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Pepperdine University
Graduate School of Education and Psychology

EXPRESSIONS OF SOCIAL SUPPORT: A QUALITATIVE ANALYSIS OF
PSYCHOTHERAPY WITH CLIENTS WHO HAVE EXPERIENCED TRAUMA

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Celine F. Crespi-Hunt M.S.

July, 2013

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

This clinical dissertation, written by

Celine F. Crespi-Hunt

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

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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

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DEDICATION

For Valentino

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I offer my sincere gratitude to Rebecca Rutchick and Christopher Ogle, who supported this work from start to finish not only as "lab-mates" but also as true friends. Thank you for your graciousness, accountability, and humor throughout this team journey.

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Finally, I would like to express my gratitude to the participants and staff at the Brockton Juvenile Resource Center who initially inspired this work and opened my eyes to the healing potential of social support during the darkest times. Thank you.

VITAE

CÉLINE F. CRESPI-HUNT, M.S., ATR

EDUCATION:

Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA

Enrolled in the APA-accredited Doctor of Clinical Psychology program, August, 2013

Cumulative GPA: 3.9/4.0

Dissertation

- Expressions of social support: A qualitative analysis of psychotherapy with clients who have experienced trauma.
 - Chairperson: Dr. Susan Hall, J.D., Ph.D.
 - Committee members: Dr. Shelly Harrell, Ph.D., Pepperdine University; Dr. John Briere, Ph.D., University of Southern California.
 - Preliminary oral examination successfully completed on August 30, 2011.
 - Application for research involving human subjects approved by the University's Institutional Review Board on November 8, 2011.
 - Completion of qualitative data analysis: December 2012; final oral examination: May 2013.

Florida State University, School of Visual Arts and Dance, Tallahassee, FL

Master of Science in Art Education, major in Art Therapy, August 2006

Cumulative GPA: 4.0/4.0

Educational Honors:

- 2006-present: Member of the Phi Kappa Phi Honor Society, the oldest honor society in the nation and is open to students who achieve scholarly excellence in all academic disciplines.
- 2005: Named to the Chancellor's List, a national organization that recognizes the academic achievements and honors of graduate students as selected by university faculty.
- 2004-2006: Awarded University Assistantship to fund educational endeavors throughout graduate experience.

Lesley College of Lesley University, Cambridge, MA

Bachelor of Science, major in Art Therapy, *Summa Cum Laude*, May 2004

Cumulative GPA: 3.83/4.0

Educational Honors:

- 2004: Lesley College Distinguished Service Award for perseverance and enthusiastic commitment to service.
- 2002: Sally K. Lenhardt Award for leadership and academic achievement.
- 2002: Named to the Who's Who Among American College and University Students list.
- 2001: Lesley College Book Award for highest academic standing in the first

- year class.
- 2000-2004: Awarded annual \$5,000 Lesley Scholar Award from first year to graduation.

CLINICAL TRAINING EXPERIENCE:

Pacific Clinics, Monrovia & Pasadena, CA

August, 2012-August, 2013

Psychology Intern in APA-accredited Internship Program

Child/Adolescent/Family Track

Training Director: Dr. Beth Jenks, Ph.D.

Clinical Supervisors: Dr. Charles Chege, Psy.D.; Dr. Mark Rosenblatt, Psy.D.

- Primary placement: Pacific Clinics East Outpatient Clinic, community mental health center.
 - Facilitated clinical intake interviews and developed treatment plans with children, adolescents, and their families seeking mental health services.
 - Provided individual and family therapy for children, adolescents, and transitional age youth presenting with a range of Axis I disorders.
 - Conducted crisis assessment and intervention with clients at risk of suicide and self-harm.
 - Co-facilitated a weekly Seeking Safety group for adolescents aged 14-17 who experienced trauma, substance abuse, mood, and anxiety disorders.
 - Provided therapy and case management services for adults with severe and chronic mental illnesses.
 - Co-led a therapy group for adult members of the Wellness Center (member-run day treatment center for adults with severe mental illness) focused on the leadership skills required to facilitate peer support and activity groups.
 - Participated in weekly individual and group supervision. Reviewed session recordings with individual supervisor and participated in case conceptualization discussions with supervision group.
 - Participated in weekly staff and team meetings to collaborate on challenging clinical cases.
 - Maintained documentation of clinical services within the standards of the Los Angeles County Department of Mental Health.
- Secondary placement: Passageways, full-service provider for homeless populations.
 - Provided individual therapy for adults who experienced homelessness and on-going risk of homelessness.
 - Assessed and monitored client risk for suicide, self-harm, and threats to basic needs. Provided support and intervention for a range of crisis situations.
 - Developed and led an art therapy group for adult clients who experienced social withdrawal and isolation.
 - Participated in community outreach services to connect consumers to

- agency resources.
- Attended weekly team meetings to coordinate multidisciplinary services for program consumers.
 - Consulted with collateral support resources to ensure continuity of care of for therapy clients.
 - Participated in weekly individual supervision to review video recordings of sessions, case conceptualization, and treatment planning.
 - Completed documentation of all clinical services within the requirements of the Los Angeles County Department of Mental Health.
- Completed psychological evaluations for clients receiving services at the community-based agency. Conducted interviews with clients, parents, and collateral resources. Participated in trainings related to report writing, Rorschach administration and interpretation, Roberts-2 administration and interpretation with Dr. Glen Roberts, assessment of malingering, and neuropsychological assessment. Administered, scored, and interpreted a range of clinically indicated assessment instruments. Completed integrated assessment reports; provided feedback and consultation to clients, their families, and collateral support providers.
 - Provided weekly peer supervision to a clinical psychology practicum student focused on case conceptualization, therapeutic interventions, professional development, and self-care. Participated in weekly group supervision for peer supervisors.
 - Participated in and completed training in the following Evidence Based Practices (EBPs): Seeking Safety, Aggression Replacement Training (ART), Promoting Alternative Thinking Strategies (PATHS), and Interpersonal Psychotherapy (IPT). Also, attended training sessions in ProAct, assessment and treatment of psychosis and psychotic disorders, play therapy, substance abuse assessment and intervention, and child abuse prevention. Participated the 21st Annual Mental Illness & Law Enforcement Systems (M.I.L.E.S.) conference sponsored by Pacific Clinics focused on prescription drug abuse amongst adolescent populations.
 - Designed and conducted a research project for the agency in order to gain insight into the help-seeking behaviors of the populations served within the large community service provider. Developed a questionnaire on help-seeking behaviors for mental health related stressors with a peer intern. Facilitated completion of questionnaire by consumers at several agency locations. Findings will be presented to the agency in July, 2013 as part of the internship research colloquia:
 - *Where to turn: Avenues for help-seeking behaviors in a community mental health population.*

Patton State Hospital, Patton, CA

September, 2011-July, 2012

Psychology Clerk

Training Directors: Dr. Annette Ermshar, Ph.D., ABPP; Dr. Robert Welsh, Ph.D., ABPP

Clinical Supervisor: Dr. Julie Yang, Psy.D.

- Conducted clinical intake interviews, psychodiagnostic, and neuropsychological screening assessments, and report writing with patients at a maximum-security forensic hospital housing judicially committed patients under the following commitment types: not guilty by reason of insanity, not competent to stand trial, mentally disordered offender, mentally disordered sex offender, and various civil commitments. Completed 25 psychological assessment reports.
- Trained in and administered clinically relevant psychological assessments for the completion of psychodiagnostic and neuropsychological evaluations.
- Co-facilitated a weekly social skills group with a licensed clinical psychologist for men with severe and chronic mental illnesses.
- Participated in consultation with multidisciplinary treatment teams comprised of psychiatrists, psychologists, social workers, nurses, and behavior technicians.
- Attended weekly training seminars and group supervision on topics including introduction to forensic psychology, clinical interviews with chronically mentally ill patients, and psychodiagnostic assessment administration and interpretation. Attended training workshop on Prevention and Management of Assaultive Behavior (PMAB).
- Attended weekly individual supervision with a licensed clinical psychologist, which include live supervision of clinical interviews and assessment administrations.

Bienvenidos Children's Center, Montebello, CA

September, 2010-March, 2012

Child and Adolescent Therapist Trainee

Supervisor: Dr. Bruce Rush, Psy. D.

- Provided mental health therapy for children, adolescents and their families at the community mental health agency.
- Provided family and individual therapy for clients referred through the *Victims of Crime* program; therapy included trauma-focused interventions (i.e., TF-CBT) and reunification family services.
- Conducted comprehensive interviews and developed treatment goals with clients and their families; completed assessment reports and maintained documentation of therapy sessions, collateral case coordination, and treatment progress.
- Administered psychological assessments in comprehensive evaluations with children and adolescents.
- Completed integrated reports based on results of assessments and clinical interviews with clients, their guardians, and collateral sources.

- Completed Los Angeles County Department of Mental Health training on paperwork and procedures; maintained clinical files within the parameters of the Los Angeles County Department of Mental Health.
- Participated in weekly individual and group supervision.
- Participated in weekly team meetings and didactic trainings on topics related to the mental health care and evaluation of children and adolescents.
- Provided collateral coordination of services with teachers, school counselors, pediatricians, and pediatric specialists.

Pepperdine University Community Counseling Center, Encino, CA

September, 2010-June, 2012

Doctoral Practicum Trainee

Supervisors: Dr. Gitu Bhatia, Psy.D.; Dr. Anat Cohen, Ph.D.

- Provided individual counseling services for adults and children in the community counseling center and at an area public school.
- Conducted intake interviews and developed treatment goals with clients; completed assessment reports and clinical documentation.
- Administered and interpreted periodic measures of progress including the Outcome Questionnaire (OQ-45.2), Working Alliance Inventory – Short Version (WAI-S), Multidimensional Scale of Perceived Social Support (MSPSS), and Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS).
- Participated in weekly group supervision, which included case presentation and review of session recordings.

South Central Training Consortium: Hope Gardens Family Center, Sylmar, CA

September, 2009-August, 2010

Doctoral Practicum Trainee

Supervisor: Dr. Shelly Harrell, Ph.D.

- Provided individual and family therapy for women, adolescents, children and senior residents at the community homeless shelter.
- Co-facilitated a parenting group for mothers, a support group for senior women, and an interpersonal relationship group for adult women with fellow trainees.
- Conducted biopsychosocial interviews and developed treatment goals with clients; completed assessment reports and maintained progress notes and documentation of therapeutic progress.
- Continued to increase understanding of the community psychology model and participated in its application at the shelter.
- Participated in weekly team meetings and clinical supervision; developed professional relationships with peer trainees, multidisciplinary staff, and the community of people experiencing homelessness.
- Participated in the agency community as a member of the mental health team; this included joining with residents and staff during agency events, writing occasional articles for the agency newsletter, providing an in-service training

on self-care for staff, and maintaining healthy and professional boundaries.

Brockton Juvenile Resource Center, Brockton, MA

February, 2007-August, 2009

Clinician

- Coordinated clinical services for adolescent males aged 13-17 who were on probation in a day treatment setting.
- Assessed mental health needs and referred clients and their families to appropriate community resources.
- Used assessment tools, including Global Appraisal of Individual Needs – Quick, Full Version (GAIN-Q Full) and Substance Abuse Subtle Screening Inventory – Adolescent Version (SASSI-A), and clinical interviewing skills in the initial intake process.
- Provided group and individual therapy focused on self-esteem, emotional issues, anger management, and employment and life skills training. Facilitated twice-weekly Dialectical Behavior Therapy (DBT) treatment groups for program participants.
- Attended DBT continuing-education trainings to increase knowledge and improve implementation of group interventions.
- Collaborated with clients and their families to assess educational options and assisted in transition to post-program academic avenues.
- Assisted clients in development of job readiness skills including completing job applications, preparing resumes, understanding rights related to background checks and privacy, interviewing skills, and social skills related to job retention.
- Developed and maintained relationships with network of community-based service providers, schools and educational programs, and employers that offer auxiliary supports to enhance clients' strengths.
- Coordinated field trips and guest speakers related to clinical curricula, life skills development and vocational interests including visits to Boston area museums and interactive discussions with local employers and an area radio personality and musician.
- Facilitated weekly clinical and multidisciplinary meetings to coordinate care with direct care staff, educators, and probation officers.
- Represented clinical staff in monthly working group meetings with professionals from Massachusetts's Office of Community Corrections and Juvenile Probation.

Old Colony YMCA Mental Health Clinic, Brockton, MA

January, 2008-June, 2009

Clinician

- Provided mental health counseling services to families and individuals (i.e., children, adolescents, and adults) in two area homeless shelters.
- Conducted comprehensive assessments of clients' personal histories, levels of functioning, and current needs.
- Collaborated with clients to identify treatment goals and develop treatment

objectives.

- Assisted clients in self-advocacy in the community and provided linkages to community-based support services.
- Facilitated periodic reviews of progress with clients and aided in restating of goals to reflect personal strides.
- Participated in service utilization review meetings, supervision, and consultations for coordination of care.

Special Consultant

- Developed model for the Open Art Studio within the agency's new Teen Center to provide local youth, ages 15-19, with a safe environment to creatively express their experiences, needs, and emotions.
- Facilitated weekly Open Art Studio session at the agency's community-based Teen Center in collaboration with the Boys and Girls Club.
- Invited by Old Colony YMCA CEO to meet with corporate philanthropist to promote the Teen Center's mission in a successful effort to secure continued funding for the teen program.

South Bay Mental Health Center, Brockton, MA

August, 2006-January, 2007

Staff Clinician, Trauma Team

- Conducted intake interviews, developed treatment plans, and documented all services provided in individual mental health treatment for in-home and office-based services.
- Facilitated goal-oriented, short-term individual and family therapy with diverse population of clients who had trauma histories.
- Coordinated care with community service providers including Department of Children and Families (DCF) (formerly Department of Social Services), primary care physicians, and school adjustment counselors.
- Identified and made appropriate referrals to area agencies based on client needs.
- Participated in weekly staff meetings and individual supervision as well as attended specialized training programs for optimal service provision.

Florida State University Counseling Center, Tallahassee, FL

August, 2005-April, 2006

Graduate Art Therapy Trainee

- Provided counseling and art therapy services to the University's diverse population of over 30,000 students to aid in adjustment issues, depression, anxiety, eating disorders, substance abuse, and students at risk of suicide.
- Independently conducted in-take assessments, crisis intervention, and individual therapeutic treatment for a caseload of over 20 students.
- Co-led a weekly process-oriented art therapy group for women about self-esteem with a licensed clinical social worker.
- Developed an arts-based presentation and experiential activity to explore emotions related to body image for National Eating Disorders Awareness Week and participated in the planning group for campus activities throughout

the week.

- Recorded client progress notes and presented case studies to licensed professional staff members and peer interns.
- Participated in individual supervision with a licensed professional, group supervision with pre-master's and pre-doctoral interns, and weekly didactic training sessions.

Center for the Protection of Children's Rights, Bangkok, Thailand
May, 2005-June, 2005

Graduate Art Therapy Trainee

- Selected by University faculty to travel to Thailand and provide art therapy services to children and adolescents, ages 5-14, who experienced physical and sexual abuse, exploitation, and neglect.
- Planned and led art therapy groups and therapeutic art activities, such as individual esteem and identity directives and group murals. Co-facilitated small group sessions for over 20 children and adolescents.
- Recorded client progress and presented therapeutic achievement to the Thai treatment team. Collaborated with treatment team for continued treatment planning and interventions.

Wakulla County Public Schools, Wakulla County, FL

January, 2005-April, 2005

Graduate Art Therapy Trainee

- Provided art therapy services to elementary, middle, and high school students with developmental and behavioral issues that impact learning in a rural community.
- Planned and led art therapy groups and facilitated individual and group therapy for students.
- Recorded and kept client case notes to develop treatment plans and follow therapeutic progress.
- Conducted collateral consultations with teachers and classroom staff to gather information about students' school functioning and coordinate therapeutic and educational services.
- Participated in weekly individual supervision with a registered art therapist in order to obtain professional support and feedback.

McLean Hospital, Child Psychiatric Unit at Franciscan Children's Hospital, Brighton, MA

January, 2004-May, 2004

Undergraduate Clinical Education Trainee

- Assisted clinical mental health counselor with latency-aged clients in therapeutic games and educational activities in the short-term in-patient hospital setting.
- Developed and facilitated art projects and therapeutic group activities for children and adolescents with Axis I diagnoses.
- Attended hospital training sessions and gained knowledge of hospital's

residential program functions.

United South End Settlements, Harriet Tubman House, Boston, MA

January, 2003-June, 2003

Undergraduate Art Therapy Trainee and Literacy Tutor

- Supported adults from diverse backgrounds working toward General Education Diplomas in the community center's education program.
- Tutored adult students in developing literacy and writing skills.
- Assisted with and led extracurricular art projects including a personal shrine project and the development of a student- written poetry book.

Spaulding Rehabilitation Pediatric Unit, Boston, MA

September, 2001-December, 2001

Undergraduate Child Life Trainee

- Assisted professional child life specialist with individual and group activities for children in long-term, in-patient rehabilitation care.
- Interacted with patients and their families in treatment and social activities.
- Attended weekly staff meetings and educational seminars.

PSYCHOLOGICAL ASSESSMENT TRAINING AND PROFICIENCY:

Cognitive Assessment

- Wechsler Adult Intelligence Scale (Fourth Edition; WAIS-IV)
- Wechsler Intelligence Scale for Children (Fourth Edition; WISC-IV)
- Woodcock Johnson Tests of Achievement and Cognitive Abilities (Third Edition).
- Wide Range Achievement Test - Fourth Edition (WRAT-4)
- Delis-Kaplan Executive Function System (D-KEFS)
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
- Beery-Buktenica Developmental Test of Visual-Motor Integration – 5th Edition (VMI-5)
- Mini-Mental Status Exam (MMSE)

Personality Assessment

- Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2)
- Minnesota Multiphasic Personality Inventory, Second Edition, Restructured Form (MMPI-2RF)
- Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)
- Millon Clinical Multiaxial Inventory (Third Edition; MCMI-III)
- Personality Assessment Inventory (PAI)
- Revised NEO Personality Inventory (NEO PI-R)
- Rorschach
- Thematic Apperception Test (TAT)
- Roberts-2

Forensic Assessment

- Miller Forensic Assessment of Symptoms Test (M-FAST)
- Structured Interview of Reported Symptoms (Second Edition; SIRS-2)
- Test of Memory Malingering (TOMM)
- Inventory of Legal Knowledge (ILK)
- Validity Indicator Profile (VIP)

Other Relevant Assessment Instruments

- Beck Depression Inventory (Second Edition; BDI-II)
- Beck Anxiety Inventory (BAI)
- Beck Hopelessness Scale (BHS)
- Trauma Symptom Checklist (TSC-40)
- Trauma Symptom Checklist for Children (TSCC)
- Children's Depression Inventory (CDI)
- Revised Anxiety Scale – Second Edition (RCMAS-2)
- Achenbach System of Empirically Based Assessment Youth Self Report (ASEBA YSR)
- Achenbach System of Empirically Based Assessment Child Behavior Checklist (ASEBA CBCL), (Age 1 ½-5 and Age 6-18)
- Conner's Continuous Performance Test – II (CPT-II)
- Conner's Rating Scale – Revised (CRS-R) (Parent, Teacher, and Adolescent Self-report Versions)
- Vineland Adaptive Behavior Scale, Second Edition (Vineland – II)

LEADERSHIP APPOINTMENTS:

Founding Member of the Pepperdine Forensic Psychology Association

September, 2011-August, 2012

- Assisted in establishing the student-initiated organization of the Pepperdine Forensic Association (FPA) within the Pepperdine community.
- Coordinated networking meetings, panel discussions, and lectures related to forensic psychology topics such as careers in forensic psychology, criminal and civil forensic issues, forensic assessment, and risk assessment with forensic populations.
- Disseminated Association's news and information to the student population.
- On-going involvement with the Pepperdine FPA: invited to speak at a panel event in November, 2012 about training experiences at a large state hospital.

Pepperdine Psy. D. Student Government Association:

Third Year Representative to the Program Steering Committee

September, 2011-August, 2012

- Elected by the students of the Psy. D. program to a one-year term.
- Attending monthly meetings of the Steering Committee of the Psy.D. program with faculty members of the program's Executive Committee. Acted as liaison between students and faculty to effectively share information, ideas, and concerns for improving the doctoral program.

- Served as voting member of the Student Government Association to plan academic, service, social, and self-care activities for the student population.

Governmental Affairs Chair of the New England Art Therapy Association
2008-2009

- Elected by members of the Association to a two-year term.
- Served as liaison between the national association and regional chapter regarding political issues within and pertinent to the art therapy profession.
- Coordinated legislative announcements and initiatives within the Association and developed network amongst art therapists related to governmental issues such as state licensure and credentialing.

President of the Florida State University Art Therapy Association
2005-2006

- Elected by peers to organize ongoing Association events and participated in the development of new projects and activities such as a reception featuring student artwork and welcome activities for new students.
- Coordinated community-based service learning projects such as mural projects at local human service agencies.

President of Lesley College Student Senate
2003-2004

- Elected by the student body to plan and facilitate Senate activities and service work on campus and in the community.
- Coordinated and led monthly meetings, planning sessions, and activities pertaining to student life. Participated in leadership activities with members of the Executive Board of the Student Senate.
- Facilitated focus group discussions with students on the decision to transition from a women's college to a co-educational college. Presented findings of student discussions to the College's Board of Trustees.
- Developed a panel presentation on understanding of media influence and consumption of news media that was open to the student population; the panel was comprised of professors and administrators from throughout the University.

PROFESSIONAL DEVELOPMENT:

Teaching and Supervision Experience:

- Pepperdine Community Counseling Clinic, Los Angeles, CA: September, 2011-August, 2012
 - Peer Supervisor for second and third year practicum trainees completing psychological assessment batteries and integrated reports under the supervision of Dr. Carolyn Keatinge, Ph.D.
 - Facilitated trainings for trainees learning a range of cognitive and personality assessment measures. Reviewed trainees' administration and scoring of all assessment measures included in integrated batteries.

- Reviewed and provided feedback on trainees' integrated reports. Attended weekly group supervision sessions to support trainees' assessment experience.
- Pepperdine University, Los Angeles, CA: September, 2011-June, 2012
 - Teaching Assistant for Master's and Doctoral level cognitive and personality psychological assessment courses supervised by Dr. Susan Himmelstein, Ph.D.
 - Facilitated training sessions for students learning cognitive and personality assessment tools. Reviewed student administration and scoring of psychological assessments required for class assignments.
 - Pepperdine Community Counseling Clinic, Encino, CA: September 2011-June, 2012
 - Peer Supervisor for first year practicum student-trainees under the supervision of Dr. Anat Cohen, Ph.D.
 - Facilitated weekly individual peer supervision sessions to support, encourage, and guide the first year student-trainees' training experience. Reviewed the trainees' clinical documentation including progress notes, intake summaries, and treatment summaries. Reviewed video recordings of the trainees' counseling sessions with student-trainees to provide feedback and opportunities for reflection on clinical skills. Fostered the development of the supervisory and mentorship relationship. Participated in weekly group supervision for peer supervisors at the clinic.
 - Art Institute of Boston, Boston, MA: July, 2008
 - Developed course titled, "Introduction to Art Therapy" for summer Pre-College program for motivated high school students.
 - Facilitated four-week intensive class focused on the understanding of art as a therapeutic process, symbolic uses of art, personal expression in art, and art therapy as a profession.
 - Planned lectures and prepared presentations for each class sessions as well as developed directives for the creative process related to each class topic.
 - Lesley College, Cambridge, MA: September, 2003-December, 2003
 - Teaching Assistant to Dr. Michaela Kirby, Psy.D. for undergraduate Abnormal Psychology class. Attended all class sessions, prepared study materials, coordinated additional educational supports for students and graded tests and assignments.

Research Experience:

- Pepperdine University: December, 2011-December, 2012
 - Independent coder for two qualitative content analyses on factors related to post-traumatic trajectories (i.e., cultural worldview and humor). Reviewed psychotherapy session recordings and transcripts to identify client-participant expressions of cultural worldview and humor in therapy following traumatic experiences. Collaborated with primary researchers to reach coding consensus for inter-rater

reliability.

- Pepperdine University: May, 2010-May, 2011
 - Site Supervisor for the Pepperdine Applied Research Center (PARC) lab at Pepperdine's Community Counseling Center in Encino, CA.
 - Responsible for supervising a team of three graduate research assistants, coordinating data creation and entry at one of Pepperdine's three community counseling centers and submitting data to the PARC database for scholarly research. Research data was gathered from de-identified clinical material including intake and treatment summaries, periodic measures of treatment progress and therapeutic alliance, and session recordings.
- Pepperdine University: April, 2010-May, 2011
 - Research Assistant to the PARC lab, supervised by Dr. Susan Hall, J.D., Ph.D.
 - Generated research files from clinical charts for inclusion in the PARC database and lab research projects by de-identifying clinical material; assisted with entering clinical research material into SPSS database.
- Florida State University: August, 2004-August, 2005
 - Research Assistant to Dr. David Gussak, Ph.D. and Dr. Penelope Orr, Ph.D. Assisted with ongoing research projects including coding of participant responses in survey studies as well as preparation of course materials.

Continuing Education:

- November, 2012: Completed Interpersonal Psychotherapy, Level A.
- October, 2010: Completed Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) online training.
- August, 2008: Certified in Massachusetts CANS (Child and Adolescent Needs Assessment) for use with clients aged 0-21 who utilize state-subsidized behavioral health insurance.
- Maintained understanding of risk and resiliency factors related to suicide through attending the 2007 Massachusetts Suicide Prevention Conference and a risk assessment training provided by the Massachusetts Society for the Prevention of Cruelty to Children in October 2008.

Licensing and Credentialing Eligibility:

- June, 2012: Joined the Early Entry Program for earning Board Certification from the American Board of Professional Psychology (ABPP).
- February, 2010: Earned the Art Therapy Registration (ATR) by the Art Therapy Credentials Board.
- August, 2008: Completed post-graduate clinical field experience and supervision requirements for the Massachusetts Licensed Mental Health Counselor (LMHC) credential.
- April, 2008: Successfully completed the National Clinical Mental Health Counseling Examination by the National Board for Certified Counselors.

Professional Affiliations:

- Student member of the American Psychological Association (APA), the Los Angeles County Psychological Association, and the San Gabriel Valley Psychological Association.
- Student Affiliate of APA's Division 37, Society for Child and Family Policy and Practice; Division 41, American Psychology-Law Society; and Division 56, Trauma Psychology.
- Member of the American Art Therapy Association and the International Networking Group of Art Therapists.

Publications:

- **Crespi-Hunt, C.**, Ogle, C., Rutchick, R., & Hall, S. (November, 2012). *Psychotherapy with trauma survivors: Client expressions of protective factors*. Paper proposal submitted for the 2013 conference of the American Psychological Association, Honolulu, Hawaii.
- **Crespi-Hunt, C.** & Hall, S. (October, 2012). *Identifying social support expressions in therapy with a Salvadorian trauma survivor*. Poster presented at the annual Diversity Challenge of the Boston College Institute for the Promotion of Race and Culture, Chestnut Hill, Massachusetts.
- **Crespi-Hunt, C.** & Hall, S. (August, 2012). *Expressions of social support in the therapy of trauma survivors*. Poster presented at the annual conference of the American Psychological Association, Orlando, Florida.
- Kirby, M., Stevens S., **Hunt, C.** (August, 2009). *Body-casting as a means of personal and social transformation*. Paper presented at the annual conference of the International Expressive Arts Therapy Association, Cambridge, Massachusetts.
- Kirby, M., **Hunt, C.** & Smith, S. (November, 2007). *Body-casting as a medium of transformation*. Paper presented at the annual conference of the American Art Therapy Association, Albuquerque, New Mexico.
- Argyrides, M., Ramous, C., & **Hunt, C.** (October, 2006). *Teaching and training diversity: Are we missing something?* Paper presented at the annual Diversity Challenge of the Boston College Institute for the Promotion of Race and Culture, Chestnut Hill, Massachusetts.
- Rosal, M., Moore, M., Bostick, B., **Hunt, C.** & Moncrief, A. (November, 2005) *Art therapy in Thailand: Student internship experiences*. Panel discussion at the annual conference of the American Art Therapy Association, Atlanta, Georgia.
- **Hunt, C.** & Moncrief, A. (October, 2005). *Art therapy students in Thailand. Newsletter of the International Networking Group of Art Therapists.*

ABSTRACT

One commonly accepted protective factor, social support, is hypothesized to be both helpful and harmful following exposure to traumatic events (Bonanno, 2008; Ellis, Nixon, & Williamson, 2009; Lyons, 1991). Although at least 10 theoretical models have been proposed to explain the relationship between social support and post-traumatic responses, existing theories do not adequately capture the multidimensional experience of social support, which is comprised of several constructs and structures (e.g., received and perceived support; support functions and content). Moreover, existing social support theories have not been studied in research related to therapy with traumatized clients. The present study, therefore, examined how clients who experienced trauma expressed social support in psychotherapy. A qualitative content analysis was conducted using a directed coding system developed for this study that was based on the constructs and structures commonly discussed in psychology literature on post-traumatic experiences, namely: (a) received support, (b) perceived support, (c) extended support, (d) social support functions, and (e) social support contents.

The current study observed that clients who have experienced trauma are likely to mention social support in sessions but that salient factors related to the benefits and harms associated with social support were discussed less. Although many expressions of social support fell into “not otherwise specified” categories because the quality or type of support experienced was not clearly stated, inductive analysis identified the following salient factors: support needs, relationship elements, planned future support activities, past perceived support, and past support that did not occur. The study also provided

support for some existing models of social support and trauma (i.e., network orientation, stress-buffering, erosion, social-cognitive processing, and COR models).

Clinical implications related to social support discussions in individual therapy include the need to examine and potentially change therapists' views of social support. Psychotherapists are encouraged to explore the support relationships identified by clients, as well as the quality and types of support experienced and perceived, in order to understand the role and impact of social support and address the benefits and risks associated with support. Clinicians should also recommend that clients engage in adjunctive mutual aid and affiliative support groups.

Chapter I: Literature Review

Considerable research has been conducted related to understanding individuals' responses to traumatic experiences and implications for their treatment. More specifically, the identification of factors of risk and resilience and patterns of outcome responses, known as trajectories (Bonanno, 2008), have informed understanding of how individuals respond to experiences of trauma (Pan & Chan, 2007). Recent literature emphasizes the need for increased understanding of resilience, post-traumatic growth, and protective factors to better inform clinical interventions for individuals who experience trauma. One commonly accepted protective factor, social support, is hypothesized to aid in effective coping following exposure to traumatic events (Lyons, 1991). Additionally, lack of social support is widely accepted as a risk factor for vulnerability to trauma (Bonanno, 2008; Ellis, Nixon, & Williamson, 2009; Lyons, 1991). Although several theoretical models have been proposed to explain the relationship between social support and post-traumatic responses (e.g., stress buffering or erosion models), these models differ in their understanding of how social support impacts, or is impacted by, post-traumatic functioning. Therefore, further research is needed to understand the role of social support in post-traumatic trajectories, including resilience and post-traumatic growth. Furthermore, empirically informed recommendations for addressing social support in psychotherapy with individuals who have experienced trauma are limited. Research specific to social support in the therapy of trauma survivors is required to develop more accurately informed interventions.

The purpose of the proposed study is to examine how individuals who have experienced trauma express social support in psychotherapy. First, a review of literature

related to positive psychology and trauma is presented to provide conceptual definitions of trauma and post-traumatic trajectories. Then, research related to the role of social support in the experience of traumatized individuals is reviewed. Finally, this chapter presents an overview of social support and psychotherapy with individuals who have experienced trauma. The findings of the proposed study may increase insight into how social support presents and can be used in psychotherapy with individuals who have experienced trauma. The implications of this knowledge are related to improving training and implementation of strengths-based approaches with traumatized populations.

Positive Psychology and Trauma

The field of positive psychology aims to understand the full spectrum of human experience, beyond dysfunction and maladaptive responses to stressors (Seligman & Csikszentmihalyi, 2000). A positive psychology perspective proposes a holistic approach to account for both the negative and positive elements of the human experience, including the traumatic experiences.

To this end, positive psychology examines the processes by which individuals, groups, communities, and institutions survive and, more importantly, thrive in the face of adversity (Gable & Haidt, 2005; Seligman & Csikszentmihalyi, 2000). Therefore, positive psychological research and study includes the examination and analysis of the positive subjective experience of the human condition, individual characteristics that contribute to the subjective experience, and positive communities and institutions. These three core elements are known as the “three pillars” of positive psychology (Seligman & Csikszentmihalyi, 2000).

Positive psychology is built upon earlier psychological theories and approaches including meaning making, models of health, and positive human characteristics as observed in a range of literature (e.g., Allport, 1958; Gable & Haidt, 2005; Jung, 1933; Maslow, 1968; Terman, 1939). Despite the longstanding theoretical foundations of positive psychology, many criticisms of the field have been observed in recent literature. For example, some critics claim that positive psychologists take a simplistic, “Pollyanna” view of the human experience through recognition of only positive aspects of life, overlooking negative aspects (Held, 2004; Lazarus, 2003). Another critical argument observed that positive psychology uses faulty reasoning that is meaningful or effective for only individuals who are generally optimistic and happy by nature (Miller, 2008). However, proponents of positive psychology assert that the goal of the field is not based on the eradication of work focusing on pathology and dysfunction, but rather on increasing understanding of resilience, strength, and growth that are intrinsic to the human condition (Gable & Haidt, 2005).

Another significant criticism of positive psychology is related to the Western value system, and specifically individualism, on which it is based. In this way, positive psychological theory appears to be ethnocentric in that it is focused on a Western view of the “self” (Christopher & Hickinbottom, 2008). Critics note that conceptualization of “self” varies across culture and time, and argue that positive psychologists be aware of assumptions and values that shape the field of study that may manifest or require adaptation for use and congruence in non-Western cultures.

Despite criticisms of the field, clinical research indicates that important implications emerge from positive psychological theories. Therefore, positive

psychology models can be practically integrated and used in therapy through such approaches as responding to, reflecting, and incorporating client strengths into the therapeutic process (Lambert & Erekson, 2008). For example, “positive psychotherapy” (PPT) refers to the clinical practice of positive psychology evidenced to reduce depressive symptoms (Seligman, 2002; Seligman, Rashid, & Parks, 2006). The therapeutic process involved in PPT focuses on fostering positive emotions, engagement, and meaning, which are core components of happiness (Seligman, 2002; Seligman, Rashid, & Parks, 2006). Interventions used in PPT, which are known as “positive psychology interventions” (PPIs), aim to foster positive feelings, behaviors, and cognitions and have been observed to be effective in decreasing depressive symptoms and enhancing overall well-being (Sin & Lyubomirsky, 2009). PPIs that were found to be effective included strength building approaches through socialization, writing letters of gratitude, replaying positive experiences, and engaging in optimistic thinking. These therapeutic efforts focused on enhancing the individual’s existing strengths, rather than repairing pathology or deficits.

One case example of a positive psychology treatment approach with an adult client who experienced the trauma of sexual abuse in his childhood used the therapist’s focus (and encouragement of the client’s focus) on his strengths and functioning, as opposed to weaknesses, dysfunction, and pathology. This approach resulted in the client’s conceptualization of himself as someone who was victimized instead of a victim (Erickson, 2010).

It should be noted that PPT and related PPIs were observed to be more beneficial with clients from individualistic cultures than clients from collectivistic cultures (Sin &

Lyubomirsky, 2009), which is congruent with concerns about cross-cultural implications of positive psychology (Christopher & Hickinbottom, 2008). Therefore, use of PPIs in therapy should factor in cultural backgrounds and values in order to maintain cultural congruence with client experiences (Sin & Lyubomirsky, 2009).

Trauma. Although traditional theories and research on trauma often underestimate the ability of an individual to remain psychologically and physically healthy in the face of traumatic adversity, more recent approaches address the potential for growth and learning from such adversity (Linley & Joseph, 2005). This section reviews definitions of trauma used in psychological literature, complex trauma, and the effects of trauma on development.

The Diagnostic and Statistical Manual of Mental Disorders' (DSM-IV-TR; American Psychiatric Association, 2000) definition of trauma is the most widely used definition in trauma research and is held as the standard in the field of clinical psychology (Weathers & Keane 2007). The components included in the DSM-IV-TR definition of trauma include the objective or actual threat or event, and the subjective or emotional response to the traumatic event. "Traumatic events" are operationally defined within the context of Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) diagnoses. According to the DSM-IV-TR, a traumatic event which meets the criteria for post-trauma or acute stress diagnosis is one involving:

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. (p. 463)

The Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID; First, Spitzer, Gibbon, & Williams, 2002) included examples of traumatic events such as life threatening combat exposure, rape or sexual assault, physical violence or assaults, serious accidents, life threatening natural or human-initiated disasters, and witnessing the death or serious injury of another person. Although PTSD research has traditionally focused on *external* traumatic events (e.g., war, assault, or accidents), it is important to note that *internal* stressors or experiences such as a medical crisis (e.g., stroke) have recently been included in definition of traumatic events (Bruggimann, Annoni, Staub, & Van der Linden, 2006; Merriman, Norman, & Barton, 2007). Therefore, both external and internal trauma events were recognized in purposes of this study.

Also involved in the DSM-IV-TR inclusionary criteria is that the event must be responded to with fear, helplessness, or horror. Yet, debate exists both for and against the DSM-IV-TR definition of trauma (Norris, 1992; Weathers & Keane, 2007). Norris (1992) argued for an objective definition of trauma that does not rely of the emotional responses and consequences of individuals who have experienced traumatic events. Her proposal instead focused on “violent encounters with nature, technology, or humankind” (p. 409) rather than the outcome experience included in the DSM-IV-TR definition.

Conversely, Weathers and Keane (2007), in their review of challenges related to defining traumatic events, supported the DSM-IV-TR inclusion of the stressors related to traumatic experiences. Although the authors acknowledged that emphasis on the subjective appraisal of an event as a core component of the definition increases the

challenge of operationally defining the event as traumatic or stressful, they highlighted the utility of the multiple dimensions of the shared framework. Dimensions in defining trauma include the type of experience, degree of intensity, length of duration, and proximity to the experience. Weathers and Keane observed the strength in the flexibility of the DSM-IV-TR framework.

McNally (2004) proposed that the breadth of the definition, including both objective and subjective components, may be too inclusionary, resulting in broad variance of “trauma” experiences and populations in trauma research. As a result, the implications for research using the definition may include cases that are inappropriate to “real” trauma experiences and populations but meet the DSM-IV-TR definition for trauma. However, as a former member of the DSM-IV PTSD committee, McNally (2004) recognized the shortcomings in the adoption of too narrow or rigid of a definition of trauma, which could result in the exclusion of some individuals with very real post-traumatic symptoms from provisions of necessary services.

Friedman, Resick, Bryant, and Brewin (2011) addressed some of the historical shortcomings in defining trauma in their proposed changes to PTSD diagnostic criteria for the next edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The authors presented literature that suggested that the diagnostic criterion (Criterion A) requiring the direct witnessing of a traumatic event paired with a subjective emotional response (e.g., fear, hopelessness, or horror) may be not be necessary in defining trauma. The reviewed clinical research indicates that very few people meet the remaining PTSD criteria without meeting Criterion A. It was suggested, then, that any stressor or event that caused PTSD symptoms should be included in the definition of trauma. However,

the counterargument observed by Friedman and colleagues (2011), indicated that removing Criterion A from the diagnostic criteria of PTSD would oppose the basic construct of the disorder, which was developed to categorize maladaptive reactions to a traumatic events. Their review of the available research led the authors to propose a revised and narrowed delineation of Criterion A. They suggested that in cases in which an individual “learns about” another person being involved in a traumatic event, that second individual should be a “close relative or close friend” (p. 755) in order for the event to be considered a “trauma” for the individual. Additionally, Friedman and peers (2011) stated that witnessing traumatic events distally (e.g., in pictures or electronic media) should only constitute traumas when witnessed within the individual’s “vocational role” (p. 755).

Friedman et al. (2011) also suggested changes to the remaining DSM-V PTSD criteria. Specifically, the authors proposed that, the three existing DSM-IV-TR clusters of symptoms (i.e., re-experiencing, avoidance/numbing, and hyperarousal) be expanded to four categories in the DSM-V based on factor analysis studies of the avoidance/numbing cluster. This separation of avoidance and numbing would result in four distinct symptom clusters of (a) intrusive symptoms, (b) avoidance behaviors, (c) negative alterations in cognitions (e.g., numbing and detachment), and (d) alterations in arousal and reactivity. Additionally, Friedman and colleagues (2011) noted the proposed development of a new section expected in the DSM-V, “trauma-and stressor-related disorders,” that would move existing trauma related disorders (i.e., PTSD and ASD) out of the anxiety disorders section.

In addition to experiences of trauma that may be confined to a single exposure or event, individuals may be exposed to multiple or chronic traumas that often occur in interpersonal experiences and begin early in life, which are referred to as “complex trauma” (Courtois, 2008). Although the prototypic complex trauma examples are related to childhood abuse, the definition of complex trauma has expanded to include “catastrophic, deleterious, and entrapping traumatization occurring in childhood and/or adulthood” (p. 86). Thus, examples of complex traumas include sexual and physical abuse, community violence, traumatic medical interventions and severe and chronic illnesses. The cumulative result of repetitive and prolonged trauma is often lasting disturbances in biological, psychological, and social functioning. It appears that the combined effects of multiple traumas contribute to the development of post-trauma symptoms in ways that are different from the effects of a single trauma or even the one trauma that identified as the most severe incident (Briere, Kaltman, & Green, 2008). Symptoms associated with complex trauma experiences include: mood disturbances, cognitive symptoms, somatoform distress, heightened avoidance responses, changed self-capacities, and post-traumatic distress (Briere & Spinazzola, 2005). In addition to symptoms of PTSD, the accumulated effects of childhood sexual trauma include: dissociation, somatization, depression, and anxiety (Briere, Kaltman, & Green 2008; Cloitre, Cohen, Edelman, & Han, 2001; Follette, Polusny, Bechtle, & Naugle, 1996). A study by Briere and colleagues (2008) identified a linear relationship between the cumulative impacts of multiple childhood traumas and later symptom complexity. The authors suggested that the accumulation of traumas impacts survivors in ways that exceed the effects of specific trauma experiences (Briere et al., 2008).

These constellations of symptoms have recently been captured in diagnoses such as Complex Posttraumatic Stress Disorder (CPTSD) and Developmental Trauma Disorder (DPD) (van der Kolk, 2001; Williams, 2006). CPTSD and DPD may stem from pervasive and multifaceted types of traumas such as child abuse, domestic violence, human trafficking, war-related experiences, and medically-related traumas from long-term illness and interventions (Courtois, 2008). DPD specifically describes the adverse effects that severe and chronic early traumas have on development. Even beyond the CPTSD and DPD disorders, survivors of childhood trauma such as sexual or physical abuse are at increased risk for attention deficit/hyperactivity disorder, depressive disorders, and a range of problems across childhood and adulthood (Heim & Nemeroff, 2001; Reiland & Lauterbach, 2008).

