☐	_____
EXTENDED UNEMPLOYMENT	☐	☐	☐	☐	☐	☐	_____
ADOPTION	☐	☐	☐	☐	☐	☐	_____
FOSTER CARE	☐	☐	☐	☐	☐	☐	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	☐	☐	☐	☐	☐	☐	_____
FINANCIAL STRAIN OR INSTABILITY	☐	☐	☐	☐	☐	☐	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	☐	☐	☐	☐	☐	☐	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	☐	☐	☐	☐	☐	☐	_____
DEATH AND LOSS	☐	☐	☐	☐	☐	☐	_____
ALCOHOL USE OR ABUSE	☐	☐	☐	☐	☐	☐	_____
DRUG USE OR ABUSE	☐	☐	☐	☐	☐	☐	_____
ADDICTIONS	☐	☐	☐	☐	☐	☐	_____
SEXUAL ABUSE	☐	☐	☐	☐	☐	☐	_____
PHYSICAL ABUSE	☐	☐	☐	☐	☐	☐	_____
EMOTIONAL ABUSE	☐	☐	☐	☐	☐	☐	_____
RAPE/SEXUAL ASSAULT	☐	☐	☐	☐	☐	☐	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	☐	☐	☐	☐	☐	☐	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	☐	☐	☐	☐	☐	☐	_____
DIAGNOSED OR SUSPECTED MENTAL ILLNESS	☐	☐	☐	☐	☐	☐	_____
SUICIDAL THOUGHTS OR ATTEMPTS	☐	☐	☐	☐	☐	☐	_____
SELF HARM (CUTTING, BURNING)	☐	☐	☐	☐	☐	☐	_____
DEBILITATING ILLNESS, INJURY, OR DISABILITY	☐	☐	☐	☐	☐	☐	_____
PROBLEMS WITH LEARNING	☐	☐	☐	☐	☐	☐	_____
ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	☐	☐	☐	☐	☐	☐	_____
FREQUENT FIGHTS AND ARGUMENTS	☐	☐	☐	☐	☐	☐	_____
INVOLVEMENT IN LEGAL SYSTEM	☐	☐	☐	☐	☐	☐	_____
CRIMINAL ACTIVITY	☐	☐	☐	☐	☐	☐	_____
INCARCERATION	☐	☐	☐	☐	☐	☐	_____

REVISION DATE 5/18/2006

4

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 <u>TWO</u> 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 HONEST/OPEN	☐	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		

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

_____

Social/Cultural (Optional)

1. RELIGION/SPIRITUALITY: _____

2. ETHNICITY OR RACE: _____

3. DISABILITY STATUS? _____

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)

Revised 12/2007

IV. <u>Psychosocial History</u>

A: <u>Family History</u> (Family constellation, family of origin and current family, family dynamics, domestic violence/abuse; Include family psychiatric, medical and substance abuse history)

B: <u>Developmental History</u> (Note progression of development milestones, as well as particular strengths or areas of difficulty)

C: <u>Educational/Vocational History</u> (Highest grade completed, strengths/weaknesses, learning issues/interventions; Work history, including any work related difficulties)

D: <u>Social Support/Relationships</u> (Current social support network; Intimate relationships and their history, especially as related to presenting problem)

E: <u>Medical History</u> (When was client last seen by a doctor? Describe current/past medical conditions, injuries, medications, procedures/surgeries)

F: <u>Cultural Factors and Role of Religion in the Client's Life</u>
(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)

Revised 12/2007

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

V.   Mental Status Evaluation

Hygiene & grooming:

Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

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

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

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

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

Thought Content (appropriate; delusions, odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

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

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

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

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 C

Telephone Intake Form

ID#_____

Pepperdine Community Counseling Center
Telephone Intake Interview

Caller Information

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

WHAT IS YOUR NAME?:_____

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

_____ ❑ M ❑ F DOB:_____ AGE: ____

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

WHAT IS (CLIENT'S) ADDRESS?: _____

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

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

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

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

WHO DOES (CLIENT) LIVE WITH? ❑ SELF ❑ OTHERS -

LIST:_____

DOES (CLIENT) HAVE CHILDREN?: _____

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

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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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 _____

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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)

8/7/08 2

ID#_____

☐ I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT VIDEO (AND SOMETIMES AUDIO) TAPED SAMPLES OF THEIR SESSIONS DURING SUPERVISION.