Existing research on the sequelae of rape, sexual abuse, and physical abuse in childhood indicates that such events can significantly impact later psychological functioning (Briere, 2004; Briere, Kaltman, & Green, 2008). For example, Stein, Dickstein, Schuster, Litz, and Resick (2012) noted that adult survivors of childhood sexual and physical abuse frequently present with high levels of emotion dysregulation and interpersonal problems. Several factors that impact the experience of trauma in survivors of childhood sexual abuse have been observed. Namely, characteristics of (a) the sexual abuse, (b) the survivor, (c) the perpetrator, and (d) the response from available social support (Leahy, Pretty, & Tenenbaum, 2003; Neumann, Houskamp, Pollock, & Briere, 1996). Leahy, Pretty, and Tenenbaum (2003) summarized factors that have been correlated to poorer outcomes, or greater degrees of negative post-traumatic functioning, that include: earlier trauma exposure (e.g., physical abuse, natural disasters, traumatic

accidents; Briere, 1996); sexual abuse that was perpetrated by a trusted individual (e.g., a guardian or authority figure; Beitchman et al., 1992); highly invasive sexual traumas (Kendall-Tackett, Meyer-Williams, & Finkelhor, 1993); and dissociation occurring during the traumatic event(s) (Johnson, Pike, & Chard, 2001).

Social support has been observed to play a critical role in mediating the potential negative long-term outcomes of childhood sexual trauma (Leahy et al., 2003).

Consistency in the availability of social support following early sexual trauma is an important protective factor (Leahy et al., 2003; Runtz & Schallow, 1997; Spaccarelli & Kim, 1995). However, posttraumatic distress is likely to increase when social support resources fail to adequately respond to disclosure of abuses (Briere, 1997; Leahy et al., 2003). For example, more than half of the highly distressed participants in Leahy and colleagues' (2003) qualitative study on the narratives of adult survivors of sexual abuse reported experiencing non-helpful or inadequate support from therapists.

Early exposure to trauma has also been associated with neurobiological changes that may contribute to the difficulties described above (Heim & Nemeroff, 2001). For example, researchers have observed a correlation between abuse (e.g., physical, sexual, or emotional) and neglect in childhood and neurotransmitter systems (i.e., corticotrophin-releasing factor neurotransmitter) that results in increased sensitivity and responsiveness to stress. Also, women with abusive histories displayed greater amounts of adrenocorticotrophic hormone than women without histories of abuse. Increased rates of substance dependence of approximately 50%, as well as lower levels of adrenocortiotrophin hormone responsiveness, have been observed among individuals with PTSD who experienced trauma in childhood or adulthood (Santa Ana et al., 2006).

While trauma has been associated with neurobiological, cognitive, and behavioral problems, it is also important to consider the influence of risk factors such as gender, ethnicity or culture, age at which the trauma occurred, the severity of the trauma, post-trauma stressors, and social support following the trauma (Brewin, Andrews, & Valentine, 2000). In their meta-analysis of 77 research studies, Brewin, Andrews, and Valentine (2000) identified that the presence of the risk factors described above increase the likelihood for development of PTSD symptoms. However the authors observed that not all of the risk factors were consistent across all of the studies examined. Additionally, they identified a larger effect size for age of trauma onset among men than among women, suggesting that interaction effects between variables likely impact overall risk for PTSD. In another meta-analysis, Ozer, Best, Lipsey, and Weiss (2008) observed the following variables to be predictive of PTSD: severity of perceived threat during the trauma; history of family mental illness; pre-trauma psychological functioning and well-being; dissociation and emotional responses during the trauma; and post-traumatic social support. This meta-analysis extended the previous study by Brewin and colleagues (2000) by focusing on the psychological experiences that occurred during the trauma (i.e., “peritraumatic”), as opposed to only pre-trauma factors, in the etiology of PTSD (Ozer et al., 2008).

Others have argued that the DSM-IV-TR does not adequately account for and include cultural considerations in trauma related to ethnic minorities (Scurfield & Mackey, 2001). Tummala-Narra (2007) recommends that, “the way in which trauma is experienced by the individual or community and the way it should be approached from a clinical standpoint is highly influenced by cultural history” (p. 39), indicating that

defining trauma must also be culturally informed. Because the DSM-IV-TR is based in Western values and “norms”, non-Western responses to trauma that may be “normal” in other cultures are not accounted for in the current PTSD criteria. The DSM-IV-TR and current research and clinical practices do not account for all cultural expressions of post-traumatic symptoms, which may be subtle and nuanced (Ruchkin et al., 2005). As a result, researchers have argued for a more inclusive range of trauma responses in defining PTSD, and have suggested that PTSD may be a culture bound syndrome (Bracken, Giller, & Summerfield, 1995; Briere & Scott, 2006).

Another significant absence from the DSM-IV-TR is race-related traumas such as abuse (i.e., verbal and physical) that occurs as a result of an individual’s race or ethnicity (Scurfield & Mackey, 2001). Scurfield and Mackey (2001) observed that the words “racism” and “racist” are not included in the DSM-IV-TR and stated, “the silence in the DSM-IV-TR about race-related stressors is deafening” (p. 25).

In some ways, persecution and discrimination experienced in relation to one’s cultural background can be considered traumatic as it may significantly impact one’s sense of security, interpersonal relationships, and well-being (Scurfield & Mackey, 2001; Sorsoli, 2007). Racial oppression and violence can impact whole communities and populations and result in inter-generationally experienced trauma. Human-caused events such as African American slavery, Native American genocide, Nazi Holocaust, and Japanese American internment are examples of how prolonged traumas can be collectively experienced and passed on to future generations (Tummala-Nara, 2007). Tummala-Narra (2007) observed that “a racial or ethnic community’s collective memory of past traumas helps to create a ‘second generation’ of survivors” (p. 41). As a result of

these types of collective traumas, future generations of oppressed groups are often at increased risk for traumatic experiences. For example, Native American women are at greater risk for experiencing child abuse and neglect as well as sexual and physical assaults (Walters & Simoni, 2002).

Additionally, clients from racial and ethnic minority groups are often misdiagnosed when presenting with symptoms of anxiety, which may be misidentified as psychotic symptoms (Frueh, et al., 2002). For example, African American combat veterans who were diagnosed with PTSD endorsed more items indicative of psychotic symptoms on one self-report measure than did Caucasian American veterans in the same study, while other self-report measures used in the study did not glean a similar difference. The authors hypothesized that items in the measure may have represented trauma related dissociation rather than psychosis. Because beliefs about and attitudes towards trauma vary among and within cultural groups, mental health professionals may misidentify, and by extension misdiagnose, individual presentation and experiences as maladaptive (Antai-Otong, 2002).

Another example of the impact of culture on trauma responses was observed in a study that examined the effects of recent political wars on community responses to violence against Latin American women (Radan, 2007). The author proposed that women have largely been silenced in seeking help or reporting violent and sexual assaults and domestic violence due to an earlier, collective fear of terrorization by militarized police during the war. A common ancillary problem faced by Central American women is separation from primary support networks (e.g., family) due to patterns of migration that occur in response to violence. Experiences of immigration may then contribute to a

sense of multiple identities (e.g., the self that was known in the place of origin as well as the self, which may quite literally represent a new name, in the new home) that are perceived as maladaptive in north American cultures but that are quite adaptive in the context of Central American sociopolitical factors. Additionally, in many Latin American cultures, somatization of post-traumatic and anxiety symptoms is the cultural norm but such symptoms may not be reported unless directly asked. Therefore, Radan (2007) proposed that North American mental health professionals may miss or underestimate the effects of traumatic experiences on Central American trauma survivors, and women in particular.

Given the arguments related to defining trauma, and the evidence for the cumulative psychological effects of childhood sexual and physical traumas, described above, it was important to identify an operational definition of trauma for the purposes of this study. Because this dissertation study was conducted prior to the publication of the DSM-V, “trauma,” in the current study, was defined primarily using the description in the DSM-IV-TR with some modifications. McNally’s (2004) suggestion that the definition be limited to only direct experiencing or witnessing of serious threats to physical integrity (or death) was included in the operational definition. Indirect witnessing or vicarious experiencing of traumatic events (e.g. seeing a threatening event on television) was not included in the purposes of this study. Therefore the following parts of the DSM-IV-TR definition of trauma were used to define “trauma” for the purposes of this study:

direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or [directly] witnessing

an event that involves death, injury, or a threat to the physical integrity of another person. (p. 463)

Also, threats to physical integrity will include culturally-based traumas such hate crimes, aggressive verbal attacks, and threatening discrimination in which the individual perceives physical danger. Finally, events will only be qualified as traumatic if the individual experiences subjective fear, helplessness, or horror.

Trajectories of trauma. One widely held view is that individual outcomes following traumatic events fall into patterns of disruption or dysregulation, which are identified as trajectories (Bonanno, 2008). Existing research identified patterns “nonresponding” (i.e., no post-trauma distress), “partial responding” (i.e., some post-trauma distress), and “responding” (i.e., post-trauma distress) that comprise the basic trajectories of post-traumatic symptomology (Stein et al., 2012). According to Bonanno (2008), four, more specific, observed trajectories include a) a “chronic” disruption in functioning, b) a “delayed” onset of dysregulation that increases over time, c) “recovery” in which an initial interruption in typically stable functioning decreases over time and pre-trauma functioning is resumed, and d) “resilience” in individuals who maintain a relatively stable equilibrium in the aftermath of the traumatic event. To this end, “resilience” is distinguished from “recovery” in the context of post-traumatic trajectories in that resilient individuals present with minimal levels of symptoms that are commonly correlated with trauma responses (Bonanno, 2008) (e.g. ruminative thoughts related to the traumatic event, avoidance of elements associated with the trauma, and heightened levels of arousal following the trauma; DSM-IV-TR). Resilience is also distinguished from a fifth trajectory known as “post-traumatic growth”. Posttraumatic growth (PTG) refers to

individuals who are vulnerable to and often experience distress following trauma but also experience growth after the trauma (Tedeschi, Calhoun, & Cann, 2007). Levine, Laufer, Stein, Hamama-Raz, and Solomon (2009) highlight an important distinction between resilience and PTG: resilient individuals experience trauma and remain relatively unchanged while people who experience PTG make meaning and reconstruct their worldviews out of their struggle following the trauma. This section describes the negative trajectories of trauma as well as resilience, and PTG.

Negative trajectories of trauma. Traumatic experiences have been associated with negative outcomes that may be short-term or long-lasting (Bonanno, 2008). Indeed, some post-traumatic trajectories represent these negative consequences. Many of the negative outcomes of trauma are included in the DSM-IV-TR criteria for PTSD, including: “intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event,” “recurrent and intrusive distressing recollections of the event,” “efforts to avoid thoughts, feelings, or conversations associated with the trauma,” and “hypervigilance” (American Psychiatric Association, 2000, p. 468). While fear and helplessness are associated with PTSD, interpersonal difficulties, hostility, and anger have also been observed in the post-traumatic experience (Orth & Wieland, 2006; Taft, Watkins, Stafford, Street, & Monson, 2011). Many types of traumas and intense stressors have been associated with the etiology of PTSD symptoms, including: war, terrorist attacks, natural disasters, childhood sexual abuse, domestic violence, rape and sexual assault, sex trafficking, torture, violent crimes, and life-threatening illness (Woo & Keatinge, 2008). The most common traumatic events that are associated with the onset of PTSD symptoms are adult sexual

abuse, childhood physical abuse, and physical assaults related to military experiences (Brewin, Andrews, & Valentine, 2000; Clancy et al., 2006).

While the symptom criteria of PTSD included in the DSM-IV-TR capture the psychological distress that can emerge from traumatic experiences, the specifiers included in the diagnosis for the disorder highlight the negative trajectories that have been observed in trauma literature. In the DSM-IV-TR, “chronic” is used to specify PTSD symptoms that have lasted three months or longer (American Psychiatric Association, 2000) which corresponds to the “chronic” trajectory of distress following trauma exposure when the negative response is sustained and long-lasting (Bonanno, 2008). The specifier “with delayed onset” is used in the DSM-IV-TR to refer to PTSD symptoms that onset at least six months after the traumatic event (American Psychiatric Association, 2000) which parallels the “delayed” trajectory when distress is observed after a period of time has passed and continue to increase as time progresses (Bonanno, 2008). Finally, the “acute” specific in the DSM-IV-TR diagnosis of PTSD connotes symptoms that last for less than three months (American Psychiatric Association, 2000). A similar trend is observed in the “recovery” trajectory as initial distress quickly abates and pre-trauma functioning in maintained over time (Bonanno, 2008). These negative trajectories of post-traumatic responses appear to align with the psychological distress that can follow traumatic experiences, which are captured in the DSM-IV-TR diagnosis of PTSD; however, these are not the only outcomes of traumatic experiences and are not the only potential patterns in functioning following trauma.

Although there appear to be some symptom responses to traumatic experiences that are generally consistent across cultures, such as social withdrawal, sleep problems,

difficulty concentrating, and guilt, the impact and effects of trauma is clearly not universal (Antai-Otong, 2002). Culture appears to have important impacts on symptomatic expressions of trauma. For example, Salvadorian refugees, and other Central American groups, often exhibit somatic expressions of trauma-related distress such as stomach pains and discomfort, headaches, and extreme body heat, which appear to be more acceptable than verbally expressed emotions (Tummala-Nara, 2007).

Also, negative race-related experiences appear to be related to negative psychological outcomes (Clark, Anderson, Clark, & Williams, 1999; Jackson et al., 1996; Scurfield & Mackey, 2001). Specifically, researchers have observed a relationship between racial discrimination and perceived racism and psychological distress (Jackson et al., 1996) including negative effects of physical and psychological health (e.g., paranoia, anger, and anxiety). Other research indicates that difficulties in interpersonal relationships and confusion and/or ambivalence related to one's racial identity are also common outcomes of negative race-related experiences (Scurfield & Mackey, 2001). Factors that may contribute to the impact of the negative race-related experience include severity, onset, and frequency, as well as the individual's role in the event (e.g., guilt, anger).

Therefore, an individual's cultural experience or context may be impacted or be related to experiences of and responses to trauma, particularly amongst groups who experience culturally-based oppression. In this way, cultural context plays an important role in understanding an individual's post-traumatic experience. The next sections discuss two other trajectories of trauma: resilience and post-traumatic growth.

Emergence of resilience research. The majority of early trauma research focused on individuals who did not cope well following exposure to trauma, whereas limited attention was given to resilient individuals (Lyons, 1991). Yet, as Lyons (1991) observed over twenty years ago, it was established that the majority of individuals exposed to trauma appeared resilient and represented a wide range of post-trauma adaptations, even though long-term outcomes in response to trauma were largely unknown.

The first generation of resiliency research sought to identify risk and protective factors of resiliency, which appeared relevant when resilience was widely believed to be a personal characteristic (Pan & Chan, 2007). Risk factors included individual characteristics (Lyons, 1991; Pan & Chan, 2007) such as psychiatric history (Bonanno, 2008; Pan & Chan, 2007), difficulty with pre-trauma coping (Bonanno, 2008; deRoon-Cassini, Mancini, Rusch, & Bonanno, 2010; Lyons, 1991), and low intelligence (Bonanno, 2008) as well as long-term environmental issues (Pan & Chan, 2007) such as limited social support (Bonanno, 2008; Ellis et al., 2009; Lyons, 1991), limited access to educational experiences (Bonanno, 2008), and community stressors (Pan & Chan, 2007). Bonanno (2008) hypothesized, “It seems likely that at least some of these factors, if inverted, would predict resilient functioning (p. 107).” Therefore, observed protective factors included consistent support networks of significant individuals (Lyons, 1991) and increased access to and participation in education (deRoon-Cassini et al., 2010). The ability to find meaning in the outcomes of traumatic experiences and other stressors has also been observed as a protective factor (Lyons, 1991).

de-Roon-Cassini and colleagues (2010) indicated that the nature of the trauma itself impacts resiliency. That is, trauma that is perpetrated by another person is more

likely to result in chronic distress while accidental trauma is more likely to result in resilience (de-Roon-Cassini et al., 2010). Also, Lyons (1991) hypothesized that some personality characteristics may increase the likelihood of trauma exposure. Therefore, it appears that a variety of factors, such as the nature of traumatic experiences and personality characteristics, impact the individual's post-traumatic response. Still, de-Roon-Cassini and colleagues suggest that continued understanding of resiliency requires the need for further research to thoroughly identify protective and risk factors that influence post-traumatic trajectories. Continued inquiry in this area will likely increase understanding of how a variety of variables impact post-trauma response trajectories in varied populations over long periods of time.

These findings and implications for further study highlight the shift to the second generation of resilience research, which sought to understand the underlying processes of how protective factors mediate risk factors that influence responses to trauma exposure (Pan & Chan, 2007). The second generation of resiliency research brought a shift from examination of static traits that emerged with the first generation of the research to the focus on resilience as a process. With the shift in focus, researchers viewed the process of resilience as a balance of both risk and protective factors that propel individuals through the stressful event and its aftermath. In both generations of research, literature related to trauma and resiliency frequently highlights the unique experiences of the individual (Bonanno, 2008; Pan & Chan, 2007).

Accordingly, the individual's culture and context must be considered in the resilience trajectory. Tummala-Narra (2007) observed that communities of people that face traumatic events, such as racial violence, can develop "collective resilience" as

shared hope and trusting relationships are developed to promote survival. Also, consistent family support has been observed to be a form of resilience among culturally diverse populations (Banyard, Williams, Siegel, & West, 2002; Hernandez, 2002). Spiritual beliefs and creative expression have been found to contribute to effective coping in some ethnic minority groups (Walters & Simoni, 2002). Similarly, cultural and spiritual beliefs can provide a buffer against the negative effects of trauma and encourage individuals to silently endure intrapsychic pain for the broader good of the community (Tummala-Narra, 2007). Also, strong cultural identities have been associated with resilience, indicating that connection to culture and history can buffer against distress for families confronted with multiple stressors (Clauss-Ehlers, Yang, & Chen, 2006). Indeed, Westphal and Bonnano (2007) observed that, “the multiple pathways to resilient outcomes undoubtedly vary in adaptive value across different people, situations, and cultural contexts” (p. 425).

Defining resilience. In addition to variation in individual experiences, definitions of “resilience” within the literature vary widely. Many psychologists and mental health professionals regularly use the term but it has been difficult to define because it frequently appears to be used in broad reference to “coping” (Miller, 2003). Elements of commonly used operational definitions of “resilience” include the absence of pathology or PTSD, adaptive behavior, and the ability to go on in the face of adversity (Levine et al., 2009; Miller, 2003). When taking the perspective that resilience is a personal trait, which was common in earlier resilience research, resilience was defined as a set of characteristics, which develop out of adverse and stressful experiences, that allow the individual to “rebound” from challenges (Pan & Chan, 2007). When taking the view that

resilience is an individual process, which emerged in the second generation of resilience literature, resilience was defined as not as a stable set of traits developed through earlier experiences, but as the ongoing interaction between the individual and the environment in which the individual is able to draw from both internal and external resources to adapt to changing stressors in a range of ways (Pan & Chan, 2007).

Yet, Pan and Chan's (2007) work indicates the need for more thorough and clear definition of resilience to aid general understanding. Miller (2003) suggests components to be resolved to develop a unified understanding of the term, including distinction from other positive outcomes that have been observed in trauma research. He questions to what degree must an individual experience "success" after trauma in order to be perceived as resilient and whether resilience occurs only after severe trauma or if it is also observed following less significant stressors (Miller, 2003). Thus, for the purposes of this study, "resilience" will be used to refer to the experience of an individual exposed to trauma (as defined previously) in which minimal disruption occurs and few symptoms of mental disorder emerge.

Because of varied definitions of resilience, it appears that measured rates of resilience range within the literature (Pan & Chan, 2007). Given the spectrum of definitions of "resilience", measured rates of resilience in populations of people who experience trauma span from an estimated 10% to 70% in research. This variance is likely related to conceptualization of types of trauma as well as perceived ability to adapt to the traumatic experience (Pan & Chan, 2007).

Miller (2003) identifies that although the concept of resilience is frequently and broadly applied to clients across the lifespan, most research into resilience have occurred

in younger populations. Despite this dearth of empirical evidence, the concept is implicitly applied to adult populations (Bonanno 2008; Miller, 2003). This indicates again the importance of comprehensive conceptualization of the term that should stem from empirical research that can be generalized across the lifespan. Therefore, continued research must occur with populations of adults who experience trauma. To this end, understanding of contemporary views of trauma trajectories aids in defining resilience.

Resilience as a trajectory of trauma. Recent studies of individuals who were hospitalized for severe physical injury following a single-incident traumatic injury found that the four widely accepted post-trauma response trajectories (chronic, delayed, recovery, and resilience) hold true for people within the first six months of rehabilitation for traumatic injury (de-Roon-Cassini et al, 2010; Quale & Schanke, 2010). Moreover, these studies (de-Roon-Cassini et al, 2010; Quale & Schanke, 2010) concluded that the majority of individuals maintained generally stable functioning with minimal or no symptoms of PTSD during the initial rehabilitation period. Additionally, Quale and Schanke (2010) observed that exposure to one traumatic event resulting in severe injury increased membership rates in the resilience trajectory while exposure to multiple or concurrent stressors decreased rates of resilience. Therefore, their findings suggest that levels of resilience likely change over the course of the lifetime and support Bonanno's (2008) hypothesis that resiliency, which is a unique and individualized experience, following trauma exposure is more common than has historically been believed.

However, de-Roon-Cassini and colleagues' (2010) study did not incorporate the post-traumatic growth trajectory as has been observed in other literature related to resilience. Similarly, because of the structure of Quale and Schanke's (2010) study,

which assessed individuals immediately following traumatic injury, post-traumatic growth was not measured. A major limitation of the authors' (Quale & Schanke, 2010) use of the "distress" trajectory rather than the chronic and delayed trajectories that have been identified in other related literature is that individuals may have been categorized into trajectories that do not reflect their long-term outcomes. As such, it appears that the findings of this study can only be generalized in the immediate aftermath of traumatic injury. A longitudinal approach would likely provide more information about response patterns. To this end, these studies (de-Roon-Cassini et al, 2010; Quale & Schanke, 2010) highlight the need for additional research that is conducted long after the trauma occurs to inform clinical implications. Also, the exclusion of the post-traumatic growth model may similarly overlook important factors that will inform understanding of and interventions for people who are exposed to trauma.

Understanding resilience. Current views of trauma trajectories, or patterns of behaviors and functioning following exposure to trauma, indicate that individual responses to traumatic incidents vary widely amongst survivors and can even vary within an individual throughout the lifespan (Bonanno, 2008; de-Roon-Cassini et al., 2010; Quale & Schanke, 2010). Moreover, the factors that may enhance resilience in one area may not necessarily be generalized across all experiences for an individual (Bonanno, 2008). Given the wide variance in individual responses to trauma exposures, it appears that attention must be given the impact of context and culture on those responses. Protective factors likely vary across cultures, but some commonalities have been noted, such as the role of social support in coping. For example, "family resilience" has been

observed in Chinese cultures when individuals within the family face stressors outside of the family system (Pan & Chan, 2007).

Despite advances in understanding the construct, resilience has frequently been misunderstood. Researchers and clinicians most frequently expect some level of dysregulation in response to trauma (Bonanno, 2008). Yet as has been observed in other related literature, PTSD symptoms, which have previously been anticipated to occur in response to traumatic experiences, are not actually the normal response trajectory for individuals who experience trauma. Studies have shown that many adults are able to experience trauma and maintain generally stable equilibrium, which has been referred to as “resilience.”

Clinical implications of resilience. When mental health professionals assume that significant emotional disruption will occur as a result of trauma, resilience can even be viewed as maladaptive (Bonanno, 2008). It appears then, that resilience may be more common than has been accepted in the mental health professions.

People from Western cultures who hold assumptions that tend to view physical traumas and loss in functioning as devastating and finite contribute to the general belief that individuals who experience such loss cannot return to pre-trauma life (Quale & Schanke, 2010). Quale and Schanke (2010) proposed that the cultural underestimation of human capacity for resilience stems from the “insider-outsider distinction.” That is, “outsiders,” or people not within the population, are most likely to conduct research into what the experience of being “inside” the population is like. Therefore, they are likely to make more negative assumptions about the “insiders” experiences than the “insiders” themselves actually experience. In rehabilitation psychology, this phenomenon

frequently means that psychologists expect severe physical injury that results in disability to be highly emotionally devastating while people who experience these injuries are actually able to identify positives in their recovery and are even surprised by their own ability to cope.

Given the belief that post-traumatic dysregulation is normal, practitioners have historically assumed that debriefing immediately after a traumatic event will ultimately decrease later disruption. Contrary to this assumption, recent empirical evidence suggests that debriefing is largely ineffective and Bonanno (2008) posits that it may even reduce one's natural level of resilience and contribute to higher levels of individuals who experience the recovery trajectory.

Bonanno (2008) indicates that increased efforts are required for understanding factors that contribute to and enhance resilience. It is likely that deepened understanding of resilience will result in development and utilization of resilience-based interventions in clinical practice (Quale & Schanke, 2010).

Growth models. Although agreement on a theoretically grounded definition of personal growth seems difficult at best, some have argued for such a definition in order to assist clinicians in their understanding of “mental health” as more than the absence of pathology (Robitschek & Keyes, 2009). According to Sheldon, Kasser, Smith, and Share (2002), models of growth can be conceptualized as belonging to two basic processes: stage models of personality development and “catastrophe” models.

Stage models (e.g., Erikson, 1963) provide the common perspective that growth occurs through the successful negotiation of transitions between developmental life stages. In one such model, Hy and Loevinger (1996) explained that from a

developmental perspective, psychological growth typically includes increased self-awareness, self-acceptance, and social integration.

Baltes, Staudinger, and Lindenberger (1999) offered another developmental framework for the conceptualization of growth in which growth is defined as reaching higher levels of adaptive capacity and functioning. These authors departed from the unidimensional, age-related developmental approach and contended that allocation of resources for the purpose of growth is predominantly influenced by dynamic interactions between multiple biological and cultural factors within the context of an ever-changing society. Furthermore, the potential for growth is present throughout the lifespan as adaptive challenges from multiple biological and cultural interactions continue to present themselves.

A third example of a stage model is Keyes' (2002) personal growth initiative, which conceptualized mental health and personal growth as including three domains established through factor analysis: emotional, psychological, and social well-being. This model suggests that personal growth is multidimensional and occurs when one moves along a continuum toward well-being in these three areas.

Finally, from a humanistic perspective, Rogers (1961) considered growth as a process in which one moves toward becoming more of his or her own potentialities and operating as a fully functioning person who is engaged with life more fully and authentically. Rogers (1977) described this actualizing tendency of human beings as basic to human motivation. According to his theory, life is an active, not passive process in which organisms have an innate basic tendency toward self-regulation and away from

control by external forces. For these reasons, Rogers (1977) portrayed individuals achieving growth as those who are

coming closer to being whole persons – who are moving toward a knowledge of, and harmony with, their innermost experience, and who sense, with an equal lack of defensiveness, all the data from the persons and objects in their external environment. These persons would constitute an increasing flow of wisdom and action. (p. 251)

The second perspective on psychological growth is offered by “catastrophe” models (Sheldon et al., 2002), which focus on the growth that occurs following traumatic situations (Tedeschi & Calhoun, 2004) or dramatic changes in a person’s life situation (Showers & Ryff, 1996).

The belief that adverse experiences have the potential to lead to positive change has long been held throughout history (Tedeschi et al., 2007). For example, numerous world religions, including Christianity, Judaism, Hinduism, and Islam, include elements of the meaning and transformational qualities of suffering (Sheikh, 2008; Tedeschi et al., 2007). Additionally, in the field of psychology, positive psychologists cite the works of people such as Victor Frankl (Tedeschi et al., 2007) and Carl Rogers who reflected on the concept of growth in the face of adversity (Sheikh, 2008). Although the study of responses to trauma has often focused on the negative outcomes of traumatic events, recent psychological research has sought to increase understanding of growth (Tedeschi & Calhoun, 1996; Tedeschi et al., 2007), which Sheikh (2008) described as “the paradox that profound personal value can arise out of profound personal tragedy” (p. 86).

The study of positive outcomes of trauma emerged as reports of growth following exposure to trauma became increasingly common (Tedeschi & Calhoun, 2004).

According to the catastrophic perspective, growth occurs in response to emotional traumas (Tedeschi & Calhoun 1995) that result in dramatic change in circumstances (Showers & Ryff, 1996) and challenge individuals' existing understanding of the world in which they live (Tedeschi & Calhoun, 2004). Exposure to traumatic events then leads some individuals to reconceptualize their understanding of the world and reformulate assumptions to accommodate these difficult experiences (Tedeschi & Calhoun, 2004). For this group of people, significant life stressors can lead to increased insight, sense of meaning, well-being, connectedness, spirituality and interpersonal values (Tedeschi & Calhoun, 1996; 2004).

The "organismic valuing process" refers to the theory of growth that states that individuals are intrinsically motivated toward reconstructing their assumptive worlds in the aftermath of trauma in a way that is consistent with their pre-existing, personal tendencies toward growth and actualization (Linley & Joseph, 2005). Stemming from this theory, the process of formulating positive understanding from traumatic experiences in the growth process (Levine et al., 2009) is referred to in a variety of growth-related terms including post-traumatic growth, adversarial growth, benefit finding, stress-related growth, thriving, optimism, and hardiness (Tedeschi & Calhoun, 2004; Tedeschi et al., 2007). The concept of post-traumatic growth provides a thorough explanation of the process of growth following traumatic experiences in a way that is consistent with the model of post-traumatic trajectories, and appears to be the most fitting for conceptualizing the positive outcomes that arise from the struggle of coping with trauma.

The following subsections, therefore, highlight the distinction between resilience and post-traumatic growth and expand upon the definitions of PTG from the literature by describing the domains of change frequently observed in individuals who experience PTG and the process in which PTG occurs. It then describes how PTG has been assessed and what factors it has been related to, and concludes with clinical implications.

Resilience and post-traumatic growth. Resilience and post-traumatic growth represent different outcome trajectories of trauma. Instead of using the term resilience, Bonanno (2008) used the term “recovery” to describe the trajectory of individuals who initially experience some level of distress in the aftermath of traumatic experiences. This process does not appear to characterize what Tedeschi and colleagues (2007) conceptualized as post-traumatic growth as it lacks the growth element

Yet, because the terms have often been used interchangeably in the literature, Levine and colleagues (2009) sought to clarify their relationship. Resilience typically refers to a combination of personal characteristics and ability to use those traits in response to trauma that allow individuals to carry on with minimal distress or interruption in functioning, whereas post-traumatic growth appears to represent the pattern of initial vulnerability and distress following trauma that ultimately leads to a process of coping that results in positive outcomes, meaning-making, and changed behaviors (Levine et al., 2009).

Defining post-traumatic growth. Just as resilience has been viewed as both a personal trait and process that changes over the lifetime (Pan & Chan, 2007), post-traumatic growth has been viewed in both perspectives. As a trait, post-traumatic growth has been perceived as a resource that contributes to resiliency (Hobfoll et al., 2009).

However, when viewed as a process, post-traumatic growth is believed to develop over time, as the individual is able to cognitively process traumatic experiences (Salsman Segerstrom, Brechting, Carlson, & Andrykowski, 2009; Tedeschi et al., 2007).

PTG has frequently been defined in the literature as “positive psychological change experienced as a result of the struggle with highly challenging life circumstances” (Tedeschi & Calhoun, 2004, p. 1). Regarding the experiences after which PTG can occur, Tedeschi and Calhoun (2004) posited that PTG can grow out of a variety of distressing events, which they refer to as emotionally “seismic.” That is, they liken traumas, or psychological crises, to earthquakes that challenge the individual not only physically but also emotionally in terms of their assumptions and worldviews, safety, and even personal identity (Tedeschi & Calhoun, 2004). In this way, their definition of “trauma” appears broader than the definition held in the DSM-IV TR, which describes trauma as experiencing or witnessing a threat to the physical integrity of the self or another person that results in fear, helplessness, or horror (American Psychiatric Association, 2000).

The positive psychological changes in PTG can further be understood as the process of strengthening self-perception, ability to relate to others, and meaning of experiences following exposure to trauma (Mols, Vingerhoets, Coebergh, & van de Poll-Franse, 2009). Similarly, Tedeschi and Calhoun (1996; 2004) observed five domains in which these changes occur: changed perception of the self, increased appreciation for life, sense of new possibilities, spiritual change, and perceived improvements in interpersonal relationships.

Domains of change. First, their work indicates that changes in self-perception (i.e., sense of strength and sense of vulnerability) are common amongst individuals who experience PTG. Increased sense of strength includes self-reliance and an increased sense of competence and assertiveness in facing later challenges, which often stems from having lived through a traumatic experience (Tedeschi & Calhoun, 1996). Frequently, as individuals cope with trauma, their beliefs in their abilities to cope with other challenges strengthen (Sheikh, 2008). At the same time, individuals who experience PTG are usually confronted with their own vulnerability (Sheikh, 2008; Tedeschi & Calhoun, 1996). This paradox of both strength and vulnerability is characteristic of the perception of the self as able to cope with the inevitable trials that the individual will encounter (Tedeschi & Calhoun, 2004).

Second, people who experience PTG frequently report an increased appreciation for life, which includes reorganizing priorities, living life to the fullest each day, and recognizing the value of their lives (Tedeschi & Calhoun, 1996). This occurs as individuals reprioritize aspects of their lives that were previously viewed as unimportant, including elements that may have been taken for granted (Tedeschi & Calhoun, 2004). Recognizing the value in even simple experiences can also lead to changed approaches to daily life (Tedeschi & Calhoun, 2004). Thus, increased appreciation for life is often conceptualized as a “changed sense of what is important” (p. 6).

Closely related to increased appreciation for life is the domain of identification of new possibilities. These new possibilities refer to new paths or directions in life that the individual may recognize in the aftermath of the traumatic event (Tedeschi & Calhoun, 2004), including career choice and commitment to social causes (Sheikh, 2008).

Spiritual change is the fourth domain of change in PTG, which is not limited to religious individuals (Sheikh, 2008; Tedeschi & Calhoun, 2004). Spiritual growth encompasses strengthening of beliefs (Tedeschi & Calhoun, 1996) and meaning from connection to something greater than the self, which is not limited to traditional concepts of God but also includes views of nature and the universe (Sheikh, 2008). This area of growth may occur as increased processing of existential questions (Tedeschi & Calhoun, 2004) may alter the individual's assumptions or beliefs about life's meaning (Tedeschi & Calhoun, 1996). Similarly, spiritual growth may contribute to the individual's recognition of meaning related to the trauma itself (Tedeschi & Calhoun, 1996). Forgiveness is also frequently related to spirituality and religious practice, which has implications for the PTG experience (Schultz, Tallman, & Altmaier, 2010). That is, intrinsic religiosity and religious practice may provide avenues for meaning-making and many world religions encourage forgiveness. Forgiveness can be a pathway to release negative emotions and provide the individual with a sense of purpose (Schultz et al., 2010). Spirituality and faith can lead to a sense of strength during periods of vulnerability associated in the aftermath of trauma (Tedeschi & Calhoun, 2004).

Fifth, a sense of improved quality of relationships with others is not uncommon in the experience of PTG. These relational improvements include deepened connection to members of the social support network (Tedeschi & Calhoun, 1996) as well as the loss of other relationships (Tedeschi & Calhoun, 2004) as trauma survivors determine who their "real friends" are (Sheikh, 2008). Individuals who experience PTG frequently separate from unhealthy relationships that lack meaning, while fostering existing relationships, and even initiating new ones, of a deeper level (Sheikh, 2008). These types of changes in

relationships likely stem from the individual's increased sense of empathy towards others (Tedeschi & Calhoun, 1996) and, simultaneously, the increased motivation to maintain meaningful and healthy relationships (Tedeschi & Calhoun, 2004). In this way, the relational experience in the post-traumatic growth is significant (Calhoun & Tedeschi, 1999) and social support is an important element of the process (Prati & Pietrantonio, 2009). Social support and post-traumatic growth will be discussed later in this chapter.

The post-traumatic growth process. It is also helpful to underscore the importance of the term struggle in the definition of PTG, since PTG does not occur as a direct byproduct of traumatic experiences but instead develops out of the individual's struggle to face those experiences (Tedeschi & Calhoun, 2004). More specifically, Tedeschi and Calhoun (2004) present a model for understanding the development of PTG in the aftermath of experiencing traumatic events. Their model involves an initial trauma that is followed by six components that lead to post-traumatic growth observed across the domains of change described previously. The six elements involved in the PTG process are distress following the exposure to trauma, ruminations or intrusive thoughts of re-experiencing the event, cognitive processing of the experience and its aftermath, self-disclosure of the event, the use of social support in restructuring schemas and beliefs following the traumatic experience (Sheikh, 2008; Tedeschi & Calhoun, 2004). This model for understanding the process of PTG does not reflect a linear phase or stage process (Tedeschi & Calhoun, 2004); instead, it incorporates factors that contribute to the overall experience of PTG (Sheikh, 2008). Therefore, the six components, which are described next, allow individuals to move towards growth while experiencing disruption initiated by trauma (Sheikh, 2008; Tedeschi & Calhoun, 2004).

The PTG process begins with a pre-trauma level of functioning that is interrupted by a traumatic event, which causes distress (Salsman et al., 2009; Tedeschi & Calhoun, 2004). Although Tedeschi and Calhoun's (2004) definition of trauma is broad, they clarify that the event that triggers the PTG process must challenge the way the individual views and functions in the world. Similar to the development of PTSD, PTG occurs out of the psychological distress caused by the traumatic experience (Salsman et al., 2009). Sheikh (2008) summarizes the distressing catalyst of Tedeschi and Calhoun's (2004) PTG process aptly: "According to this model, a trauma is an event that profoundly challenges an individual's fundamental schemas, beliefs, goals, as well as the ability to manage emotional distress, and profoundly affects that individual's life narrative" (p. 87).

The disruption to the individual's way of being initially presents in ruminative thoughts related to the traumatic event, which is the second element of the PTG process (Salsman et al., 2009; Sheikh, 2008; Tedeschi & Calhoun, 2004). The term "ruminations" refers to conscious, themed thinking that recurrently occur in absence of direct environmental cues but are instead easily cued due to the relationship between the thoughts and the individual's goals (Martin & Tesser, 1996). Ruminative thoughts following exposure to trauma are often related to the individuals' attempts to make sense of the incongruity between their existing schemas and the unfathomable event experienced (Tedeschi & Calhoun, 2004). These intrusive and recurrent thoughts are the individual's first intrapsychic attempt to work through the traumatic experience (Salsman et al., 2009; Tedeschi & Calhoun, 2004). Although ruminations of traumas may contribute to symptoms of PTSD, they also give way to cognitive processing which leads

to positive outcomes including meaning-making and integration of understanding of events (Salsman, et al., 2009).

Cognitive processing is the third element of the PTG experience. It is the term that Tedeschi and Calhoun (2004) use to describe the progression from ruminating, which connotes negative, intrusive thinking, to working through thoughts related to traumatic experiences. Cognitive processing occurs through repeated exposure to memories and thoughts related to the trauma. Whereas ruminations are associated with distress, cognitive processing facilitates useful thinking that results in effective adaptation to the psychological challenges initiated by the trauma (Salsman et al., 2009). In contrast to ruminations, in which individuals focus on personal goals that they believed they could achieve but were made unattainable by the trauma (Martin & Tesser, 1996), cognitive processing occurs as individuals release those unattainable goals and begins to move forward with new, adapted and realistic self-goals (Tedeschi & Calhoun, 2004). It is argued that cognitive processing is central to PTG as attempts to manage ruminations and cognitive assessments of the trauma provide positive and effective accommodation that allows the individual to work the traumatic experience into an adapted worldview (Sheikh, 2008). In this way, the individual is able to process the experiential information of the trauma that caused significant emotional disruption. Cognitive processing facilitates intellectual and emotional understanding of the traumatic event that is incorporated into the individual's way of viewing and functioning in the world (Tedeschi et al., 2007).

Salsman and colleagues (2009) examined associations between colorectal cancer survivors, PTG, PTSD symptoms, other mental health issues including symptoms of

depression and anxiety, and the role of cognitive processing in the aftermath of cancer diagnosis. Their findings suggest that the type of cognitive processing is related to PTSD symptomology and PTG. That is, intrusive, ruminative processing was more frequently correlated to symptoms of PTSD, as well as depression and anxiety while more effortful, deliberate processing and cognitive rehearsal were more frequently associated with PTG and not other diagnostic symptoms (Salsman et al., 2009). However, Salsman and colleagues (2009) observed that the data set was gathered from participants approximately thirteen months after initial diagnosis; they note that participants may require additional time to process negative cognitions and develop PTG. Therefore, it was recommended that further study of PTG occur in longitudinal designs (Salsman et al., 2009), which was supported by Mols and colleagues (2009) in their recommendations for continued inquiry.

Another study examined cognitive processing and PTG among stroke survivors (Gangstad, Norman, & Barton, 2009). More specifically, Gangstad and colleagues (2009) studied PTG experiences, cognitive processing of traumatic events, symptoms of depression and anxiety, as well as a variety of demographic factors in a sample population of 60 stroke survivors (self-identified “White British” adults between the ages of 41 and 88 years at an assessment and rehabilitation center in the United Kingdom) who had all experienced strokes 5-99 months prior to the time of the study. Their findings indicated that stroke survivors indeed experienced PTG, albeit at somewhat lower levels than other survivors of medically related traumas (e.g., breast cancer; Gangstad et al., 2009). Cognitive processing in particular was observed to connect with reported experiences of PTG, such that increased levels of PTG were found with the

following types of cognitive processing: restructuring, downward appraisals, perseverance, and denial. Additionally, the findings suggested that PTG rates increased with longer periods of time since the stroke event, which was consistent with PTG theory that PTG takes time to emerge (Tedeschi & Calhoun, 1995). However, like previous studies that were limited in the time since trauma (e.g., Salsman et al., 2009), the average length of time since the traumatic events in this study was fairly short (i.e., an average of 32.03 months; Gangstad et al., 2009). These results provide further support for longitudinal studies, as suggested by Salsman and colleagues (2009) and Mols and colleagues (2009).

Self-disclosure is the fourth element of the PTG process and is related to the area of cognitive processing. In trauma literature, disclosure is defined as client that consist of the following: (a) descriptions of a traumatic event; (b) evaluative content about the traumatic event (e.g., beliefs, attitudes, or thoughts); and (c) affective content (e.g., feelings and/or emotions related to the traumatic event; Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rimé, 2001). In PTG literature self-disclosure refers the individual's attempt to decrease the level of emotional distress caused by the trauma and related thoughts through cathartic expression, which includes written and verbal expression (Sheikh, 2008). There is no decisive evidence that indicates whether written or verbal disclosure is more beneficial to PTG. For example, journal writing appears to provide opportunities for and aid cognitive processing and disclosure. Conversely, social constraint, or inhibition, appears to inhibit cognitive processing and block disclosure of trauma, and trauma-related cognitions, to important supports (Tedeschi & Calhoun, 2004). Therefore, the ability to express, in a variety of

ways including talking and writing (Sheikh, 2008), is an important element of cognitive processing (Tedeschi & Calhoun, 2004). The process of disclosure to supportive others then provides the individual with additional perspectives that can be integrated into the change process (Tedeschi & Calhoun, 2004). In this way, self-disclosure, and the perspective gained from it, contributes to the individual's reconstruction of the personal narrative (Sheikh, 2008). In this way, the element of releasing cognitions related to the traumatic experience through disclosure to others appears to facilitate cognitive processing and links the post-traumatic experience to empathic understanding from the social support network.

Social support, which is the fifth area of the PTG process, is closely related to self-disclosure. The use of social support often plays an important role in the experience of PTG (Tedeschi & Calhoun, 2004). Specifically, the elements of seeking social support in coping with the trauma and feeling satisfied with those supports are associated with PTG (Sheikh, 2008). The quality and stability of the social support system impacts the degree of empathic understanding the individual receives when thoughts and feelings related to the trauma are disclosed (Tedeschi & Calhoun, 2004). For example, individuals with a ruminative coping style are likely to seek and benefit from social support, despite initial discomfort around discussing the trauma; these individuals are less likely to experience depressive symptoms when they seek social support (Nolen-Hoeksema & Davis, 1999). In this way, it appears that accessibility to positive and effective supports provides individuals who have experienced trauma with opportunities for self-disclosure and verbal processing of cognitions with empathic people in their

lives. The role of social support in the experience of trauma will be further discussed in the next section.

Finally, as each of these elements is processed and the individual conceptualizes growth, a reduction in distress is observed. The final piece of the PTG process occurs with opportunities for new schemas and a revised self-narrative (Tedeschi & Calhoun, 2004). It should again be noted that even as growth occurs, some degree of distress may concurrently persist. Ongoing distress contributes to further cognitive processing which facilitates growth in other areas (Sheikh, 2008). In this way the PTG experience is not a linear development but rather an “ongoing and interactive” process (Tedeschi & Calhoun, 2004, p. 12).

Time and post-traumatic growth. The role that time plays in PTG is still in debate. Some researchers have indicated that PTG is an effective coping strategy in the immediate aftermath of trauma exposure, but others have suggested that it is an ongoing process that emerges over time (Sawyer, Ayers, & Field, 2010), and still others believe that post-traumatic growth occurs after the traumatic experience. The findings of a meta-analysis help to clarify confusion in the PTG literature related to the factor of time in the PTG process (Sawyer et al., 2010). Sawyer and colleagues (2010) suggest that PTG may initially be used as an adaptive coping technique to deal with the threat to physical integrity, while over time PTG increases to become more enhancing of overall well-being.

Supporting Sawyer et al.’s (2010) understanding of the time factor, Mols and colleagues’ (2009) study of breast cancer survivors ten years after initial diagnosis and treatment found higher levels of life satisfaction related to interpersonal relationships,

appreciation for life, and personal growth than in the general population of women who did not experience cancer. More specifically, they reported that benefit finding and post-traumatic growth are separate but related constructs. Benefit finding refers to finding value in adversity, whereas PTG refers to the process of successful coping that emerges from the struggle with the post-traumatic experience (Mols et al., 2009). Mols and colleagues (2009) explained that benefit finding may be more likely to occur in the immediate aftermath of diagnosis while post-traumatic growth is a longer process requiring more time to develop.

Other research highlighted the need for more longitudinal research on PTG. Hobfoll and colleagues' (2009) study measured levels of distress in individuals exposed to the traumatic events of the Second Intifada within four years of the experience. Their findings suggest that the majority of individuals included in their sample experienced the chronic distress trajectory. However, these individuals were likely continuously exposed to residual threats of trauma and ongoing unrest in their communities. As a result, these individuals may not have been provided with ample time in which to cope with the traumatic events to which they were exposed. Given more time without trauma exposure, alternative response trajectories, such as PTG, may emerge (Tedeschi et al., 2007). In sum, the nature of post-traumatic growth is a process that occurs over time, and is in need of further research with diverse populations to examine/confirm existing hypotheses.

Post-traumatic growth assessment and correlates. This subsection begins by introducing some methods for measuring and assessing PTG. It then shares information regarding populations studied and correlates of PTG in recent studies involving TPI.

PTG has been measured using a variety of methods including self-report measures, reports of individuals' functioning by others, and studies of relationships in which couples report on the shared relationship. The Posttraumatic Growth Inventory (PTGI) is the self-report measure frequently used in PTG research. Tedeschi and Calhoun developed the PTGI as an instrument to measure perceived benefits of a wide variety of traumatic experiences. In developing this self-report inventory, they reviewed existing literature on perceptions of benefits stemming from exposure to trauma. Their review found three general areas in which benefits were perceived: changes in the self, changes in interpersonal relationships, and changes in life philosophy. They then created inventory items worded to reflect positive change in these areas; the measure used a Likert scaling in which respondents were asked to rate their experience from no change in that area to great change in that area. Through a series of studies, Tedeschi and Calhoun (1996) attempted to validate and standardize their measure of PTG. Their work resulted in a 21-item, self-report inventory that shows internal consistency, test-retest reliability, and appears to measure PTG stemming from a range of stressful and traumatic events (Tedeschi & Calhoun, 1996).

However, Tedeschi and Calhoun (1996) note that the primary limitation of the development of the PTGI stems from the generalizability of the college-student population in which the measure was normed to the general population. Tedeschi and Calhoun (1996) assert that the results of their studies and the applicability of the PTGI can indeed be generalized to the broader population due to the nature of "significant" and "severe" traumas reported by participants in the development of the measure. Additionally, Sheikh (2008) observed that the domains of growth measured in the PTGI

mirror domains of change examined throughout PTG literature including in qualitative and descriptive research. For example, Woodward and Joseph (2003) identified themes related to growth domains in the narratives of adult survivors of childhood abuse.

Using various assessment tools, PTG has been examined in widely varied populations of individuals exposed to trauma including grief and loss, health crises, interpersonal violence, natural disasters, and war (Sheikh, 2008; Tedeschi & Calhoun, 1996). Moreover, literature indicates that PTG occurs across gender, age, and culture (Sheikh, 2008). The following two recent studies serve as examples of research with diverse populations struggling with threats to physical integrity, which highlight correlates of PTG.

In one recent research study, Mols and colleagues (2009) conducted a non-experimental correlational study to increase understanding of three variables often associated in the aftermath of trauma related to breast cancer experiences. Specifically, they examined well-being, post-traumatic growth and benefit finding as three separate constructs that have been observed in the experiences of breast cancer survivors. The design of the study used several self-report measures, including the PTGI, to assess each construct in a random sample of ten-year breast cancer survivors in the Netherlands (Mols et al., 2009). The analysis of participant responses indicate that women who survived breast cancer, as evidenced by a long disease-free period, generally experienced benefit finding and those who experienced high levels of life satisfaction were likely to experience post-traumatic growth. The researchers' analysis of the data suggests that long-term survivors of breast cancer generally attribute some positive outcome to their cancer experiences. They also found that experiences of PTG were positively correlated

with perceived emotional intensity of cancer, perceived threat to physical integrity and life, opportunities for discussing breast cancer, communication with other survivors, support partners, socioeconomic status, effective and positive coping, and time since diagnosis. Although the authors suggest that their results are generalizable to existing PTG research, which has mainly stemmed from research within the U.S., some concern exists as to the applicability of Dutch cultural norms and values to other global populations.

A recent meta-analysis of PTG research related to cancer and HIV/AIDS examined the relationship between PTG and physical and psychological well-being among adults who faced stressors related to illnesses that threaten physical integrity; the meta-analysis indicated that several moderators exist in the relationships between critical illness, PTG, and well-being (Sawyer et al., 2010). In their analysis of thirty-eight studies of PTG, many of which used the PTGI as primary measure of PTG, in populations of adults diagnosed with cancer or HIV/AIDS, Sawyer and colleagues (2010) concluded that PTG following diagnosis of these serious illnesses is correlated to more positive mental health, better self-reported physical health, and less negative mental health. In addition to time since diagnosis, the meta-analysis identified moderators and non-moderators of PTG and serious physical illness. Age and ethnicity were identified as important moderators: younger adults were more likely to report PTG and positive mental health while older adults were more likely to report negative mental health; non-white samples reported higher levels of PTG, positive mental health, and better perceived physical health than predominantly white samples, which were more likely to report negative mental health. They also identified that gender does not appear to moderate the

relationship between PTG and serious illness, which is contrary to earlier PTG research. The researchers suggest that their findings can be further examined through future longitudinal studies and likely have significant clinical implications, which will be discussed in the next section.

Finally, research has examined personality correlates with PTG. Sheikh (2008) identified four personality factors that are associated with growth: optimism, high self-esteem, self-efficacy, and hardiness. Similarly, Tedeschi and Calhoun have observed that optimism (Tedeschi & Calhoun, 1996), extraversion, and openness to experience (Tedeschi & Calhoun, 2004) are common characteristics of individuals who experience PTG. Additionally, agreeableness and conscientiousness are personality traits that have been associated with PTG populations (Sheikh, 2008).

Clinical implications and applications of PTG. Given what is currently known about PTG, there are several implications for therapy with individuals who have experienced trauma. First, clinicians need to maintain self-awareness that allows them to follow clients' readiness for processing and change without expecting either extreme distress or immediate growth (Calhoun & Tedeschi, 1999; Sheikh, 2008). Sheikh (2008) suggests that clinicians should recognize their values that may impact beliefs about the potential for post-traumatic growth. It is also important for clinicians who conduct trauma-related psychotherapy to maintain awareness of how hearing narratives of client's traumatic and post-traumatic experiences impact their own intrapsychic experiences (Calhoun & Tedeschi, 1999). Calhoun and Tedeschi (1999) recommend that clinicians actively reflect on the ways in which working with clients who have experienced trauma affect them, which may have many adverse effects, so that they may remain open to the

potential for growth in their clients. To this end, clinicians are encouraged to engage in regular self-care and reflective practice in order to remain an effective facilitator of post-traumatic growth.

Second, the approach that clinicians take to therapy with clients who have experienced trauma can take considerations related to PTG into account (Calhoun & Tedeschi, 1999). What therapists actually do in post-traumatic therapy can also be guided by what is known about the process of PTG (Calhoun & Tedeschi, 1999; Sheikh, 2008). Specific approaches or skills for clinicians are: a) listening without solving, b) observing growth as it occurs, c) labeling growth as it is observed, and d) using accurate language (Calhoun & Tedeschi, 1999). Listening without solving refers to bearing witness to clients' evolving trauma narrative and the impact of the traumatic experience as the client experiences the emerging changes in the narrative. Observing growth refers to encouraging the discussion of growth as opportunities arise without overemphasizing growth or pressuring the client to find or acknowledge elements of growth. Labeling growth refers to verbal acknowledgement of growth as the client identifies it and not before the client reflects on it. Accurate language refers to appropriately labeling PTG as emerging from the coping process and not the trauma itself. These approaches will likely foster a balanced environment that allows the PTG process to emerge in therapy without pressure or discouragement.

While the skills described above aim to facilitate the therapeutic environment, the following are strategies that can be useful in allowing PTG to emerge and become present in therapy sessions. Because cognitive processing is central to the PTG process (Tedeschi et al., 2007), active engagement in the client's trauma narrative is likely to

facilitate the transition from rumination to cognitive processing. That is, meaning-making can be facilitated through journaling and a range of cognitive-behavioral tasks such as comparing pre- and post-trauma experiences, and realizations of personal strengths in areas impacted by the trauma (Sheikh, 2008).

Third, therapists can tailor strategies for facilitating PTG in therapy to clients' individual manifestations of cultural factors. For example, when growth presents in a specific domain related to the client's cultural background, such as spiritual change in a client who has a strong religio-cultural identity, the therapist should respond by labeling the growth appropriately without focusing on areas where growth is not observed (Sheikh, 2008).

Finally, therapists can address environmental factors that impact PTG in the therapeutic process. Specifically, social support can be addressed and strengthened through the therapeutic process. Clinicians can work with clients to identify supportive individuals in their lives, strengthen supportive connections that enable clients to benefit from validating disclosure, and encourage withdrawal from harmful, invalidating, or negative social contacts (Sheikh, 2008). Although these recommendations appear sound, it should be noted that they are garnered from theoretical understanding of PTG and practical experience (Calhoun & Tedeschi, 1999), as opposed to empirical research of, or with, clinicians who work with trauma populations.

Social Support and Trauma

Research conducted over the past thirty-five years indicates that individuals who have networks of people (e.g., family, spouses, and friends) that provide support, both psychological and material, experience better health and well-being than individuals who

are isolated or report fewer, or less helpful, others in their lives (Barker & Pistrang, 2002; Cohen & Wills, 1985). Indeed, the belief that social support is beneficial and protective when facing day-to-day stressors, as well as more significant life challenges, has long been accepted in the fields of psychology, medicine, and sociology (Cohen, Gottlieb, & Underwood, 2000). Social support has been observed to benefit both psychological and physical wellness (Barker & Pistrang, 2002). More recently, research efforts have been focused on understanding the role, and usually the “power,” of social support amongst vulnerable populations, including populations who are at “at risk” due to events such as childhood abuse, adult traumas, and other life stressors (e.g., chronic illnesses; Cohen, Gottlieb, & Underwood, 2000; homelessness or incarceration; Savage & Russell, 2005; multiple medical stressors; Vogel et al., 2012). The relationship between social support and post-traumatic responses has been observed to be highly consistent and social support is often considered an important factor in the post-traumatic experience (Brewin, et al., 2000; Clapp & Beck, 2009; Ozer, et al., 2008). However, understanding of the specific mechanisms and process by which social support impacts post-traumatic responses and functioning continues to be unclear and debated in the literature (Clapp & Beck, 2009). Also, there is limited understanding of the ways in which social support factors into the development and maintenance of stress related disorders (e.g., PTSD) (Robinaugh et al., 2011).

Given the ongoing exploration of the relationship between social support and post-traumatic experiences in psychological research, clinical implications involving social support in the treatment of individuals who have experienced trauma have been largely theory based (Cohen et al., 2000). Therefore, increased understanding of social

support after trauma, specific to psychotherapy with clients who experienced trauma, is an important area for continued research. This section discusses elements related to the current understanding of social support by first discussing definitions and constructs of social support, reviewing the structures of social support, and describing theoretical models proposed to understand the relationship between social support and post-traumatic experiences (including post-traumatic growth). This section concludes with a discussion of clinical implications of social support and psychotherapy, including measurement of social support in psychotherapy, with individuals who have experienced trauma.

Social support definitions and constructs. Throughout history, the human need to affiliate has been observed, particularly in the aftermath of traumatic events (Joseph, Williams, & Yule, 1995; Kaniasty & Norris, 1995). Often following traumatic experiences, outpourings of help have rallied to assist those impacted by devastating events (Kaniasty, 2011). Survivors often seek each other out with a need to talk about what happened (Joseph et al., 1995; Lepore, Ragan, & Jones, 2000). In a broad sense, this human exchange is commonly referred to as “social support” (Cohen et al., 2000).

However, current conceptualizations of social support appear to be more complex than simply “helping behaviors.” The process and experience of social support, in both giving to and accepting support from others, is highly complex and cannot be defined by the presence/absence of it as has been implied in some trauma literature (Clapp & Beck, 2009).

Similarly, historical sociological examination of social support proposed a uni-dimensional relationship between social support and well-being. Social support was

purported to promote well-being while the loss of social resources and reduction in social relationships and participation was believed to be detrimental to well-being (Cohen et al., 2000). More recently, in psychological literature, a “main effect” model was proposed that suggested that positive social support experiences contributed to overall well-being as it promoted other areas of psychological health and growth such as stability, confirmation of self-worth, and positive affective experiences (Cohen et al., 2000; Cohen & Wills, 1985). Study of the main effect model indicates that while general participation in social systems is beneficial to well-being, it does not necessarily enhance coping or adaptive responses to stressful events, suggesting that there are multiple factors within social support that impact its role in various situations.

Thus, Joseph, Yule, Williams, and Hodgkinson (1994) note that studies of the main effect model represents a shift towards the current, multidimensional view of social support, which examine various aspects of social support experiences and the interaction between social support and other post-traumatic factors. One significant finding that supports the multidimensional perspective on social support is that negative social support (e.g., conflict or invalidating responses to emotion expression) is more detrimental than simply the absence of support (Robinaugh et al., 2011; Tarrier, Sommerfield, & Pilgram, 1999; Ullman, 1996; Zoellner, Foa, & Brigidi, 1999). Therefore, it is useful to examine the structures of social support, which include the content and functions of support relationships, as they appear to impact the role of social support in the post-traumatic experience. Understanding of the structures of social networks provides a frame for the constructs that have been identified that relate to the

overall social support experience, which includes received and perceived support, extended support, social embeddedness, and the seeking of social support in coping.

Social support structures. Examination of social support structures provides a frame for conceptualization of social systems and potentially supportive relationships between people. Regarding the structure of social support systems, or “networks”, they can be likened to a social “map” consisting of points representing the people in contact with a given individual (Tolsdorf, 1976). “Support structure” indicates presence or existence of relationships and provides a numerical overview of points on the map (Cohen & Wills, 1985). That is, social support structure refers to the number of people, size of the network, density and proximity of subgroups, connections between individual and clusters of people, and quality of the links between people (Tolsdorf, 1976). Social networks may be homogenous (e.g., family systems) or more diverse webs of people from a variety of areas in the individual’s life (Savage & Russell, 2005). The structure of social support systems can change over time and are particularly susceptible to change following traumatic events (Clapp & Beck, 2009). Research has indicated that post-traumatic changes in social support structure impact psychological functioning (e.g., Kaniasty & Norris, 1993; Norris & Kaniasty, 1996).

Savage and Russell (2005) suggest that homogenous structures of social networks are likely to have important implications following experiences of trauma. They offer two examples of how the homogeneity of a social network may impact a survivor. First, they explain that homogenous social networks in which the trauma occurred (e.g., an abusive family) continue to affect the ways in which social support is experienced and future relationships develop by fostering problematic relational patterns. Second, they

note that homogenous social groups can support or encourage other risk factors that may impact trauma exposure and coping (e.g., social networks surrounding substance abuse). These examples illustrate that the structure of a survivor's social network may be limited and offer few options for support and coping (Savage & Russell, 2005).

Social support content. In the social network map, the content of the social relationships refers to the specific links that describe the connections between people (Tolsdorf, 1976). Rieck, Shakespeare-Finch, Morris, and Newberry (2005) observed that types of social support relationships generally fall into either formal (e.g., professional service providers) or informal (e.g., family and friends) categories. In fact, Barker and Pistrang (2002) noted that formal and informal supports are often viewed quite differently, and research related to the two types of support often appears in different areas of the literature. The description of content links are broadly varied and include both informal and formal relationships: “primary kin, secondary kin, primary friend, secondary friend, economic, recreational, political, religious, sexual, fraternal, mutual aid, and service” (Tolsdorf, 1976, p. 409).

As of the early 2000s, limited research had focused on the role of informal supports and no studies had compared the benefits of formal and informal supports (Barker & Pistrang, 2002). More recently, a qualitative study of support resources among African-Americans who experienced traumatic grief due to the homicides of family members observed that individuals were more likely to turn to informal support relationships in the grief coping (Sharpe, 2008). Specifically, the main support contents that were sought for coping were primary and secondary kin, primary friend (i.e., “fictive kin”), and other, more distal friends. However, the process of grieving was also

improved by assistance from formal support contents. Support from formal content relationships was likely to come from within the cultural community (e.g., African-American community service providers, historically Black universities, and faith-based organizations; Sharpe, 2008). Barriers to receiving support from other types of formal contents were related to historically-founded fear and mistrust of, as well as stigma and taboos surrounding, institutional service providers (Sharpe, 2008).

Within any social community, there may be a variety of social support contents. Besser and Priel (2010) observe that within communities there are “natural support systems” (p. 167) that have the potential to be supportive and protective but that also may be disrupted following traumatic events. For example marriage, or spousal, relationships are often cited as important content of social support that fulfill several functions, which will be described next, within a single relationship (Cohen & Wills, 1985). In this example, a marriage relationship constitutes family, friend, and sexual content in the experience of social support. Additionally, these content areas may provide a source of support when the couple is faced with a traumatic stressor or may be disrupted by stressors. In this way, it is apparent that content categories often overlap in any given relationship between people, thereby furthering the complexity of the social network (Tolsdorf, 1976).

Functions of social support. The functions of the social relationships provide more specific understanding of the connections between people within the social network. The functions of social support are the services that are provided within the relationship (Tolsdorf, 1976).

Functions may be mutual or unidirectional, and include multiple relational types, including support, advice, and feedback (Tolsdorf, 1976). Support refers to an action that aims to help or assist an individual achieve goals or cope with stressors. The functions that are provided in social support may be emotional, such as words of encouragement, or tangible, such as money. Advice refers to communication aimed at providing instruction or direction towards goal achievement. Feedback is the process of evaluation that intends to inform the individual of his or her progress.

Other support functions that have been identified are esteem, informational, social companionship, and instrumental (Cohen & Wills, 1985). Esteem support refers to communication that enhances the individual's self-esteem by asserting the value and worth of the individual and promoting a sense of acceptance. This function is also referred to as emotional support, expressive support, and close support. However, Lakey (2007) distinguishes between esteem support and emotional support. Esteem support bolsters the individual's sense of self, whereas emotional support responds to the individual's affective experiences (Lakey, 2007). Informational support, which is also known as advice and cognitive guidance, is the support that helps and guides understanding, definition, and coping processes of stressful and traumatic experiences (Cohen & Wills, 1985). For example, the guidance or understanding gained from informational support can assist the individual in perceiving the trauma as one in which adequate coping resources are available, or as an overwhelming event. Social companionship fulfills the human need for connectedness and affiliation with other. This type of support, referred to as belongingness and diffuse support, offers distraction from distress and promotes positive affect. Finally, instrumental support refers to the provision

of material support, aid, and necessary services. It has also been described as tangible support and material support. Instrumental support following a natural disaster may provide the individual with shelter or social companionship may allow the individual brief distraction from the trauma.

Recent research has sought to understand the benefits of various types of support functions in post-traumatic experiences. It has been suggested that some support functions may be more adequately matched to certain types of trauma (Gabert-Quillen et al., 2012; Glass, Perrin, Campbell, & Soeken, 2007). For example, in a study of Australian university students who had experienced or witnessed traumatic events that were assessed to meet the DSM-IV-TR (2000) definition of “trauma,” both emotional (e.g., words of encouragement and expressions related to affective experiences) and practical (e.g., assistance with daily tasks) types of support were correlated to experiences of PTG (Rieck et al., 2005). Somewhat similarly, in a study of survivors of motor vehicle accidents who experienced symptoms consistent with PTSD, emotional support was observed to be more beneficial to psychological functioning (e.g., lower levels of distress) than other types of support functions, such as instrumental support and social companionship, that were less significantly associated with lower level of trauma-related symptoms (Gabert-Quillen et al., 2012). Conversely, Glass and colleagues (2007) suggested that practical, or instrumental, support was more beneficial to, and more significantly moderated PTSD symptoms among, urban women who survived sexual violence than cumulative social support experiences. Therefore, future research should explore whether the type of trauma experienced may influence the type of support (e.g.,

emotional; practical) needed as well as how it is related to decreasing the risk for developing PTSD symptoms and increasing PTG.

Also, the function of the support relationship appears to stem from the quality of the interpersonal relationship. It appears that one relationship that fulfills an adequate function area is more beneficial than numerous superficial relationships (Cohen & Wills, 1985). Additionally, Cohen and Wills (1985) indicated that the degree to which the functions provided within the support relationship match the individual's needs is significant in the efficacy of the support. This supposition found support in recent research reviewed above (e.g., Gabert-Quillen et al., 2012; Glass et al., 2007) that suggests that the individual's need areas may be related to the type of trauma experienced. Therefore, positive and effective support experiences are likely to occur in relationships that fulfill particular need areas.

Received social support. Received support refers to “naturally occurring helping behaviors that are being provided” (Norris & Kaniasty, 1996, p. 498) by others. This refers to the actual provision and receipt of support between individuals (Kaniasty & Norris, 1995). Joseph, Williams, and Yule (1995) extended the basic definition of received support to: the support that is provided when needed. Scholz, Kliegel, Luszczynska, and Knoll (2012) further specified that received support “refers to the recipients' retrospective reports of actual support transactions” (p. 361). In this way, received support is the described support that occurs as individuals' needs arise following exposure to significant challenges and traumatic events (Joseph, Williams, & Yule, 1995). Received support is mobilized in the aftermath of stressors and crises when individuals in social networks offer assistance and help to each other (Kaniasty & Norris,

1993). Examples of received support include provisions of relief after disasters, emotional support from friends and family during illness, and legal assistance following violent crimes.

This construct of social support is comprised of the numerous functions and may be either helpful or harmful as they are provided in the social support experience. On the one hand, it contributes to coping processes following exposure to trauma (Norris, Byrne, Diaz, & Kaniasty, 2008). Some literature indicated that received support reduces or protects against psychological distress after trauma (Cohen & Wills, 1985; Lyons, 1991). However, on the other hand, Lepore, Glaser, and Roberts (2008) and Norris and Kaniasty (1996) noted that numerous studies have observed a positive relationship between received support and post-traumatic distress. Although the directionality of the relationship between the two variables has not been conclusively determined, several hypotheses have been proposed. It may be that received support occurs during periods of heightened distress, and thus becomes associated with post-traumatic symptomology (Norris & Kaniasty, 1996), or that receiving support is threatening to self-esteem, which contributes to increased distress (Lepore et al., 2008; Norris & Kaniasty, 1996). Additionally, the effects of received support, either positive or negative, may vary across different age groups across the lifespan (Scholz et al., 2012). For example, research has indicated that younger adults are likely to experience a negative association between received support and well-being whereas the negative association decreases among older populations.

Given the possibilities for the relationship between received support and post-traumatic distress, several researchers suggest that the support received should be wanted,

relevant, and appropriate to the individual's needs (Cohen & Wills, 1985; Kaniasty & Norris, 1995; Norris & Kaniasty, 1996; Wilsey & Shear, 2007). It is also important to recognize that received support is a separate construct than perceived support, though it may be difficult to differentiate the two constructs (Laffaye, Cavella, Drescher, & Rosen, 2008; Norris & Kaniasty, 1996).

Perceived social support. Whereas received support refers to the actual helping behavior in supportive relationships, perceived support describes the belief that support will be available during times of need (Joseph et al., 1994; Kaniasty & Norris, 1995; Norris et al., 2008; Norris & Kaniasty, 1996). Although it is a separate construct than received support, perceived social support develops out of experiences with received support. Experiences with positive and effective received support lead to beliefs that future support will also be helpful and available (Clapp & Beck, 2009; Kaniasty & Norris, 1993; Norris & Kaniasty, 1996). Studies have shown that survivors who received “more” social support in the immediate aftermath of natural disasters displayed increased levels of perceived support later (Kaniasty, 2011; Norris & Kaniasty, 1996).

Perceived support has been studied more extensively than received support (Norris et al., 2008). Most survivors who believe that supportive others are available and willing to help experience fewer symptoms of distress than survivors who feel isolated and uncared about. Research indicates that perceived social support is associated with decreased symptoms of PTSD in several trauma related populations, including veterans and burn victims (Widows, Jacobsen, & Fields, 2000). Perceived social support is likely more effective than received support because the belief that support is available is, in itself, supportive during times of stress. Conversely, received support may occur as

unhelpful, unwanted, or critical and, consequently, be unsupportive (Norris & Kaniasty, 1996).

Therefore, the experiences of stressful and traumatic events are also risk factors for decreased expectations for the availability of support and beliefs about the quality of interpersonal relationships (Kaniasty, 2011). For example, Kaniasty's (2011) recent longitudinal study of perceived support examined a community in Poland over the 20 months following a devastating flood. Individuals who received inadequate help (i.e., "not enough help" per self-reports) immediately following the disaster later reported perceptions of disharmony within their community and expectations about limited compassion and generosity from others. Additionally, these individuals indicated having less trust in others and a diminished sense of mutual aid within their community. Significantly, those people who experienced challenges in disclosing feelings and beliefs about negative received support reported later levels of negative expectations for support and tended to withdraw from interpersonal experiences (Kaniasty, 2011).

Yet, Laffaye and colleagues (2008) observe that distinguishing between perceptions of available social supports and the actual availability of social support is difficult. However, the distinction between perceived and received social support is important as each appears to fulfill different functions and contribute differently to post-traumatic experiences. Perceived social support has been described as "superior" to received support in its ability to contribute to well-being following stress (Norris & Kaniasty, 1996). Therefore, differentiating between the two, though difficult, is likely helpful in understanding the effects of social support following trauma, and any implications for psychotherapy with trauma survivors.

Extended social support. Although received and perceived support are often highlighted in trauma and social support research, little emphasis is placed on giving or extending support to others. Yet, literature indicates that giving support to others or caregiving represents an important support construct (Pulcino et al., 2003), and is an important element involved in the social support experience (Simpson, Rholes, Oriña, & Grich, 2002). For the purposes of this dissertation, “extended support” is defined as the experience of providing social support to others, which involves the giver’s perceptions about the interaction(s).

Stemming from theories of attachment (e.g., Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1973, 1980), styles of and perceptions about extended support are hypothesized to develop from the quality of care received in early relationships (Simpson, et al., 2002). For example, individuals who develop secure attachment styles are generally well-attuned and responsive to distress experienced by important others later in their lives, while individuals who develop avoidant or insecure attachment styles are later likely to be misattuned or have difficulty perceiving and responding to the distress of significant others. Also, the latter group of individuals may experience the support needs of others and related extended support as burdensome (Simpson et al., 2002). Therefore, like perceived support, later experiences of extended support appear to stem from earlier experiences of received support.

Recent literature indicates that gender is also an important factor in extended support experiences (Pulcino et al., 2003; Robertson et al., 2006). For example, Pulcino and colleagues (2003) found that women, more so than men who also lived in the Ground Zero area [race/ethnicity not specified], were likely to perceive the responsibilities related

to the care of others and concern for the community at large as burdensome, which was observed to increase emotional strain and risk for the development of PTSD. They further suggested that extending support to others (e.g., as volunteers in rescue centers) may negatively impact an individual's ability to cope with trauma-related stressors by increasing the perceived burden of caring for others, thereby diminishing coping capacities (Pulcino et al., 2003).

Similarly, increased support responsibilities and strained extended support experiences of Somali and Oromo women refugees in the United States were observed to be related to increased risk for exposure to trauma and post-traumatic distress when compared to other refugee women from the same region who had fewer social responsibilities (Robertson et al., 2006). Specifically, the researchers observed that women who had large families (i.e., 6 or more children) experienced more stress-related problems than women who had smaller families or no children and higher rates of trauma-exposure and torture than did other women or men. Further, the study's findings suggest that women who had large families had fewer resources than women with fewer or no children, which likely contributed to their diminished capacity for coping and increased trauma-related problems. That is, fulfillment of familial responsibilities and caring for multiple children may decrease women's participation in activities and networks that may be beneficial in coping, or may contribute to feelings of isolation and perceived loneliness. However, providing support to others, as observed in mutual support, which will be described later in this chapter, can provide individuals with opportunities for helping others that may increase positive perceptions of self (e.g., view of the self as a strong survivor; Calhoun & Tedeschi, 1999).

Pulcino and colleagues (2003) suggest that gender roles, which are likely influenced by cultural practices and expectations, impact extended support experiences and perceptions related to those experiences. For example, women who are primary caregivers within “traditional” gender roles may experience more demands and stress in relationships, which may increase during crises and traumatic experiences (Pulcino et al., 2003). Specifically, Pulcino et al. observed greater disparity between gender and rates of PTSD in “more traditional societies” and less difference between gender and occurrence of PTSD in groups with women in more non-traditional gender roles such as police officers. However, a major limitation of such an observation is that the authors did not include culture and ethnicity in their demographic variables and instead operationalized “traditional gender roles” based on income, degree of financial control, level of education, and primary caregiver status. Therefore the degree to which culture may have impacted individuals’ gender roles and their extended support experiences in their sample is unknown. Conversely, Robertson and colleagues (2006) who examined women’s post-trauma and support experiences in the context of Somali and Oromo culture observed that women with greater sociocultural responsibilities of caregiving were observed to experience increased post-traumatic symptomology (Robertson et al., 2006). Moreover, these authors emphasized the importance understanding the cultural context of the individual and her social obligations, including extended support, in the recovery process. In sum, the process and experience of extending support to others, which may be influenced by attachment, gender and other cultural factors, can impact an individual’s post-traumatic response.

Social embeddedness. Kaniasty and Norris (1993; 1995; Kaniasty, 2011; Norris et al., 2008) describe social embeddedness as “the size, activeness, and closeness of the survivor’s network” (Norris et al., 2008, “Protection Afforded by Social Resources,” para. 2). Cohen and colleagues (2000) refer to this construct of social support as “social integration,” which they define as “characteristics of social networks” (p. 6) that include the diversity and size of the social network, involvement in a variety of social activities, and the degree of support that is received.

It appears that embeddedness in a social system supports general well-being (Cohen & Wills, 1985). Kaniasty and Norris suggest that the types and quality of support relationships, as well as the individual’s level of participation in the social network, which are elements that constitute social embeddedness, are related to mental health and psychological well-being following traumatic events (Kaniasty & Norris, 1993; Kaniasty & Norris, 1995; Kaniasty, 2011; Norris et al., 2008). However, embeddedness may not provide similar benefits during times of stress (Cohen & Wills, 1985). Research indicates that social embeddedness is likely to deteriorate following traumatic experiences (Kaniasty & Norris; 1993; Kaniasty, 2011). Cohen and colleagues (2000) observe that support factors related to well-being and distress are unclear and require further examination.

Social support coping and needs. Social support coping refers to the process of seeking social support as a coping strategy following traumatic experiences (Prati & Pietrantonio, 2009). Additionally, literature suggests that individuals who experience traumatic events, often have the need for support from others (Cohen & Wills, 1985; Gabert-Quillen et al., 2012; Glass et al., 2007; Kaniasty & Norris, 1995). Therefore, this

subsection describes the use of social support in coping and research related to the support needs of trauma survivors.

Cohen and Wills (1985) make a distinction between social support coping and social embeddedness: participation in a social network does not necessarily enhance coping after trauma. However, it appears that *seeking* social support in the coping process contributes to the quality and quantity of available supports (Prati & Pietrantonio, 2009).

In addition, seeking social support has been observed to enhance positive appraisals of traumatic events and to promote positive health outcome following traumatic experiences (Swikert & Hittner, 2009). The use of social support in coping during times of stress provides individuals with opportunities for active problem solving and processing of traumatic experiences (Prati & Pietrantonio, 2009).

Women may be more likely than men to seek social support coping due to social factors that encourage women, more than men, to turn to relationships for support during crises (Swikert & Hittner, 2009). Swikert and Hittner (2009) also observed social support coping to be a mediating factor between gender and post-traumatic growth and suggested that women's use of social support in coping is likely an important factor in their post-traumatic experiences. Despite the observation of gender as a mediating factor, social support coping has been observed to be related to post-traumatic growth (Tedeschi & Calhoun, 2004) in both men and women (Swikert & Hittner, 2009).

Although seeking support in the coping process has been observed to benefit post-traumatic experiences, little research has focused on expressions of the need for social support. For the purposes of this study, "support needs" are defined as statements

expressing the need, desire, longing, or wish for received, extended, or perceived support in the form of support from others or provision of support to others.

In the review of social support literature related to post-traumatic experiences, limited research or theories related to expressions of support needs among individuals who experienced trauma were identified. One study that focused on indigenous humanitarian aid workers in Guatemala included questions, in focus group discussions and survey questionnaires, of need areas following exposure to community violence (Putman et al., 2009). The researchers identified the primary areas of support needs identified by aid workers were for additional training, governmental support for their work (e.g., law enforcement protection), emotional support, and financial resources for their work. As a result of these findings Putman et al., provided suggestions for institutional supports for indigenous aid works such as transportation, formal psychotherapeutic services, and safety plans. They also noted that peer networks may be useful in supporting aid workers exposed to community violence. However, no specific recommendations were provided for ways in which provision of support to the sample population would adequately meet their stated needs from their own perspective.

Another recent study sought to examine the needs of military families with a veteran family member who survived multiple traumas (Wilder Schaaf et al., 2013). Wilder Schaaf and colleagues (2013) noted that there was minimal empirical research that identified and assessed the needs of families of veterans who survived multiple traumatic injuries in rehabilitation settings. Therefore, their study used the Family Needs Questionnaire, which is a 40-item self-report measure that is commonly used to assess the perceived met and unmet needs of families following a survivors' brain injury (Kreutzer

& Marwitz, 1989), to quantitatively measure families' needs when facing traumatic brain injuries and other threats to physical integrity (e.g., burns, amputations, hearing loss, orthopedic injuries) of military relatives. Results indicated that families generally perceived their needs related to the professional health information of their loved ones from service providers as being met in the rehabilitation setting. However, their needs for emotional and instrumental support in managing day-to-day responsibilities and activities outside of the rehabilitation center were not adequately met. Therefore, the researchers recommended that services and networks should be developed to address these additional need areas (Wilder Schaaf et al., 2013). However, like the recommendations made by Putman and colleagues (2009), these recommendations did not include specific suggestions for ways in which to meet the identified need areas.

Summary of social support constructs and structures. Current understanding of received and perceived support, social embeddedness, and social support coping and needs highlight the multifaceted concept of social support. Although there is clearly much conceptual overlap in the constructs described above, each represents important elements of social support, particularly in relation to post-traumatic experiences. Moreover, none of the constructs adequately defines social support on its own. Therefore, each of the constructs described above contribute to the operational definition of social support in this study. For the purposes of this study that focuses on clients' trauma experiences, social support will be defined as the interpersonal networks that are experienced, sought, or needed by an individual during or in the aftermath of traumatic events that provide, or attempt to provide, that person with tangible and/or emotional help and that are expected to contribute, either positively or negatively to his or her post-

traumatic experience. Additionally, for expressions of social support that may not concern a threat to physical integrity, social support will be defined as personal or direct client experiences within or beliefs about interpersonal networks and relationships that are anticipated, needed or desired, offered or received to provide him or her with either positive or negative helping behaviors.

Social support models and post-traumatic experiences. Exposures to trauma both activate and threaten personal and environmental resources for coping (Besser & Priel, 2010). Social support is a coping resource that can be activated when individuals appraise a traumatic event as stressful. Additionally, existing literature indicates that perceived social support contributes to psychological well-being during periods of stress, constitutes a protective factor, and promotes resilience in the face of traumatic experiences. But trauma can also may trigger beliefs about helplessness and incapacity for coping (Cohen & Wills, 1985), which may lead to significant disruptions in interpersonal relationships and sense of identity and safety (Besser & Priel, 2010). Accordingly, lack or absence of social support has been observed as a risk factor in individuals exposed to trauma, especially for people exposed to prolonged and shared trauma, such as war or armed conflict.

This section describes ten models related to understanding social support and post-stress experiences. It first discusses six models that have been developed to provide a framework for understanding the process of social support and use of social support during times of stress (i.e., personality, network orientation, stress-buffering, erosion, deterioration, and deterioration deterrence models) followed by descriptions of three models that include social support in the etiological development of PTSD (i.e., appraisal,

social-cognitive processing, and conservation of resources models). This section concludes with a discussion of social support in the PTG model. To date, evidence supporting one model over the other is limited, and indicates the need for further investigation in the understanding of the relationship between social support and post-traumatic experiences (Clapp & Beck, 2009). This section provides brief descriptions of these models used to understand the role of social support in post-traumatic experiences.

Personality model. According to Blatt's model of self-definition and interpersonal relatedness (Blatt, 2008), perceptions of and responses to events are impacted by personality characteristics and interpersonal relatedness (Besser & Priel, 2010). In this model of personality, the interplay between self-definition and interpersonal relatedness give way to personality style, which facilitates psychological well-being and capacity for stress management. More specifically, depending on personality type, different modes of cognitive processing and coping will be favored and employed by the individual (Besser & Priel, 2010; Blatt, 2008). For example, individuals with dependent personality traits may be more likely to rely on social support in coping whereas self-critical personality types may rely more heavily on internal resources for coping (Besser & Priel, 2010).

Perceptions of social support appear to mediate personality traits and symptoms of distress amongst individuals who are exposed to trauma (Besser & Priel, 2010). It appears that personal characteristics, beliefs, and capacities impact the use of social support in response to traumatic experiences. That is, it is the individual's beliefs about possible benefits and risks of seeking support, capacity to identify and preserve support, and actual use of support that contributes to its effectiveness in mediating trauma-related

distress rather than the level of need or “helplessness” evoked by the trauma (Besser & Priel, 2010).

One recent study (Campos, Besser, Ferreira, & Blatt, 2012) sought to examine personality factors in Portuguese women’s adjustment to breast cancer diagnoses using self-report measures of distress (e.g., depressive symptoms) following their initial cancer diagnoses. The authors found that self-criticism and dependence on others, both factors included in Blatt’s (2008) model, were correlated with higher rates of distress following diagnosis (Campos et al., 2012). Because Campos et al.’s (2012) study examined dependence as a personality trait, future research is needed to explore the possible connection between dependence on others as a personality trait and to individual’s actual use of support in mediating post-traumatic distress.

Network orientation. Although contemporary usage of the term “social network” often refers to online connections between people, social network theory has defined “social networks” more broadly as the units of people with whom an individual is in contact with and the social behaviors that occur in the linkages between people (Tolsdorf, 1976). In this way, social network theories expand beyond the concept of “family” to incorporate all of the people with whom an individual has regular contact. Social networks have been observed to mediate behavior related to personal crises and stressors, help-seeking behaviors, and perceived happiness.

Within a social map, “network orientation” refers to the way in which an individual is affiliated with his or her social network in order to seek and receive support in times of need (Tolsdorf, 1976). Clapp and Beck (2009) defined network orientation as “one’s attitudes and expectations concerning the usefulness of employing social resources

in times of need” (p. 238). The process by which a network orientation is adopted occurs at both the individual level and the interpersonal level, such that it is comprised of the ongoing relationship between the individual and the social network. There is mutual interaction between the individual and the social environment resulting in the individual’s perception of the social network, which influences the degree to which he or she will reach out to the network during periods of stress (Tolsdorf, 1976).

The process of the development of network orientation is complex and involves several factors (Tolsdorf, 1976). These factors are related to the influence of early relationships, the structure of social networks, the content of social relationships, and the functions of interpersonal relationships.

Because network orientation develops over time, early interpersonal relationships are particularly influential in shaping the individual’s perceptions, beliefs, and schemas about the role and meaning of others in his or her life (Tolsdorf, 1976). Orientation to the social network is developed through earlier experiences in which support is sought, obtained, and perceived within primary support groups (Clapp & Beck, 2009; Tolsdorf, 1976). Over time, perceptions of social support as helpful, effective, and available contribute to positive network orientation, whereas support that is perceived as ineffective and rejecting develops into negative network orientation (further discussed below). Thus, beliefs and attitudes stemming from earlier experiences shape associations and expectations for continued support during times of need, such as in the aftermath of traumatic experiences (Clapp & Beck, 2009). Established network orientations then impact how stress is perceived, which coping strategies will be employed, how the social

network will be involved in the process, and the overall response or outcome of the stressor (Tolsdorf, 1976).

The system of relationships within a social network is multidimensional and varies in form and function, providing a myriad of opportunities for the development of network orientation over time (Tolsdorf, 1976). Yet, despite their complexity, network orientations are usually described as either positive or negative (Clapp & Beck, 2009; Tolsdorf, 1976). Positive network orientation refers to the belief and anticipation that it is safe and meaningful to seek support, advice, and feedback from members of the social network who will be available to meet the individual's needs (Tolsdorf, 1976). This system of beliefs stems from earlier experiences in which the social network was able to provide the needed support, or in the absence of opportunities for needs to have been met, facilitate the belief that support will be available when needed. Individuals who have positive network orientation are typically open to seeking the support of others during distressing periods and are able to disclose or share enough of their experiences and feelings for members of the social network to provide adequate functions to aid the coping process. Moreover, these individuals are often able to reflect on histories of having experienced support from important others during times of stress. In the experience of positive network orientation, members of the social network, or "network resources," are often perceived as helpful.