☐ (PER CLINIC POLICY) I ASKED THE POTENTIAL CLIENT FOR PERMISSION TO HAVE THE INTAKE THERAPIST GIVE THEM A CALL PRIOR TO THE INTAKE SESSION

☐ I INFORMED THE POTENTIAL CLIENT THAT THE INTAKE SESSION IS 2.5 HOURS IN LENGTH AND THAT THIS SESSION HELPS THE THERAPIST AND HIS/HER SUPERVISOR GAIN A BETTER UNDERSTANDING OF THE POTENTIAL CLIENT'S PRESENTING PROBLEMS. GATHERING THE INFORMATION DURING THIS FIRST SESSION IS CRUCIAL FOR TREATMENT PLANNING. I ALSO INFORMED THE POTENTIAL CLIENT OF THE IMPORTANCE OF ARRIVING PROMPTLY FOR THE SESSION.

☐ I INFORMED THE POTENTIAL CLIENT THAT FOLLOWING THE INTAKE SESSION, THE THERAPIST WILL PROVIDE HIM/HER WITH FEEDBACK AND MAKE TREATMENT RECOMMENDATIONS WHICH MAY BE FOR CONTINUED TREATMENT IN OUR CLINIC OR MAY BE A REFERRAL TO ANOTHER CLINIC.

☐ I INFORMED THE CLIENT THAT THEIR PLACEMENT WITH A THERAPIST IS SOMEWHAT DEPENDENT ON THE POTENTIAL CLIENT'S TIME FLEXIBILITY.

☐ (PER CLINIC POLICY)I CREATED A CLIENT FILE AND PLACED THE TELEPHONE INTAKE INTERVIEW IN IT.

☐ (PER CLINIC POLICY) I PROVIDED THE CLINIC DIRECTOR WITH THE TELEPHONE INTAKE INTERVIEW.

☐ (PER CLINIC POLICY) I ASSIGNED THE POTENTIAL CLIENT TO A THERAPIST.
THERAPIST:_____

☐ I INFORMED THE POTENTIAL CLIENT ABOUT THE CLINIC LOCATION AND PARKING ARRANGEMENTS.

☐ I CONTACTED THE REFERRAL SOURCE AND THANKED THEM.

☐ (PER CLINIC POLICY) I SCHEDULED THE INTAKE SESSION.
DATE:_____
TIME:_____
THERAPIST:_____

sample

Appendix D

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 E

Participant Selection Tracking Sheet

ID	Total # of Sessions	Exp of Trauma Phys/Psych (CIA; Intake; Tx Summary; Phone Intake)	Death/Loss; SA; PA; Rape/Sexual Assault; Illness/Injury/Disa-bility	I/C	Trauma Discussion Session #	Other Demogra-phic Factors

Appendix F

Coding Manual

RESEARCH PROJECT CODING MANUAL

This training manual is intended to describe the methods of transcription and coding that will be utilized for the team's dissertation research projects. The specific therapy tapes used in the projects will be of clients and therapists at Pepperdine University clinics selected based on inclusion/exclusion criteria (e.g. individual adult clients representing diverse ethnicities, genders, religions, and presenting issues). Renee Sloane, Ani Khatchadourian, and Chris Howells will be using this for their respective dissertations to gain a more in-depth understanding of how clients discuss trauma in therapy. Your role as a research assistant will be to transcribe videotaped psychotherapy sessions containing discussions of trauma identified by the researchers.

I. CODING TIMING OF TRAUMA DISCUSSION INSTRUCTIONS

The first step involves the researcher-participants identifying when trauma discussions take place during the videotapes psychotherapy session. This involves understanding the definitions of trauma as well as discussions about it.

Definition of Trauma

A broad definition of trauma includes threats to one's psychological integrity (Briere & Scott, 2006), as well as one's reactions and responses to the events themselves (Hall & Sales, 2008). Briere and Scott (2006) suggest that trauma applies to both threats to *psychological* integrity and threats to *physical* integrity, whereas definitions of trauma in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA], 2000) only apply to threatened *physical* integrity to meet criteria for a traumatic stress diagnosis.