Conversely, negative network orientation refers to the belief and understanding that it is not safe, useless, or, at times, dangerous to seek support, advice, and feedback from individuals in the social network. The set of beliefs that give way to negative network orientation stem from hostile, rejecting, misattuned and uninvolved interpersonal

experiences in the early social environment (Tolsdorf, 1976). Negative interactions within the primary social environment are then extremely influential in the development of negative network orientation. In particular, victimization and abuse provide foundation for profound negative network orientation (Clapp & Beck, 2009). Individuals with negative network orientation have been observed to avoid self-disclosure due to possible embarrassment or threats to personal integrity. These individuals also lacked engagement in disclosure resulting in others' inability to help or assist them (Tolsdorf, 1976). In one study, families of individuals with negative network orientation were unaware of distress until it reached clinical significance, resulting in psychiatric hospitalization. Therefore, negative network orientation appears to facilitate internalized coping strategies and the absence of external supports that can be called upon during times of stress. In this way, trauma then plays a significant role in shaping perceptions of social support and resulting network orientation (Clapp & Beck, 2009).

Trauma has the capacity to cause fundamental shifts in understanding of the "self, others, and the world" (Clapp & Beck, 2009, p. 238), which may result in the development of negative beliefs related to social support, then contributing to the emergence of negative network orientation. Shifts in perception and attitude are likely to emerge in the aftermath of trauma in relation to actual changes in the support network (e.g., due to trauma-related death of a significant individual), changes in demands from or within the social network, and misunderstanding or frustration in the support system due to trauma-related symptoms (e.g., depression, PTSD symptoms). Then, as the individual perceives rejection, loss of support, and misunderstanding, negative network orientation develops and impacts the individual's ability to seek and obtain effective social support.

For example, the relationship between negative network orientation and diminished trust, increased suspicion, and increased social avoidance was observed in a sample of low-income women who were sexual abuse survivors. Because network orientation is believed to develop over time, it stands to reason that early experiences provide a longer interval for supporting experiences to confirm existing beliefs about the support of others. Therefore, Clapp and Beck (2009) suggest that PTSD is more likely to occur amongst individuals with negative network orientation, and, in particular, be prevalent amongst individuals who experienced early life victimization and subsequent negative network orientation.

Stress-buffering model. One model used to understand the potential causal contribution of social support on well-being in stress-related experiences is the stress-buffering model (Cohen & Wills, 1985). The stress-buffering model hypothesizes that supportive relationships and networks contribute to effective coping and protect against the development of stress-related symptoms following exposure to stressors (Clapp & Beck, 2009; Cohen & Wills, 1985). Although the original conceptualization of the stress-buffering model was focused on social support in stressful events, it has implications for traumatic and post-traumatic experiences (Clapp & Beck, 2009). This model posits that the function of social support is a preventative agent for post-traumatic pathology (Cohen & Wills, 1985). The previously discussed recent study by Gabert-Quillen and colleagues (2012) provided some support for the stress-buffering model. The authors suggested that the moderating relationship that they observed in social support on rates of post-traumatic distress indicated that positive experiences with social support buffered against the development of PTSD symptoms.

The buffering process of social support may occur in two places: the appraisal of the stressor and/or in the coping response to the stressor. Regarding the first point of social support intervention, traumatic events are perceived as stressful through an appraisal process in which the individual feels helpless or believes that available coping resources are inadequate. Social support may intervene in the appraisal process to bolster the individual's confidence in coping capacity and effectiveness, thereby shifting perception of the traumatic event to a manageable stressor (Cohen & Wills, 1985). The second point of intervention in the stress-buffering process can occur in the physiological, emotional, and behavioral response to the stressor.

The intervention and its placement in the post-traumatic experience appear to stem from the functions performed by the relationship or networks. Although many functions occur within supportive relationships, four important functions of social support are observed in the stress-buffering model: esteem support, informational support, social companionship, and instrumental support. These relational functions mediate post-traumatic responses to stressors in both the appraisal and coping processes.

Deterioration models. While other models seek to describe the positive relationship between social support and post-traumatic experiences and often conceptualize social support as a protective or preventative factor in the development of PTSD symptoms, deterioration models of social support examine the impact of PTSD symptoms on social support networks and relationships (Clapp & Beck, 2009; King, Taft, King, Hammond, & Stone, 2006). The erosion model posits that PTSD symptoms, such as social withdrawal and numbing, have a negative effect on social support, resulting in the deterioration, or "erosion," of relationships and sources of support (Clapp & Beck,

2009). The deterioration model of social support recognizes that stressful events have the potential to diminish perceived social support with a resulting negative effect on psychological well-being and coping (Kaniasty & Norris, 1993; Norris & Kaniasty, 1996). An extension of the deterioration model, which is referred to as the deterioration deterrence model, suggests that when adequate support is mobilized and received in the aftermath of a traumatic event, it can mediate the often detrimental deterioration of perceived social support (Kaniasty & Norris, 1995; Norris & Kaniasty, 1996).

Erosion model. The erosion model was originally observed and developed in research with military populations and veterans who experienced chronic PTSD (King et al., 2006; Laffaye et al., 2008). Recent studies with combat veteran populations suggest that the mediating potentials of social support diminish when PTSD symptoms become chronic (King et al., 2006; Laffaye et al., 2008). Laffaye and colleagues (2008) suggest that the effects of social support are more influential over the course of PTSD symptoms as opposed to the development of PTSD symptoms. While some types and functions of social support may initially buffer against the development of trauma-related symptoms, chronic symptoms (e.g., detachment, isolation, irritability) are likely to contribute to the weakening of those supports (King et al., 2006). Further research is required to determine the possible generalization of veteran experiences to other populations. In addition, King and colleagues (2006) suggest that research methods may impact findings related to the relationship between social support and PTSD, which are limited in abilities to measure directionality and accuracy of relationships between variables. Despite these limitations, several studies have indicated that a relationship exists between severe and chronic PTSD symptoms and erosion of social support relationships.

Within the erosion model of deterioration of social support in the PTSD experience, both interpersonal stressors and resources for social support are examined (King et al., 2006; Laffaye et al., 2008). Interpersonal stress and problems often occur amongst individuals who experience PTSD (King et al., 2006). For example, interpersonal stressors such as conflict and negative reactions within the social network have been observed to predict development of PTSD symptoms (Laffaye et al., 2008). However, it is also likely that presence of PTSD symptoms negatively impact existing interpersonal relationships (King et al., 2006). Military veterans who experience PTSD have been observed to have difficulties in social problem-solving, parenting tasks, marital relationships, and socialization. King and colleagues hypothesize that it is the presence of PTSD within the observed veteran population that affects the quality of social relationships and negative outcomes in those relationships.

The second area that is examined in the erosion model is social support resources, which include the types and functions provided by the available social support structures. It appears that various sources or types of social support may differ in relation to post-trauma responses (Laffaye et al., 2008). Laffaye and colleagues (2008) observed that support received from spouses, relatives, trauma-related peers (i.e., veteran friends), and non-trauma-related peers provided different support functions and were impacted differently by PTSD symptoms in a combat veteran population. For example, veterans appear to seek the support of veteran peers, who constitute the largest portion of their social networks, more frequently than their families and non-veteran peers. Therefore, peers who have some connection to the trauma experience appear to provide an important function in post-trauma social support, although these supportive relationships may erode

as trauma-related symptoms increase (Laffaye et al., 2008). In this way, it appears that the type or source of social support contributes to the benefits that may be derived from the relationships as well as the potential for deterioration of the relationships as trauma-related symptoms emerge.

The functions that are facilitated by the relationships in veterans who experience PTSD are also related to the erosion process. These functions include the quality of support offered within the relationship, reactions and responses from the social support source to the trauma experience, and the perceived benefit of the support (Laffaye et al., 2008). Specifically, instrumental and emotional support functions appear to be the most commonly received social support amongst veterans who experience PTSD.

Instrumental support is received from both relatives and veteran-peers, and emotional support stems primarily from veteran-peer relationships. Relationships with spouses and relatives appeared to provide equal levels of support and interpersonal stress for veterans. Conversely, support received from veteran friends appears to be effective in meeting support needs of veterans because the provided support is generally perceived as stress-free and undemanding, although these relationships are likely to erode when trauma-related symptoms become severe or chronic. A similar erosion trend was observed in support from non-trauma-related peers; greater interpersonal stress was observed in non-veteran friendships as symptoms worsened and remained present over time.

Deterioration model. The deterioration model of social support suggests that some traumatic events result in diminished perceptions of social support, which then contributes to the deterioration of the buffering potential of available supports (Kaniasty & Norris, 1995). Traumatic events that impact entire communities or social support

networks have the potential to both directly affect individuals through threats to physical integrity and immediate loss, as well as indirectly through the erosion of perceived support from social networks (Norris & Kaniasty, 1996). Many traumatic events have the potential for long term alteration of available social supports. The deterioration model has been observed to occur following events such as disasters (e.g., hurricanes), “exit events” (e.g., death), chronic events (e.g., prolonged illnesses), and human-caused events that impact communities (e.g., factory closings) (Kaniasty & Norris, 1993). For example, disasters such as floods often impact members of social communities simultaneously (Kaniasty, 2011; Kaniasty & Norris, 1993).

According to this model, the deterioration of social support in the aftermath of disasters and other stressful events is said to occur as a result of changes in perceived support (Kaniasty, 2011; Kaniasty & Norris, 1995). When entire communities are impacted by traumatic events, individuals within the support systems who may otherwise have been sources of support are often victims themselves. Consequently, the help that may have been anticipated in pre-trauma perceptions of social support may not meet expectations and result in disappointment following trauma exposure (Kaniasty, 2011). Therefore, as perceptions of social support diminish and participation in social networks and relationships, or social embeddedness, reduces, psychological distress is likely to increase (Kaniasty, 2011; Kaniasty & Norris, 1993; Norris & Kaniasty, 1996).

The deterioration of social support due to changes in perceived support has been related to the rules of relative need and relative advantage (Kaniasty, 2011; Kaniasty & Norris, 1995; Norris et al., 2008). The rule of relative need postulates that the help and support that often emerges following a critical disaster is distributed based on severity of

impact stemming from the trauma. Therefore, the most help often goes to those most affected by the stressor, such as those who endure the greatest physical or property damage (Kaniasty, 2011; Kaniasty & Norris, 1995; Norris et al., 2008). However, relative need is also impacted by the rule of relative advantage. Relative advantage refers to the personal characteristics that influence who receives the most support following a community disaster. These characteristics include gender, race, age, marital status, and level of education (Kaniasty, 2011; Kaniasty & Norris, 1995). As a result, younger white women who are married and more educated are more likely to receive community help in the aftermath of disasters than community members who experience similar levels of trauma impact who are older African American men who are not married and who received less education (Kaniasty & Norris, 1995).

The intersection of relative need and relative advantage is related to two concerning patterns that contribute to deterioration of perceived social support (Kaniasty & Norris, 1995). The first, which is known as the pattern of neglect, is observed in the discrepancy of received help amongst individuals with equivalent needs but differing relative advantage. This pattern then contributes to greater deterioration of perceived social support amongst community networks of socioeconomically marginalized groups who face the greatest challenges in receiving support. The pattern of neglect was observed in the aftermath of Hurricane Hugo and a similar trend was observed amongst some of the most disadvantaged survivors of Hurricane Katrina (i.e., evacuees who are HIV positive and of low socioeconomic status; Cieslak et al., 2009).

The second trend, or pattern of concern, is related to older community members and occurs in relation to the level of impact they experience as a result of the community

trauma (Kaniasty & Norris, 1995). The pattern of concern is observed as older community members receive significant concern and support from younger community members when facing severe need, such as threat to physical integrity in the aftermath of disaster. However, older community members receive significantly less concern and support from younger sources of support when the consequence of the traumatic event is less severe, such as property loss. These patterns indicate that the distribution of support following events of community trauma is often unequal and likely contribute to the deterioration of perceived social support over time.

Deterioration deterrence model. The deterioration deterrence model is an extension of the deterioration model of social support (Norris & Kaniasty, 1996). The deterioration deterrence model of social support indicates that when support that is initially mobilized immediately following the traumatic event is appropriate and adequate to need areas, expectations and perceptions of effective support will be maintained. This model is consistent with research that suggests that individuals may have specific needs for support related to trauma experiences (Gabert-Quillen et al., 2012; Glass et al., 2007) and that support is likely most effective when appropriately matched to need areas (Cohen & Wills, 1985). This process of mobilization of effective support then reduces, or deters, the deterioration of perceived support observed in the deterioration model (Kaniasty, 2011; Kaniasty & Norris, 1995; Norris & Kaniasty, 1996). Therefore, the deterioration deterrence model of social support suggests that adequate received support following trauma exposure contributes to the maintenance of positive perceived support, which is an important protective factor in coping and psychological well-being (Kaniasty, 2011; Norris et al., 2008; Norris & Kaniasty, 1996).

Etiological models of PTSD that involve social support. The interaction of social support with other factors such as intensity of trauma, personality characteristics, and coping responses has been observed to contribute to the etiology of PTSD (Brewin et al., 2000). Positive and negative aspects of social support have been described as an important predictor of PTSD in models of the etiology of PTSD (Brewin & Holmes, 2003; Ozer et al., 2008). More specifically, the elements of social support such as perceptions of support and social environment impact the cognitive processes in which distressing psychological symptoms emerge (Brewin & Holmes, 2003). Accordingly, two models, cognitive appraisal (Joseph et al., 1995) and social-cognitive processing (Lepore, 2001), propose explanations for the role of social support in the etiology of PTSD (Brewin & Holmes, 2003). This section first discusses social support as a predictor of PTSD and then describes the appraisal, social-cognitive processing, and Conservation of Resources models, detailing the role of social support in some etiological models of PTSD and post-traumatic experiences.

Social support as a predictor of PTSD. PTSD literature often sites social support as a predictor of symptoms of PTSD following trauma (Cohen & Wills, 1985). Although there is significant evidence that social support impacts the experience of PTSD, it remains unclear what aspects of, and through which mechanisms, social support effects the development and maintenance of PTSD (Robinaugh et al., 2011). Two important meta-analyses (Brewin et al., 2000; Ozer et al., 2008) that have focused on understanding the factors related to the development of PTSD observe that social support is one of the most significant predictors in the development of PTSD. Other important factors include pre-trauma functioning, severity of trauma, gender, race, and level of education (Brewin

et al., 2000; Ozer et al., 2008). Most research on the relationship between social support and PTSD examines the positive aspects of social support that can serve as protective factors (Brewin & Holmes, 2003). Research focus tends to be on perceptions of emotional support including aspects such as meaning-making and managing psychological distress rather than practical support such as financial assistance and navigating governmental agencies (Ozer et al., 2008).

However, it appears that negative aspects of social support, such as lack of support and unhelpful or critical support, are also important considerations in the prediction of PTSD (Brewin & Holmes, 2003). Literature indicates that a negative social environment is a stronger predictor of the development of PTSD than a positive social environment. Impairments or inadequacies in social support appear to impact interpersonal resources that may otherwise be beneficial in the aftermath of traumatic experiences (Besser & Priel, 2010). A lack of social support appears to be a significant risk factor when examined in relation to the severity of the trauma experienced and ongoing post-trauma stressors (Besser & Priel, 2010; Ozer et al., 2008). Negative social support appears to be more common amongst women than men and women who experience negative social support report higher rates of PTSD than do men with similar social environments (Brewin & Holmes, 2003).

It appears that the effects of social support are more significant the longer the period of time since the trauma (Ozer et al., 2008). Social support has been observed to be more predictive of PTSD in studies where more than three years had passed since the time of trauma exposure. Ozer and colleagues (2008) suggest that social support may be more effective in reducing the effects of distress over time rather than in the immediate

aftermath of trauma because it may be more useful when distress symptoms are clearly presented. Additionally, the impact of social support is likely cumulative over time, possibly contributing to long-term benefits of positive aspects of support (Ozer et al., 2008). Brewin and colleagues (2000) offer a different hypothesis, suggesting that the interactions between other pre- and post-trauma variables may differ amongst individuals. This may indicate that social support is both a predictive and intervening variable in the development of PTSD. Further research to understand the relationship between social support and the development of PTSD has been recommended in the existing literature (Brewin et al., 2000; Brewin & Holmes, 2003; Ozer et al., 2008). In the meantime, however, etiological models of PTSD attempt to understand the relationship between predictive variables and PTSD experiences.

Appraisals of trauma. Cognitive appraisals refer to the thinking processes that occur as an individual experiences a traumatic event that guide attempts at coping (Joseph et al., 1995; Widows et al., 2000). Appraisals are composed of initial interpretation of the stressor and secondary assessment of available resources for managing the stressor (Joseph et al., 1995). As individuals appraise a situation as harmful, fear-inducing, or threatening, cognitive processes are engaged to activate coping approaches (Widows et al., 2000). Joseph and colleagues (1995) suggest that traumatic events are initially processed at the time of the trauma; however, initial processing is generally inadequate. Therefore, traumatic events are later appraised and reappraised as the individual attempts to cognitively understand and integrate the experience. The process of cognitive appraisals is influenced by personality and environmental factors, of which social support is an important aspect (Joseph et al., 1995).

Social support interacts with other personal and environmental resources during the appraisal process (Joseph et al., 1995). Literature suggests that social support may influence cognitive appraisals following traumatic experiences (Ellis et al., 2009). Social support has the potential to contribute to and challenge the content of appraisals, diminish negative appraisals, reduce the significance of negative meaning-making, and activate problem-solving and adaptive behaviors (Cohen & Wills, 1985; Ellis et al., 2009). Input and information received from others during the appraisal process affects the individual's understanding and attributions of the traumatic event as well as emotional responses and approaches to coping following the event. In this way, received support has the potential to contribute to or reduce distress (Joseph et al., 1995).

Examination of social support within the cognitive appraisal model focuses on received support and its impact on the appraisal process (Joseph et al., 1995). For example, "crisis support" refers to the fulfillment of required needs in the immediate aftermath of trauma. It typically presents amongst supportive others who are available and willing to listen and offer emotional support. Research indicates that adequately received crisis support contributes to lower levels of avoidant psychological symptoms after the traumatic event. In their study of cognitive appraisals and social support in relation to acute stress symptoms amongst children who experienced trauma, Ellis and colleagues (2009) observed that positive social support was more protective against symptoms of depression after trauma exposure as opposed to symptoms of distress in the acute phase following the trauma. They suggest that the benefits of social support may take longer to emerge and become effective in the appraisal process (Ellis et al., 2009). Conversely, inadequate or unhelpful social environments may contribute to higher levels

of avoidant behaviors and maladaptive forms of coping (Widows et al., 2000). In this way, the availability of and contact with others who offer emotional and practical support, appear to provide trauma survivors with responses that impact the cognitive appraisal process (Joseph et al., 1995).

While received social support affects the content of the appraisal process, perceptions related to social support influence the degree to which support may be sought and received (Widows et al., 2000). Decreased perceptions of social support and social constraint appear to be related to negative appraisals of traumatic experiences and the development of PTSD symptoms (Widows et al., 2000). Joseph and colleagues (Joseph et al., 1994; Joseph et al., 1997) suggest that attitudes towards emotional expression affect social support experiences and the appraisal process; however they suggest that further research is needed to understand this relationship. Inhibition of emotional expression stemming from such attitudes has been associated with symptoms of distress and health problems (Joseph et al., 1994). Also, beliefs that expressing emotions to others indicates personal weakness may decrease the likelihood of seeking support. Receiving support may negatively impact self-esteem when the perception of accepting support is as a sign of weakness (Joseph et al., 1995). Just as the benefits of received support following trauma experiences impact the appraisal process, it appears that negative attitudes and perceptions about social support also affect cognitive appraisals of the traumatic event.

Social-cognitive processing. The most widely known theory of social cognition was developed by Bandura (1997; Cieslak et al., 2009). Bandura's social cognitive theory posits that multiple factors, including cognitive, social, and environmental

contribute to functioning and opportunities for growth, particularly in the face of stressors (Bandura, 1997). This theory indicates that the individual is a proactive agent who has influence over his or her life circumstances (Bandura, 1997; Benight & Bandura, 2004). Benight and Bandura (2004) suggest that factors of the social cognitive theory contribute to the development of self-efficacy, which promotes psychological functioning and well-being. Moreover, low levels of self-efficacy have been observed to be predictive of PTSD in populations of adult survivors of terrorist attacks and civilian adolescents exposed to war (Benight & Bandura, 2004). Self-efficacy refers to the belief that one has the ability to manage and control his or her own functioning, that one is not a passive participant in an influential environment (Bandura, 1997; Benight & Bandura, 2004). This perspective on self-efficacy has important implications in post-traumatic experiences as the belief that one can cope with the many demands related to the traumatic event likely influences the coping process.

Because of its focus on agency and self-efficacy, social cognitive theory views social support as an indirect or secondary factor in the post-traumatic experience (Benight & Bandura, 2004). Therefore, for the purposes of this study, the model of social-cognitive processing, proposed by Lepore and colleagues (Lepore, 2001; Lepore Silver, Wortman, & Wayment, 1996), which focuses on the role of social environment in cognitive processing, will be described in more detail than Bandura's social cognitive model.

The social-cognitive processing model posits that social environment is a significant factor in the cognitive process following traumatic experiences (Lepore, 2001; Lepore et al., 1996; Widows et al., 2000). Lepore and colleagues have examined the

model amongst cancer survivors (1998, 2008), bereaved mothers (1996), and in controlled research settings of acute stressors (2000). As in the cognitive appraisal model, existing research indicates that further exploration and examination is required to fully understand the ways in which social support influence cognitive processing of traumatic events (Lepore, 2001; Lepore et al., 1996; Lepore et al., 2000; Lepore & Hegelson, 1998). However, the social-cognitive processing model proposes hypotheses for the interactional relationship between social support experiences and post-trauma cognitive processing (Lepore, 2001; Lepore et al., 2000; Widows et al., 2000).

The first, which is referred to as the completion hypothesis, suggests that discussing and verbally processing traumatic events with supportive, noncritical others helps the individual to construct a narrative of the experience which helps to make meaning of the events and re-establish or re-organize pre-trauma beliefs about the self, others, and world (Lepore, 2001; Lepore et al., 2000). Incomplete processing of traumatic experiences may contribute to the development of PTSD symptoms, including intrusive thoughts related to the trauma (Lepore et al., 1996). The second hypothesis, or the desensitization hypothesis, suggests that social expression of traumatic events provides the individual with opportunities to be exposed to the trauma-related cognitive material, which decreases avoidance of stressful material, and allows for the development of positive or neutral responses to the material, which decreases the occurrence of intrusive thoughts related to negative emotional responses (Lepore, 2001; Lepore et al., 2000). The desensitization process likely decreases the development of the PTSD symptom of avoidance of trauma stimuli (Lepore et al., 1996). Lepore and colleagues

(2000) suggest that the desensitization process is more likely to occur with emotionally significant stressors as opposed to more minor or short-lived stressors.

The social-cognitive processing model also proposes that the responses received by trauma survivors impact the efficacy of social support in cognitive processing (Lepore, 2001). Successful cognitive processing of traumatic events is facilitated when social support and social environment is positive and empathic (Lepore, 2001, Lepore & Helgeson, 1998; Lepore et al., 1996). Conversely, negative, critical, and unsupportive social environments appear to impair cognitive processes and adjustment following traumatic experiences (Lepore, 2001, Lepore & Helgeson, 1998; Lepore et al., 1996), which may contribute to the development of PTSD symptoms of intrusive thoughts and avoidance (Lepore et al., 1996). It is hypothesized that survivors who receive negative responses to emotional disclosures, may become expressively inhibited and socially constrained, resulting in avoidant coping strategies and increased intrusive thoughts. This results in difficulty processing and integrating trauma-related material and problems managing difficult emotions (Lepore, 2001; Lepore & Helgeson, 1998; Lepore et al., 1996). Lepore and colleagues (1996, 1998) have observed that bereaved mothers and prostate cancer survivors who were socially constrained were more likely to have intrusive thoughts, engage in avoidant thinking, and be expressively inhibited than peers who did not experience social constraint. A more recent study that examined the social cognitive processing of trauma survivors (e.g., survivors of motor vehicle accidents and other accidents, survivors of traumatic grief) found that higher levels of social constraint contributed to lower levels of self-disclosure and increased post-traumatic distress (Belsher, Ruzek, Bongar, & Cordova, 2012). The social-cognitive processing model

appears to be consistent with other models examining social support and post-traumatic experiences in that positive social support appears to contribute to psychological well-being after traumatic experiences while negative social support appears to be related to psychological distress following trauma exposure.

Conservation of resources. Hobfoll (2001) proposed the Conservation of Resources (COR) model to predict stress response outcomes to a variety of stressors, including post-traumatic experiences. Hobfoll distinguishes the COR model from appraisal- and cognitive-based models because the COR model focuses on the environmental context as opposed to the personal processing emphasized in other models. The COR model suggests that “resources” are required and relied upon to maintain well-being, particularly in the face of adversity and stress (Hobfoll, 2001; Johnson et al., 2009). “Resources” refer to personal characteristics, social conditions, and environmental factors that are valued by the individual and are relevant to goal attainment and well-being (Halbesleben, 2006; Hobfoll, 2001). Resources are important because they contribute to coping and reduction of distress (Hobfoll, 2001; Joseph et al., 1995). The COR model suggests that stress occurs as resources are threatened or lost or when existing resources are insufficient, or are not adequately regained, when strained. As stress occurs, resources are used in responses and coping strategies and must be replenished for ongoing coping (Halbesleben, 2006; Hobfoll, 2001). When resources are expended and are not sufficiently replaced, “spirals” of resource loss occur, resulting in diminished coping, psychological distress and vulnerability to post-traumatic symptomology (Hobfoll, 2001; Johnson et al., 2009). Research on survivors of devastating hurricanes indicates that resource loss is a significant predictor of PTSD (e.g.,

Carver, 1993; Ironson et al., 1997). Traumatic events contribute to the considerable expenditure of, with limited opportunity to regain, resources that in other circumstances may be more adequately conserved and maintained to promote well-being (Johnson, et al., 2009).

Hobfoll (2001) suggests that the process of resource conservation occurs within the context of the individual and social environment and is highly influenced by cultural values and processes. Hobfoll (2001) stated that “the encounter of the self with stress is primarily situated in social context or involving social consequences” (p. 338). Social support, which is an element of the social context, therefore represents an important resource in the COR model (Halbesleben, 2006; Hobfoll, 2001). In COR literature, social support has been described as a “key psychosocial resource” (Johnson et al., 2009). COR theory posits that social support is itself an important resource and can bolster, through replacement or reinforcement, other resource areas that may be insufficient or depleted (Halbesleben, 2006; Hobfoll, 1988). Social support is hypothesized to reinforce positive self-perceptions that may be threatened by stressors thereby impacting the self within the social environment (Hobfoll, 1988).

A meta-analytic review of social support and burnout within the COR model indicates that the relationship between social support and conservation of resources may not be as clear or simple as indicated in the theoretical literature (Halbesleben, 2006). Halbesleben (2006) suggests that it is the specific functions that are provided in social support relationships that likely contribute to the conservation and use of resources, which are not adequately considered in Hobfoll’s model. Similarly, Joseph et al. (1995) indicate that many existing theories of post-traumatic distress, including COR, are limited

in understanding of social factors that contribute to post-traumatic experiences. Indeed, Hobfoll's (2001) model suggests that resources likely overlap and interact with each other in the conservation process. Hobfoll likens the complexity of resources to "caravans" in that they often link to each other and impact other areas with their presence or absence. Specifically, social support is hypothesized to impact, and be impacted by, self-esteem and coping styles (Hobfoll, 2001). Therefore it appears that further investigation and understanding of the role of social support in post-traumatic experiences is required.

Social support and post-traumatic growth. The PTG literature suggests that social support is an important element in the PTG experience (Prati & Pietrantonio, 2009). For example, Calhoun and Tedeschi (1999) state that, "the variety of social groups and communities to which the individual belongs may well have a significant influence on the likelihood of post-traumatic growth" (p. 20). Schaefer and Moos (1998) suggest that social support influences coping and adaptation to stressors, which contribute to personal growth, through more positive appraisals of traumatic experiences and engagement in adaptive coping (Schaefer & Moos, 1998).

More recently, Tedeschi and Calhoun's (2004) model of PTG cites social support as an important predictor of the growth experience following traumatic events. Tedeschi and Calhoun (1996, 2004) propose a process for the ways in which social support contribute to PTG. The support experience following traumatic events develops from pre-trauma relational patterns and changes in the individual's schemas that stem from the trauma (Calhoun & Tedeschi, 1999). Supportive relationships then provide the individual with opportunities for developing narratives and integrating other perspectives

into changing schemas (Tedeschi & Calhoun, 2004). Expression of trauma narratives to others facilitates emotional expression that can foster a sense of deepened intimacy in relationships (Tedeschi & Calhoun, 2004). This process then contributes changes in the individual's participation and role in relationships (Calhoun & Tedeschi, 1999).

Two areas, self-disclosure (Prati & Pietrantonio, 2009; Tedeschi & Calhoun, 2004), and mutual support (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2004), are related to social support and appear to contribute to the process of social support in the PTG experience. These areas are discussed next, followed by an alternative view of the relationship between social support and PTG.

Self-disclosure. Tedeschi and Calhoun (2004) suggest that the experience of emotional expression and responses received from supportive others contribute to the development of PTG (Tedeschi & Calhoun, 2004). Self-disclosure appears to promote emotional expression and provide deepened feelings of relating to others (Calhoun & Tedeschi, 1999). Additionally, as experiences are disclosed and emotions are expressed, desensitization to negative feelings may occur (Manne et al., 2004; Prati & Pietrantonio, 2009). Self-disclosure and emotional expression, which are significant predictors of PTG (Manne et al., 2004; Prati & Pietrantonio, 2009), must occur in the context of supportive relationships (Calhoun & Tedeschi, 1999) and thus are intrinsically connected to social support.

Mutual support. Mutual support is the support that occurs amongst individuals who have experienced similar events, including traumas. Although both mutual support and extended support both involve providing support to others, extended support only refers to the unidirectional experience of offering support to others.

Tedeschi and Calhoun (2004) suggest that mutual support is particularly important as survivors may view others who have “been there” as credible, which can influence their willingness to accept their perspectives and support. They further suggest that other survivors may be looked to for assurance that life and growth can continue after the traumatic event and may provide models for survival (Calhoun & Tedeschi, 1999). Survivors may also experience a greater sense of acceptance with other survivors (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2004). Also, narratives and experiences shared between survivors contribute to “vicarious post-traumatic growth” or spreading of lessons learned from traumatic events (Tedeschi & Calhoun, 2004). This process facilitates a sense of helping and empathizing with others that benefits the individual through recognition of her own strength and what she has to offer to others (Calhoun & Tedeschi, 1999).

Alternative view of social support and PTG. Despite these favorable views of social support in the PTG process, debate continues about the relationship between social support, social support coping, and PTG (Linley & Joseph, 2005). In their meta-analysis on factors that contribute to PTG, Prati and Pietrantoni (2009) observed that the effect size for the influence of social support on PTG was medium and suggest that further research is required to understand the relationship. Furthermore, in a study of patients with HIV responses to a natural disaster, the presence of social resources was not directly related to PTG but more specifically to improved relating to others (Cieslak et al., 2009). Similar findings have been observed amongst other research with individuals facing life-threatening illnesses.

One hypothesized explanation for the variance in effect size of factors related to PTG was proposed by Zoellner and Maercker (2006) regarding the construct of PTG. They suggest that growth after trauma may represent several different processes including coping and cognitive manipulation of distressing material (Zoellner & Maercker, 2006). They present a model of PTG, referred to as the Janus-Face model, which suggests that self-deceptive, or illusory, strategies may be used to make meaning following traumatic events that can co-occur with other constructive elements of growth. The Janus-Face model further posits that social influence may contribute to deceptive beliefs related to meaning-making and growth stemming from traumatic experiences (Cieslak et al., 2009). For example, a supportive other may offer “benefits” observed from the trauma that may deceptively influence the survivor’s feelings or beliefs that may contribute to long-term distress. Cieslak and colleagues (2009) suggest that understanding the relationship between social support and PTG may also be impacted by the use of broad measures social support and growth in PTG research. They recommend the use of measures of growth that “match” types of support being examined.

Summary of models. All of these models attempt to clearly delineate the role of social support in post-traumatic experiences, either specifically to the relationship between social support and stress responses or in incorporating social support into the development of PTSD symptoms or post-traumatic growth. However, no one model appears to comprehensively capture and explain the relationship between social support and post-traumatic experiences.

While all of these models use some construct or structure of social support described previously in this chapter and included in the operational definition of social

support for this study, the organization and prominence of various elements of social support differ amongst the models. For example, perceived support figures prominently in most models (e.g., personality model, network orientation, erosion model, deterioration and deterioration deterrence models, and appraisal model). Similarly, the network orientation, stress-buffering, erosion, and COR models emphasize the impact of functions fulfilled by social support in the post-traumatic experience. Interestingly, received social support, which is described as the most basic construct of social support (i.e., “helping behaviors”; Clapp & Beck, 2009), has been significantly cited in the post-traumatic experience in only a few models, including the deterioration deterrence, appraisal, and social-cognitive processing models.

Although the constructs and structures described above highlight the commonalities observed in the conceptualization of social support across the ten models, the impact and outcomes of social support appear to distinguish the models from each other. More specifically, many of the models related to social support and post-traumatic experiences described in this section appear to be associated with either positive or negative outcomes of trauma exposure. For example, the stress-buffering model hypothesizes a positive post-traumatic response when social support intervenes (Cohen & Wills, 1985), whereas the deterioration models are related to negative post-traumatic responses and diminished social support (Clapp & Beck, 2009; Kaniasty & Norris, 1993; Kaniasty & Norris, 1995). These potential outcomes of traumatic experiences parallel the trajectories described earlier in this chapter. Therefore, these models may provide insight into the role of social support in chronic distress, recovery, resilience, and post-traumatic growth trajectories. Indeed, PTG research indicates that social support is an important

element in the PTG experience (Prati & Pietrantonio, 2009; Tedeschi & Calhoun, 1999). However, because these models do not comprehensively explain the relationship between social support and post-traumatic responses, such understanding cannot be garnered from existing literature. Accordingly, many researchers suggest the need for clarified understanding of this relationship (e.g., Clapp & Beck, 2009; Joseph et al., 1997; Joseph et al., 1995; Prati & Pietrantonio, 2009).

In sum, it is clear from review of the models described above, that social support has the potential to contribute to positive outcomes of trauma, such as successful coping and meaning-making, as well to negative outcomes, such as diminished self-esteem and psychological distress. Also, these models further point to the multifaceted nature of social support, which is comprised of perceived support, received support and the functions provided, as well as the type, or content, of the support relationships. Yet, none of the models integrate all of the constructs into understanding of social support experiences in responses to trauma within the psychotherapeutic context. Therefore, this study seeks to examine these constructs of social support in the post-traumatic experience from the perspective of clients who have survived traumatic events. The next section describes the clinical implications of social support in the psychotherapy of clients who have experienced trauma.

Social support and psychotherapy with people who have experienced trauma. Clinical implications regarding social support in psychotherapy with individuals who have experienced trauma are largely based on the theoretical constructs and models described above (Goldsmith, 2004). Review of existing literature indicates that most recommendations for interventions involving social support stem from theoretical

conceptualization of social support and its constructs, as there appears to be a lack of research stemming from psychotherapeutic studies. This section begins with the clinical implication of social support and trauma, is followed by the measurement of social support in psychotherapy, and ends with social support and therapy modalities.

Clinical implications of social support and trauma. Many studies examining the relationship between social support and post-traumatic experiences indicate that “important implications for therapeutic intervention” (Joseph et al., 1994, p. 523) can be garnered from their findings (e.g., Clapp & Beck, 2009; Joseph et al., 1994; Joseph et al., 1995; King et al., 2006; Lepore et al., 2000). Indeed, it has been suggested that clinical interventions should focus on developing or accessing adjunctive social support (Thrasher, Power, Morant, Marks, & Dalgleish, 2010). Such interventions could involve increasing help-seeking from friends and family (Joseph et al., 1994), developing social skills and interpersonal communication (King et al., 2006), improving perceptions of social support (Besser & Priel, 2010), encouraging participation in social activities (Norris & Kanisty, 1996), and increasing social support (Prati & Pietrantonio, 2009). Such interventions are notable given that research has indicated that low levels of social support diminish overall treatment efficacy for individuals with chronic PTSD (Thrasher et al., 2010). The treatment recommendations appear to stem from assumptions about the beneficial relationship between social support and post-traumatic experiences.

Recommendations for social support and psychotherapy with clients who have experienced trauma, which are based on clients’ social support need areas, include the development of new social ties and intervention aimed at facilitating support within the existing network (Gottlieb, 2000). Strategies to develop new ties are matching clients

with appropriate one-to-one services (e.g., mentor programs or services that provide “friendly visitors”) or group format services (e.g., support groups or social activity groups). Interventions focused on the existing social network include inclusion of identified supportive others in goal-setting, training others to be “surrogate therapists”, or “mobilizing” the natural supports available to the client through the use of psychoeducation (Gottlieb, 2000). It should be noted that these interventions are not specifically geared toward clients who are trauma survivors but rather more general populations.

Additionally, stemming from their model of post-traumatic growth, Calhoun and Tedeschi (1999) offer recommendations for assisting clients to make changes in their relationships. Their suggestions are: be aware of and provide appropriate community-based resources for support groups; encourage and accept clients’ narratives of traumatic experiences; prepare clients for sharing their experiences with others through normalizing the disclosure process and practicing in role-play scenarios; recognizing and sharing observations of change and growth in clients related to their interpersonal relationships; and provide psychoeducation about some of the challenges often associated with the process of disclosure and social support experiences.

Despite these recommendations for the positive role of social support in psychotherapy with clients who have experienced trauma, research indicates that the implications for social support in post-traumatic experiences can be mixed (Goldsmith, 2004). Missing from these discussions is the more nuanced view of social support described previously in this chapter, which indicates that the varied constructs and

structures of social support may impact the effect it has on post-traumatic experiences. It appears that few recommendations include cautionary statements.

In some literature on the use of social support interventions (that are not specific to trauma survivors), the potential for negative social support outcomes is included (e.g., Goldsmith, 2004; Gottlieb, 2000). Savage and Russell (2005) are more specific in their suggestion that there is need for caution when existing social networks are relied upon in coping and healing. They further indicate concern in situations where professional support may be limited and informal supports may be encouraged and state, “trauma distress may not be easily tractable and may require not only social supports but also professional expertise and services to help ease symptom distress” (Savage & Russell, 2005, p. 213). In their study of acute stress symptoms and social support in children, Ellis and colleagues (2009) also caution that social support can have negative effects on post-traumatic experiences. Therefore, they provide suggestions, including psychoeducation for parents and CBT interventions for children, to reduce the impact of negative social support on children’s post-traumatic functioning (Ellis et al., 2009). However, specific interventions related to the potential negative outcomes of social support in therapy with adult trauma survivors is absent from existing literature.

Measurement of social support in psychotherapy. Also missing are clear recommendations for the incorporation of assessment of social support into treatment. Although numerous measures of social support and its constructs and structures have been developed, these tools are primarily used in various areas of psychological research (Brissette, Cohen, & Seeman, 2000; Wills & Shinar, 2000). The lack of published attention to incorporating social support assessment in individual adult psychotherapy

appears to be a significant limitation, since obtaining a “baseline assessment” of clients’ social support experiences at the start of treatment has been recommended (Goldsmith, 2004; Gottlieb, 2000). Moreover, research indicates that social support is most beneficial when it is appropriately matched to the recipient’s needs (Cieslak et al., 2009; Cutrona, Shaffer, Wesner, & Gardner, 2007; Goldsmith, 2004; Gottlieb, 2000). Accordingly, Brissette and colleagues (2000) note that, “research in the field of social integration would benefit from a closer alignment with the intervention tradition” (p. 77). To inform, implications for the use of social support assessment in therapy, this subsection briefly discusses self-report measures, interview protocols, qualitative assessment, and behavioral observation of social support.

In clinical and social psychology research, social support has been measured through a variety of self-report questionnaires that examine individual constructs and structures of social support (Brissette et al., 2000). Review of the existing trauma literature focused on social support indicates that self-report measures are the primary tool in assessing social support experiences. For example, received social support can be measured using the Inventory of Social Supportive Behaviors (ISSB), which consists of 40-items that examine receipt of various types of support during the previous 30 days (Barrera, Sandler, & Ramsay, as cited in Wills & Shinar, 2000). An example of a perceived support measure is the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988; Zimet, Powell, Farley, Werkman, & Berkoff, 1990). The MSPSS measures subjective feeling and beliefs about the adequacy of social support from family, friends, and significant others using a 12-item questionnaire (Zimet et al., 1988; Zimet et al., 1990). Functions of social support can be

measured using the Social Provisions Scale that includes 24 items related to six functions (e.g., validation of self-worth or advice) that may be provided (Cutrona & Russell, as cited in Wills & Shinar, 2000). Support content has been measured through the 12-item Social Network Index (SNI), which examines the occurrence of experiences in 12 types of relationships including primary kin (e.g., parents, spouse, or children), secondary kin (e.g., parents-in-law), primary friends (e.g., close friends), secondary friends (e.g., co-workers or classmates), and affiliative relationships (e.g., relationships from participation in organized groups; Cohen, 1991).

A major limitation of these self-report measures is that they are retrospective in nature, requiring an individual to reflect back on support experiences over the previous months and up to one year (Brissette et al., 2000). Therefore, self-assessment of support experiences and beliefs may be influenced by other intervening events and may not accurately reflect earlier events. To this end, Brissette et al. (2000) suggested the development of daily assessments of support experiences or natural study of support as it occurs. And more recently, diary measures, in which respondents are asked to record daily experiences with social support, have been found to be useful in increasing the precision of social support measurement on a day-to-day basis (Lakey, 2007) (see discussion of behavioral observations below for further information regarding diary measures). All of the self-report measures described have been used in psychological research with adults, and none are specific to traumatic or post-traumatic experiences.

Also, these measures may not adequately capture the social support experiences of culturally diverse populations as the structure of networks may be different across cultures and different functions may be provided or valued (Brissette et al., 2000). For

example, communities of Korean, Chinese, and Filipino immigrants in the U.S. have been observed to have broad social networks in which support resources are shared throughout the network. These social support experiences may not likely not well-represented in the self-report measures described above.

Social support has also been measured through interview protocols that are more integrative than the measures described above (Wills & Shinar, 2000). For example, the UCLA Social Support Interview (UCLA-SSI) is a 70-item interview that asks the individual to identify a recent stressor, and then asks about individuals who may have provided associated support. The UCLA-SSI is a particularly useful tool because it examines numerous elements of social support within one interview: support content (e.g., parent); functions of support (e.g., instrumental); quality of received support, including negative aspects; and perceived availability of support.

Although the UCLA-SSI was developed from interviews in which adult participants were asked to think about support experienced associated with a stressful event (i.e., something troubling or difficult to deal with), it was not specifically related to trauma-related stressors (Dunkel-Schetter, Folkman, & Lazarus, 1987). Another limitation of this tool is the closed-ended, directed nature of the interview questions, which do not allow for open or spontaneous expression of social support experiences. Also, it is a lengthy measure when compared to the briefer self-report inventories.