To capture the more conservative definition of trauma as an event that threatens one's physical integrity (Briere & Scott, 2006), traumatic events consistent with DSM-IV-TR criteria in the Family Data Section of the Client Information Adult Form include: Death and Loss, Sexual Abuse, Physical Abuse, Rape/Sexual Assault, Debilitating Illness Injury, or Disability. Events subsumed under the more broad definition of trauma include events that may threaten one's psychological integrity, such as Emotional Abuse and Separation/Divorce.

Definition of Trauma Discussion

Based upon definitions of disclosure in the literature (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rimé, 2001), discussions of trauma will be identified in participant videotapes as verbalizations consisting of (a) descriptions of the traumatic event, (b) evaluative content such as thoughts, beliefs, and

attitudes about the traumatic event, and (c) affective content such as one's feelings and emotions about the traumatic event.

Procedures for Identifying Trauma Discussion

The start point should be noted on the transcription by writing the word Start next to the talk turn that initiates the trauma discussion. . When the discussion changes to a topic other than a trauma discussion, again pause the video and write the word Stop next to that talk-turn.

Example: I have had a difficult marriage START. Most of the time my husband hits me. Sometimes he even throws things at me… STOP.

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:
                        T = Therapist; C = Client

CONFIDENTIAL VERBATIM TRANSCRIPT

Verbatim Transcript of Session	Initial Coding Impressions
[content removed for dissertation publication]	

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

Research assistants will transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of therapist and/or client statements to then be coded. Attached at the end of this section is a template that you will use for your transcriptions. After reading this manual and discussing questions during

training, you will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the practice, we will review with you a completed transcript to check your work and address any questions.

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

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

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

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

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

For consistency, use **only** the following for exclamations:
- Uh
- Um
- Uh-huh
- Mm-hmm
- Unh-uh

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

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

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

Example: Interruption

> T1: Do you feel like he was ignoring you or…
> C2: No, I just felt like he wasn't understanding what I was saying.
>
> Interruption and continuation
>
> T1: He was coming toward me and I felt, I felt…
> C2: Scared?
> T2: …scared and confused.

Quotation Marks:

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

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

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

Example: They said, What are you doing here?

3. When a thought is quoted, do not use quotation marks, but do set the thought apart by commas and capitalize the first letter of the first word quoted.
Example: I thought, Where am I?
When you have completed the transcription, please go through the session one time to make sure you have captured all the spoken data, and an additional time to ensure you have noted all the significant non-verbal behaviors.

TRANSCRIPTION TEMPLATE

CONFIDENTIAL VERBATIM TRANSCRIPT

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:	

<u>VERBATIM TRANSCRIPT FOR CODING TRAINING</u>
<u>William Miller Therapy Session from APA Series III-Behavioral Health and Counseling</u>

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.

Verbatim Transcript of Session	
[content removed for dissertation publication]	

III. CODING OVERVIEW

The third step of the process involves the researcher-participant engaging in three distinct coding processes to be completed in the following order: (a) open coding for themes related to trauma, (b) therapist use of autonomy support factors, and (c) therapist use of Calhoun and Tedeschi's (1999) recommended counseling strategies. Operational definitions and codes relevant to each process are discussed in the following sections.

A. <u>Open Coding</u>:
Open coding is a three-part inductive process that involves examining data and organizing it categorically and hierarchically so that it can be organized in a manner that clusters specific groupings of ideas into categories that become increasingly broad. The specific steps of the process involve: a) identifying themes, b) creating categories, and c) abstraction. The researcher begins this process by examining the data and noting themes that emerge naturally.
During the first step, the researcher-participant should simultaneously watch the videotapes while reading through the corresponding section in the session transcript. The researcher-participant should make notes and write down all thoughts/ideas about specific themes that emerge in both the content and the process of the therapy session, which answer the research question, in the margins of the transcript. The researcher participant should complete the first stage of this process as many times as necessary (i.e., multiple passes over the data) until he/she feels he/she has captured all of the relevant themes. The following techniques will be used to identify themes: analyzing repetitions in ideas, concepts, or language, the use of metaphors and analogies, transitions in process, non-verbal behaviors, and the presence of indigenous typologies (Ryan & Bernard, 2003).