Next, social support has been infrequently measured through qualitative assessment such as treatment narratives (e.g., Wilsey & Shear, 2007, which is further described later in this section). Wilsey and Shear (2007) suggest that “qualitative methods are particularly useful for exploration of individually meaningful topics such as

social support, affording a nuanced exploration of the contribution of others” (p. 803). In their study of complicated grievers, Wilsey and Shear used a grounded theory approach to analyze participants’ narratives. That is, they used an open coding approach to analyze each sentence in participants’ narratives, and identified and refined themes that emerged. Although their study yielded a descriptive perspective on social support experiences among complicated grievers, the methods employed appear to occur infrequently in other social support research, including studies focused on clinical implications.

A final method for measuring social support that attempts to address limitations of other assessment tools is behavioral observation (Reis & Collins, 2000). The other measures of social support described above focus on individuals’ subjective assessment of their social experiences, which may be misleading or biased given that they rely on recollection of support experiences after they have occurred (Lakey & Cohen, 2000; Reis & Collins, 2000). Accordingly, Lakey and Cohen (2000) observed that “social support research has yet to identify the naturally occurring concepts that people use to think about their relationships” (p. 39). Reis and Collins (2000) proposed that assessment of social support must include focus on the actual relational interactions that occur between people. To fill this need, behavior observation methods attempt to objectively look at actual social interactions as they occur in real or recorded time.

Objective behavioral observation methods examine specific interactional behaviors that occur between people (Reis & Collins, 2000), and garner greater specificity in identifying the variables of social support at play (Liotta & Jason, 1983) than compared with self-report social support measures. For example, observational measures involve the examination of interpersonal interactions by trained researchers

who may conduct frequency counts of supportive behaviors or assess the quality of the supportive behaviors (Lakey & Cohen, 2000). Assessment of social support through behavioral observations may also capture collectivistic exchanges, common in many non-Western cultures, which may be difficult to capture in existing self-report and interview measures (Reis & Collins, 2000). Finally, observational methods are useful for monitoring and assessing change in social support relationships over time as it occurs in relational interactions (Liotta & Jason, 1983), which is likely useful in capturing nuances that may be distorted in measures relying on subjective memory (Reis & Collins, 2000).

Several behavioral observation methods used to assess social support in relationships require participants (usually dyads) to talk about a problem one of them is facing while being recorded or observed (Reis & Collins, 2000). The assessment then consists of an interval in which the individuals engage and interact freely followed by analysis of the interaction by trained coders. Analysis is typically based on behavioral criteria specified in the assessment protocol. An example of a behavioral observation measure for social support is the Social Support Behavior Code, which has been studied with married couples (SSBC; Cutrona & Suhr, 1992). The SSBC examines video recordings of 10 minute intervals in which participants are asked to disclose something that is currently distressing to each other. Coders then examine the helping behaviors of the participant in the supporter role for frequency of 23 functional behaviors (e.g., provision of esteem, emotional, informational, and instrumental support; Cutrona & Suhr, 1992; Reis & Collins, 2000). Although the SSBC has good inter-rater reliability in behavioral analysis of functions of social support in situations where it is actually

provided, rather than retrospectively and subjectively recalled by the recipient, it is not yet widely used in research (Lakey, 2007).

Another type of behavioral observation that is used in measuring social support is daily experience, or diary, studies (Lakey, 2007; Reis & Collins, 2000). Daily experience measures require participants to keep logs of social support experiences that include feelings, thoughts, and behaviors that occur during experiences of social support. Although diary studies are not considered an objective measure as are behavioral observation assessments, they do gather a great deal of naturalistic data that capture many elements of multifaceted social support experiences. Moreover, this data is gathered as the individual experiences social support rather than recalling experiences months later (Reis & Collins, 2000), thereby providing more precise experiential assessments (Lakey, 2007). The format of daily experience measures may be based on intervals (i.e., the individual completes entries at a regularly scheduled time), signals (i.e., the individual records entries when prompted by an alert), or events (i.e., entries are made when supportive interactions occur; Reis & Collins, 2000). One example of a daily experience measure is the Rochester Interaction Record (RIR), which requires participants to report on all social interactions that last more than 10 minutes. Diary measures of social support provide analysts with a great deal of information that can be examined for many aspects of social support experiences and the natural variations that occur in support relationships.

Although behavior observation and daily experience measures capture elements of social support experiences that may not be included in self-report or interview assessments, there are limitations to these methods (Reis & Collins, 2000). One

significant limitation is that these methods are highly labor intensive. Behavioral observation measures require a great deal of effort in coding and analyzing relational interactions. Diary studies require significant effort on the part of participants who must make numerous entries during the course of the assessment. These measures are also time-consuming, require more resources than other social support assessments, and can be quite costly.

Although behavioral observation measures involve considerable, effort, time and resources, they have relevance for the current study's qualitative research design. Examination of client expressions of social support in therapy sessions offers a naturalistic view of social support experiences. Clients may discuss their subjective experiences with social support spontaneously in therapy without relying on directed retrospective assessments. Also, Wills and Shinar (2000) suggest that studies of social support may benefit from multidimensional views of the social support experience through examination of the quality of perceived and received support, support functions, and the types or contents of support relationships. Therefore, a multidimensional content analysis of expressions of social support over the course of therapy with clients who have experienced trauma should gain insight into social support experiences that may not be afforded from other methods.

Social support and therapy modalities. While many of the recommendations for social support in therapy with clients who have experienced trauma appear to be focused on enhancing the individual's use of support in the aftermath of trauma, as described above, the modalities of therapy that are recommended to do so involve multiple clients, such as support groups and couples therapy (e.g., Calhoun & Tedeschi, 1999; Cohen et

al., 2000; Gottlieb, 2000; Helgeson & Gottlieb, 2000; Lepore, 2001; Lepore et al., 2000) rather than individual psychotherapy. In this way, the focus of recommendations for interventions related to social support involve the individual's existing networks or the development of new social networks for trauma survivors within the context of therapy (Cohen et al., 2000), as opposed to processing and fostering of the social support experience in individual therapy. Gottlieb (2000) suggests that therapy modalities in which the individual uses existing or develops new supports offer different benefits than individual psychotherapy. Specifically, the individual experiences effects that stem from direct, personal interactions with others rather than from interventions engineered by a professional therapist.

Given the lack of research in the context of individual therapy, this subsection briefly reviews relevant research on social support and psychotherapy in the context of individual therapy in areas outside of trauma treatment. One recent meta-analysis that examined the impact of extratherapeutic social support on psychotherapeutic outcomes in 27 clinical studies indicated that social support has a lower effect on therapeutic outcomes than clinicians may anticipate (Roehrle & Strouse, 2008). The researchers suggest that mental health professionals may be likely to overestimate the influence of social support during treatment. They further cite consistent effect sizes across the varied studies (i.e., mean correlation of .13), which used different interventions, related to social support and its constructs. Roehrle and Strouse (2008) suggest that the consistency across studies of social support is evidence of the limited influence of social support of psychotherapeutic outcomes. The meta-analysis concluded that social support variables alone likely have minimal impact on therapeutic outcomes, although they may interact

with other extratherapeutic factors (e.g., therapeutic alliance) for a more cumulative influence.

Another recent study qualitatively examined treatment narratives of individuals who experienced complicated grief during the course of standardized interpersonal psychotherapy (Wilsey & Shear, 2007). All of the study's participants discussed social support experiences during the course of their narratives and the researchers identified themes related to perceived social support. Wilsey and Shear (2007) identified themes of positive support nearly half of the narratives, which included available and affectionate help as well as support that honored participants' losses. They also observed descriptions of a lack of support, including feeling unsupported and dissatisfied, in the narratives of more than half of the participants. The negative support narratives described others as rude, unhelpful, or combative and often resulted in participants feeling anger towards the individual providing support. In addition, reports of negative support occupied nearly double the amount of space in the narratives than positive support. These findings suggest that various elements of social support are likely to emerge in client descriptions of support and that descriptions of social support in therapy are likely nuanced. Therefore, the authors suggest that social support cannot be evaluated only by presence or absence. Given that these findings are specific to the manualized treatment used in the study, which was specifically developed for the treatment of individuals experiencing complicated grief, examination of client expressions of social support in other forms of therapy with individuals who have experienced other types of trauma is an important area for future research.

Summary of clinical implications of social support. In sum, many researchers indicate that social support is an important factor in the post-traumatic experience and offer suggestions about the use of social support in therapy (e.g. Calhoun & Tedeschi, 1999; Clapp & Beck, 2009; Joseph et al., 1995; Thrasher et al., 2010), but the social support literature often states that further research is needed to understand the clinical implications of social support (e.g., Kaniasty & Norris, 1995; Lepore et al., 2008; Prati & Pietrantonio, 2009). Also, the generalized suggestions on promoting social support in therapy fail to acknowledge and adequately address the potential for social support to contribute to distress following traumatic experiences. Another major limitation of the suggested clinical implications for social support in therapy after trauma is that the recommendations are developed from community and laboratory samples rather than actual psychotherapy studies (e.g., Joseph et al., 1994; King et al., 2006; Lepore et al., 2000). Also, while social support has been measured in a variety of methods, measurement has usually occurred in research rather than psychotherapy. Finally, review of psychotherapeutic literature on the use of social support in treatment indicates an absence of research specific to trauma populations. Although some research has focused on social support in the context of psychotherapy (e.g., Roehrle & Strouse, 2008; Wilsey & Shear, 2007), none has examined social support and post-traumatic experiences in psychotherapy. As such, the clinical assessments and interventions may not be accurately generalized to the unique needs of individuals who have experienced trauma. Therefore, investigation of the ways in which clients who have experienced trauma bring discussions of social support into therapy will likely provide contribute to the current dearth of research in this area.

Purpose of the Study

Research on the post-traumatic responses of people who experienced trauma indicate that their experiences are characterized by trajectories, or patterns of behavior and functioning (Bonanno, 2008), which have been used to inform psychotherapy interventions for trauma populations (Levine et al., 2009). Social support is commonly accepted as both a protective (Lyons, 1991) and a risk factor in the post-traumatic experience (Bonanno, 2008; Ellis et al., 2009; Lyons, 1991). Accordingly, numerous theoretical models have been developed to explain the relationship between social support and post-traumatic experiences (e.g., stress-buffering, erosion, deterioration, and deterioration deterrence models). However, existing theories do not adequately capture the multidimensional experience of social support, which is comprised of several constructs and structures (e.g., received and perceived support and the functions and content of support), in the post-traumatic experience. Additionally, the clinical implications that stem from existing social support theories have not been studied in psychotherapeutic research related to therapy with clients who have experienced trauma. Therefore, this study sought to explore the ways in which clients who have experienced trauma, and specifically those events that threaten physical integrity, express social support in psychotherapy.

Specifically, this study aimed to gain a nuanced view of client expressions of social support through qualitative analysis of the content of psychotherapy sessions in which discussions of trauma occurred. This study explored the question: how do clients who have experienced trauma express social support in psychotherapy?

Chapter II: Method

This chapter describes a summary of the methods that were used to conduct the current study. The chapter begins with a brief overview of the qualitative research design chosen for this study, a directed content analysis approach to qualitative psychotherapy research. Then, the participants, instrumentation, and procedures that were followed are explained, followed by ethical considerations and the data analysis steps taken.

Research Design

Qualitative research is often used in clinical psychology research as a group of methodologies which provides unique description of the human experience (Morrow, 2007) by answering “how?” and “what?” questions, in contrast to the “why?” questions that quantitative research generally focuses on (Mertens, 2009; Morrow, 2007).

Qualitative approaches to research are closely related to clinical practice and are often familiar to the unique audience of researchers, scholars and practitioners within the field of counseling psychology because qualitative methodologies reflect the phenomena of narrative, language and feelings that are intrinsic to human processes and the psychotherapy process (Morrow, 2007). A variety of qualitative research designs have been used increase understanding of such topics as multiculturalism, identity development, and grief (Creswell, Hanson, Clark, & Morales, 2007). Qualitative approaches are useful for exploring and clarifying variables that may be difficult to identify and for examining existing literature or theories for which additional information may be needed (Morrow, 2007). Therefore, a qualitative approach to the current study of clients’ expressions of social support in psychotherapy was taken to provide a nuanced approach to observing the many elements of social support that are often related to the

post-traumatic experience in existing literature but have been studied only limitedly in the psychotherapy process.

In qualitative designs, the research question guides the methodological approach (Creswell, et al., 2007; Morrow, 2007). Because the current study focused on expressions of social support, the use of a content analysis was used. Content analysis refers to a group of methods for examining textual data (Hsieh & Shannon, 2005). The general approach involves analyzing language-based data for information ranging from initial impressions to quantifying word usage within a specific conceptual area. The process involves coding and analyzing textual data, often from interviews, for concepts and variables related to the area of study. Although a firm definition of content analysis is difficult to identify, the methodological approach can be better understood within the framework of the specific type of content analysis. A directed content analysis was used in the current study to inform the development and subsequent use of codes for social support and analysis of psychotherapy.

Directed content analysis refers to the process of examining a theory or phenomenon through identification of key concepts within textual data. The directed approach allows for exploration of theories that may not be well-defined as well as gaining additional insights into existing frameworks and models (Hsieh & Shannon, 2005). While content analyses can be in either inductive or deductive forms (Elo & Kyngäs, 2008), directed content analyses are typically deductive in as nature as they are informed by existing theory (Hsieh & Shannon, 2005). An “inductive” approach is used when existing knowledge or understanding of a phenomenon is limited or absent. A “deductive” approach, on the other hand, is used when an existing theory or model is

available to guide the structure of the content analysis (Elo & Kyngäs, 2008). This study used both deductive and inductive approaches to the content analysis. First, constructs and structures (i.e., received support, perceived support, extended support, support functions, and support content) of social support that are commonly used in theoretical literature were used to develop codes for analyzing the content of therapy sessions. Second, inductive analyses were used as the researcher allowed themes to emerge from other expressions of social support that did not fit coded existing constructs and structures (i.e., support needs) in the transcribed therapy sessions.

Participants

This section first describes the steps taken in selecting the sample for the current study. Then, detailed summaries of each of the selected client-participants, including demographic information, presenting problems, and information about their social support resources are provided. Table 1 details a brief summary of the five selected client-participants.

Client-participants. This study used purposeful sampling, which was consistent with recommendations for this type of qualitative research (Creswell, 2009; Denzin & Lincoln, 1998; Mertens, 2009), to select five psychotherapy cases that contained adequate data from an archival database related to a Southern California university's three community counseling centers. The researcher gained approval from her university's Institutional Review Board (IRB; Appendix A) before accessing the database for case selection and examination. Each client participant reviewed and provided written informed consent to allow therapy records (written, audio, and/or video material) to be included in the research database. Also, therapists, who were master's and doctoral level

student trainees, completed written informed consent for including their written, audio, and/or video records to be included in the archival database. Before therapy materials were included in the database, identifying information, such as names, dates of birth, and city names, were removed from records. All clients and therapists included in the database were assigned random identification codes created for the purpose of the database to replace use of names.

In order to select client participants that are appropriate for this study, inclusion and exclusion criteria was met. All participants were at least 18 years old at the time of intake and were fluent in English. Also, participants completed written consent for participation in the research database and provided consent for inclusion of video materials in the database (Appendix B). Additionally, the therapist from each selected case provided written consent for inclusion and use of written and video materials (Appendix C). For the purposes of this study, only psychotherapy cases that contained sufficient data, which referred to the case records included in the database, were included. “Sufficient” data was defined as the inclusion of video recordings of therapy sessions and written materials consisting of the Telephone Intake Summary, Client Information Adult Form, Intake Evaluation Summary, and Treatment Summary (see Procedure section). The written materials indicated that the client participant experienced trauma, using the operational definition provided in the previous chapter. Finally, each participant had at least one session recording (video) in which the traumatic and/or posttraumatic experience was discussed.

Potential participants were excluded from this study based on two exclusion criteria. In order to ensure the confidentiality of potential participants and reduce

possible researcher bias, cases in which the researchers personally knew either the client or therapist were not included. Also, only clients who received adult individual psychotherapy, as opposed to couples, family therapy, or child/adolescent individual therapy, were included in the study's sample.

Client-Participant 1. Client-Participant 1 (CP1) was a 28-year-old, African-American, heterosexual woman who identified as Christian. Four years before beginning therapy, CP1 moved from an urban area in the central southern part of the United States to a large metropolitan area in California. It was documented that CP1 was involved in a complicated but committed long-distance relationship with a man who remained in the city from which she moved. At the time of intake, CP1 maintained steady employment in the accounting department at a travel agency; despite her stable employment, she described financial struggles as a prominent stressor. CP1 initiated individual therapy due to problems expressing her feelings in relationships with her friends and her boyfriend. She hypothesized that these difficulties stemmed from the childhood trauma of being raped by her uncle, who was also her babysitter, when she was in the third grade. She said she later thwarted her uncle's attempt to rape her on a second occasion when she threatened to disclose the sexual assault to her mother. CP1 indicated that she had never previously disclosed the trauma history and stated that her uncle is no longer living. It was documented in the Intake Evaluation Summary that she maintains a relationship with her mother but had not previously met her father. Additionally, she identified, as documented in the Telephone Intake Form and the Intake Evaluation Summary, that her social support system includes her brother and an older cousin.

CP1's Client Information Adult Form showed that she included the following problems as her primary reasons for starting therapy: trouble communicating sometimes, difficulty expressing emotions, lacking self-confidence, feeling inferior to others, and difficulty controlling her thoughts. Her self-identified symptoms, as reported in the Client Information Adult Form, also included, at a lower level of intensity: having difficulty being honest/open, being suspicious of others, concerns about emotional stability, feeling lonely, feeling angry much of the time, feeling down or unhappy, feeling down on herself, experiencing guilty feelings, and concerns about finances. At intake, CP1's diagnosis was a V-code of Partner-Relational Problem, with a Global Assessment of Functioning (GAF) of 75. She participated in 21 therapy sessions that were focused on the exploration of her early trauma and the goal of increasing her ability to communicate her emotions with others.

Client-Participant 2. Client-Participant 2 (CP2) was a heterosexual, European-American, woman who was 47 years old and single at the time of intake. CP2 did not indicate a religious affiliation at the time of intake; it was documented in the Intake Evaluation Summary that although she believed in God, she had no religious group identification. She immigrated to the United States from England, where she was born and raised, more than 14 years prior to intake. She experienced several serious medical conditions that contributed to her being unable to work and for which she was seeking disability benefits at the start of treatment. Before initiating therapy services at the clinic, she reportedly experienced a stroke approximately one year with subsequent loss of eyesight over time as well as other medical problems that included diabetes, neuropathy, and balance problems. She initially sought psychotherapy due to symptoms of frequent

crying and excessive skin-scratching that which she believed was a compulsive behavior in response to trigger of the loss of her eyesight. CP2 identified having “great social support” in her life, which she reported was beneficial as she faced these challenging medical conditions.

At the start of treatment, CP2 indicated the following problems on the intake paperwork as being the significant reasons for which she sought therapy: concerns about emotional stability, feeling lonely, feeling nervous or anxious, feeling down or unhappy, experiencing guilty feelings, difficulty making decisions, needing to learn to relax, and concerns about physical health. Following the initial intake, CP2 was not assigned any Axis I or Axis II diagnoses. Her treatment goals focused on exploring and addressing feelings stemming from her loss of eyesight, and addressing issues from her childhood, such as feelings of abandonment and dependency that were reactivated due to her physical condition. Because no Termination Summary was available for CP2, the overall course and outcome of her treatment was unspecified but other records such as the Appointment Log and sessions recording (i.e., DVDs) indicated that she participated in 12 therapy sessions.

Client-Participant 3. Client-Participant 2 (CP3) was a Hispanic, Christian, married woman who was 21 years old at the start of therapy. She was born in El Salvador and lived there until she was 19 years old, when she immigrated to the United States. When she began treatment, CP3 was sharing a home with her husband, to whom she had been married for one and a half years, and was employed as a sales representative. At the time of intake, CP3 reported experiencing symptoms of depression (e.g., suicidal ideation, anhedonia, worthlessness, guilt, and feelings of sadness,).

irritability (e.g., anger and impulsivity), conflict in her relationship with her husband, and limited social support in her life. CP3 also indicated that she had a long history of physical and emotional abuse perpetrated by her biological mother and maternal grandmother that occurred between the ages of 11 and 17. Additionally, she reported two occurrences of sexual abuse, but did not specify her age at the time of sexual abuse instances or the identity of the perpetrator.

CP3 indicated on the intake forms these primary problems as the reason for her obtaining therapy services: family difficulties, feeling nervous or anxious, and needing to learn to relax. She also noted the following symptoms as areas of concerns but to a lesser degree: difficulty making or keeping friends, difficulty in sexual relationships, being suspicious of others, concerns about emotional stability, feeling angry much of the time, feeling down or unhappy, feeling guilty, thoughts of taking your own life, and difficulty controlling your thoughts. Following the initial intake, CP3 was diagnosed with Major Depressive Disorder (Recurrent, Severe, Without Psychotic Features) with both Dysthymic Disorder and PTSD being assigned as rule-outs on Axis I. Dysthymic Disorder was eventually ruled out during treatment. However, she was assigned the additional diagnosis of Borderline Personality Disorder on Axis II during the course of treatment. The Termination Summary for CP3 noted that she participated in 31 sessions using Dialectical-Behavioral Therapy interventions aimed at decreasing the her suicidal ideation and increasing her capacity for distress tolerance, emotional regulation, and communication skills. CP3 withdrew from therapy before termination was recommended by her therapist and, consequently, was provided with other community referrals for further services.

Client-Participant 4. Client-Participant 4 (CP4) was a married woman and mother of four daughters who was 39 years old at the time of intake. Her self-identified ethnicity was Black, Caucasian, and American Indian. Although she identified in the Client Information Adult Form that she is “spiritual,” the Intake Evaluation Summary indicated that CP4 did not have any specific religious or spiritual affiliation or membership. At the start of treatment, CP4 indicated that she was a stay-at-home mother and was the legal conservator of her elderly grandmother (i.e., her father’s mother). She also listed previous, intermittent employment as a paralegal over a period of 16 years.

CP4’s presenting concern and reason for seeking treatment was related to the significant emotional distress she experienced after learning that her father had allegedly molested her non-biological daughter (i.e., her husband’s cousin who she and her husband had legal guardianship of and had raised since she was 10 years old) 4 years prior to the start of treatment. CP4’s ability to cope with the emotional distress following the discovering was complicated by her own history of sexual abuse, which consisted of “touching and oral sex,” by her paternal grandfather that occurred when the client-participant was 7 years old. She indicated that memories of her sexual abuse history, including threats by her grandfather not to disclose the abuse, were triggered by information she discovered related to the abuse that her father likely inflicted on her daughter.

At intake, she reported experiencing feelings of guilt, anger, anxiety, and sadness. CP4 identified experiencing difficulties with concentration, sleep, and her ability to trust others. She observed that emotional distress she was experiencing was also contributing to strain in her relationship with her husband. Despite some relational problems in her

marriage, CP4 identified that she had high levels of social support from her close friends and her husband, which she described as a blessing. She also noted on the intake paperwork concern, to a lesser degree, related to the following symptoms: feelings related to having been abused or assaulted, family difficulties, trouble communication sometimes, being suspicious of others, concerns about emotional stability, feeling down or unhappy, feeling angry much of the time, under pressure and feeling stressed, difficulty controlling your thoughts, difficulty making decisions, feelings confused much of the time, and concerns about finances.

Following the clinical intake, CP4 was diagnosed with the following Axis I disorders: Adjustment Disorder with Mixed Anxiety and Depression and (V-code) of Sexual Abuse of a Child. According to the Intake Evaluation Summary, cognitive-behavioral-therapy was planned for CP4's treatment with focus on the goals of decreasing feelings of resentment and anger and increasing trust in others. Because the Termination Summary and Appointment Log for CP4 were not available, the specific course, approach, and duration of treatment were unknown. However, there were three DVD session recordings included in the research file for CP4, so it can be surmised that psychotherapy lasted for at least three sessions.

Client-Participant 5. Client-Participant 5 (CP5) was a 28-year-old heterosexual, woman who was married with two children but was separated from her husband at the start of treatment. She identified as Caucasian and Protestant. At the time of intake, CP5 was employed as an administrative assistant. She was self-referred for treatment due to symptoms of exhaustion, confusion, and fear, and stated that she was close to “falling apart.” CP5 described a history of sexual abuse during her childhood that included

several years of abuse that was perpetrated by a neighbor beginning when she was 4 years old, and later being sexually abused by her father when she was 14 years old. She also stated that approximately one year before the start of treatment she separated from her husband, who she married when she was 21 years old, due to physical and verbal abuse by her husband.

CP5 indicated on the initial intake paperwork that the primary reason she sought therapy was to “learn to relax.” She also noted the following other important reasons for seeking therapy: feelings related to having been abused or assaulted, marital problems, difficulties in sexual relationships, trouble communicating sometimes, difficulty expressing emotions, afraid of being on your own, lacking self-confidence, feeling inferior to others, concerns about emotional stability, feeling down or unhappy, feeling nervous or anxious, under pressure and feeling stressed, feeling confused much of the time, concerns about physical health, concerns with weight or body image, feeling controlled/manipulated, and concerns about finances. Following the initial intake, CP5 was diagnosed with the following Axis I disorders: Posttraumatic Stress Disorder (PTSD), Depersonalization Disorder, and Dysthymic Disorder. CP5’s initial treatment goals related to exploration of her abuse history, identification and connection to emotional and physical experiences, and an increase of her ability to use available social support resources. Because no Termination Summary was available for CP5, there was no further information known about the overall course and theoretical approach to treatment. Also, there was no Appointment Log available for CP5, so the specific length of her treatment was unknown. However, there were 13 DVD session recordings

included in the research file; therefore, her psychotherapy experience lasted at least 13 sessions.

Table 1
Client-Participant Demographic Information

CP	Age	Gender	Ethnicity	Traumatic Event	DSM-IV-TR Diagnoses
1	28	Female	African-American	Child Sexual Abuse	Partner-Relational Problem
2	47	Female	European-American	Stroke/Blindness	No Diagnoses
3	21	Female	El-Salvadorian	Child Phys/Sexual Abuse	MDD; R/O PTSD; BPD
4	39	Female	Black, American Indian, Caucasian	Child Sexual Abuse	Adjustment Disorder w/ Anxiety and Depression
5	28	Female	Caucasian	Child Phys/Sexual Abuse; DV	PTSD; Depersonalization Disorder; Dysth. Disorder

Note. CP = Client Participant; PTSD = Posttraumatic Stress Disorder; MDD = Major Depressive Disorder; BPD = Borderline Personality Disorder; DV = Domestic Violence; Dysth = Dysthymic

Researcher-participants. This study included a team of three research-participants, who were doctoral students in a clinical psychology program, and one research-auditor, who was a faculty member in the clinical psychology program and supervised research stemming from the archival database. The use of a team, or multiple, researcher format with an auditor was aimed at providing varied perspectives and minimizing individual biases as related to the complex nature of the data examined (Hill, Thompson, & Williams, 1997). This section provides descriptions of each of the coders and auditor's background and professional views, which include areas of bias.

Coder 1. The primary researcher, and author of this study, was a 31-year-old Caucasian, female doctoral student in clinical psychology. She was married and was

raised in the northeastern part of the United States in a working class, Catholic family. She was among the first generation of her family to be born in the United States with her father and maternal grandparents emigrating from Newfoundland, a former colony of Great Britain and current province of Canada. Coder 1 primarily conceptualized clients from a psychodynamic perspective. She generally practiced dynamically-oriented psychotherapy in her clinical training; however, she also incorporated strengths-based approaches and mindfulness practice in work with clients. Coder 1 was a Registered Art Therapist (ATR) and completed master's training in art therapy; she continued to use art therapy techniques in her clinical work. Therefore, she also valued varied forms of expression and interpersonal connection in the therapeutic experience that extended beyond "traditional talk therapy" and incorporated visually expressive media and interaction in the creative process.

Stemming from her academic and field training in these areas, Coder 1 viewed and valued interpersonal relationships as highly significant in the human experience. She believed that early, as well as ongoing, relationships impact a person's sense of self and understanding of the world. Consistent with self psychology theory, Coder 1 believed that the need for relationships and connectedness to others never disappears but rather changes over time based on experiences. In this way, she believed that the role of interpersonal relationships after traumatic experiences have the potential to be supportive and contribute to healing, while recognizing that some relationships may be detrimental. Coder 1 strongly believed in the healing potential of the therapeutic relationship, particularly in the post-traumatic experience. She conceptualized the therapeutic relationship as a potentially significant source of support that can contribute to the

experience of, and need for, interpersonal connectedness that exists throughout the lifespan.

Coder 2. The second coder (Coder 2) was a 29-year-old, Caucasian, married, female clinical psychology doctoral student. Coder 2 generally conceptualized and treated psychotherapy clients from a cognitive-behavioral perspective. More specifically, she believed that dysfunctional or maladaptive thinking, which develops as a result of early and/or impactful life experiences, strongly influences how an individual thinks about and interprets situations. Accordingly, she believed that the identification and modification of various levels of thought in therapy contribute to improvements in mood and behavior. Consistent with this perspective, Coder 2 also viewed the therapeutic relationship and a sense of authenticity as necessary elements upon which such change can occur. Coder 2 strongly believed in the incredible healing capacity of relationships in both her personal and professional life. In particular, she was interested in the restorative power of interpersonal support and connectedness as it relates to one's experience of stress and adversity.

Coder 3. The third coder (Coder 3) was a 28-year old Caucasian male doctoral student in clinical psychology. He, his parents, and his grandparents were all born in the United States. He was raised in a middle class home southwestern state where he lived for 20 years before moving to California for graduate school. In general, Coder 3 conceptualized clients and clinical cases from humanistic/existential as well as cognitive-behavioral perspectives. He conceptualized a client as someone generally driven toward personal growth while navigating core, existential dilemmas. He strongly believed in the human potential for growth beyond that of simple symptom reduction and is encouraged

by therapies and theoretical frameworks that foster such growth through illuminating meaning in the human condition. In his academic pursuits, clinical training, and clinical experience, Coder 3 developed an appreciation for deep existential concerns that often loom underneath more superficial problems. Among these existential concerns, fear of death was particularly interesting to him in that it seemed to be the root of both debilitating terror as well as motivation for growth. In addition, Coder 3 believed that social support was an important factor in the growth process as it provides individuals with opportunities for exploring existential concerns with supportive others and for coping with crises.

Auditor. The auditor, and dissertation chair, for this study was a married, Christian, European-American female who held advanced degrees in both psychology (Ph.D.) and law (JD). She was an associate professor of clinical psychology in a tenured position at a Southern California university. Her research interests were related to positive and forensic psychology. Her clinical conceptualization was primarily from a cognitive-behavioral perspective with the incorporation of strengths-based approaches to treatment. Thus, the auditor believed that social support can be an important source of strength and protective factor for individuals who have experienced trauma. In addition, she was interested in how clients' social support experiences may contribute to the coping process and may help and/or hinder the therapeutic process.

Instrumentation

The researcher created a directed coding system for the content analysis of expressions of social support made in therapy by clients who experienced trauma based on the constructs and structures commonly discussed in psychology literature on post-

traumatic experiences. Based on the literature related to social support in the post-traumatic experience reviewed in the previous chapter, the researcher identified the following five areas of social support: (a) received support, (b) perceived support, (c) extended support, (d) social support functions, and (e) social support contents.

Additionally, in reviewing client expressions of social support experiences, statements of (f) support needs were identified as salient elements of social support experiences following exposure to trauma, which became a sixth area category in the coding statements of social support. Finally, the seventh category, which was referred to as (g) other, was used to capture discussions of social support that were consistent with the purposes of the study, yet did not fit within any of the five aforementioned social support categories. Given the conceptual overlap among these categories in the overall social support experience (e.g., received support is comprised of support functions; Kaniasty et al., 2008 and perceived support develops out of experiences with received support (Clapp & Beck, 2009), some expressions of social support were coded in one or more of the identified categories. These elements of social support served as the coding categories (see coding manual in Appendix D for more detailed coding procedures), and are discussed in the subsections that follow.

Received support codes. The set of received support codes was used when clients reported on naturally occurring helping behaviors that were provided to them by others during therapy sessions involving discussion of trauma. This definition of received support was expanded and clarified from the initial definition, “support that was provided or given,” that was used during the two practice sessions. These codes were used when the client-participant referred to the quality of received social support as

positive (RS1; “My sister’s help was such a blessing!” “It was so helpful to hear those comforting words from my rabbi.”), negative (RS2; “My brother said he would take care of the kids but he never showed up;” “She was supposed to help, but what she said really offended me.”), or not otherwise specified (RS3; “The church gave us food and clothes;” “My social worker called to check in on me.”).

Perceived support codes. Expressions of perceived support were used when the client-participant expressed beliefs about support to be received that may stem from previous support experiences, which was updated from the original definition of “beliefs about support” following the pilot coding sessions. Such expressions were coded as positive (PS1; “I just know my friends will always be there for me, ready to help me out.”); negative (PS2; “I can’t rely on anyone and I doubt I ever will.”); or not otherwise specified (PS3; “Sometimes you can count on your friends and sometimes you can’t.”).

Extended support codes. Client-participant expressions of extended support were used to categorize client-participants’ explicit indications of support, or beliefs about support, that were provided to others, which clarified the initial definition of “support that she provided to others” from the practice coding sessions. Expressions of extended support were coded as positive (ES1; “It felt so good to be needed for once! I was the person she talked to and counted on;” “I’m good at taking care of people. It just comes naturally to me.”); negative (ES2; “Everyone is always relying on me for everything. I’m so sick of constantly taking care of everyone else;” “she is too sick. I’m just not cut out to take care of her. I’ll mess everything up!”); or not otherwise specified (ES3; “I got so annoyed that I had to help him but I felt better after doing it;” “I took over

the childcare duties for them;” “I see myself as the caretaker in my family. I’ll always take care of them.”).

Support needs codes. Expressions of social support that reflected client-participant needs, desires, or wishes for support were coded in the content analysis. The *Support Needs* coding category was developed during the pilot analysis because client-participant expressions of social support that fell into the “other” category were observed to be related to stated needs for support from other and desires to provide to others. Statements of support needs were coded as from others (SN1; “I just wish someone would tell me what will happen.”); to others (SN2; “I knew I would feel better if I helped them in some way.”); or not otherwise specified (SN3; “I went to church because I just needed to be around people.”).

Social support function codes. The researcher-participants coded the functions of social support, or the types of support received, that client-participants report in sessions in which discussions of trauma occurred. It was determined during the practice coding process that support functions would only be coded in descriptions of support that client-participants received from others. Such codes were used when the client expressed esteem support (F1; “Receiving that card from her let me know how special I am.”); emotional support (F2; “He was just so understanding when I cried.”); advice or informational support (F3; “She told me that what happened was illegal and I should talk to a lawyer;” “He told me what happened while I was in the hospital.”); feedback from others (F4; “My best friend told me I’m getting better every day.”); instrumental support (F5; “My mother let us stay at her place and borrow her car.”); social companionship (F6;

“When we were at the beach and laughing together, I totally forgot about how bad everything has been.”); or not otherwise specified (F7; “I talked and she listened.”).

Social support content codes. Another coding category was used for the social support content, or type of support, that client-participants expressed in sessions that involved trauma discussions. These codes were used when the client described primary kin (C1; “I have a hard time talking to my parents about it;” “My husband is my biggest support.”); secondary kin (C2; “My wife’s parents stayed with us after the accident.”); primary friend (C3; “My three closest friends are the guys I grew up with;” “My best friend just ‘gets’ me.”); other friend (C4; “It was nice to talk to a friend;” “I never really talked about personal stuff with the other moms at the playgroup.”); sexual or romantic support content (C5; “I’ve been dating this girl for about six months;” “My boyfriend was always the person I went to when things got bad.”); support stemming from group or organization affiliation (C6; “The people in my hiking group have been so understanding when I’ve had to cancel.”); mutual aid relationships related to the traumatic event(s) (C7; “The women in my support group have shared so much.”); support content that comes from professional service providers (C8; “I just didn’t connect with my previous therapist.”); or not otherwise specified (C9; “This guy listened to me and let me cry;” “I told the woman that I didn’t care.”). Additionally, it was determined during the analysis of the pilot sessions that all assigned support content codes should also record the specific relationship in brackets (e.g., C1 [mother]).

Other social support codes. Finally, because social support can be defined in many ways and involve varied constructs, client-participant expressions of social support did not always fit within the categories described above. In the directed content analysis

approach, it is common to allow for additional themes to emerge from the qualitative data (Hsieh & Shannon, 2005). Therefore, an additional code was included for client expressions of social support that did not fall into any other code or was not otherwise specified (SS; “Even though my mother passed away, I still get so much strength from thinking of her and talking to her.”). Following the initial practice coding sessions, one new coding category emerged: *Support Needs* (described above). No other codes emerged from the “other” category during the qualitative process; themes that emerged from this coding category are discussed in the next chapter.

Procedure

Sample Selection. Purposeful sampling was used in this study to identify participants most appropriate to the research question and study design (Creswell, 1998). Although purposeful sampling is not likely to result in a participant group that is representative of the entire clinical population being investigated, as may occur with random sampling, the sampling method was indicated for the current study in light of the limited number of participants for the research design and specified research question (Mertens, 2009). Also, generalizability was not considered a critical factor the qualitative research design (Creswell, 1998). Purposeful sampling is generally recommended when conducting extensive analysis of a small number (e.g. four or five) of cases (Creswell, 1998); this study included five former psychotherapy cases who met the inclusion and exclusion criteria. The procedures for selecting those cases are described below.

Step 1: Obtaining a list of potential participants. The researchers began by obtaining the complete list of research records of clients whose therapy had ended and whose clinical records had been de-identified and entered into the archival database.

Step 2: Narrowing the list based on demographic inclusion criteria. The researchers then narrowed the list of potential participants to only those who were at least 18 years old at the time of intake, were English speaking, and participated in individual psychotherapy.

Step 3: Narrowing the list based on experiences of trauma. The list of potential participants was next limited to include only those clients whose database records indicated that they experienced trauma. As described in the previous chapter, for the purposes of this study, trauma was defined as having witnessed or experienced a threat to physical integrity and felt an accompanied sense of horror or helplessness. Using McNally's (2004) definition of trauma, which was more restrictive than the definition included in the DSM-IV-TR, traumatic events referred to:

direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or [directly] witnessing an event that involves death, injury, or a threat to the physical integrity of another person. (p. 463)

Common examples of traumatic events, as discussed in the previous chapter, include life threatening combat situations, major disasters, violent assault or rape, and witnessing bodily injury to or death of others (First, et al., 2002) as well as childhood physical and sexual abuse (Stein et al., 2012) and life threatening medical events (Bruggimann et al., 2006; Merriman et al., 2007). Threats to physical integrity that stemmed from race and culture-related stressors also represent traumatic events that were included in this study in accordance with recommended cultural considerations (e.g., Scurfield & Mackey, 2001; Tummala-Narra, 2007). This study used multiple data instruments to determine whether

a potential participant has experienced a traumatic event, including available written clinical research data from the clients' therapy experiences.

The data instruments that were used to determine if the trauma history inclusion criterion was met were related to the written documentation of psychotherapy services. The researchers first examined the Family Data section of the Client Information Adult Form (Appendix E), in which the client indicated "Which of the following have family members, including yourself, struggled with," in response to a thorough list of potentially traumatic situations. The researchers then checked for places where participants marked, "Yes – This Happened" in the "Self" column for any of the following distressing events: discrimination (e.g. hate crimes), death and loss, rape/sexual assault, sexual abuses, physical abuse, injury, disability, or debilitating illness.

The researchers also used the Telephone Intake Form (Appendix F), the Intake Evaluation Summary (Appendix G), and the Treatment Summary (Appendix H) to determine if potential participants experienced traumatic events. The Telephone Intake Form included the Reason for Referral section, which described the client's initial motivation for seeking therapy services. The researchers reviewed this portion of the Telephone Intake Form to determine if histories of traumatic experience(s) or distressing symptoms related to prior traumatic events were associated with the stated reason for referral. The Intake Evaluation Summary also included several sections that indicated the presence of trauma histories: Presenting Problem/Current Condition (Section II), History of presenting Problem and Other Psychological Conditions (Section III), Psychosocial History (Section IV), DSM-IV-TR Multiaxial Diagnosis (Section VIII), and Treatment Recommendations (Section X). The researchers examined each of these areas for

descriptions of possible trauma experiences that may have been the focus of clinical attention. Finally, the researchers reviewed the Treatment Summary for indications that trauma-related symptoms and/or diagnosis or post-traumatic experiences were the focus of clinical attention and discussion during the course of treatment. Once all of these research documents were examined, the researcher-participants reached consensus that at least one of the available forms of information was indicative of a trauma history for a given client before continuing with the additional sample selection steps. The researchers tracked trauma history information from the clinic forms amongst potential participants on a Word document (Appendix I).

Step 4: Narrowing selection based on discussions of trauma. Potential participants were included only if their therapy involved discussions of their traumatic, or post-traumatic, experience(s) during at least one video recorded psychotherapy session. The researchers examined each participant's session video recordings for observations that such discussions occurred. Discussions of trauma, as defined in literature on disclosure, consisted of the following possible verbalizations: (a) narratives of the traumatic event(s); (b) beliefs, thoughts, or attitudes related to the event(s); and (c) feelings or emotions about the events(s) (Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker et al., 2001). Sessions that were identified as containing the longest trauma discussions (see Step 5) were then transcribed and coded. Further information about discussions of trauma is provided in the Coding Manual (Appendix D).

Step 5: Selecting specific sessions. In cases where more than one session recording was available for a given client, one session recording was selected for transcription and analysis. The single session was chosen based on the length of time of

trauma discussion. The session in which the most amount of time was spent on a trauma related discussion, as compared to other available session recordings for that client, was selected. This step was taken to select sessions for CP1, CP2, CP3, and CP4 because more than one of the available session recordings contained discussions of trauma. The available sessions were reviewed and the length of the trauma discussions were observed; then for each client-participant, the session with the longest cumulative amount of time discussing trauma experiences was selected for inclusion in the study.

Step 6: Narrowing selection based on cultural diversity. Once the potential sample was narrowed, the researchers obtained a sample of participants who were demographically and culturally varied in terms of age, ethnicity, and religiosity or spirituality. Demographic and cultural characteristics of potential participants were determined from multiple clinic forms included in the archival database. For example, clients' age and gender were indicated in the Telephone Intake (Appendix F). Clients also had the option to include religion/spirituality, ethnicity or race, and disability status in the Social Cultural (Optional) section of the Client Information Adult Form (Appendix E). Finally, cultural information was also included in the Cultural Factors & Role of Religion in Client's Life portion (section F) of the Intake Evaluation Summary (Appendix G). The researchers examined each of these areas in order to determine the demographic and cultural characteristics of potential participants. Although the researchers attempted to select participants with varying genders, the only potential participants available at this step in the selection process were women. Therefore, all selected client-participants were female.

Transcription. Selected sessions were transcribed by four masters-level graduate students in psychology who volunteered as research assistants. The research assistants were first trained in the transcription process and were then instructed in the verbatim transcription method adapted from Baylor University's Institute for Oral History. Instructions for the transcription process are included in the Coding Manual (Appendix D).

Coding. The coders for this study were the three researcher-participants, who were doctoral students in clinical psychology. The study's auditor was its research supervisor and dissertation chair. Before coding any cases for the study, the coders and auditor practiced on two sample cases in order to reach a 75 percent agreement. Generally an 80 percent agreement is recommended for this type of study (Miles & Huberman, 1994); however, in this study a 75 percent agreement was used because it is the highest possible agreement short of unanimous. The researcher-participants agreed that a 75 percent consensus should be reached across the two pilot sessions, otherwise additional practice sessions would be independently coded and reviewed to improve inter-rater reliability before moving on to the sessions included in the study. The coders were each trained on the study's coding process, including all relevant terms, concepts, factors, and issues for identifying expressions of social support within the recorded sessions (Ryan & Bernard, 2003). The instructions that were used for training coders are detailed in the Coding Manual (Appendix D).

Human subjects/ethical considerations. The study's researcher was committed to maintaining and protecting the confidentiality and rights of the participants and upholding ethical standards and practices for their treatment. The methodology used to

conduct the study was non-invasive and all research information and material came from an archival database that did not require direct contact with participants. Additionally, four precautions were used in the creation of the archival material within the database. First, each therapy client at the community clinics was provided with a verbal explanation (from their therapist) of the limits of confidentiality for therapy and confidentiality issues related to participation in the research database during the informed consent process at the start of treatment. Each participant in the current study provided written consent for their psychotherapy records (i.e., written, audio, and video material) to be included in the database prior to the start of therapy (Appendix B). Second, each therapist whose records were used in this study provided written consent for their written, audio, and visual records to be used in the database (Appendix C). Third, after therapy was terminated, research assistants generated a de-identified research file for each client in which all potentially recognizable information was redacted from both the client's and the therapist's written materials in order to ensure confidentiality as the information was transferred to the database. Each client and therapist whose information is included in the database was given a research identification number in order to track material in the database without the use of identifying information (Mertens, 2009).

The researcher was also committed to the ongoing, ethical and confidential handling of the participants' de-identified research data. To this end, each of the researcher-participants/coders and transcribers completed both an Institutional Review Board (IRB) certification course (Appendix J) to promote the maintenance of ethical standards regarding research on human subjects and confidential health information. Confidentiality was further protected by excluding any cases in which any of the

researcher/participants personally knew either the client or therapist. Also the research assistants (i.e., transcribers [Appendix K] and coders [Appendix L]) involved in the current study signed confidentiality agreements delineating expectations and procedures for maintaining the confidentiality of information contained in the research materials.

Data analysis approach. Because this study employed a naturalistic, directed content analysis, the researcher used a deductive analysis to explore and validate existing theory-based constructs (Hsieh & Shannon, 2005). Specifically, constructs and structures of social support in the post-traumatic experience provided the conceptual basis for the analysis. The following elements of social support comprised the seven coding categories for the study: received support, perceived support, extended social support, support needs, social support functions, social support contents, and other expressions of social support not adequately captured in the previous categories. These coding categories are described in the previous Instrumentation Section and in the Coding Manual (Appendix C). The constructs and structures of social support that were used in the coding categories were used in the qualitative analysis of the expressions of social support made in psychotherapy by clients who experienced trauma. The researcher followed the guidelines indicated by Hsieh and Shannon (2005) as steps for the directed content analysis: transcribing, highlighting, coding text, auditing, reaching consensus, evaluating data, and presenting findings. This section describes these steps in more detail.

Step 1: Transcription. Selected session recordings (selection criteria are described in the Procedure section above) that contained client discussions of traumatic, or post-traumatic, experiences were transcribed, in their entirety, by volunteer research

assistants. Researcher-participants then reviewed the recordings and transcriptions to ensure accuracy in the transcribing process.

Step 2: Highlighting. The session transcripts were then read by the researcher-participants who independently highlighted all text that appeared, on first impression, to contain client expressions of social support.

Step 3: Coding selected text. The researcher-participants next independently coded all of the highlighted areas that they each identified in the transcriptions using the predetermined codes for constructs and structures of social support: (a) received support (RS1; RS2; RS3), (b) perceived support (PS1; PS2; PS3), (c) extended support (ES1; ES2; ES3), (d) social support functions (F1; F2; F3; F4; F5; F6; F7), (e) social support contents (C1; C2; C3; C4; C5; C6; C7; C8; C9), and (f) other discussions of social support (SS) that were consistent with the purposes of this study but did not fall in any of the previous categories (see the Instrumentation section above and Coding Manual in Appendix C for descriptions of the coding categories).

Thus, all expressions of direct social support experiences for the client-participants stated within the selected sessions were coded and analyzed in the context of one of their sessions in which discussions of trauma occurred. It was beyond the scope of this dissertation to code sessions with clients who had not experienced trauma. The researcher also did not separate out the trauma discussions from the other content in the sessions because the intent of this qualitative study was to be more exploratory and inclusive in order to provide a rich contextual understanding of the participants' experiences and to inform future research (e.g., others may decide to compare frequencies and forms of social support used during trauma discussions to those outside

of trauma discussions). Because the focus of the study was on the social support experiences of trauma survivors, the researchers decided to examine the sessions in entirety and code all statements that clients made about their own social support experiences (e.g., types and functions of support), as all included client-participants experienced a threat to physical integrity.

Each researcher-participant independently examined and coded the transcript data before meeting as a group to discuss individual choices and results in coding and reached a consensus on social support codes. The use of multiple researchers in this study allowed for diverse perspectives and opinions to be included in the analysis, which is recommended to improve the accuracy of the captured complexity of the data and decreases the impact of individual biases (Hill et al., 1997). However, Harris and Lahey (1982) observed that this method of coding increases the potential for group bias (i.e., when one researcher modifies their decisions to achieve consensus with other raters, which is known as consensual observer drift). To address potential group biases, each researcher retained records of his or her independent codes as well as the group consensus codes. Also, the researcher-participants documented any inter-rater disagreement that occurred during the group discussion and the rationale that was used in achieving their final decision in the audit trail, which allowed the auditor to be aware of and understand the researchers' judgment process (Orwin, 1994). Finally, the researcher-participants discussed any individual biases they recorded in their separate audit trails maintained in the *Microsoft Word* documents that may have impacted their coding when achieving consensus and included summaries of such discussions in the shared *Google Document* audit trail.

During the group discussion of consensus, the researchers analyzed the final, “other,” category to identify any significant themes that may warrant additional coding categories or subcategories relevant to the purposes of the study (Hsieh & Shannon, 2005). After coding the initial practice sessions, the new code, (g) support needs (SN1; SN2; SN3), emerged from the participant-client’s expressions of social support in the (f) other discussions of social support category and is further detailed in the Coding Manual included in Appendix C. The coding of identified text in this step was recorded and tracked using their individually maintained *Microsoft Word* documents.

The researcher-participants used the technique of bracketing to record individual expectations and biases that may have influenced the data collection process. Bracketing is commonly used in qualitative research in order for researchers to reflect on biases that may emerge and thereby reduce the effects of personal assumptions on the collection process and analysis of qualitative data (Ahern, 1999). In accordance with the bracketing process, each researcher-participant maintained a record of such factors as: (a) possible assumptions about gender, age, race, and socioeconomic status; (b) individual values that the researcher held and believed to impact his or her potential for objectivity; (c) possible role interference or conflict; (d) the researcher’s interest in the data and the degree to which such interest may have disposed the researcher to favorable interpretations of the data; and (e) any personal feelings that resulted in diminished neutrality. Although it is recommended that reflections be maintained in bracketing journals, the research participants recorded reflections related to the bracketing process in the individually maintained audit trails so that discussions of such factors could be easily integrated into group discussions. That is, the research-participants recorded reflections in alignment

with their records of their individual coding decisions for easier reference later. The recorded bracketing reflections kept by the researchers as well as the auditor were used throughout the coding process and group discussions related to obtaining group agreement on the coded data.

Fleiss' kappa coefficient (K; Fleiss, 1971) was used to calculate the inter-rater reliability amongst the three coders before group discussions. The K score for each code within client-participants and averages across client-participants are summarized in Table 2. The statistical inter-rater reliability measure was used in order to determine if the agreement between coders was greater than what would be expected if coders assigned random codes (Gwet, 2010). Because this study uses three coders to analyze the selected sessions, the use of Fleiss' kappa was indicated to calculate inter-rater reliability (i.e., more than two raters were present; Fleiss, Cohen, & Everitt, 1969).

Suggested measures of significance vary for K values and there are no universally agreed upon significance value. The guidelines suggested by Landis and Koch (1977) indicate that $K < 0$ reflects poor agreement, $0.01 < K < 0.20$ represents slight agreement, $0.21 < K < 0.40$ indicates fair agreement, $0.41 < K < 0.60$ signifies moderate agreement, $0.61 < K < 0.80$ denotes substantial agreement, and $0.81 < K < 1.00$ indicates almost perfect agreement. A negative value for K represents agreement that is worse than expected change.

The average pre-group discussion agreements for each of the coding categories were: 0.83 for the received support codes (almost perfect); 0.90 for the perceived support codes (almost perfect); 0.87 for the extended support codes (almost perfect); 0.83 for the support needs codes (almost perfect); 0.70 for the support functions codes (substantial);

0.99 for the support content codes (almost perfect); and 0.84 for the not otherwise specified category (almost perfect). Table 2 displays a summary of the inter-rater reliability agreements for the coding categories across client-participants from the initial independent coding process.

Table 2
Average Inter-rater Reliability Coefficients Among Three Coders For Coding Categories, Across Participants (Pre-Group Discussions)

	Average Fleiss' Kappa	Average Observed Agrmt.	Average Expected Agrmt.		Average Fleiss' Kappa	Average Observed Agrmt.	Average Expected Agrmt.
RS	0.834	0.997	0.972	F	0.699	0.998	0.988
PS	0.901	0.998	0.984	C	0.992	0.999	0.927
ES	0.872	0.997	0.980	SS	0.839	0.995	0.959
SN	0.829	0.997	0.978				

Note. RS = Received Support; PS = Perceived Support; ES = Extended Support; SN = Support Needs; F = Support Functions; C = Support Content; SS = Expression of Social Support Not Otherwise Specified; Agrmt. = Agreement.

As displayed in the table below (Table 3), coders had an average pre-group discussion agreement of 0.86 for RS1 (almost perfect), 0.75 for RS2 (substantial), 0.89 for RS3 (almost perfect), 0.96 for PS1 (almost perfect), 0.95 for PS2 (almost perfect), 0.79 for PS3 (substantial), 1.00 for ES1 (almost perfect), 0.72 for ES2 (substantial), 0.89 for ES3 (almost perfect), 0.73 for SN1 (substantial), 0.90 for SN2 (almost perfect), 0.86 for SN3 (almost perfect), 1.00 for F1 (almost perfect), 0.66 for F2 (substantial), 0.89 for F3 (almost perfect), -0.003 for F4 (worse than expected), 0.82 for F5 (almost perfect), 0.68 for F6 (substantial), 0.84 for F7 (almost perfect), 1.00 for C1 (almost perfect), 1.00 for C2 (almost perfect), 1.00 for C3 (almost perfect), 1.00 for C4 (almost perfect), 0.99 for C5 (almost perfect), 1.00 for C8 (almost perfect), 0.96 for C9 (almost perfect), 0.84

for SS (almost perfect). Because the codes C6 and C7 were not used in any of the selected sessions, the average agreement for the two codes was undefined.

Table 3
Inter-rater Reliability Coefficients Among Three Coders (Pre-Group Discussions)

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
RS1				F4			
1	0.499	0.998	0.997	1	N/A	1	1
2	1	1	0.939	2	-0.004	0.993	0.993
3	1	1	0.936	3	N/A	1	1
4	1	1	0.957	4	-0.002	0.996	0.996
5	0.799	0.998	0.989	5	N/A	1	1
Avg.	0.859	0.999	0.963	Avg.	-0.003	0.998	0.998
RS2				F5			
1	0.749	0.998	0.994	1	0.748	0.997	0.987
2	N/A	1	1	2	1	1	0.969
3	N/A	1	1	3	1	1	0.993
4	0.748	0.996	0.986	4	1	1	0.957
5	N/A	1	1	5	0.331	0.996	0.993
Avg.	0.748	0.998	0.996	Average	0.815	0.999	0.980
RS3				F6			
1	0.954	0.998	0.966	1	0.552	0.994	0.986
2	0.757	0.986	0.942	2	0.498	0.996	0.993
3	0.886	0.995	0.958	3	N/A	1	1
4	0.885	0.993	0.937	4	1	1	0.989
5	1	1	0.993	5	N/A	1	1
Avg.	0.896	0.994	0.959	Avg.	0.683	0.998	0.993

(continued)

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
PS1				F7			
1	1	1	0.995	1	0.332	0.997	0.995
2	0.843	0.993	0.955	2	0.898	0.996	0.965
3	N/A	1	1	3	1	1	0.972
4	1	1	0.957	4	1	1	0.947
5	1	1	0.987	5	1	1	0.993
Avg.	0.961	0.998	0.979	Avg.	0.846	0.999	0.974
PS2				C1			
1	0.840	0.995	0.970	1	1	1	0.918
2	1	1	0.979	2	1	1	0.959
3	N/A	1	1	3	1	1	0.609
4	1	1	0.978	4	1	1	0.513
5	N/A	1	1	5	1	1	0.580
Avg.	0.946	0.999	0.985	Avg.	1.000	1.000	0.716
PS3				C2			
1	0.633	0.994	0.983	1	1	1	0.935
2	0.798	0.996	0.983	2	N/A	1	1
3	N/A	1	1	3	1	1	0.807
4	1	1	0.989	4	1	1	0.765
5	0.749	0.998	0.991	5	N/A	1	1
Avg.	0.795	0.997	0.989	Avg.	1.000	1.000	0.901
ES1				C3			
1	1	1	0.995	1	1	1	0.995
2	1	1	0.989	2	1	1	0.900
3	N/A	1	1	3	N/A	1	1
4	N/A	1	1	4	1	1	0.968
5	N/A	1	1	5	1	1	0.993
Avg.	1.000	1.000	0.997	Avg.	1.000	1.000	0.971
ES2				C4			
1	0.425	0.994	0.989	1	1	1	0.918
2	N/A	1	1	2	1	1	0.863
3	N/A	1	1	3	1	1	0.986
4	0.748	0.996	0.986	4	1	1	0.989
5	1	1	0.993	5	1	1	0.993
Avg.	0.724	0.998	0.994	Avg.	1.000	1.000	0.950

(continued)

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
ES3				C5			
1	0.873	0.995	0.962	1	0.985	0.997	0.787
2	0.745	0.989	0.959	2	N/A	1	1
3	N/A	1	1	3	N/A	1	1
4	0.951	0.993	0.843	4	N/A	1	1
5	1	1	0.980	5	N/A	1	1
Avg.	0.892	0.995	0.949	Avg.	0.985	0.999	0.957
SN1				C6			
1	0.569	0.995	0.989	1	N/A	1	1
2	0.748	0.996	0.986	2	N/A	1	1
3	N/A	1	1	3	N/A	1	1
4	0.596	0.993	0.982	4	N/A	1	1
5	1	1	0.967	5	N/A	1	1
Avg.	0.728	0.997	0.985	Avg.	N/A	1.000	1.000
SN2				C7			
1	0.761	0.994	0.973	1	N/A	1	1
2	0.798	0.996	0.983	2	N/A	1	1
3	1	1	0.986	3	N/A	1	1
4	0.958	0.996	0.914	4	N/A	1	1
5	1	1	0.993	5	N/A	1	1
Avg.	0.903	0.997	0.967	Avg.	N/A	1.000	1.000
SN3				C8			
1	0.665	0.997	0.990	1	1	1	0.808
2	0.907	0.996	0.962	2	1	1	0.863
3	N/A	1	1	3	1	1	0.951
4	1	1	0.968	4	1	1	0.869
5	N/A	1	1	5	1	1	0.993
Avg.	0.857	0.998	0.984	Avg.	1.000	1.000	0.897
F1				C9			
1	1	1	0.995	1	0.856	0.997	0.978
2	1	1	0.979	2	1	1	0.854
3	N/A	1	1	3	N/A	1	1
4	N/A	1	1	4	1	1	0.957
5	N/A	1	1	5	1	1	0.967
Avg.	1.000	1.000	0.998	Avg.	0.964	0.999	0.951

(continued)

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
F2				SS			
1	N/A	1	1	1	0.830	0.994	0.962
2	1	1	0.969	2	0.839	0.986	0.912
3	1	1	0.986	3	1	1	0.979
4	-0.002	0.996	0.996	4	0.898	0.996	0.964
5	N/A	1	1	5	0.899	0.998	0.978
Avg.	0.666	0.999	0.990	Avg.	0.839	0.995	0.959
F3							
1	1	1	0.995				
2	0.748	0.996	0.986				
3	N/A	1	1				
4	1	1	0.978				
5	0.799	0.998	0.989				
Avg.	0.887	0.999	0.989				

Note. RS = Received Support; PS = Perceived Support; ES = Extended Support; SN = Support Needs; F = Support Functions; C = Support Content; SS = Expression of Social Support Not Otherwise Specified; C-P = Client-Participant; Agrmt. = Agreement; Avg. = Average.

Following the completion of independent coding, the coders discussed their individual decisions as a group to reach consensus, or agreement, on the assigned codes. Data that was determined to fall into the *Expression of Social Support Not Otherwise Specified* (SS) category was reviewed to decide if such expressions were categorized by a sub-category of any existing codes or if a new coding category was represented (Hsieh & Shannon, 2005). As reported previously, a new code category, Support Needs was developed through inductive analysis of the general “other” category following the two practice sessions. No further codes emerged from the client-participants expressions that fell into the “other” category.

In the discussion of coding decisions, the coders included reflections on biases that emerged and possibly influenced the independent and group coding processes. For example, the researcher-participants frequently discussed the definition of social support and returned to the operational definition of social support stated in the previous chapter as questions of what types of interpersonal interactions constituted “support.” The primary researcher-participant observed that her bias was to be more inclusive of interpersonal interactions as support whereas Coder 2 tended to be more conservative in labeling expressions as social support. However, it was helpful to discuss, as a group, interpersonal interactions to clarify and identify when descriptions of interactions represented clearly stated occurrences of “naturally occurring helping behaviors” (Norris & Kaniasty, 1996, p. 498). Further discussion of researcher biases is discussed at the end of this chapter.

Step 4: Submission of codes to the auditor. After initial consensus was reached amongst the researcher-participants, the group codes were submitted to the study’s auditor. The auditor’s effective and accurate appraisal of the coded data required a detailed account of the researcher-participants’ analysis process up to this point (Lincoln & Guba, 1985). Therefore, the researchers maintained an “audit trail” to record their decision-making processes involved in the research design and procedures for data collection and the steps taken when examining and reporting the data. Halpern (as cited in Lincoln & Guba, 1985) recommended the inclusion of the following material in the audit trail: (a) raw data; (b) the products of data reduction and analysis, including researchers’ notes and qualitative summaries; (c) notes on the synthesis and reconstruction of data, such as themes and definitions of categories and emerging

categories; (d) reports on literature that support decision-making; process notes on methods and rationale; and (e) notes related to trustworthiness. The audit trail maintained for this study used a shared *Google Document* to record the codes assigned for each highlighted expression of social support, summaries of the discussions that led to assigning the codes, the final consensus counts for each assigned code, notes of themes and connections within and across participants, descriptions of research biases that occurred during the coding process, decisions related to clarifying existing codes and the development of new codes (i.e., support needs), supporting information from the literature (e.g., definition of social support) used in making coding decisions, and communication with the study's auditor used to determine the final codes.

Step 5: Reaching consensus on final codes. Once the auditor reviewed and verified the research team's decisions and judgments on the coded material, the group of researcher-participants reconvened and discussed the final codes. The team and the auditor then made decisions in order to achieve a final consensus, and established the finalized codes for analysis.

Table 4 details the across-participant averages of the post-group agreements for the main coding categories, which were all in the near perfect range according to Landis and Koch's (1977) guidelines. Table 5 displays the average post-group discussion agreements of the final coding within and across client-participants. The coders achieved near perfect agreement for the majority of codes, such that $K=1.00$ for RS2, PS1, PS3, ES1, ES2, SN1, SN2, SN3, F1, F2, F4, F5, F7, C1, C2, C3, C4, C5, C8, and C9; $K=0.99$ for PS2, ES3, and SS ; $K=0.98$ for RS3; $K=0.96$ for F3; and $K=0.88$ for RS1. The coders' inter-rater reliability for F6 was substantial ($K=0.80$). As reported in the pre-

discussions coefficients, the average agreement for C6 and C7 were not calculated because the two codes were not used in any of the selected sessions.

Table 4

Average Inter-rater Reliability Coefficients Among Three Coders For Coding Categories, Across Participants (Post-Group Discussions)

Code	Average Fleiss' Kappa	Average Observed Agrmt.	Average Expected Agrmt.	Code	Average Fleiss' Kappa	Average Observed Agrmt.	Average Expected Agrmt.
RS	0.952	0.999	0.974	F	0.965	0.999	0.989
PS	0.995	0.999	0.984	C	1.000	1.000	0.927
ES	0.996	0.999	0.981	SS	0.994	0.999	0.945
SN	1.000	1.000	0.972				

Note. RS = Received Support; PS = Perceived Support; ES = Extended Support; SN = Support Needs; F = Support Functions; C = Support Content; SS = Expression of Social Support Not Otherwise Specified; Agrmt. = Agreement.

Table 5

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

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
RS1				F4			
1	0.498	0.997	0.994	1	N/A	1	1
2	1	1	0.929	2	N/A	1	1
3	1	1	0.986	3	N/A	1	1
4	1	1	0.957	4	1	1	0.989
5	0.908	0.998	0.976	5	N/A	1	1
Avg.	0.881	0.999	0.968	Avg.	1.000	1.000	0.998
RS2				F5			
1	1	1	0.995	1	1	1	0.986
2	N/A	1	1	2	1	1	0.969
3	N/A	1	1	3	1	1	0.993
4	1	1	0.989	4	1	1	0.957
5	N/A	1	1	5	1	1	0.987
Avg.	1.000	1.000	0.997	Average	1.000	1.000	0.978

(continued)

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
RS3				F6			
1	1	1	0.972	1	0.908	0.998	0.983
2	0.939	0.996	0.942	2	0.498	0.996	0.993
3	0.940	0.998	0.960	3	N/A	1	1
4	1	1	0.917	4	1	1	0.989
5	1	1	0.993	5	N/A	1	1
Avg.	0.976	0.998	0.957	Avg.	0.802	0.999	0.993
PS1				F7			
1	1	1	0.995	1	1	1	0.995
2	1	1	0.948	2	1	1	0.969
3	N/A	1	1	3	1	1	0.972
4	1	1	0.957	4	1	1	0.947
5	1	1	0.987	5	1	1	0.993
Avg.	1.000	1.000	0.977	Avg.	1.000	1.000	0.975
PS2				C1			
1	0.940	0.998	0.973	1	1	1	0.918
2	1	1	0.989	2	1	1	0.959
3	N/A	1	1	3	1	1	0.613
4	1	1	0.978	4	1	1	0.513
5	1	1	0.993	5	1	1	0.577
Avg.	0.985	0.999	0.986	Avg.	1.000	1.000	0.716
PS3				C2			
1	1	1	0.990	1	1	1	0.935
2	1	1	0.979	2	N/A	1	1
3	N/A	1	1	3	1	1	0.813
4	N/A	1	1	4	1	1	0.765
5	1	1	0.980	5	N/A	1	1
Avg.	1.000	1.000	0.989	Avg.	1.000	1.000	0.903
ES1				C3			
1	1	1	0.995	1	1	1	0.995
2	1	1	0.989	2	1	1	0.900
3	N/A	1	1	3	N/A	1	1
4	N/A	1	1	4	1	1	0.968
5	1	1	0.993	5	1	1	0.993
Avg.	1.000	1.000	0.995	Avg.	1.000	1.000	0.971

(continued)

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
ES2				C4			
1	1	1	0.990	1	1	1	0.918
2	N/A	1	1	2	1	1	0.863
3	N/A	1	1	3	1	1	0.986
4	1	1	0.989	4	1	1	0.989
5	1	1	0.993	5	1	1	0.993
Avg.	1.000	1.000	0.994	Avg.	1.000	1.000	0.950
ES3				C5			
1	0.956	0.998	0.964	1	1	1	0.779
2	1	1	0.969	2	N/A	1	1
3	N/A	1	1	3	N/A	1	1
4	1	1	0.859	4	N/A	1	1
5	1	1	0.980	5	N/A	1	1
Avg.	0.989	0.999	0.954	Avg.	1.000	1.000	0.956
SN1				C6			
1	1	1	0.990	1	N/A	1	1
2	1	1	0.989	2	N/A	1	1
3	1	1	0.993	3	N/A	1	1
4	1	1	0.968	4	N/A	1	1
5	1	1	0.967	5	N/A	1	1
Avg.	1.000	1.000	0.969	Avg.	N/A	1.000	1.000
SN2				C7			
1	1	1	0.958	1	N/A	1	1
2	1	1	0.979	2	N/A	1	1
3	1	1	0.986	3	N/A	1	1
4	1	1	0.927	4	N/A	1	1
5	1	1	0.993	5	N/A	1	1
Avg.	1.000	1.000	0.968	Avg.	N/A	1.000	1.000
SN3				C8			
1	1	1	0.990	1	1	1	0.808
2	1	1	0.959	2	1	1	0.863
3	N/A	1	1	3	1	1	0.951
4	1	1	0.957	4	1	1	0.869
5	N/A	1	1	5	1	1	0.993
Avg.	1.000	1.000	0.981	Avg.	1.000	1.000	0.897

(continued)

Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.	Code, C-P	Fleiss' Kappa	Observed Agrmt.	Expected Agrmt.
F1				C9			
1	1	1	0.995	1	1	1	0.986
2	1	1	0.979	2	1	1	0.854
3	N/A	1	1	3	N/A	1	1
4	N/A	1	1	4	1	1	0.957
5	N/A	1	1	5	1	1	0.967
Avg.	1.000	1.000	0.995	Avg.	1.000	1.000	0.953
F2				SS			
1	N/A	1	1	1	1	1	0.949
2	1	1	0.969	2	0.970	0.996	0.884
3	1	1	0.986	3	1	1	0.979
4	N/A	1	1	4	1	1	0.947
5	N/A	1	1	5	1	1	0.967
Avg.	1.000	1.000	0.991	Avg.	0.994	0.999	0.945
F3							
1	1	1	0.990				
2	1	1	0.989				
3	1	1	0.993				
4	1	1	0.978				
5	0.799	0.998	0.989				
Avg.	0.959	0.999	0.988				

Note. RS = Received Support; PS = Perceived Support; ES = Extended Support; SN = Support Needs; F = Support Functions; C = Support Content; SS = Expression of Social Support Not Otherwise Specified; C-P = Client-Participant; Agrmt. = Agreement; Avg. = Average.

Step 6: Evaluation of the coded data. The study's researcher next analyzed the data to identify patterns in the data that were related to type of traumatic event, received or perceived social support, extended support, support needs, functions of social support, contents or types of social support, and expressions of social support that did not fit any other pre-determined category. An Excel spreadsheet was used to track frequencies of these codes.

Step 7: Presentation of findings. Finally, the primary researcher presented the findings from the content analysis in a rank order of the frequencies of the types of coded data. Specifically, the constructs and structures of social support that were discussed most often in psychotherapy sessions that included discussions of traumatic and post-traumatic experiences were presented before other elements of social support that were less often discussed in the sessions. Also, the researcher presented examples of expressed social support in sample quotations to provide a more nuanced understanding of the social support experiences that clients brought up in therapy when talking about trauma. Additionally, the types of expressions of social support by clients who experienced trauma, and ways in which support was expressed in therapy, were compared to the constructs and structures of social support that were described in existing literature. Finally, the expressions of social support observed in this study were discussed in relation to the theoretical models of social support and the post-traumatic experiences by providing examples of the models from each of the client-participants.

Researcher bias. The primary researcher regularly reflected on personal biases that had possible impacts on coding decisions during the data analysis steps. For example, the primary researcher tended to over-include client-participant statements in expressions of social support. This tendency stemmed from the researcher-participant's bias towards a broad and inclusive definition of social support as definitions of the term "social support" varied widely in the literature. Therefore, her assumption that most interpersonal interactions represented social support was monitored throughout the coding process. In the coding process, the primary researcher frequently returned to the

operational definition of social support used in this study (e.g., “naturally occurring helping behaviors”) in order to make coding decisions.

Also, group discussions among the coders were helpful in addressing the primary researcher’s bias as it was not shared by Coder 2. Coder 2 tended to under-include client-participant statements in coding for expressions of social support because her bias was that support occurred only when interpersonal exchanges were beneficial to the recipient. Coder 3’s initial decision-making usually fell somewhere between Coder 1 and Coder 2 and brought yet another helpful perspective to discussions. Therefore, the consensus discussions were useful in reviewing the definition of social support used in this study and factoring in the perspectives of the three coders.

A secondary bias that emerged during the coding process was the researcher-participant’s assumption that social support experiences are positive. This assumption was attributed to Coder 1’s value on interpersonal relationships and belief in the benefits of connectedness with others over the course of the lifespan. This was particularly true for the *Received Support* and *Perceived Support* codes such that Coder 1 tended to assign RS1 and PS1 codes more frequently than did the other researcher-participants. Consequently, it was important for the primary researcher to be aware of attending to negative feelings expressed by client-participants in relation to social support experiences.

Finally, based on Coder 1’s family culture related to generations in a geographically, politically, and economically isolated region (i.e., an island in the North Atlantic) as well as her family history of immigration, a bias was observed in her assumption that family relationships are supportive and helpful. This assumption was

particularly evident when coding Sessions 1, 3, 4, and 5, which all involved family members as perpetrators during traumatic events. Therefore, the primary researcher continuously monitored this assumption when reviewing client-participant's descriptions of interactions with and beliefs about family relationships and support within family systems.

Although the primary researcher constantly monitored for the influence of these biases and assumptions on coding decisions, it was important to engage in group discussions with the team of four researchers. The use of four researcher-participants contributed to the maintenance of a balanced view of social support expressions stemming from four varied perspectives.

Chapter III: Results

This chapter provides the summary of results from the qualitative and quantitative directed content analysis of expressions of social support experiences in psychotherapy sessions with survivors of traumas. Client-participant expressions of social support were analyzed using the social support codes that were developed from existing theories, constructs, and structures of social support (e.g., Clapp & Beck, 2009; Cohen & Willis, 1985; Joseph et al., 1995; Lakey, 2007; Norris & Kaniasty, 1996; Pulcino et al., 2003; Tolsdorf, 1976) using the operational definitions provided in the Methods section and included in the Coding Manual (Appendix C): (a) *Received Support* (RS1, RS2, RS3); (b) *Perceived Support* (PS1, PS2, PS3); (c) *Extended Support* (ES1, ES2, ES3); (d) *Support Needs* (SN1, SN2, SN3); (e) *Support Functions* (F1, F2, F3, F4, F5, F6, F7); (f) *Support Content* (C1, C2, C3, C4, C5, C6, C7, C8, C9); and (g) *Other* (SS).

The purpose of the qualitative and quantitative analyses was to examine how survivors of trauma express social support experiences in psychotherapy and to extend existing theories and models of the role of social support in post-traumatic responses to how social support is discussed by clients in psychotherapy. Given the study's focus on how social support was expressed by trauma survivors, it did not compare codes that occurred during trauma discussions versus other session content. The following sections present data analysis of the findings both across participants and within participants. The quotations included in the content analysis are from the client-participants and were identified in the transcribed sessions included in the study unless otherwise stated.

Content Analysis

The directed content analysis of client-participant expressions of social support in psychotherapy sessions with trauma survivors, involving general therapy discussions as well as trauma discussions, yielded a total of 1,370 total transcribed talk turns, which included 827 social support codes. This data indicates that client-participants' verbal expressions of social support occurred in 60.36% of possible talk turns in psychotherapy sessions involving discussions of trauma. The number of talk turns in each session ranged from 184 to 418, with an average of 274 (SD = 95.92). Therefore, the total number of codes assigned within each session was impacted by the number of available talk turns within each session, which varied significantly among the 5 selected sessions (e.g., Session 1 included 418 talk turns whereas Session 4 included only 184 talk turns). Although the number of talk turns varied across participants, the percentage of social support expressions observed in the transcribed sessions were fairly consistent and ranged from 52%-62% for most client-participants. Session 4 represented a significantly higher rate of social support expressions with an average of more than one social support expression per talk turn (109.2%). Table 6 includes the percentages of social support expression observed in each session included in the study.

Within each of the 5 transcribed sessions, the number of total social support codes ranged from 119 to 220, with an average of 165.4 (SD = 42.96). It should be noted that, based on the design of the social support codes, multiple codes were frequently assigned within single talk turns. For example, in a talk turn where a client-participant described received support provided by a family member, a *Received Support* code and a *Support Content* code were assigned; *Support Functions* codes often co-occurred with *Received*

Support codes. Also each mention of types of support resources, or *Support Content*, was coded within each talk turn; thus, multiple content codes were often assigned within single talk turns. Table 6 displays the total number of talk turns and social support codes for each of the sessions.

Table 6
Number of client-participant talk turns and coded expressions of social support

	Client-Participant 1	Client-Participant 2	Client-Participant 3	Client-Participant 4	Client-Participant 5
# of Talk Turns	418	189	278	184	300
Total # of Codes	220	119	147	201	140
% of Codes in the Total Talk Turns	52.6%	62.9%	52.8%	109.2%	46.6%

The presentation of the frequencies of the constructs and structures of social support in therapeutic discussions of trauma illuminated the ways in which client-participants spoke about and reflected on social support experiences following traumatic events. Among the 827 coded client expressions of social support, the categories were coded in the following order from most to least frequent: 585 (70.73%) were coded as *Support Content* (C1, n=296; C8, n=81; C2, n=76; C5, n=53; C4, n=37; C9, n=27; C3, n=15; C6, n=0; C7, n=0), 49 (5.92%) were coded as *Received Support* (RS3, n=28; RS1, n=19; RS2, n=2), 49 (5.92%) were coded as *Support Functions* (F5, n=13; F7, n=13; F3, n=8; F6, n=6; F2, n=5; F1, n=3; F4, n=1), 42 (5.07%) were coded as *Support Needs* (SN2, n=20; SN1, n=12; SN3, n=10), 38 (4.59%) were coded as *Other* (SS, n=38), 35 (4.23%) were coded as *Extended Support* (ES3, n=28; ES2, n=4; ES1, n=3), and 29 (3.50%) were coded as *Perceived Support* (PS1, n=12; PS2, n=10; PS3, n=7). The total

number of social support codes within and across participants (i.e., transcribed sessions) are displayed in Table 7 below.

Table 7
Frequency Data for Social Support Codes Within and Across Sessions

Code	Client-Participant 1	Client-Participant 2	Client-Participant 3	Client-Participant 4	Client-Participant 5	Total Codes
RS1	2	7	2	4	4	19
RS2	1	0	0	1	0	2
RS3	6	7	6	8	1	28
<i>Total</i>	<i>9</i>	<i>14</i>	<i>8</i>	<i>13</i>	<i>5</i>	<i>49</i>
PS1	1	5	0	4	2	12
PS2	6	1	0	2	1	10
PS3	2	2	0	0	3	7
<i>Total</i>	<i>9</i>	<i>8</i>	<i>0</i>	<i>6</i>	<i>6</i>	<i>29</i>
ES1	1	1	0	0	1	3
ES2	2	0	0	1	1	4
ES3	8	3	0	14	3	28
<i>Total</i>	<i>11</i>	<i>4</i>	<i>0</i>	<i>15</i>	<i>5</i>	<i>35</i>
SN1	2	1	1	3	5	12
SN2	9	2	1	7	1	20
SN3	2	4	0	4	0	10
<i>Total</i>	<i>13</i>	<i>7</i>	<i>2</i>	<i>14</i>	<i>6</i>	<i>42</i>
F1	1	2	0	0	0	3
F2	0	3	2	0	0	5
F3	2	1	1	2	2	8
F4	0	0	0	1	0	1
F5	3	3	1	4	2	13
F6	4	1	0	1	0	6
F7	1	3	4	4	1	13
<i>Total</i>	<i>11</i>	<i>13</i>	<i>8</i>	<i>12</i>	<i>5</i>	<i>49</i>
C1	21	6	83	86	100	296
C2	14	0	34	28	0	76
C3	1	10	0	3	1	15
C4	18	15	2	1	1	37
C5	53	0	0	0	0	53
C6	0	0	0	0	0	0
C7	0	0	0	0	0	0
C8	46	15	7	12	1	81
C9	3	15	0	4	5	27
<i>Total</i>	<i>156</i>	<i>61</i>	<i>126</i>	<i>134</i>	<i>108</i>	<i>585</i>
SS	11	12	3	7	5	38
Total Codes	220	119	147	201	140	827
Total Talk Turns	418	189	278	184	301	1,370

Findings Across Participants

This section describes the rank order and percentages of social support codes across all 5 selected sessions. Additionally, this section provides qualitative examples of client-participant expressions of the social support codes.

Support content. Client-participants expressions of social support were most often coded for *Support Content* (585 codes), which comprised 70.73% of all verbal expressions of social support made by client-participants when looking at all 5 transcribed sessions. *Support Content* codes were used to capture client-participant descriptions of types of social support. Therefore, client-participants most frequently mentioned or stated specific support relationships or types of support relationships when discussing experiences of social support. Because the *Support Content* category of codes had the most number of individual code types (i.e., 9 individual codes within the *Support Content* category) when compared to all other code categories, statements that were highlighted for coding for expressions of social support had a greater chance of falling into the *Support Content* codes than all other code categories. Additionally, each reference to support relationships, including use of pronouns that clearly referred to support resources, were coded, even if such references occurred outside of specific expressions of other social support constructs related to experiences of or beliefs about support.

Primary Kin relationships (C1, 296 codes) were coded most frequently and accounted for 50.59% of all *Support Content* codes and 35.79% of the total expressions of social support. Client-participants frequently described support relationships with members of their family of origin (e.g., mother, father, brother, sister) as well as their

spouses and children (e.g., husband, daughter, son). All client-participants in the current study referred to primary family relationships. For example, CP5 stated, “So, yeah so and we only ate two meals a day, so if you missed one, you were really hungry” (C198) in reference to her family of origin (i.e., “we”), consisting of her mother, father, and brother. When CP4 discussed her “guardianship daughter” (i.e., her husband’s cousin for whom she and her husband had legal guardianship and had raised since the age of 10 years), her use of the pronoun, “she”: “...I feel like she should have trusted me, and come to me so I could have protected her, you know...” (C126) received a C1 code (along with a SN code, as discussed below). CP2 made the fewest references to primary kin relationships and her total number of expressions involving primary family relationships was significantly lower than all of the client-participants.

The second most often occurring of the *Support Content* codes was *Service* (C8, 81 codes), which comprised 13.84% of the content codes and 9.79% of the total social support codes. Client-participants made frequent references to their therapists (i.e., “you”) as well as other service providers such as physical therapists and former therapists. The five client-participants all made some reference to professional support providers. CP1 most frequently referred to service providers (56.7% of the total C8 codes across participants), specifically the therapist, and CP5 least frequently mentioned service providers (1.23% of the total C8 codes across participants), with only one reference to the therapist, when compared to all of the client-participants. One example of an expression involving a service provider was observed when CP2 described encouragement she received from her physical therapist:

And she would say, ‘C’mon, c’mon, you can do it.’ And I’m like, ‘I’m gonna fall

on you and kill you.’ She said, ‘If you’re gonna fall, I’ll move out of the way.

Believe me. You’re not going to fall, it just feels like you’re going to.’ She said,

‘Just walk two steps and you’ll be right there’ (C106)

Secondary Kin codes (C2, 76 codes) were the third most frequently occurring of the *Support Content* codes. *Secondary Kin* codes represented 12.99% of the *Support Content Codes* and 9.18% of the overall social support codes. CP3 and CP4 described numerous relationships with extended family members and frequently referred the secondary kin relationships. CP3 expressed, “So one time I get so angry, I say ‘I’m going to call the police’ and this and that and my grandma and my aunt go, ‘if you do that, you’re gonna live on the streets...’” (C166). CP4 stated, “Ok, my grandmother is in assisted living. That’s my father’s mother and I am the one that takes care of everything for her” (C26). Neither CP2 nor CP5 made any mention of secondary family relationships.

The fourth common *Support Content* code was *Sexual/Romantic* (C5, 53 codes), representing 9.05% of the *Support Content* codes and 6.40% of all of the social support codes. It should be noted that all *Sexual/Romantic* codes occurred in one client-participant session (CP1). However, because spousal relationships were included in the primary family category, other client-participants referred to their marriage partners, but such expressions were coded only as C1 and not C5. Therefore, the romantic partner relationships that were coded as C5 referred only to non-marriage romantic relationships. CP1 described support exchanges with her current and previous romantic partners. For example, when describing relational problems with her current boyfriend, she used “we” in reference to herself and her partner. CP1 expressed, “... we was just getting along way

too good” (C291) and “... we have communication problems ‘cause that’s the issue there...” (C292).

Client-participant expressions of *Other Friend* codes (C4, 37 codes) occurred in 6.32% of the *Support Content* codes and 4.47% of the total social support codes. C4 was used to code several expressions related to supportive friendships that were not specifically identified as close or primary friendships. These codes were only given in CP1 and CP2’s sessions. For example, CP1 said, “Oh, ok, ‘cause my friends on weekends, sometime we like to do certain stuff” (C9). Although she described the relationships as friendships, she did not explicitly describe those relationships as primary friendships. Similarly, CP2 expressed, “[physical therapist] didn’t want me to do it but [acquaintance] was there and he was like, ‘Come on. She’s not here, she doesn’t know you’re going to do it’” (C108) when describing encouragement received from a peer without describing the peer as a close friend.

The *Support Content* code, *Other* (C9, 27 codes) represented 4.61% of the content codes and 3.26% of the overall social support codes. C9 was used to capture stated support relationship types that did not fit into any other *Support Content* category. Four of the five client-participants made some reference to support content that did not represent any of the other content categories; CP3 did not make any support content references that fell into the C9 category. Of the client-participants who made C9 statements, CP2 made the most references to support resources that were coded as C9. She made 15 statements that were coded as C9 as compared to CP1 (C9 = 3), CP4 (C9 = 4), and CP5 (C9 = 5). C9 codes were most frequently related to vague or unspecified references to support relationships (e.g., “everyone”, “people”). When CP2 described

having difficulty leaving her home when supportive others were unable to take her out she used the broad term “everybody” to refer to her support resources: “And everybody seems to have been so busy...” (C5). No other across-participant themes were observed in expressions that fell into the *Support Content Other* category.

Primary Friend (C3, 15 codes) was coded in 2.56% of the *Support Content* codes and 1.81% of all of the coded expressions of social support. CP3 did not refer to any primary friendships. CP2 made 10 references to supportive friends and referred to primary friends more frequently than did CP1 (C3 = 1), CP4 (C3 = 3), and CP5 (C3 = 1). For example, CP2 described receiving assistance from a friend she identified as being close during a medical appointment. Such assistance was captured in her statement, “...I think then [friend] realized I don’t see things until they are this close to me and then it is too late for me to stop my momentum” (C96), when describing the guidance she needed to navigate through the hospital. CP1 also described a supportive relationship with a close friend: “You know, I told my old roommate, like the closest person to me here” (C100).

Two of the *Support Content* codes were not used in any of the client-participant expressions of social support. Neither *Affiliative* (C6, 0 codes) nor *Mutual Aid* (C7, 0 codes) occurred in the 827 verbal expressions of social support.

Received support. The next most commonly coded social support categories were *Received Support* (49 codes) and *Support Functions* (49 codes), with both categories comprising 5.92% of the total coded expressions of social support among the 5 selected sessions. It was not surprising that the frequency of the *Support Functions* codes and the *Received Support* codes were fairly similar across the five sessions included in

this study because the functions codes were used to capture the type of support that occurred in expressions of received support. *Received Support* codes were used to identify client-participant statements and descriptions of social support that was provided by others to the client-participants.