<u>Non-Exhaustive List of Open Coding Techniques to Identify Themes During Open Coding</u>

Codes	Examples	Comments
Repetitions in Ideas, Concepts, or Language	a) T1: "That sounds really scary" b) T8:"It sounds like you felt	Consist of topics and language that occurs and reoccurs in the content of the therapist responses (e.g.,

	afraid"	particular words or phrases).
The Use of Metaphors and Analogies	T: "I wonder if, as your thoughts come to you, you could imagine them as leaves floating by in a stream, passing in and out of consciousness"	This represents therapist's use of symbolic imagery to illustrate or explain thoughts, feelings, behaviors, or experiences in a manner that schematically resonates with the client.
Transitions in Process	T: "While you were talking about your feelings about the car accident, it reminds me of the time we discussed the death of your father" T5: "You seem to be getting physically uncomfortable. Would it be helpful if we stopped so that you could use some of the relaxation techniques we practiced?"	These consist of naturally occurring shifts or changes in speech. These can include changes in topic, pauses, changes in voice tone, or other verbal or non-verbal behaviors that modify the client-therapist process.
Non-verbal Behaviors	T: (silence), (nodding) or "Um-hmm"	These might include therapist silences, gestures, and auditory indications of agreement and disagreement
Indigenous Typologies	T: "What you're describing is a flashback, and it can consist of feeling as if you are re-experiencing the traumatic event"	These are expressions that are idiomatic and/or colloquial to the speaker. They may reflect culturally, religiously, regionally, etc., specific use of words and phrases that have been used by the therapist, but which may originate from either the therapist or the client.

Then, the researcher-participant should scrutinize data that does not already appear to have been assigned to a theme to determine whether themes appear to be missing.   As multiple participants/transcriptions/sessions are being examined in this study, the researcher-participant should complete this first stage with each examined participant/transcript/session before proceeding to the second stage.

During the second stage, the researcher-participant works to organize individual themes from all transcripts and videotaped sessions categorically into clusters. Themes that are specific in nature should be grouped together based on similarities. The researcher-participant should pay attention both to similarities and dissimilarities among themes added to a cluster.

Codes	Examples	Comments

Reflecting Fact (Code EMP1a)	T: "So what I'm hearing is that you kind of grew up in a warzone." T: "What you're saying is that there was never really someone you could look up to when you were growing up."	The therapist reflects or rephrases or restates the client's content or *factual* utterance Differential: EMP4a takes precedence over EMP1a if therapist response could be interpreted as both
Reflecting Emotion (Code EMP1b)	T: "It sounds like you felt ashamed when you told your mother about what your step-father was doing to you."	The therapist reflects or rephrases or restates the client's feelings or *emotional* utterance about client's own experience Differential: EMP4b takes precedence over EMP1b if therapist response could be interpreted as both
Understanding of Content – Affect/Feeling (Code EMP4b) (Tx:Ty)	T: "What was that like for you? How did it feel to be around people such a young age?" T: "You seem to have a pattern of worrying about others."	The therapist verbally communicates accurate understanding about the client's own *feelings* by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client (both parts must be present within two consecutive therapist verbal talk-turns to receive this code)
Nonverbal Referent (Code EMP2)	T: "I notice that when you talk about what your step-father did to you, you quickly change the subject and look away from me."	The therapist reflects or rephrases or restates the client's aspects of *nonverbal* behavior
Shared Feeling or Experience (Code EMP3)	T: "There was a time after my mother passed away that I had a hard time seeing other mothers and daughters spend time together."	Therapist self-discloses, making an explicit statement that he or she either shares the client's emotion or has had/would have a similar experience Differential: This is a higher order conveyance of empathy than EMP1b; EMP4b takes precedence if therapist response could be interpreted as both.
Understanding of Content – Cognitive (Code EMP4a) (Tx:Ty)	T: "So I'm curious, how much time do you spend thinking about your step-father?" C: "Um, I'm not sure. I feel like I was just always worrying about him; my memories of him are on my mind." T: "Wow, so you do think about him quite a bit."	The therapist verbally communicates accurate understanding of the client's *thoughts* or *situation* by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client (both parts must be present within two consecutive therapist verbal talk-turns to receive this code)
Understanding of Content – Ambiguous Fact/Feeling (Code EMP4a) (Tx:Ty)	T: "So did you feel like you worried about him all the time?" C: "I usually can't fall asleep every night because my memories of him everything." T: "Yeah. Hmm, so it sounds like you felt like you could never have peace of mind."	The therapist verbally communicates accurate understanding of the client's verbalizations by probing, with explicit questions, to understand more fully and reflecting verbal understanding back to client; the verbalizations are neither clearly a fact nor an emotion (both parts must be present within two...)

		consecutive therapist verbal talk-turns to receive this code). Differential: This is a higher order conveyance of empathy than EMP1c; EMP4c takes precedence if therapist response could be interpreted as both.

During the third stage, abstraction, the researcher-participant begins the process of abstraction, or arranging themes from the transcripts and videotaped sessions hierarchically. Specific sub-themes should be compared and grouped together into more abstract and broader categories that represent an overarching parent theme for the combined themes. The researcher-participants independently each should continue this process, moving back-and-forth between the specific subcategory level and more general levels until each one can no longer break down categories into smaller units that fall within the broader concepts, and can no longer more broadly define themes. At the end of the abstraction process, researcher-participants should compare their hierarchies with one another to evaluate them for similarity as well as disparity. Non-shared themes that are found in this checking process should be analyzed to determine if they can be re-conceptualized under a different theme, or re-categorized under a different category or branch in the hierarchy.

B. Autonomy Supportive Factors:
The second step of the coding process involves the researcher-participant coding autonomy supportive behaviors of the therapist. Operational definitions, codes, and examples of autonomy supportive behaviors can by found in the table below for the researcher-participant to use in coding therapist behaviors in the transcribed sessions: (a) "Unconditional positive regard," (b) "Empathy," (c) Egalitarianism/Providing choices," (d) "Psychoeducation," (e) "Empowerment", and (f) "Core Values."

Coding System for Identifying Therapist Autonomy Supportive Factors

Identifying Use of Autonomy Supportive Factor *Unconditional Positive Regard*

Code	Example	Comments
Validation (Code UPR)	T: "Of course you are going to feel angry towards the man who violated you."	The therapist explicitly states that the client is entitled to think, feel, and/or behave in the way that he or she is or wants to

Identifying Use of Autonomy Supportive Factor *Empathy*

Codes	Examples	Comments
Providing Choices – Administrative. *Providing Choices – Therapeutic Material* (Code EgPc2)	T: "Well, I can either be really directive with you, or I can take more of a 'sit back and listen' approach. It's up to you." T: "So, I'm curious what you, would like to talk about today?"	Therapist provides choices or allows client to direct decision-making in the context of issues related to the delivery of Therapist provides choices or allows client to direct decision-

	T: "Would you feel more comfortable coming in every other week instead?"	psychotherapy services, such as appointment time, intervention options, etc.

Identifying Use of Autonomy Supportive Factor *Egalitarianism/Providing Choices*

Identifying Use of Autonomy Supportive Factor *Psychoeducation*

Codes	Examples	Comments
Providing Information – Symptoms, Theory, Treatment (Code PSY)	T: "It is common for people who have been through what you have to avoid certain triggers of memories of the event." T: "It sounds like everything you're experiencing is connected, and explains how you got here in one piece." T: "There is a type of therapy approach called mindfulness skills training that might be really helpful for you to be in the present moment and not worry so much about the future." T: "Having that psychological assessment done can really help clarify some of the symptoms you have been experiencing."	Therapist provides information that helps to clarify the cause or effect of client's symptoms and presenting problem in order for client to become more aware and in control of his or her experience; therapist provides information regarding prognosis and/or treatment (or any additional services related to treatment) fully and carefully so that client may have awareness and control of his or her own experience; therapist provides information regarding a psychological theory

Identifying Use of Autonomy Supportive Factor *Empowerment*

Codes	Examples	Comments
Conveying Confidence in Ability to Make Changes – Competence (Code EPW1)	T: "I remember you told me that you left your dad's house as a teen because of the abuse. I really believe that if you could do that then, you can walk away from our current abusive relationship as well." T: "You learned very early on to be a strong and independent woman."	Therapist verbally communicates confidence in the client's ability to make changes in a positive direction and/or reinforces strengths and positive characteristics of the client

| Emphasizing Control (Code EPW2) | T: "What do you think the best decision would be for you?"