Within the *Received Support* category, the *Received Support: Not Otherwise Specified* code (RS3, 28 codes) that contained unspecified, vague, ambivalent, or mixed expressions of support provided to the client-participants was used most frequently and represented 57.14% of *Received Support* codes and 3.38% of all social support codes. All of the client-participants expressed experiences of received support that fell into the RS3 category; RS3 represented the most frequently used *Received Support* code for all client-participants. CP3 described an experience in which her mother attacked her, which was followed by an offer from a friend for a place to stay. CP3 did not describe the instrumental support offered by her friend as either positive or negative in her statement, "...my friend was there and she just, 'stay over tonight'" (C156). An example of mixed feelings related to received support was included in Session 4. CP4 described a therapy intervention used by a previous therapist that evoked a mixed reaction in her, which represented an RS3 statement. She reported, "...and she explained to me what she did and why she did it and I understood intellectually but don't [expletive] do that to me again" (C136).

The *Positive Received Support* code (RS1, 19 codes) occurred second most frequently among the *Received Support* codes, which accounted for 38.77% for the *Received Support* codes and 2.29% of all coded expressions of social support. All five of the client-participants referred to positive experiences of received support, with CP2

making the most number of RS1 expressions (36.8% of the total RS1 codes across participants). CP3 made a statement of RS1 when she described a phone call from her sisters in her country of origin as she reported, “You know, they kinda comfort me a little bit so” (C103). CP2’s transcript included a stronger affirmation of beneficial assistance received from a friend following an injury to her foot. She expressed, “I mean, [friend’s name], is very, I call her ‘Florence Nightingale’ when she is doing my nurse/maid stuff. She took very good care of my foot for me” (C114).

Negative Received Support (RS2, 2 codes) was the least commonly occurring *Received Support* code and represented 4.08% of the *Received Support* codes and 0.24% of the total social support codes. Only two of the client-participants, CP1 and CP2, referred to negative received support experiences and each made only one expression that fell into the RS2 category. One example of RS2 occurred in Session 1 when CP1 described insufficient support received from a previous romantic partner:

And he was like, ‘oh, I’m gonna take you.’ He was like, ‘you know what? I’m gonna call, I’m gonna tell my friend [name], he’ll come pick you up and we’ll, he’ll take us.’ And I’m like, ‘alright’ but in my head, I’m like, ‘yeah right, I’m not waiting, I’m going.’ So by the time he got out of class, I’m like, ‘dude, I’m already at the mall.’ Like he was like, you’re there?’ (C88)

This statement reflects support received from her previous boyfriend in his offer to provide her with transportation. However, she described that his offer did not adequately meet her need and, therefore, represented an instance of RS2.

Support functions. As stated previously, *Support Functions* (49 codes) represented 5.92% of all client-participant expressions of social support, and were

defined as client-participant expressions of services provided in received support. The most frequently used *Support Functions* codes were *Instrumental* (F5, 13 codes) and *Support Functions: Not Otherwise Specified* (F7, 13 codes) with each accounting for 26.53% of the *Support Functions* codes and 1.57% of all coded expressions of social support. All five of the client-participants made statements that fell into the F7 category. No clear patterns or themes were observed in the expressions coded as F7 across participants. An example of F5 occurred when CP4 explained how her stepmother had helped her initiate her first therapy experience: "...my stepmom, she was the one that brought it to my attention. 'That's your underlying issue, you have to work on that...' ... I said, 'you know what? You find somebody and I'll go.' And she did" (C90). One example of F7 was observed in CP3's description of being protected from physical harm (i.e., abuse by her mother) by female family members, which did not fit into any other *Support Function* code. CP3 stated, "... my aunts sometime protect me from my mom" (C164). Other expressions that were coded as F7 will be discussed later in this chapter in the within-participant results sections.

The second most commonly occurring of the *Support Functions* codes was the *Advice/Informational* (F3, 8 codes). The *Advice/Informational* codes constituted 16.32% of the coded *Support Functions* statements and 0.96% of the total social support codes. All client-participants in the current study made one or two references to F3 experiences. Examples of F3 were observed in statements such as CP5's expression, "and see, my brother, being older and wiser, taught me that you can get food, you just have to sneak it" (C199). CP3 also described receiving advice from her grandmother when she stated,

“and I just left ‘cause my grandma, go, you know, ‘Go somewhere ‘cause she, she gonna, she going to kill you, so she will, she can, she will,’ right.” (C155).

Social Companionship (F6, 6 codes) was the third most frequently coded *Support Functions* type, representing 12.24% of the *Support Functions* codes and 0.72% of all coded client-participants expressions of social support. Three client-participants, CP1, CP2, and CP4, referred to experiences of social companionship. CP1 made the most frequent expressions of F6 (F6 = 4) with CP2 and CP4 making only one F6 expression each. CP1 provided an example of F6 when she described peer relationships from her adolescence, “... it was like a group of us girls and boys just hanging out together.”

The *Emotional* (F2, 5 codes) code was used in 10.20% of the coded *Support Functions* expressions and 0.60% of all expressions of social support. Only CP2 and CP3 referred to F2 experiences. For example, CP2 described receiving emotional support from her close friend/roommate, “And when we were driving to the hospital [friend] said, ‘what are you so frightened?’ ...” (C143).

Esteem (F1, 3 codes) was coded in 6.12% of the *Support Functions* codes and 0.36% of the overall social support codes. F1 expressions were observed in only Sessions 1 and 2. CP2 also provided an example of F1 when she explained encouragement she received from her physical therapist: “But she wanted me to walk without the walker. I’m like, ‘I can’t do that.’ ‘Yes you can, you can walk without the walker’” (C104).

The least commonly occurring *Support Functions* code was *Feedback* (F4, 1 code), which accounts for 2.04% of the *Support Functions* codes and 0.12% of the total number of social support codes. The only example of F4 among all 5 sessions occurred

in Session 4 when CP4 reported on feedback she received from her husband: “my husband says things like all the time, like, ‘you don’t trust men, you barely trust me’ and it makes me sit and think, ‘that’s not, that’s not good’” (C113).

Support needs. *Support Needs* (42 codes) were the fourth most frequently used category of codes when identifying client-participant expressions of social support in the transcribed sessions, which accounted for 5.07% of all of the coded expressions of social support across the selected sessions. *Support Needs* codes were used to capture client-participants’ statements of wishes for social support from others or desires to provide others with support. The most frequently used *Support Needs* code was *To Others* (SN2, 20 codes), which was used for statements articulating the desire to provide others with support and occurred in 47.61% of the *Support Needs* expressions and 2.41% of all of the expressions of social support. All client-participants expressed the need or desire to provide others with support, with CP1 and CP4 making the most frequent reference to SN2 expressions (45% and 35%, respectively, of the total SN2 codes across participants), and CP3 and CP5 making the fewest (5%, each, of the total SN2 codes across participants). For example, CP3 stated, “I can do better, you know, with helping them somehow” (C134) and, “...if I could, I can do something to help my sisters not take [mistreatment by their mother]” (C163) in reference to her desire to provide support to her sisters who remained in her country of origin.

The second most used *Support Needs* code was *From Others* (SN1, 12 codes), which was used for expressions indicating the need to be provided with support by others. Expressions coded with *From Others* represented 28.57% of all *Support Needs* codes and 1.45% of the total number of coded statements of social support. Expressions

of SN1 were observed in all the transcribed sessions included in the study. Client-participants expressed needs from the following support contents: parents and boyfriend (CP1); “people” in general (CP2); husband (CP3); grandmother (CP4); and husband and mother (CP5). SN1 was observed when CP1 discussed the wish for her boyfriend to include her in interactions with the mother of his child. She stated, “Like I want him to introduce us, so she can already know me” (C286). CP5 also expressed a need from her partner in her statement, “... so I told him, if this is going to work, you have to contribute x every single month” (C87), which reflected her need for financial support.

Support Needs: Not Otherwise Specified (SN3, 10 codes) represented 23.80% of the Support Needs codes and 1.20% of the overall social support codes, and was used when client-participant expressions of support needs did not clearly fall into the *From Others* or *To Others* categories. Three of the five client-participants, CP1, CP2, and CP4, made expressions of SN3. All expressions that were coded as SN3 were related to the need or desire for mutual exchanges of support such as multidirectional communication. For example, CP1 described the desire to engage in conversation (i.e., both from and to) with the therapist about a specific trauma related topic when she expressed, “I want to talk about when you was talking about child abuse” (C213). CP2 clearly stated something she did not desire in her statement, “I just didn’t want to ask for help” (C146), that suggested needs related to communication. SN3 was also used to code CP4’s wish for improved communication (i.e., both from and to) with her husband in her statement, “I just wish our communication was better” (C165).

Other. The code, *Other*, was used for expressions of social support that did not fit into any of the other defined categories for coding. *Other* (SS, 38 codes) was the fifth

most frequently coded category and accounted for 4.59% of all of the coded social support statements. All client-participants referred to support experiences or beliefs that fell into the *Other* category. Two patterns emerged in the across-participant inductive analysis of expressions in the SS category: relationship factors (e.g., communication and relational issues) and planned future support. SS was used to code statements reflecting relational issues that did not align with any of the other coding groups. For example, CP1 reported, "...we have communication problems" in regards to her relationship with her romantic partner. Although this statement reflected an exchange within an identified support relationship, the expression did not clearly represent received support, perceived support, or other constructs of social support included in the other codes. Similarly, SS was used to capture other statements describing relational qualities. This was evident in CP5's statement about her relationship with her mother: "Well, considering that she is absolutely clueless, I would say it's pretty good" (C242). An example of planned future support occurred when CP3 described upcoming holiday plans with her mother-in-law: "We're gonna cook together and have a dinner..." (C276).

Other SS expressions did not represent themes across-participants. For example, only CP2 expressed past perceived support, which did not fit into the *Perceived Support* category, as her statement reflected a previous belief as opposed to a future belief. CP2 stated,

...and I said, 'I've spent so long in the hospital when I was little and I was in isolation. Nobody was allowed in to come visit me except through the glass wall.' I said, 'I think, all my life, I worried about going into the hospital because I wouldn't have any visitors.' Nobody would come and see me. I'd be the one

patient that didn't have any visitors. I said, 'that would be so sad. She doesn't have any visitors' (C143).

Further discussions of within-participant SS results are included later in this chapter.

Extended support. The next most recurrent coding category was *Extended Support* (35 codes), which represented 4.23% of all coded client-participant expressions of social support among the 5 selected sessions. *Extended Support* was used when coding expressions pertaining to providing others with support or beliefs about the support provided by the client-participant to others. *Extended Support: Not Otherwise Specified* (ES3, 28 codes) was the most frequently used code among the *Extended Support* codes and made up 73.68% of all *Extended Support* codes and 3.38% of the total coded statements. Four of the five client-participants made expressions of ES3; the transcript for Session 3 did not have any expression in the ES3 category. The statements that were included in the ES3 category represented impartial statements of providing support to others. For example, CP1 discussed beliefs about providing support to her romantic partner that were not clearly identified as having a positive or negative impact on her. She reported, "...he's leaving and I got to take care of him" (C320), indicating a belief about her duty to offer care to another person. CP5 also provided an example of a statement of factual, instrumental support that she extended in her marriage without stating the degree (i.e., positive or negative) to which the provision of support impacted her. She stated, "... and I pay all the bills and all the food and all the gas and all the clothes and whatever" (C95).

Negative Extended Support (ES2, 4 codes) was the second most commonly used of the *Extended Support* codes, which accounted for 11.42% of the *Extended Support*

codes and 0.48% of all social support codes. Three sessions, 1, 4, and 5, included statements that were coded as ES2. An example of ES2 was made by CP4 when she stated:

...and it angers me so much and I'm the one that does everything for you. Like, I'm not working right now but I feel like I am 'cause I'm over here all the times with you. And I got a baby on my hip, I'm trying to make calls for you. And put your laundry away and [expletive]... (C59)

In this instance, the client-participant expressed negative feelings related to providing support to an elderly family member in which she described feeling burdened and angered by the “work” she was providing for the family member.

The least frequently coded *Extended Support* code was *Positive Extended Support* (ES1, 3 codes), which comprised 8.57% of the *Extended Support* codes and 0.36% of the overall social support codes. Three client-participants each referred to one positive experience of providing support to others: CP1, CP2, and CP5. CP2 articulated an example of ES1 in her expression, “Over the years I have helped a lot of people and, you know, the karma? What goes around comes around and I've always been the first one there to help anybody so I had a lot of that come back to me.” (C145).

Perceived support. The *Perceived Support* (29 codes) coding category occurred least frequently among the seven categories of social support codes. *Perceived Support* codes were used for client-participant expressions of beliefs about the availability of future support and represented 3.50% of the total number of coded expressions of social support across the 5 transcribed sessions. *Positive Perceived Support* (PS1, 12 codes) was the most frequently used *Perceived Support* code and represented 41.37% of all

Perceived Support statements and 1.45% of all social support expressions. Expressions of PS1 were observed in four of the five transcribed sessions but did not occur in Session 3. One example of PS1 was made by CP4, who stated, “I have a circle of friends that are very good friends... that I can lean on, yeah” (C65, C66) when the therapist observed that she appeared to have a “strong social support network.” CP2 also described positive beliefs about the availability of social support when she expressed, “I’ve got endless amount of support there” (C28) in reference to available social support in her country of origin as well as, “And I have endless amount of support here” (C29) in regards to where she currently lived while preparing for her long term care needs.

The second most commonly used *Perceived Support* code was *Negative Perceived Support* (PS2, 10 codes) that accounted for 34.48% of the expressions coded for *Perceived Support* and 1.20% of all coded expressions of social support. Although CP3 did not make any expressions of PS2, all of the other client-participants did. CP1 made the most number of expressions of PS2 (PS2 = 6) compared to the other client-participants who made only one (CP2 and CP5) or two (CP4) expressions of PS2 each. PS2 was observed when CP5 described believing that she was currently unable to depend on her husband financially due to earlier experiences of inconsistency in his provision of instrumental support. She stated, “I can’t depend on him because he has contributed...” (C84) “... over the course of our marriage, but not dependably and consistently...” (C85). Additionally, CP4 expressed a belief that her support needs were not being met by her husband when she stated, “...me needing to be able to come to you is not there right now... with this situation...” (C163).

Perceived Support: Not Otherwise Specified (PS3, 7 codes) was the least commonly used *Perceived Support* code, which comprised 24.13% of the expressions coded for *Perceived Support* and 0.84% of all coded social support statements. Three client-participants expressed PS3 statements: CP1, CP2, and CP5. No clear patterns or themes emerged in the inductive analysis of expressions coded as PS3. One example of PS3 was observed when a client-participant described a reaction she expected from the therapist before she shared her response to a question in a therapeutic game. CP1 stated, “You’re gonna laugh. It wasn’t as good as yours,” (C338) which reflected the client-participant’s expectation of how the therapist would respond to information she had not yet shared. CP1 laughed at the end of the statement of her expectation and did not clearly state whether the potential laughter from the therapist would have a positive or negative effect on her. Therefore, the statement was coded as PS3. CP2 also made a statement about perceived support she would receive following an upcoming surgery that was not specified as being either positive or negative. She stated, “I mean I don’t usually have a problem saying ‘Can someone take me for a walk?’ or hopefully after the surgery, I won’t need anybody to do that. I didn’t need, for the last 9 months, I didn’t need anybody to do that” (C6). This statement reflected a future belief of not needing support that stemmed from past experience. Further discussion of PS3 expressions are discussed in the results of within-participant analysis in the next section of this chapter.

Findings Within Participants

This section presents the qualitative (e.g., quoted client-participant statements of social support) and quantitative findings (e.g., frequency hierarchies of codes) of social support expressions within each of the 5 transcribed psychotherapy sessions.

Client-participant 1. As stated in the client-participant descriptions in the Methods section, CP1 was a 28-year-old, African American female who self-identified as heterosexual and Christian. CP1 experienced childhood sexual abuse by her maternal uncle and was raped by her uncle when she was in the third grade.

At the start of the transcribed psychotherapy session, which occurred one third of the way through therapy (i.e., 7 of 21 sessions), that was included in the content analysis for CP1, the therapist introduced a therapeutic board game that the therapist described as a “feeling game” (T14). During the course of the session, CP1 and the therapist took turns answering questions such as “Share a discovery that you have made recently that has improved your life” (T31) and “What would you do if you were told you were going to die soon?” (T335). Following the question, “Talk about something you will never forget,” CP1 initiated discussion of her experience of childhood sexual trauma. She later returned to the general topic of child abuse when the game provided the opportunity for her to ask an open ended question to the therapist. When given the chance to comment on a previous discussion in the game, CP1 stated, “...Okay, so, I want to talk about when you was talking about child abuse. So, you said that, um, it’s never the victim’s fault...” (C213). CP1 also discussed problems in her current romantic relationship and made connections between her current experiences and earlier romantic relationships. In addition, she commented on areas of frustration in interpersonal functioning and financial difficulties.

CP1’s selected session had a total of 418 talk turns that were coded for expressions of social support. In total, CP1 made 220 statements of social support, which represents 52.63% of the overall number of talk turns. The frequency hierarchy of coded

categories of CP1's social support expressions was: *Support Content* (156 codes; 70.90% of the total codes); *Support Needs* (13; 5.90% of the total codes); *Extended Support* (11 codes; 5.00% of the total codes); *Support Functions* (11 codes; 5.00% of the total codes); *Other* (11 codes; 5.00% of the total codes); *Received Support* (9 codes; 4.09% of the total codes); and *Perceived Support* (9 codes; 4.09% of the total codes). Her code rankings were somewhat similar to that of the other client-participants and are discussed next.

Support content. CP1's statements related to social support experiences most frequently involved identification of support content, or specific support relationships, in her life. Specifically, she most frequently referred to past and present romantic relationships (C5; 53 codes). CP1 made several references to past support experiences with former romantic partners. For example, she referred to her first boyfriend in her statement, "... But it's kind of like, with my first boyfriend, that was a good dude, 'cause he came from like a good family and stuff..." (C81). Additionally, she discussed social support experiences within her current romantic relationship. She stated, "He became a little bit more weak to" (C281) in reference to her current boyfriend following a major stressor in their relationship.

CP1's next most frequent support content expressions were related to service providers (C8; 46 codes) and specifically the therapist. Because CP1 and her therapist were engaged in a therapeutic board game, during the session, she often referred directly to the therapist in turn-taking during the game and in responding to the therapist's answers and reflections within the game. For example, she expressed, "Ok, I understand a little bit, but I think I'll get it as we go along" (C21) in reference to herself and the therapist after the therapist explained the game to her. She later said, "I see that, you're

right. I just don't know how to do that..." (C297) to the therapist after the therapist encouraged her to allow herself to feel painful emotions.

The third most coded category among CP1's statements of support content was about members of her immediate family (C1; 21 codes). CP1 made many references to her mother and her brother throughout the session. For example, she referred to her mother when described an embarrassing interaction with her mother during her middle school experience. She explained, "... she was going through my clothes and she found it [friend's class photo] and she was like, 'Oh, so I found this picture of this boy' and I was like, 'oh, ok.' I'm like, 'ok,' I'm kind of semi-embarrassed, 'cause I don't talk to my mom..." (C193). None of CP1's expressions related to her mother involved explicitly positive support experiences. She also mentioned her brother when describing the context in which sexual abuse by her uncle occurred. CP1 explained, "...so it would just be me and my brother. We was too little to be at home alone..." (C58) and, as a result, their uncle provided babysitting services for them, which is when he abused her.

The fourth most used Support Content code in CP1's transcribed session was related to friend relationships that were outside of friendships explicitly described as primary friend relationships (C4; 18 codes). For example, she informed the therapist that she often plays games with a friend. She reported, "I want to buy a game like my friend, [friend's name]. We always play like stuff like that..." (C405). CP1 also referred to childhood friends not specified as primary friends during the session. She described a group of friends from middle school in her statement, "...It was like a group of us girls and boys, just hanging out together" (C193).

CP1 also made several references to extended family members including cousins and her uncle (C2; 14 codes). Although her uncle was the perpetrator of her childhood rape and sexual abuse, CP1 also described instrumental support she received from him as a child. For example, she reported, "...well, the only thing I remember is like going out to eat and whatever he's doing, eventually he would take us out to the restaurant and feed us and that's it..." (C59) in reference to her uncle providing her and her brother with food when he babysat them. The coders agreed to include mentions of her uncle in C2 codes because she described support received from him in childhood as well as the abuse perpetrated by him.

CP1 described more other extended family relationships in references to her cousins. For example, referred to one of her cousins when sharing the response she expected to receive if she shared a stressor from her romantic relationship with others. She laughed as she stated, "...My cousin, she would just be like, 'Are you stupid?' Like, 'What do you think that's gonna do?'..." (C302).

Finally, CP1 made one statement related to a friend relationship which she described as a close relationship (C3, 1 code). She described a conversation with her previous roommate, who she identified as a person who was close to her, in C100 when she said, "You know, I told my old roommate, like the closest person to me here. I tell him, I was like watch, 'remember I was telling you I had no money up until today?'" CP1 did not make any statements pertaining to the C6 or C7 codes.

Support needs. Most of CP1's expressions of support needs were about negative aspects of her desire or need to provide others with support (SN2; 9 codes). For example, she made several references to her desire to not provide an acquaintance with an early

morning ride to the airport. In one coded mention of this need, she stated, “I ain’t doing that...” (C111). She also discussed a more serious need related to her desire to provide support to her boyfriend’s child, which was illustrated by the statement, “... I wish I could embrace her...” (C272). A third area of her desires to provide others with support was responded to the therapist’s statement of disclosing to the client that she would tell her boyfriend she loved him if she knew she was going to die. CP1 then articulated, “No, I wish I had your answer because I don’t tell people that enough” (C348), which the coders agreed reflected a wish to tell people in her life that she loved them.

CP1 also infrequently made references to her needs for support from others (SN1; 2 codes). She expressed a desire for her romantic partner to include her in his relationship with his child that was observed in the expression, “... Like, I want him to introduce us, so she can already know me...” (C286). She also expressed a need for her parents to be available to her for support. CP1 reflected, “... because you need your parents to be here...” (C68).

She expressed two reflections of unspecified support needs (SN3; 2 codes). For example CP1 informed the therapist, “... Ok, so, I want to talk about when you was talking about child abuse...” (C213). This statement was coded as SN3 because it illustrated her need for an exchange between her and the therapist (as opposed to only receiving support from the therapist). She later described a desire for another multi-directional exchange of support between her and some friends in the statement, “It’s like easily, I’m gonna be hanging out with them since I got my check...” (C406).

Extended support. CP1’s expressions of Extended Support most often fell in to the Not Otherwise Specified category (ES3; 8 codes). For example, she described mixed

feelings about extending support to others in her statement, “Like, I don’t mind doing stuff for people, but I’m the type of person who, if I ask you for a favor, it don’t mean I owe you my life, I’m not gonna give it to you...” (C102). Although she stated that she does not mind giving support to others, she also expressed her resistance to giving too much or more than she was willing to. Another instance of ES3 expressed by CP1 occurred in C320 when she factually stated her responsibility to help him during a period of financial stability in their relationship: “... he’s leaving and I got to take care of him”. In this statement, she referred to support that she will provide for her romantic partner as he prepared to leave for a work related trip. A third example of ES3 was observed in her expression, “...I’m trying to like lower my personality so that I won’t just run over him ‘cause no man wants to be run over” (C282). This reflected that she did something to for the benefit of her romantic partner but that was not stated as either positive or negative for her own experience.

CP1 expressed some extended support experiences that were negative (ES2; 2 codes). She described two beliefs pertaining to the negative consequences of giving support to others in romantic experiences. First, she stated, “... ‘Cause when you show them that you care, they think, ‘ok, we can run over her now, she likes me’ you know...” (C81). This statement referred to her belief that showing care through support to men would result in later being taken advantage of by them. She later discussed a difficult situation in her current romantic relationship in which she expressed a belief that if she were to extend support to her partner by involving herself with his child and the child’s mother to any degree, she would then have to become fully involved, which she did not want to do. “But it’s kind of like, if I welcome that, I’m welcoming everything” (C273).

She made one statement of a positive experience in providing another with support (ES1; 1 code). After expressing the support need to help her current romantic partner, CP1 described a belief about providing him with instrumental support, which was coded as ES1 because it occurred in the context of her feelings of security in their exchanges of support. She stated, “If he needs to use my car, I don’t have a problem with that...” (C329) when also commenting on the availability of support from him if she needed it, indicating willingness from both to help the other.

Support functions. Most of CP1’s descriptions of *Support Functions* pertained to social companionship (F6, 4 codes), although all occurred infrequently. CP1 made two references to peer companionship during her adolescence in which she played basketball with a group of friends. She expressed, “...when we used to play basketball all the time...” (C192) and “... ‘Cause we would play basketball in the snow...” (C193). Both references to memories with childhood friends were coded as F6 because they illustrated social time spent with others. She also described an experience of companionship with in adulthood in which she stated, “...we kicked it, we chatted, everything was all good” (C104) in reference to an earlier experience with an acquaintance.

The second most frequently coded type of received support in CP1’s session transcription was instrumental (F5, 3 codes). She described instrumental support in the form of a ride to the mall offered by a previous boyfriend when she explained, “And he was like, ‘Oh, I’m gonna take you’...” (C88, described further below). She also identified instrumental support received from another previous partner who offered her food following an argument. She identified that support in the statement, “You know, so by the time he was like, ‘you want to go out to eat?...’” (C362).

Two descriptions of advice received from others were observed in CP1's session (F3; 2 codes) were included in the session transcript. For example, CP1 stated, "I learned something" (C243), after the therapist provided psychoeducation about sexual abuse, which indicated that she had received information from the therapist. She also expressed receiving instruction from her mother to disclose any occurrence of abuse: "... My mom has always been like, if something happens, you gotta tell me, somebody touch you, you better tell me..." (C68, described further below).

CP1 described one experience of receiving support that enhanced her self-esteem (F1; 1 code). She described a compliment that was provided to her by a former boyfriend, in which he told her, 'Dang you look good' (C197, described further later in this section). Her expression of the compliment she received from the former partner was coded as F1 because it was a statement directed to her self-esteem.

She also described one instance of social support that did not fit into any other *Support Functions* category (F7; 1 code) during the course of the session. She explained an exchange between her and her mother during her early adolescence when her mother reached out to her in an attempt to understand her in the context of her sexuality and romantic experiences. CP1 reported, "... Like, she's like, 'yeah,' but she was like 'no, no it's ok 'cause, you know, I was starting to think you was gay'..." (C195). This statement was coded as F7 because it represented an attempt by her mother to support and understand her, which did not fit with any other *Support Functions* codes. CP1 did not express any references to emotional support (F2, 0 codes) or feedback provided by others (F4; 0 codes).

Other. CP1 referred to several experiences of social support that did not clearly fit into any of the specific social support codes (SS; 11 codes). SS was used to code CP1's descriptions of the difficulty she experienced in accepting help from others (3 statements). For example, she stated, "... it took a long time for me to accept help or to accept something..." (C99) and "... you know, it sucks. Like, it's hard for me to be like, uh, 'I need,' 'can I have,' 'can I borrow?' You know?" (C117). Both examples were coded as SS because the statements did not clearly fit with other coding categories (e.g., Perceived Support or Support Needs) because she expressed the difficulty she experienced in asking and receiving help rather than beliefs about support or her needs (including what she did not want) for support.

CP1 also discussed difficulty trusting others (3 expressions), which impacted her overall social support experiences. She explained that she would not easily share information about herself in the statement, "Yeah, 'cause I like – it depends on who you are and if I like sharing information 'cause it's like, I don't know, I feel like why they be asking..." (C126). This statement represented her resistance to revealing herself because of an inferred lack of trust in others.

CP1's SS expressions were also related to problems in her romantic relationship (5 comments). Her descriptions of difficulties within the relationship illustrated salient relational issues that impacted her social support experiences with her partner but that did not specifically fall into other coding categories (e.g., *Received Support* or *Perceived Support*). For example, she expressed, "... like communication problems, yes we have them..." (C261). She later provided an analogy to highlight a significant stressor in the

relationship when she said, "... It's like you're going perfect, perfect, perfect. Here comes a big ass mountain out of nowhere in the middle of the road" (C289).

Received support. Most of CP1's descriptions of *Received Support* were not described explicitly as positive or negative (RS3; 6 codes). For example, she expressed receiving support from her mother throughout her life in the expression, "... My mom has always been like, if something happens, you gotta tell me, somebody touch you, you better tell me..." (C68, also discussed previously). This statement was coded as RS3 because CP1 did not clearly state whether the support indicated by her mother was positive or negative to her experience. In another example of RS3, CP1 indicated that she received a recent compliment from a former romantic partner, but did not qualify it as either positive or negative. She said, "... And he's like, 'Dang, you look good' and I'm like, 'Oh, thanks. I didn't then?'" (C197).

She described two occurrences of support that she received as positive experiences (RS1; 2 codes). CP1 described one previous experience of received support that was positive when she explained a previous boyfriend who offered to take her out for something to eat after a disagreement. She said, "You know, so by the time he was like, 'you want to go out to eat? 'Cause he knows that I love to eat" (C362) and "So I get that he's trying to warm me up and talk to me, so I'm just like, 'talk to him. He ain't mad no more.' So then everything's ok" (C363). Because this description of her experience occurred over two talk turns, it was coded for RS1 in each of the talk turns, thereby accounting for the two RS1 codes in the session.

One instance of received support was described by CP1 as negative (RS2; 1 code). CP1's description of a previous boyfriend offering to provide her with a ride to

the mall that was quoted previously was coded as RS2 because she saw the support her provided (i.e., offering a ride) as insufficient.

Perceived support. The majority of CP1's statements of *Perceived Support* were explained as negative (PS2; 6 codes). CP1 explained that she had difficulty accepting support from others that stemmed from her belief that any support offered by others comes at the cost of the provider wanting something in return. She said, "... anybody whose offering help wants something" (C99). She further explained the degree to which she would need help before asking. She expressed, "Well, I just, it just takes for it to be, unless I'm in dire need and I don't have a dime and I'm sorry for me to ask" (C115). This statement was coded as PS2 because it represented the belief that support would be difficult to access because it takes so much for her to be able to ask for help.

CP1 made two statements of beliefs about support that were not clearly stated as positive or negative (PS3; 2 codes). For example, she expressed the belief that the therapist would laugh at her if she shared her response to the question, "what would you do if you were told you were going to die soon?" in the therapy game. She prefaced her response to the question with, "... It's dumb. You're gonna laugh. It wasn't as good as your's" (C338). Although she implied that her assessment of her own response was negative (i.e., "dumb"), she did not specify whether the possibility of the therapist laughing at her was positive or negative. It should be noted that CP1 had responded positively to the therapist's answer to the question and did go on to share her own response with the therapist. Another statement made by CP1 was coded as PS3. She described how she expected her cousin to react to her feelings of jealousy towards her boyfriend's child with another woman. She laughed as she stated, "My cousin, she

would just be like, ‘are you stupid?’ Like, ‘what do you think that’s gonna do?’” (C302). Because she did not clearly say if that type of response from her cousin would be perceived as either positive or negative, the statement was coded as PS3.

She expressed only one perception of social support as positive (PS1; 1 code). In describing the financial strain that she and her romantic partner were currently experiencing, CP1 explained the agreement between them as, “So if something happens and I do run out of money, he can send me money. It’s easier” (C329). In this example, CP1 described the belief that her partner would be able to provide her with financial support in the event that she experienced increased monetary difficulty, which reflected her belief that material support would be available to her if needed.

Client-participant 2. CP2 was a white woman from England who immigrated to the United States more than 14 years prior to treatment. She was 47 years old at the start of treatment and described herself as heterosexual and single at the time of intake. She also reported a long history of employment as a nanny but explained that she stopped working due to health problems. She experienced a medical trauma approximately one year before entering therapy in which she suffered a stroke that resulted in the progressive loss of her eyesight and subsequent health complications (e.g., serious infection in her foot). She also had a history of unspecified abuse in her childhood.

During the course of the transcribed session, CP2 reported on ongoing problems and medical issues stemming from her earlier stroke that were contributing to increased limitations in her daily functioning. In her explanations and discussions of her acquired limitations, she reported on the role of social support in her new level of functioning and made connections to earlier social support experiences in her life. She reported on

planned medical procedures (i.e., eye surgery) related to her need areas as well as anxiety that resulted in excessive scratching behaviors.

CP2's selected session contained 189 talk turns that were examined for expressions of social support. 119 total social support codes were assigned over the course of the transcribed session. CP2's total number of social support expression comprised 62.96% of all of the talk turns. The frequency hierarchy of coded categories of CP2's social support expressions was: *Support Content* (61 codes; 51.26% of all codes); *Received Support* (14 codes; 11.76% of all codes); *Support Functions* (13 codes; 10.92% of all codes); *Other* (12 codes; 10.08% of all codes); *Perceived Support* (8 codes; 6.72% of all codes); *Support Needs* (7 codes; 5.88% of all codes); and *Extended Support* (4 codes; 3.36% of all codes).

Support content. CP2's most frequently cited *Support Content* codes, of which she made 15 expressions of each category, were: C4, C8, and C9. She described many support relationships as friendships, but often did not specify whether the friends represented close or primary friends (C4, 15 codes). For example, she made statements including: "Um, [friend], my girlfriend outside will take me with another girlfriend" (C87); "... I wanted to be friends with this girl called [name of childhood friend]" (C135); "...when I was older and friends – I was always the one that would get the bus to their house..." (C139); and "Um, I that six months ago [friend] went in for a breast biopsy..." (C150). In each of these examples, CP2 referred to friends but did not clearly qualify any of the mentioned relationships as close or primary friendships.

Given her medical condition and need for assistance in daily functioning following her stroke and the decline of her eyesight, she also made frequent reference to

support from service providers (C8, 15 codes). Specifically, C8 was used to code CP2's mentions of the therapist and her physical therapist. For example, she explained to the therapist that she would contact the therapist following an upcoming eye surgery in order to schedule the next appointment because she was not sure when she would be able to return to the clinic after the surgery. She said, "...They didn't tell me so once I know that I will give you a call" (C168). It should be noted that in this example her use of "they" was not coded for C8 because it referred to unspecified medical professionals with whom a support relationship was not clearly established. Her reference to the therapist, however, was coded because the therapist was established as a support resource throughout the context of the session in that CP2 came to therapy for support in coping with significant stressors.

An example of a C8 expression related to her physical therapist was observed in C104 when she stated, "And she was wonderful. But she wanted me to walk without the walker. I'm like, 'I can't do that.' 'Yes you can, you can walk without the walker...'" Her description of the physical therapist as helpful in the context of providing her with encouragement and support (e.g., challenging her to walk without assistance) indicated the presence of support content in her relationship with the physical therapist.

CP2 also frequently referred to types of support relationships that were not accounted for by any of the other *Support Content* codes (C9, 15 codes). CP2's expressions of C9 were most frequently related to her close friend/roommate's son with whom she also lived and with whom she exchanged social support. The coders agreed to record all references to her friend's son as C9 as her relationship with him did not clearly fall into either category related to friend because she also was a caregiver for him. For

example, she described an instruction that she received from her friend's son that supported her progress for decreasing excessive scratching. She reported, "...And I sat down with a cup of tea and all of a sudden, [friend's son] said, 'Stop scratching'" (C39).

C9 was also used to capture generalized statements about supportive people made by CP2. She used words such as "everybody," "people," and "others" to describe individuals who visited her in the hospital following her stroke and foot infection and people that she regularly relied on for general help. For example, she said, "The people are still around that they are still in my life, that they still want to help" (C156).

The next most frequently coded category for types of relationships in CP2's selected session was related to friendships that she described as close (C3, 10 codes). C3 was used to code references to two friends that CP2 identified as primary friends. One was her friend/roommate and another was a friend that she described as being an "incredible support." CP2 reported an instance in which she extended support to her friend/roommate that included mention of the primary friend: "...and then I checked on [friend/roommate] and made a cup of tea" (C59). She also described an experience in which the other close friend assisted her in attending a medical appointment. She stated, "[Friend] is very, very good and she has driven me to all my appointments and has been an incredible support" (C92).

CP2 made 6 references to members in her immediate family (C1, 6 codes), which included members of her biological family as well as her adopted family. Examples of statements involving C1 codes include: "I think the second half of my childhood with my new family. 'New family'..." (C134) and "... And, oh, I should tell you that my brother is coming to visit" (C180; included C8 code).

Unlike other client participants, CP2 did not mention any support relationships involving extended family (C2, 0 codes) or romantic or sexual partners (C5, 0 codes). Similar to all of the others, no codes were given for affiliations (C6, 0 codes), or mutual aid (C7, 0 codes).

Received support. CP2's expressions of Received Support were evenly distributed between statements of positive support provided to her (RS1, 7 codes) and statements of support that she received that were not stated as either positive or negative (RS3, 7 codes). She described positive support she provided by her friend/roommate following an injury to her foot when she stated, "... She very good care of my foot for me..." (C114). CP2 also described an RS1 experience when she reported on financial assistance from friends. She said, "I am there for the good graces of friends, I got a nice check at Christmas, so..." (C179). Another example of RS1 was included in C92 (reported previously) when discussing the support she received from her primary friend who she described as an "incredible support." She stated, "...she has driven me to all my appointments..." (C92) Because she used the example of her friend driving her to all of her appointment as evidence of why she considered her friend to be such a significant support resource, the coders agreed to assign RS1 to her description of receiving transportation from her friend.

Later in C92, she stated, "So I said, 'I need your arm.' And she said, 'Okay, no problem.' And we get into the hospital." This expression reflected a statement of support provided by a friend to help her navigate an unfamiliar area at the hospital but was not described as either positive or negative. CP2 also described an experience of RS3 in childhood in which she received friendship from a peer. She expressed, "And I

actually went over and said, ‘Can I join your game?’ and she said ‘yes.’ I was like ‘okay’...” (C136). This recollection was coded as RS3 because the peer was responsive to her request and provided the support she was looking for.

Another example of an RS3 expression involved mixed feelings about support that CP3 received. In discussing previous experiences with visitors during hospitalizations, she described an experience in which the number of visitors she had changed an earlier belief that no one would visit her, which would be “sad,” but that was also burdensome. She reported, “...And it couldn’t have been more wrong. When I was in for my stroke there were so many people that called and visited and had flowers that it was absolutely exhausting” (C143). In this example, CP2 expressed mixed emotions stemming from others showing support during a medical crisis. CP2 did not describe any received support experiences as negative (RS2, 0 codes).

Support functions. Albeit infrequent, most of CP2’s descriptions of Support Functions pertained to emotional support (F2; 3 codes), material aid (F5; 3 codes), or unspecified type of social support (F7; 3 codes). One example of an F2 expression occurred in C143 when she described her friend responding to her fear of going to the hospital: “And when we were driving to the hospital, [friend] said, ‘Why are you so frightened?’” CP2 also reported receiving emotional support from her physical therapist who responded to her fear of falling when attempting to walk. She explained that her physical therapist said, “... ‘Believe me. I will stop you from falling. You’re not gonna fall, it just feels like you’re going to.’...” (C106). Both of these examples reflect the support that CP2 received from others when displaying fear. The third example of an F2 expression occurred when she discussed her roommate’s son ability to empathize with

her needs. She expressed, "...He's been – he is very much aware of what – where I am, what I am doing and what I need to do. And for 16 years, well he is not 16 yet, he will be in April, but he's an extremely emp-empa-empathetic? Is that the word?" (C43). This statement was followed by her explanation that he had noticed her scratching, which was an anxious behavior, and was able to tell her to stop when she herself had not been aware that she was engaging in the anxious behavior. Therefore, her description of his responsiveness to her anxiety state was coded as F2.

CP2's expressions of F5 included receiving transportation to medical appointments from her close friend (C92, previously reported); financial support from friends (C179, previously reported); and medical assistance from her roommate in bandaging and cleaning her foot (C114, previously reported). Similarly, F7 was used to code CP2's report of a friend who told her to walk outside during her physical rehabilitation. She reported, "... [Physical therapist] didn't want me to do it but [Male acquaintance] was there and he was like, 'Come on. She's not here, she doesn't know you're going to do it...'" (C108). The coders agreed that this statement from a friend provided some function for her but that it did not clearly fit into other *Support Functions* categories (e.g., F1 or F4) because it was not obviously related to encouragement or feedback on her progress but more of a challenge to try something new without professional support. Another example of F7 occurred in her description of her friend giving her an arm to guide her in an unfamiliar hospital setting (C92, previously quoted). The provision of physical assistance was coded as F7 because it did not fall into any other *Support Functions* category such as material aid (i.e., F5).

Two instances of support that was provided to CP2 that enhanced her self-esteem (F1; 2 codes) were included in the session transcript. Both examples occurred when CP2 described experiences in which her physical therapist told her she could do things (i.e., walk) that she did not think she could do, which enhanced her self-esteem. She explained that her physical therapist told her, "... 'Yes you can, you can walk without the walker.' 'No I can't.' I was terrified I was going to fall over and I knew I couldn't get up. I..." (C104). She further reported, "... And she would say, 'Come on, come on, you can do it.'" With this esteem support from her service provider, CP2 was able to take a few steps during that physical therapy session and progressively increased her mobility.

CP2 described one experience of receiving instruction in the session (F3; 1 code), which occurred when her roommate's son told her instructed her to stop scratching. As previously quoted when describing C9, she explained, "...all of a sudden [friend/roommate's son] said, 'Stop scratching'" (C39).

She also described one instance of social companionship (F6; 1 code) during the course of the session. CP2 expressed companionship she experienced when she initiated a friendship in her childhood. After describing the friendship she received from the peer in C136, she stated, "...After that we started talking and we sat together at lunch and I was like, 'I have a friend all my own'" (C136) which was indicative of time spent with another. CP2 did not express any references to feedback provided by others (F4; 0 codes).

Other. CP2 described 12 social support experiences or beliefs that were categorized by any other code in the content analysis (SS, 12 codes). Many of CP2's SS statements were related to past perceptions of support (8 expressions). For example, she

stated, "... I think that I thought that for a very long time, that, nobody would want to help me..." (C142). Another expression related to early perceptions of obtaining support in developing friendships: "... I wanted her to think I was a nice person and that I had to give her something. That I wasn't just enough; I had to give her something to make her like me" (C136).

CP2 also made references to future planned support (e.g., support not yet received) that did not clearly represent beliefs about support (1 statement). Statements such as, "...my brother is coming to visit" (C180) and "...my girlfriend outside will take me with another girlfriend" (C87) referred to future occurrences of support.

A third area of SS expressions in Session 2 pertained to the quality of relationships for the client-participant (3 comments). She stated, "... [roommate and roommate's son] understand – they know exactly what I am going through. They live with me; they see on an everyday basis how it has changed my life" (C91). This statement was coded as SS because it reflected an element of understanding within the relationship, which contributed to feeling supported by others, but that did not explicitly evidence actual support or beliefs about support that fit with other coding categories.

Perceived support. The most frequently used *Perceived Support* category in the analysis of CP2's selected session was positive perceived support (PS1, 5 codes). For example, she expressed the belief that others want to help her. She explained, based on past experiences of received support, "...I really found out that there are a lot of people out there that want to help me and that, you know, care about me" (C145). She also expressed, "The people are still around, that they are still in my life, that they still want to

help me and it's like a year and a half down the road..." (C156), which also reflected the belief that others are continuously able, and want, to help her.