 T: "Well, how do *you* think you should handle the situation with your brother?"

 T: "You are the only one that can decide that for yourself." | Therapist directly acknowledges or emphasizes the client's freedom of choice, autonomy, and right to make decisions. Therapist emphasizes or implies that no one, including therapist, knows client as well as he or she knows him- or herself. Therapist refrains from an authoritarian approach of being directing or ordering and instead promotes the decision-making abilities of the client |

Identifying Use of Autonomy Supportive Factor *Core Values*

Codes	Examples	Comments
Identifying/Clarifying Personal Values (Code CV1)	T: "So it sounds to me like it is really important for you to be close to your family and feel like you are really connected with them." T: "When you look at your life today, there are some things you like, like your integrity." T: "I'm curious how much do you not trust other people?"	Therapist helps client explore what is most important to him or her, what sort of person he or she is or wants to be, what is significant and meaningful, and what he or she wants his or her life to stand for Note: This code may overlap with EMP1a or EMP1b
Committed Action – Setting Goals (Code CV2a)	T: "This week, your goal can be to spend three nights with our parents, even though it might feel uncomfortable for you at first and you might start feeling anxious." T: "I'm curious how you envision that changing for you?"	Therapist helps client set behavioral goals that are guided by his or her values
Committed Action – Effective Action (Code CV2b)	T: "In order for you to meet your goal, what are the kinds of things you will need to that day to prepare for dinner with your parents?"	Therapist helps client articulate plan and steps to take effective action to achieve goals

C. The third step of the process involves the researcher-participant coding the use of Calhoun and Tedeschi's (1999) counseling strategies.

Operational definitions, codes, and examples of the following counseling strategies recommended by Calhoun and Tedeschi (1999) are located in the table below for the

researcher-participant to use in coding therapist responses in the transcribed trauma discussions: (a) "Focus on listening without necessarily trying to solve", (b) "Label growth when it is there", (c) "Events that are too horrible", and (d) "Choosing the right words".

Coding System for Identifying Calhoun and Tedeschi's (1999) Counseling Strategies
Identifying Use of a Counseling Strategy *Focus on listening without trying to solve*

Codes	Examples	Comments
Minimal Encouraging (Code FL1)	T: "Uh-um" or "Yes", or nodding	Consist of all short utterances that the therapist does automatically such as saying "Uh-um" or "Yes", or nodding
Direct Encouraging (Code FL2)	T: "Go on… Tell me more about that night of the rape."	The therapist explicitly encourages the other to continue talking, such as saying "Go on", "Continue, or "Tell me more"
Reflecting Fact (Code FL3a)	T: "So you went to your mother's house after the rape, and then called the police."	The therapist reflects or rephrases or restates the client's content or *factual* utterance in one's own words Note: Reflection should occur within two consecutive therapist talk turns immediately following client's talk turn
Reflecting Emotion (Code FL3b) ***Reflecting Ambiguous Fact/Emotion*** (Code FL3c)	T: "So you were feeling really scared at the time you decided to go to your mother's house before calling the police."	The therapist reflects or rephrases or restates the client's feelings or *emotional* utterance in one's own words Note: Reflection should occur within two consecutive therapist talk turns immediately following client's talk turn
Nonverbal Referent (Code FL3d)	T: "I'm noticing that as you're telling me about the rape, you're really anxious—you're shaking and it's hard for you to look at me."	The therapist reflects or rephrases or restates the client's aspects of *nonverbal* behavior in one's own words
Questioning on Fact- Open Code FL4aF-O	T: "So you had been drinking a lot that night at the bar. Can you tell me more about that?"	Open questions are defined as those in which the therapist requests clarification or exploration without purposely limiting the nature of the response; excludes rhetorical

		questions
Questioning on Fact- Closed Code FL4cF-C	T: "How many drinks did you have that night?"	Closed questions elicit specific and limited information from the client, usually requesting a one- or two-word answer such as "yes" or "no" as confirmation of the therapist's previous statement; excludes rhetorical questions
Questioning on Emotion-Open Code FL4bE-O	T: "How were you feeling that night before you started drinking at the bar?"	Open questions are defined as those in which the therapist requests clarification or exploration without purposely limiting the nature of the response; excludes rhetorical questions
Questioning on Emotion-Closed Code FL4dE-C ***Questioning on Ambiguous Fact/Emotion*** Code FL4amb-C/O	T: "Were you feeling sad or lonely at the time you went to the bar?"	Closed questions elicit specific and limited information from the client, usually requesting a one- or two-word answer such as "yes" or "no" as confirmation of the therapist's previous statement; excludes rhetorical questions
Trying to solve- Treatment Intervention Code FLTS-I	T: "Next time you are starting to feel panic before a work meeting, I want you to stop what you are doing and take 10 deep breaths."	Therapist provides a treatment focused recommendation as to an appropriate choice of action regarding a situation or problem
Trying to solve-Personal advice/ Opinions Code FLTS-A	T: "I don't think it's a good idea for you to leave the bar alone after having so many drinks."	Therapist provides a personal judgment, belief, or conclusion held with confidence but not necessarily substantiated by positive knowledge or proof regarding an appropriate choice of action regarding situation or problem
Trying to solve- Ambiguous Code FLTS-Amb	T: "I really like the idea of you calling your mother twice per week in order to increase contact with her and to reduce your stress with the child care."	Therapist provides what may appear to be both personal judgment and a therapeutic intervention.

		Any therapist response that does not fit into a *any* specific PTG recommendation category, but appears closely related enough to warrant attention and further analysis
Not Otherwise Specified Code NOS		

Identifying Use of a Counseling Strategy *Label growth when it is there*

Codes	Examples	Comments
Therapist verbalized positive changes that the client identified as already present (Code LGa)	C: In the past six months I've noticed that my wife has been more patient with me and has been really supportive. I am starting to realize that maybe I have underestimated her." T: "So through this experience, your wife has been more supportive than you otherwise thought her to be."	Positive changes are defined as a transformation or transition from one state, condition, or phase to another, tending towards progress or improvement
Therapist reframed the way the client viewed certain events in a new, positive way (Code LGb)	C: In the past six months I've noticed that my wife has been more patient with me and has been really supportive. I am starting to realize that maybe I have underestimated her." T: "It sounds like one of the things you are discovering is that, at least in some ways, your illness and discomfort have served to bring you and your wife a little closer together."	Reframe is defined as to look at, present, or think of (thoughts, beliefs, ideas, relationships, etc.)

Identifying Use of a Counseling Strategy *Events that are too horrible*

Codes	Examples	Comments
Therapist shared with the client that some individuals stated they have changed in some positive ways as they coped with their trauma (Code EHa)	T: "Some people have found that through their struggle with their grief over the loss of their spouse, they have experienced some positive changes in their lives."	Change in positive ways is defined as transforming from one state, condition, or phase to another, tending towards progress or improvement
Therapist elicited whether the client thought that this was possible for him/her given what he/she has gone through	T: "Some people have found that through their struggle with their grief over the loss of their spouse, they have experienced some	Change in positive ways is defined as transforming from one state, condition, or phase to another, tending towards progress or

| (Code EHb) | positive changes in their lives. Have you ever felt that way given what you have gone though?" | improvement |

Identifying Use of a Counseling Strategy *Choosing the right words*

Codes	Examples	Comments
Therapist reinforced the positive interpretations of growth or positive changes coming from the struggle with trauma when the client made them (Code CWa)	C: Since Amanda's death, I've been trying to help other women who have lost a child by creating a support group." T: "It seems that your struggle with Amanda's death has led you to be more committed to helping others avoid your kind of pain."	Reinforced is defined as the therapist emphasizes, stresses, or supports when the client explains a positive meaning, significance, or change resulting from his or her struggle with trauma; the term "positive" refers specifically to indications of growth rather than just returning to psychological baseline Note: CWa differs from CWb in that CWa is client-initiated
Therapist chose to label or identify client statements reflecting posttraumatic growth with words that reflected the individual's struggle to survive and come to terms with the event, as opposed to the event itself (Code CWb)	C: Amanda's death led me to become more aware of the simple things in life that I took advantage of before, like the importance of spending time with my nieces and nephews." T: "Your *struggle* with the pain produced by Amanda's loss has led you to be more committed to spending time with your family."	Label is defined as the therapist describing or recognizing client statements reflecting his or her struggle to survive. Words synonymous with *struggle* include *strive, carry on, fight, wrestle, grapple, battle, contend, go up against,* or *put up a fight*. Coming to terms with the event is defined as starting to accept and deal with a difficult situation Note: CWb differs from CWa in that CWb is therapist-initiated

Coding Steps for Researcher-Participants

1. Watch the videotape of trauma discussions and read the transcript all of the way through to make sure that the transcript is accurate. Familiarize yourself with the content and process of the session.

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

3. Familiarize yourself with the open coding steps of a) identifying themes, b) creating

categories, and c) abstraction. Then, begin the coding process, simultaneously using reading the written session transcriptions and watching the corresponding session videotape

4. Familiarize yourself with coding steps for (a) use of Calhoun and Tedeschi's counseling strategies and (b) autonomy support factors.

5. Begin the directed coding process for (a) use of Calhoun and Tedeschi's counseling strategies and (b) autonomy support factors.

6. Individually, read the transcript again in detail by looking at each statement (T1, T2, etc.) and write your coding impressions on the right hand column of the transcript sheet.

7. Meet with team of coders to discuss codes and determine inter-rater reliability. Codes that meet (66%) agreement will be chosen as final codes and recorded on data tracking sheet.

8. Provide auditor with final codes to determine whether the data reflective of the codes has been abstracted by the coders. The auditor will facilitate discussion with the coders regarding discrepancies that arise with the team's judgment, and provide suggestions for changes.

9. Final codes may be entered into the Excel data-tracking sheet for further analysis.

APPENDIX G

Client Consent Form

Pepperdine University

Counseling and Educational Clinics

Consent for Services

INITIALS

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

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

- I understand and agree that my services will be provided by an unlicensed graduate student therapist who will be working under the direct supervision of a licensed mental health professional.

- I understand and agree that, as required by law, my therapist may disclose any medical, psychological or personal information concerning me to his/her supervisor(s).
- I confirm that I have been provided with information on how to contact my therapist's supervisor(s) should I wish to discuss any aspects of my treatment.

I understand and agree with the above three statements.   _____

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

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

Psychological Assessment: The clinic provides psychological and psycho-educational 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/audio taping and Observations: It is standard procedure at our clinic for sessions to be audio taped 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/audio taping

                                          _____   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.

Fees: The fee for the initial intake is nonrefundable.

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

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

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

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

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

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

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

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

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

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

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

Treatment & Evaluation of Minors:

As an un-emancipated 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

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.

<u>Please choose from the following options by placing your initials on the lines.</u>

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

  _____

<u>Please choose from the following options by placing your initials on the lines.</u>

- 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 <u>do not</u> 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 I

Researcher Confidentiality Statement

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

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

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

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

Coder Signature _____

Date _____

Witness Signature _____

Date: _____

APPENDIX J

Data Analysis Sheet

Autonomy Support Code	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
	Trauma type	*Trauma type*	*Trauma type*	*Trauma type*	*Trauma type*
	Culture	*Culture*	*Culture*	*Culture*	*Culture*
UPR					
EMP1a					
EMP1b					
EMP1c					
EMP2					
EMP3					
EMP4a					
EMP4b					
EgPc1					
EgPc2					
PSY					
EPW1					
EPW2					
CV1					
CV2a					
CV2b					

APPENDIX K

IRB APPROVAL FORM

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

April 22, 2011

Ani Khatchadourian

Protocol #: P0411D03
Project Title: *Exploring Ways in Which Trainee Therapists Address Autonomy When Working With Culturally Diverse Clients Who Have Experiences Trauma: A Qualitative Analysis of an Aspect of Posttraumatic Growth*

Dear Ms. Khatchadourian,

Thank you for submitting your application *Exploring Ways in Which Trainee Therapists Address Autonomy When Working With Culturally Diverse Clients Who Have Experiences Trauma: A Qualitative Analysis of an Aspect of Posttraumatic Growth,* for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Susan Hall, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.nihtraining.com/ohsrsite/guidelines/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(4) states:

> (b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:
>
> **Category (4) of 45 CFR 46.101**, research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

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