CP2 made two statements expressing perceptions of social support that were not coded as either positive or negative (PS3, 2 codes). An example of PS3 was observed in her statement, "...hopefully after the surgery, I won't need anybody to do that. I didn't need, for the last 9 months, I didn't need anybody to do that" (C6; also coded as SN3). This expression was coded as PS3 because it reflected a future belief about support (i.e., not needing it as much) that stemmed directly from past support experiences but appeared ambivalent rather than clearly positive or negative.

CP2's expressions of perceived support were least frequently coded as negative (PS2, 1 code). She expressed concern related to her belief that her friends would eventually decrease the support they provided to her because of her history of requiring their help:

And I'm quite possibly going to wear out my welcome, like, um, that people are just gonna get fed up with me being – using up their time, using up their – and am I such a worthwhile cause for them to keep on helping me if I need it?

Support needs. CP2 made four references to support needs that expressed needs that were not clearly from or to others (SN3, 4 codes). For example, her statement, "I just didn't want to ask for help" (C146) was coded as SN3 because she did not state that she did not want help (i.e., SN1) but rather that she was resistant to asking for it. Another example of SN3 was in her statement, "I wanted to be friends with this girl called [childhood friend]" (C135). This desire was coded as SN3 because it reflected the wish for an exchange of support rather than a unidirectional wish.

The second most commonly use Support Needs code in CP2's transcript was related to the desire to provide others with support (SN2, 2 codes). One of CP2's expressions of SN2 was related to the desire to assist a friend who was being treated for breast cancer due to her own medical problems and limitations. In C151, she expressed:

And I couldn't do anything. I couldn't take her, I couldn't sit with her, I couldn't cook something and take it over. I couldn't and that would have been something that I would have done before. I would have taken her or picked her up or would have definitely, you know, been able to help.

She then made a generalized statement about her desire to be able to provide others with support. She reflected, "...The wanting to give to others is still there. I mean, I am very frustrated that I can't do it" (C154).

CP2 expressed one statement about needing support from others (SN1, 1 code) when she expressed, "... There is still something that feels like the other shoe is gonna drop. Like there's – I still have more to face, more to come, and I am still gonna need their help" (C157).

Extended support. In her least frequent code, CP2's statements of Extended Support were most often coded as "not otherwise specified" (ES3, 3 codes). For example, she expressed mixed feeling about providing a new friend with her snack in childhood. She said,

... And I gave her my bag of potato chips because I wanted her to think I was a nice person and that I had to give her something. That I wasn't just enough; I had to give her something to make her like me (C136).

Another example of ES3 in Session 2 involved a statement of providing support to her roommate without describing it as positive or negative. She stated, "...then I checked on [friend/roommate]..." which indicated the extension of supporting her close friend.

She made only one statement of positive extended support (ES1, 1 code). She described the benefit that helping others had on her in her statement, "...Over the years, I have helped a lot of people and, you know, the karma? What goes around comes around and I've always been the first one there to help anybody so I had a lot of that come back to me..." (C145). She did not make any reference to extended support as being negative (ES2, 0 codes).

Client-participant 3. CP3 was a 21-year-old woman who self-identified as Hispanic and Christian. She was married at the time that the selected session occurred. She emigrated from El Salvador independently of her family of origin three years prior to the start of therapy. She described a long history of physical and emotional abuse by her biological mother and grandmother. As a result of her abuse history she had been adopted by her maternal great-aunt and great-uncle. She also reported history of two sexual assaults in her lifetime.

CP3's primary language was Spanish and she spoke English as an acquired language. Therapy was conducted in English; therefore, her language experiences may have impacted her ability to express social support experiences and other factors in therapy. Throughout the transcribed session, CP3 described experiences of physical abuse perpetrated by her mother, violence within her family, and ongoing concerns related to the safety of her sisters, who remained in the abusive family environment in El Salvador.

CP3's transcribed session included 278 total talk turns that were coded for expressions of social support. Out of the total number of talk turns, CP3 made 147 statements of social support, which reflects 52.87% of all talk turns. The frequency hierarchy of coded categories of CP3's social support expressions is: *Support Content* (126; 86.71% of the total codes); *Received Support* (8 codes; 5.44% of the total codes); *Support Functions* (8 codes; 5.44% of the total codes); *Other* (3 codes; 2.04% of the total codes); and *Support Needs* (2 codes; 1.36% of the total codes). Unlike the other client-participants, the codes for *Perceived Support* and *Extended Support* were not used in the analysis of the selected session for CP3.

Support content. CP3's statements of Support Content were most frequently about family relationships. The most commonly occurring type of support in CP3's session was primary family (C1, 83 codes). She most frequently referred to her husband, biological mother, sisters, and adoptive parents. The following expressions include identification of C1 codes: "...I just keep things from myself, let's say with my husband..." (C183); "So anything better than my mom..." (C102); "I was just thinking about my sisters, and you know, what's going on..." (C93); "my adopted parents are actually my mom and, she's my aunt" (C108). C1 codes occurred at the most frequent rate because CP3 discussed familial issues throughout the session and every mention of primary family relationships was coded.

The second most frequently occurring type of support in Session 3 was secondary family relationships (C2, 34 codes). CP3 most often referred to her grandmother, aunts, and cousins in regards to secondary family relationships during the session. For example, she stated, "... But they're my grandma, my aunt, my cousins, they're all, you know"

(C180). She also made some references to her stepfather, who was coded as C2. An example of a social support expression involving her stepfather was, "...my mom husband, he invited us, you know, to go..." (C138). Again, because of CP3's frequent expressions related to family problems, she often mentioned specific extended family relationships; therefore, the frequency of C2 codes was high in comparison to other content and social support codes.

CP3 referred to the therapist 7 times over the course of the session, which accounted for the service codes (C8, 7 codes). For example, she said, "...but, like I told you the other day, I feel more angry..." (C208). Another example of referring directly to the therapist was observed in C215 when she stated, "Yeah, you say its good..."

CP3 made two statements pertaining to support relationships with a friend that was not explicitly stated as a primary friendship (C4, 2 codes). CP3 discussed receiving support from a friend during a traumatic experience. She explained that she left her home during a physical attack by her mother in which she went to an unspecified friend's home. She stated, "... So I left there to some friend house..." (C155). She then explained that the friend offered her a place to stay: "... So when I, my sister and my friend was there, and she just 'stay over tonight', you know..." (C156). Because the friendship was not clearly described as a close friendship, even though stress-related support was provided, her references to the friend were coded as C4. The Support Content codes for primary friend (C3, 0 codes), romantic relationships (C5, 0 codes), organizational resources (C6, 0 codes), and mutual aid relationships (C7, 0 codes) were not used in the review of CP3's transcribed session.

Received support. CP3's infrequent statements of *Received Support* were most often coded in the not otherwise specified category (RS3, 6 codes). Some of CP3's expressions of RS3 were coded as not otherwise specified because she gave impartial descriptions of received support that were not stated as either positive or negative. One expression of RS3 pertained to receiving protection for her physical integrity from her aunts during physical assaults by her biological mother. She reported, "... My aunts sometime protect from my mom..." (C164). She also described support from a friend that occurred due to violence by her mother. She made two references to her friend's offer of a place to stay during an attack by her mother (C155 and C156, previously stated).

Other statements of RS3 were not related to her trauma history and involved reservations about the type of support received. For example, she described received support from her husband in his proposal of marriage. She reported, "...he propose me to get married with him and everything. I didn't because, you know, in El Salvador you see people get married, like, you see this one with their big eye, you see them purple all over sometime..." (C254) and "...so when he asked me to get married, I'm like, 'okay, but the day that you put your hand on me, I don't care if you're my husband'..." (C256). Her description of her mixed feelings about accepting the marriage proposal resulted in the decision to code both statements as RS3.

The second most commonly occurring *Received Support* code in Session 3 was positive received support (RS1, 2 codes). She expressed RS1 when she described the beneficial effect of her sisters calling her after a stressful event. She reflected, "...You know, they kinda comfort me a little bit so" (C103). She also described helpful support

she received from her husband when he helped her to de-escalate angry feelings: "...I'm really angry sometime and he just, then he just goes to help me calm down" (C208).

Both examples indicate support that CP3 received that was helpful to her; therefore both statements were coded as RS3. CP3 did not make any statements of negative received support in the selected session (RS2, 0 codes).

Support functions. The support functions described by CP3 most frequently did not fit into any other Support Functions category (F7, 4 codes). F7 was assigned in the two talk turns related to her husband's proposal of marriage that was described previously (C254 and C256). The coders agreed on assigning F7 to the description of the marriage proposal as a function that was not categorized by any other because it represented a support type (i.e., proposal of marriage) not included in any other *Support Functions* codes (e.g., F1, F2, F3, or F6). F7 was also used to capture CP3's description of physical protection she received from her aunts during violent assaults from her mother (C164, previously quoted) because it did not fit with any other codes related to functions (e.g., F5). This was also illustrated in her statement, "... And my aunt, another aunt, she stop her, 'cause she was right on top of me, just about to do it and my other aunt just grab her..." (C155).

CP3 expressed two experiences of receiving emotional support (F2, 2 codes). For example, she described receiving emotional support from her sisters when they called her to help her feel better after a family stressor in the quotation from C103 described above. Similarly, her expression of her husband's assistance when he helped "calm down" when she was angry (C208, previously quoted) represented an example of F2.

CP3 referred to one instance of informational support (F3, 1 code) and one occurrence of material support (F5, 1 code). An example of F3 occurred in C155, when she stated, "... And I just left 'cause my grandma go, you know, 'Go somewhere 'cause she, she gonna, she going to kill you..."", which represented an example of advice provided to the client-participant during an assault by her biological mother. CP5 expressed F5 in her description of her friend offering her a place to stay (C156, previously quoted) when she escaped the attack by her mother.

The following Support Function codes were not used in the analysis of CP3's transcribed session: F1 (0 codes), F4 (0 codes), and F6 (0 codes).

Other. CP3 expressed three social support experiences that did not fall into any other coding category (SS, 3 codes). Two of CP3's expressions of social support that were coded as SS were related to planned time spent with her mother-in-law for an upcoming holiday. She reported, "Actually yeah, I'm gonna cook with my mother-in-law. She not a good cook but she's really nice" (C274) and "Yeah, we're gonna cook together and have a dinner..." (C276). Both expressions were coded as SS because they illustrated a future activity together, which did not fit with RS, ES, or F codes. Also the expressions did not involve a stated description of a belief or need pertaining to the activity, which ruled out PS and SN codes.

Another statement was coded as SS when she described not doing something (i.e., suicide) because it would not be helpful to others (i.e., her husband and sisters). When the therapist asked CP3 if she was experiencing suicidal ideation, she responded, "Well, I haven't because, I'm really, I just get the idea that with me doing something stupid, I'm not gonna help them at all..." (C132). This statement was coded as SS because it

reflected a belief that her actions could result in the lack of support to important people in her life.

Support needs. CP3 described two instances of the desire to provide others with support (SN2, 2 codes). Specifically, she described the desire to be able to help her sisters. For example, CP3 expressed, "... I can do better, you know, with helping them somehow..." (C134). She also stated, "...I just feel like I can, you know like, if I could do something to help my sisters not take [abuse]" (C163). This statement reflected her wish to be able to help her sisters escape their mother's abuse. She made one statement that reflected the desire for support from others (SN1, 1 codes), specifically for support from her husband. CP3 did not have any expressions of support needs that or that fit into the not otherwise specified category (SN3, 0 codes).

Client-participant 4. CP4 was a 39-year-old woman who identified as multi-ethnic (i.e., Black, American Indian, and Caucasian) who was married and had four children at the start of therapy. She was self-referred for psychotherapy after being informed that her father had sexually abused her "guardianship daughter." The discovery of the sexual abuse on her guardianship daughter brought up memories of the client-participant's own history of sexual molestation by her paternal grandfather during childhood. CP4's initial intake session was transcribed for inclusion in the study. The selected session involved a clinical interview to gather information about CP4's presenting problem and biopsychosocial history. During the course of the session, CP4 also discussed her history of childhood sexual abuse.

CP4's selected session had a total of 184 talk turns that were reviewed for expressions of social support. CP4 made a total of 201 statements of social support,

which represented 109.23% of the overall number of talk turns. Thus, Session 4 represented the only example in the study in which the number of total social support codes actually exceeded the total number of talk turns due to multiple codes assigned within single talk turns. The frequency hierarchy of coded categories of CP1's social support expressions was: *Support Content* (134 codes; 66.66% of all codes); *Extended Support* (15 codes; 7.64% of all codes); *Support Needs* (14 codes; 6.96% of all codes); *Received Support* (13 codes; 6.46% of all codes); *Support Functions* (12 codes; 5.97% of all codes); *Other* (7 codes; 3.48% of all codes); and *Perceived Support* (6 codes; 2.98% of all codes).

Support content. Most of CP4's stated support resources fell into the *Support Content* codes related to family relationships. Her statements of *Support Content* were most frequently coded as relationships within her family or origin or her current nuclear family (C1, 86 codes). She most frequently referred to her husband, guardianship daughter, biological daughters, and father. For example she made statements such as, "... and I'm having arguments with my husband..." (C59), "... And [guardianship daughter] was trying to figure out her place in our family..." (C121), and "And my father for years hated his father, hated him for doing that to me, for not being able to protect me..." (C54). The second most commonly occurring *Support Content* code in Session 4 was related to extended family relationships (C2, 28 codes). She most frequently referred to her grandmother in statements such as, "... And then my grandmother, I told her as soon as she got better..." (C56).

The third most frequently assigned code among CP4's expressions of *Support Content* was related to service providers (C8, 12 codes). Specifically, she frequently

referred to a previous therapist. For example, she expressed, "...she was so just dynamic in making me or helping me deal with things and not just making me have ownership of my stuff, you know what I mean, working through my life back then..." (C174). She also made one reference to the current therapist during the session.

The next most coded Support Content category was the not otherwise specified code (C9, 4 codes). Her expressions of C9 support resources were related to general statements such as, "Yeah, I take care of everybody's everything" (C82) and "... I wanted to just go and hide, you know, from everybody..." (C117). She also referred to her "support system" in C92, which was coded as C9.

CP4 also referred to support relationships involving friends. She made 3 references to friends that she identified as close or primary friendships (C3, 3 codes). For example, she referred to seeking support from "some close friends of mine" (C49) following the disclosure of alleged sexual abuse by her father towards her guardianship daughter. CP4 made one statement involving a friend that was not identified as a primary friendship (C4, 1 code) when she stated, "My friend that referred me said fifteen dollars per session?" (C181).

CP4 did not make any expressions involving romantic relationships (C5, 0 codes), relationships from affiliations or organizations (C6, 0 codes), or mutual aid relationships (C7, 0 codes).

Extended support. The majority of CP4's expressions of *Extended Support* were not stated as being either positive or negative (ES3, 14 codes). CP4 reported on instances of support that she provided to other that were described in neutral terms. For example, she stated, "... we got her into counseling right way..." (C49) when describing how she

and he husband extended support to their guardianship daughter when they became he primary caregivers. She also described taking her older daughters out for an afternoon during a period of heightened family stress in order to provide them with a sense of “normalcy.” She said, “... so I picked them up and we went and saw [movie title]...” (C128). Both of these examples illustrate expressions of support that was extended without statement of the impact on the client-participant.

CP4 described one experience of extended support that was negative (ES2, 1 code). CP4’s previously discussed ES2 statement pertained to negative feelings about the support she provided to her grandmother (C59). She did not express any positive experiences of extended support (ES1, 0 codes).

Support needs. CP4’s expressions of *Support Needs* were most frequently stated as the need or desire to provide others with support (SN2, 7 codes). Examples of CP4’s statements of the need to provide others with support were related to her desire to support her guardianship daughter and her grandmother. For example, she expressed, “... yeah, that is what I am feeling, ‘you can, you are safe’ and I just want her to know that...” (C129), which highlighted her need for her guardianship daughter to know how CP4 was feeling and to provide her with a sense of safety. She also discussed her need, as stemming from a sense of responsibility, to provide assistance to her grandmother. After stating her grandmother’s many needs due to her age and acquired limitations, CP4 said, “... So I have to do everything” (C26). The coders agreed to assign SN2 to this statement because her emphasis on “have” illustrated her need to complete tasks of assistance.

The second most commonly used *Support Needs* code in Session 4 was the not otherwise specified category (SN3, 4 codes). Her statement, “... I just wish our

communication was better” (C165) was assigned the SN3 code because her desire for improved communication represented the wish for an exchange of support rather than support either from or to others. Another example of SN3 occurred in her stated desire for her guardianship daughter to have sought her support and disclosed the sexual abuse to her. After explaining how her oldest biological daughter would have responded to attempted sexual by coming to her, CP4 stated, “...which is what I wish [guardianship daughter] would have done” (C123). This expression was coded as RS3 because it reflected her need from her guardianship daughter as well as her wish to provide her daughter with support.

CP4 also described her needs for support from others (SN1, 3 codes). For example, she stated her need for her grandmother to keep her separated from her father. She stated, “... don’t expose me to him. Period” (C57). She also expressed, “... me needing to be able to come to you is not there right now... with this situation...” (C163; also coded as PS2). This statement reflected both the need for support from her husband and a perceived lack of available support.

Received support. Most of CP4’s descriptions of *Received Support* were not explicitly stated as either positive or negative (RS3, 8 codes). Some statements that were coded as RS3 were expressions of received support that were not stated as either positive or negative. For example, when discussing support that she received following the report of alleged sexual abuse on her guardianship daughter, she said, “... over this last month or so, I’ve been talking to my mom and some close friends of mine...” (C49). In the context of the discussion, this statement referred to the support she received in factual terms of talking to others. Other expressions of RS3 illustrated ambivalent feelings

related to the support. One example occurred in C80 when she said, "... and I know it's not my fault, everyone tells me it's not my fault, but I feel that somehow I should have known..."

CP4 described 4 instances of positive received support (RS1, 4 codes). For example, she described the support that her stepmother provided in helping her start an earlier therapy experience as positive. She explained, "and she delivered me. She delivered me there. Yeah, she was the one that got me started in healing myself" (C90). She also described a more recent experience of beneficial received support in which her husband attempted to help her with tasks at home. CP4 reported, "...he's so cute, you should see him all, he's like, 'I'll cook dinner' and he's bathing the kids and he just like, 'I don't know how to fix this.' It's so cute" (C83).

One expression of received support was described as negative (RS2, 1 code) by CP4. She explained a therapy intervention from a previous psychotherapy experience to which she had a negative reaction. After explaining the intervention in which the therapist had her imagine herself as a child disclosing her sexual abuse history and how she would respond to hearing the disclosure from her childhood self, she recalled how upset she felt. She reported,

... And I looked at that empty space and I said, 'it is not your fault' and I cried so hard and then I got pissed... I was like, 'you [expletive] set me up, you [expletive]', and I looked at my stepmother and the therapist and was like, '[expletive] you both, I am so out of here and I got so angry because it felt like I couldn't stop crying...' (C132)

This description of her angry reaction to the therapy intervention led the coders to agree that her perception of the support provided by the therapist in facilitating the intervention should be coded as RS2.

Support functions. CP4's expressions of *Support Functions* were most commonly coded as material aid (F5, 4 codes) or not otherwise specified (F7, 4 codes). F5 was used to capture the support function fulfilled by her stepmother in finding her a therapist and bringing her to her earlier therapy experience. For example, she stated, "... I said, 'you know what? You find me somebody and I'll go.' And she did" (C90).

CP4's references to F7 codes were related to the psychotherapy process and interventions that occurred with a previous therapist. CP4's description of the therapy intervention described in C132 in which the therapist facilitated a visualization and discussion with her childhood self pertaining to her experience of childhood sexual abuse was coded as F7. Her statement in C174, previously discussed, about the support that her previous therapist provided in helping her to work through areas of difficulty was also coded as F7.

The next most frequently used *Support Functions* code in Session 4 was informational support (F3, 2 codes). For example, she described the explanation that her previous therapist provided her with following the aforementioned psychotherapy intervention that CP4 had a negative reaction to. She reported, "...and she explained it to me, what she did and why she did it..." (C136, which was assigned the F3 code because it represented information provided to her by the therapist. Another example occurred when CP4 said, "My friend that referred me said fifteen dollars per session" (C181).

This statement was coded as F3 because she described information provided to her about the cost of psychotherapy.

The codes for feedback (F4, 1 code) and companionship (F6, 1 code) were each used once in the selected session for CP4. She described receiving feedback from her husband in her reflection, “My husband says things like that all the time, like that too, ‘you don’t trust men, you barely trust me’ and it makes me sit and think, ‘that’s not, that’s not good’” (C113). This expression was coded as F4 because it illustrated feedback she received from her husband related to her interpersonal functioning. She described receiving companionship from her stepmother when her stepmother accompanied her to an earlier therapy experience. She stated, “... because my stepmom went with me, and she was here, I was on this couch, and the counselor was there...” (C132), which was coded as F6. CP4 did not make any expressions related to esteem (F1, 0 codes) or emotional support (F2, 0 codes).

Other. CP4 stated 7 expressions of social support that were not categorized by any of the other social support codes (SS, 7 codes). CP4’s SS statements generally referred to relational elements that did not represent explicit statements of social support but that appeared to be salient factors in her overall support relationships. For example, she described connecting with her guardianship daughter: “And see, [guardianship daughter] and I have bonded because we have similar upbringings...” (C68). She also expressed, “And I have a lot of guilt because I let him in her life...” (C80) when describing her feelings of responsibility in her guardianship daughter’s abuse history. CP4’s statement about her daughters, “... they are incredibly important to me...” (C120) captured the significance of those relationships in her life.

Perceived support. CP4 most frequently described perceptions of social support as positive (PS1, 4 codes). She identified, “I do, I have a circle of friends that are very good friends...” (C65) “...that I can lean on, yeah” (C66). After the therapist reflected, “... you have some wonderful support system” (T92), CP4 described her positive perceptions of available support in statements such as, “... support system, I do” (C92) and “I’m blessed, I’m blessed in that area” (C92).

CP4 made two references to negative perceptions of social support (PS2, 2 codes). CP4’s PS2 expressions were related to perceptions about a lack of support from her husband in her attempts to cope with her current family stressors. One example included her statement, “... and I told him too, ‘I start to communicate with you and you give me this look, this puzzled look, this look and I feel like an idiot and I shut down because I feel stupid, because you are not getting it and you can’t even fake it well...” (C161). In the overall context of the discussion, this statement was coded as PS2 because she indicated that these beliefs were ongoing and that support from her husband would not be available on a continued basis. No expressions of perceived support fell into the not otherwise specified category (PS3, 0 codes).

Client-participant 5. CP5 was a 28-year-old female who self-identified as Caucasian, Protestant, and heterosexual. She was married and had two children at the time of intake and had recently reunited with her husband at the time the selected session took place, following a separation in their marriage. CP5 reported a history of childhood sexual abuse occurring for several years that was perpetrated by a neighbor. She was also sexually abused by her father during adolescence. Throughout her childhood and adolescence, she was mistreated and neglected by her mother and was physically abused

by her father. During her adulthood, she experienced intimate partner violence in her relationship with her husband.

Over the course of the transcribed session, CP5 discussed ongoing problems in her marriage that had contributed to the recent separation and that she and her husband were attempting to resolve in their reunification. Most of the marital problems that she discussed with the therapist were related to financial stressors. In addition, CP5 described and discussed her history of abuse (i.e., physical, sexual, and emotional) that occurred within her family of origin. CP5 made many connections between her trauma history and ongoing interpersonal difficulties she experienced.

The session selected for CP5 had a total of 300 talk turns that were coded for expressions of social support. CP5 made a total of 140 statements of social support, which represents 46.66% of the overall number of talk turns. The frequency hierarchy of coded categories of CP5's social support expressions is: *Support Content* (108 codes; 77.14% of the total codes); *Perceived Support* (6 codes; 4.28% of the total codes); *Support Needs* (6 codes; 4.28% of the total codes); *Received Support* (5 codes; 3.57% of the total codes); *Extended Support* (5 codes; 3.57% of the total codes); *Support Functions* (5 codes; 3.57% of the total codes); and *Other* (5 codes; 3.57% of the total codes).

Support content. Most of CP5's statements of Support Content were about primary family relationships (C1, 100 codes). Her expressions involving primary family relationships were all related to her husband, mother, father, brother, son, and daughter. References to these individuals were observed in statements such as “Cause, I mean, you know, he's just my husband” (C18); “And then later my dad sat down and did nothing, and my mom went back to work, and he like totally did nothing” (C64); “I still say it to

my mother” (C143); and “I say it to my brother” (C144). Because CP5 primarily discussed issues related to her family of origin and her current nuclear family and each mention of these individuals was coded, C1 codes occurred at the highest frequency in Session 5.

The next most frequently used Support Content code used in Session 5 was the not otherwise specified category (C9, 5 codes). C9 was used to capture CP5’s generalized statements about people in expressions of social support. For example, she expressed, “...although I completely freak out if I can meet somebody in the supermarket and it doesn’t matter who it is because everyone in my life belongs in a certain box...” (C124) “...and if somebody is some place they’re not supposed to be according to my mind...” (C125). Her references to people in her life as “somebody” and “everyone” in this example were coded collectively as C9 because it represented one expression about beliefs and expectations for people in her life as pertaining to social support. A similar example of C9 occurred in her statement, “...I will walk past people I know very well and not say hi because I forget to” (C133). This again illustrated a generalized reference to people in her life.

CP5 made one comment pertaining to friends identified as close (C3, 1 code) and one statement related to friends not identified as primary (C4, 1 code). In the session, CP5 referred to two friends by name, who were identified in the Telephone Intake Form and Intake Evaluation Summary as being her best friends who she relied on for support. She referred to them when she explained a hypothetical situation of seeing people she knew unexpectedly. She explained that if she were to see anyone without a prior plan, “[friend] and [friend] are the only two people I’d be happy to see...” (C164). Therefore,

C3 was coded for conjointly referring to her two best friends. CP5 made reference to more distal friends when she recalled attending a conference as a teenager. She explained that she attended the conference because, “One of my friends, well actually, several of my friends were gonna be there...” (C179). In this instance there was no further information to indicate that the friends she mentioned were primary friends. Therefore, the reference to friends in C179 was coded as C4.

CP5 also expressed one statement in which she directly referred to the therapist, which was coded as a service provider (C8, 1 code). When planning for balancing both individual therapy and couple’s therapy, CP5 stated that she would prefer not to reduce the frequency of weekly individual sessions with the therapist in her explanation, “...I’d rather skip a week with him like twice a month or something...” (C15) “...than go back to one with ours, though” (C16). She referred to both the therapist and herself with the use of “ours;” therefore, C8 was coded in C16.

No expressions of extended family (C2, 0 codes), romantic or sexual relationships (C5, 0 codes), affiliative relationships (C6, 0 codes), or mutual aid relationships (C7, 0 codes) were identified in Session 5.

Perceived support. CP5’s statements of *Perceived Support* were most frequently coded in the not otherwise specified category (PS3, 3 codes). CP5’s statements of PS3 were related to beliefs about future instrumental support from her husband. She expressed mixed feelings related to her belief that future financial support from him would continue to be inconsistent. She reflected, “and I believe he’ll eventually kick in more and I don’t really care. I wouldn’t care if I could survive on it. I wouldn’t care if it

was a hundred dollars a month if I always knew it was going to be...” (C97) “...like if I could depend on it, I wouldn’t care how much...” (C98).

The second most frequently coded Perceived Support category in Session 5 was positive perceived support (PS1, 2 codes). CP5 expressions of positive perceptions of support were related to changes in her husband’s provision of support towards her. For example, in explaining changes in the support provided by her husband, she explained, “Like he respects my space” (C24). This statement was coded both as received support and perceived support because she indicated that the support she was currently receiving would be ongoing (i.e., continued support in the future). Also, she expressed a belief in the ongoing provision of positive support by her husband in her reflection, “I always notice the little things and I always appreciate them” (C30). Although this expression was also indicative of ES1 (i.e., acknowledging her husband’s support), it illustrated her appreciation of the support that she believes he will provide to her on an ongoing basis (i.e., her statement of “always” appreciating the support).

CP5 made one statement in which she described negative perceived support (PS2, 1 code). Specifically, CP5 expressed the perception that she could not depend on her husband financially based on his history of inconsistent instrumental support. She said, “I can’t depend on him because he has contributed...” (C84) “...over the course of our marriage, but no dependably and consistently...” (C85). This expression reflected the ongoing belief that monetary support from her husband would be inconsistent; therefore, her statement was coded as PS2.

Support needs. CP5 most frequent stated her *Support Needs* as needs she had from others (SN1, 5 codes). CP5’s needs for support from others involved her desire for

increased financial contributions from her husband. In one example, she described expressing her need for financial support from her husband in the statement, "... and when I told him, I said, 'this is what I mean when I need you to take care of the rent'..." (C107). Another example of her need for instrumental support within the marriage was observed in her statement, "Because I asked him to cover rent and marriage counseling" (C91).

CP5 expressed one need to provide another with support (SN2, 1 code). SN2 was used to code her statement, "...but I would also not want someone to depend fully on me" (C69). This expression was coded as SN2 because she stated a desire to not provide others with support if someone were to depend on her. She did not express any support needs that fell into the not otherwise specified category (SN3, 0 codes).

Received support. Although infrequent, CP5 most often described *Received Support* experiences as positive (RS1, 4 codes). For example, CP5 described receiving support from her husband as "cool" and "surprising" in the discussion with the therapist:

C22: ... [he] keeps surprising me. Yeah.

T23: What surprised you this week?

C23: He's offered to do stuff. He's not gotten in my way of things I'm doing.

T24: Mm-hmm.

C24: Like, he respects my space

T25: Mm-hmm.

C25: Which, he never used to do.

T26: Mm-hmm.

C26: So that's really, really cool because I value it very highly.

The overall context of CP5's description of the support her husband was providing indicated that she saw the help as beneficial; therefore, her statements of received support in C23 and C24 were coded as RS1.

CP5 referred to one experience of received support that she did not specify as either positive or negative (RS3, 1 code). CP5 described receiving support from her brother when she taught her how to sneak food in their childhood home because they were provided with only two meals per day by their parents and were often hungry. CP5 provided a description of the support without qualifying it as positive or negative. She explained that, "And see, my brother, being older and wiser, taught me that you can get food, you just have to sneak it" (C199). She did not describe any expressions of support that she received as negative (RS2, 0 codes).

Extended support. Most of CP5's statements of *Extended Support* were not specified as being positive or negative (ES3, 3 codes). For example, she described, in one instance, providing her husband with financial support that was stated only as the factual provision of support, without any description of whether it was a positive or negative experience for her. CP5 said, in explaining that because her husband provided only inconsistent financial support in their marriage, "...I'm the one that has to make something happen [financially]" (C85). She later reported, "...yeah, and I pay all the bills and all the food and all the clothes and whatever" (C95). She also explained that she provided her husband with monetary support with which to buy their daughter a birthday present when he could not afford to when she stated, "Well, I was nice enough to offer" (C105). Taken in context of the discussion in which she was describing their financial difficulties and the burden of her role as financial planner and provider for the family,

this expression was coded as ES3 because she reflected mixed feelings in having to help him despite seeing her offer a “nice.”

The discussion of financial support provided to her husband continued when CP5 reported on one experience of extended support that was negative (ES2, 1 code). She described an experience in which she was providing more financial support to her husband than she could afford. CP5 explained,

So, and he finally got that and it's, it's, well, he got it because I had to pay for the rent for this month, and because he told me that in the middle of last month, and I don't make a heck of a lot of money, that means that I had to generate more income than I was actually capable of generating... (C100)

CP5 sighed at the start of this explanation, which provided context to the financial burden she experienced in providing her husband with instrumental support. Because the extension of support was described as burdensome, this expression was coded as ES2.

She expressed one instance of support she provided to others as positive (ES1, 1 code). CP5 described extending support to her husband in acknowledging the help that he provides her with when the therapist asked her, “You told him you appreciated it?” (T30), while discussing support that CP5 was currently receiving from her husband. In response, she stated, “I always notice the little things and I always appreciate them” (C30). This was coded as ES1 because it reflected her provision of support in thanking her husband for his help while also being beneficial to her in supporting her values.

Support functions. CP5 described two experiences in which she received information from another person, her brother (CF3, 2 codes). CP5 described an example in which she received information about their childhood experiences with their mother.

She reported, "...Yeah, I asked him a few months ago. I said, 'is there any reason why I would have been just absolutely terrified of mother?' He's like, 'Yeah!'" (C251). This example illustrates an instance in which her brother gave her information she was looking for. Her other expression of F3 also involved her brother when he taught her how to sneak food in their childhood home (C199, previously quoted). In this example, she described a childhood experience in which her brother provided her with information on how to obtain food in their household because their parents provided them with limited access to food. Therefore, her brother was giving her information that she needed as a child.

Two occurrences of instrumental support were identified in Session 5 (F5, 2 codes). For example, CP5 described receiving financial support from her husband when they agreed to end their separation. She reported, "I mean, that was actually one of the stipulations for us getting back together is that he contributed x on a monthly basis" (C70). Another example of instrumental support occurred in her explanation of buying a refrigerator with her husband after they had gone without one for over a month. She stated, "I called up my husband and I was like, 'Call an appliance place. We need a fridge.' And today we went and got a fridge" (C297). Both examples represent material support she received in her relationship with her husband.

One of CP5's expressions of Support Functions did not clearly fit into any of the other Support Functions codes (F7, 1 code). For example, she said, "He's offered to do stuff. He's not gotten in my way of things I'm doing" (C23). This expression was coded as F7 because she did not clearly state what he was doing to help her but identified that

something he was doing (i.e., offering to “do stuff” and staying out of her way) was indeed helpful to her. Therefore, the unspecified support function was coded as F7.

The following Support Functions codes were not observed in Session 5: support provided to enhance self-esteem (F1, 0 codes); emotional support (F2, 0 codes); support involving feedback (F4, 0 codes); and social companionship (F6, 0 codes).

Other. Five expressions of social support were identified in Session 5 that were not captured by any of the other social support codes (SS, 5 codes). CP5 described past exchanges of support that did not occur, which were coded as SS because the statements represented the absence of support in the past that did not fit into other codes (i.e., *Received Support* or *Extended Support*) CP5 expressed support that did not receive in the past from her husband, which was coded as SS. For example she stated, “which he never used to do” (C25) in comparison to support that her husband was currently providing her with. She also reported “and he didn’t” (C48) when describing that her husband did not help her during a time of financial stress. Additionally, she described past support that she did not extend to her husband when she stated, “and I wasn’t paying anything for him” (C77). All of these expressions were coded as SS because they represented the lack of support in the past.

SS was also used to code CP5’s expression to her difficulty trusting others, which was evident in her statement, “...because apparently I don’t trust people” (C68) that she attributed as the cause of her resistance to seeking or accepting support. This statement was coded as SS because she did not explicitly state trust as a social support experience, but included it as a salient factor in her ability to depend on others.

When the therapist asked, “What is the nature of your relationship right now?” (T242) CP5 stated, “Well, considering that she is absolutely clueless, I would say it’s pretty good” (C242) in reference to her relationship with her mother, which represented a relational quality pertaining to a support relationship that was coded as SS. Although this statement did reflect a specific example of exchanged support or beliefs about support, thereby falling into the SS category, CP5 was expressing an important factor that influenced exchanges of support in their relationship.

Chapter IV: Discussion

Social support has long been considered an important factor in post-traumatic experiences and has been observed to both help and hinder individuals' functioning following events that threaten physical integrity (Bonanno, 2008; Ellis et al., 2009; Lyons, 1991). Although several constructs and structures of social support have been identified and many theoretical models have been developed to understand the role of social support in the aftermath of traumatic experiences, there is, to date, no synthesized understanding of the multidimensional experience of social support in post-traumatic functioning. Notably, existing research on social support following trauma has not emphasized clinical research from psychotherapy cases and samples. Therefore, this study examined the expressions of social support made by trauma survivors in psychotherapy sessions generally. It was beyond the scope of the study to compare our sample with clients who were not trauma survivors, as well as to compare social support expressions that occurred during trauma discussions versus other session content.

The results of this study suggested that survivors of traumatic events that threaten physical integrity frequently refer to social support relationships and experiences in psychotherapy sessions. This finding is consistent with the assertion put forth by several researchers that people have the need to associate with others following traumatic events (Joseph et al., 1995; Kaniasty & Norris, 1995) and that social support may be a salient factor in post-traumatic functioning (Barker & Pistrang, 2002; Cohen & Wills, 1985). Additionally, the finding provides support for researchers' suggestions that there are clinical implications related to social support in psychotherapy with trauma survivors (e.g., Clapp & Beck, 2009; Joseph et al., 1994; King et al., 2006; Lepore et al., 2000; Thrasher et al., 2010). However, existing literature does not provide specific

interventions or suggestions for what therapists can do to enhance social support experiences. Thus, this study, which used actual psychotherapy sessions, provides an example of how existing theories, constructs, and structures of social support can be assessed as naturally occurring within psychotherapeutic discussions with individuals who have experienced trauma, and provides guidance for ways therapists can further expand on discussions of social support in psychotherapy.

Most often (70.73% of all n=827 expressions of social support), client-participants in the study, which involved discussions through the transcribed sessions (both within and outside of trauma discussions), referred to specific support relationships, or support content. Less frequently (not exceeding 6% of the total number of support statements), they described experiences of support that was provided to them by others (i.e., received support), the types of support that were provided (i.e., support functions), their needs or wishes related to exchanges of social support (i.e., support needs), statements of unspecified social support (i.e., social support not otherwise specified), and experiences and beliefs related to providing support to others (i.e., extended support). Expressions of beliefs about the availability of support (i.e., perceived support) were made least frequently (3.50%). Thus, the code groups that represented the constructs and structures of social support reported to have the most impact on post-traumatic functioning (i.e., received support, perceived support, support functions) occurred much less frequently than the support content codes. Specifically, 5.92% of the total number of support expressions referred to *Received Support*, 5.92% highlighted *Support Functions*, 5.07% were coded as *Support Needs*, 4.59% represented *Other* statements of support, 4.23% were indicative of *Extended Support*, and 3.50% illustrated *Perceived Support*.

Yet, frequency data alone did not capture the richness of the client-participants' discussions with their therapists. Themes that emerged in client-participants' expressions of social support were examined to capture the varied quality and impacts of their described experiences. The themes further discussed in this chapter include patterns observed in expressions of support needs, relationship factors, past perceived support, and commonalities in expressions of negative perceived support as well as similarities in codes that did not occur in any of the selected psychotherapy sessions.

This chapter presents a discussion of the study's findings in the context of existing literature on social support in the aftermath of traumatic experiences. First, a brief discussion of the sample's traumatic experiences is presented. Then, the constructs and structures of social support as identified in client-participants' expressions of social support are discussed as related to existing concepts from the literature. Connections between client-participants' discussions of social support experiences and theoretical models of post-trauma social support are included later in the chapter. The chapter concludes with a summary of the study's limitations and contributions to clinical psychology research as well as directions for future research related to expressions of social support in psychotherapy with trauma survivors.

Trauma Experiences in the Sample

Based on the available written documentation in this study's research database, it was determined that all of the client-participants who met our trauma definition criteria fell into the following categories of traumas that involved threats to physical integrity: sexual abuse and rape, physical abuse and violence, and medical traumas (see Table 1). The traumas experienced by the client-participants in the current sample are consistent

with both external threats to physical integrity (First et al., 2002) and internal threats to physical integrity (Bruggiman et al., 1996; Merriman et al., 2007) that are included in existing trauma literature. In addition to the trauma discussions included in the transcribed sessions, the written information included in the research files indicated that all client-participants included in the study experienced some form of childhood trauma (e.g., sexual abuse or unspecified early life traumas). Childhood abuses are frequently involved in experiences of complex trauma, which can lead to cumulative problems in social functioning (Courtois, 2008). Because the available documentation for each client-participant indicates that they were all exposed to more than one traumatic event, their post-trauma functioning and experiences, and presenting problems at the time of treatment, may represent the combined effects of both childhood and more recent traumas rather than any one single trauma experience (Briere et al., 2008). Trauma discussions observed across sessions included expressions about traumatic events and affective experiences associated with the events; they were analyzed holistically during the sessions, rather than separated out in order to provide an inclusive and exploratory perspective on social support expressions with trauma survivors.

Expressions of sexual abuse and rape. Client-participant experiences of sexual abuse were observed in three of the five sessions. Research has indicated that survivors of childhood sexual abuse can experience emotional and interpersonal problems in adulthood (Stein et al., 2012), which is consistent with the ongoing distress observed in the current sample. Notably, the client-participants (CP1, CP4, and CP5) who discussed experiences of sexual traumas in the selected sessions also indicated difficulties with emotional functioning (e.g., concerns about emotional stability, emotional distress,

feeling down or unhappy, feeling angry much of the time) and interpersonal problems (e.g., trouble communicating sometimes, difficulty expressing emotion, feeling lonely, having difficulty being open/honest, suspicious of others, family difficulties) on the initial intake paperwork (i.e., Client Information Adult Form).

The following examples illustrate some of the ways in which client-participant experiences of sexual abuse were reported across sessions. CP1 described experiencing confusion and a strong emotional reaction surrounding her sexual abuse and rape by her uncle when she expressed, "... hell no. I'm like, say something. Like, no, I'm not doing this. Like I don't understand, like, I'm like in elementary like not kindergarten" (C62). CP1's trauma discussion highlighted her understanding that what occurred was not ok but that the experience was confusing and overwhelming. CP4, who also experienced sexual abuse, stated factually, "... My father's father molested me when I was seven" (C38) and "... See that's what his father did to me at seven" (C50). She later described affective responses to her guardianship daughter's sexual abuse by her father that stemmed from earlier feelings and experiences of her own sexual traumas. She explained, "... So for him to do this has just [been a big betrayal]..." (C54) "... on the hugest level so I've gone through crying my eyes out to being [expletive] mad as hell..." (C55). CP5 described current attempts to seek support from her mother related to her earlier history of sexual abuse by her father and a neighbor. She expressed,

... I called her up and I talked to her and I told her I was going through some times where I was trying to sort out things that happened in my life and I was actually very gentle and didn't directly blame her for anything except that I told her that I felt that she could have protected me and chose not to. For whatever

reasons, I let her off the hook and it went totally over her head. She called up my brother and said, ‘your sister doesn’t want to talk to me because of what happened with Father...’ (C236)

Expressions of physical abuse and violence. Whereas discussions of sexual abuse occurred in three sessions, expressions related to physical abuse and community violence were observed only from CP3. Tummala-Nara (2007) observed that the effects of community violence can be passed through generations. Also, Radan (2007) noted that the long-term effects of political and community unrest in Latin America, and specifically El Salvador, contribute to a population of people impacted by violence. These findings on the effects of community violence provide context for understanding CP3’s experiences of violence while growing up in El Salvador. CP3 was exposed to physical assaults that occurred in the context of an environment that was described as largely unsafe for women, with few outlets to turn to for protection. Also, many women have fled El Salvador due to patterns and experiences of violence, which was true for CP3 who emigrated to the United States following repeated physical abuses.

In particular, CP3 described experiences of being physically assaulted by her biological mother. She reported on a time when her mother attempted to kill her. She said, “... and one time, I tell her something and she get really mad about it and she follow me with the big scissors and she tried to, you know [stab me]...” (C152) and “She wait for me in the corner of the street with a knife waiting for me...” (C156). CP3 expressed fear and the absence of protection from the police since her mother knew many police officers. She also described another experience of physical abuse by her mother: “She was cooking with a thing, it was hot, she just put it in my hand ‘cause I was telling her

something, she was talking about something and I started to tell her that I wouldn't, I wasn't agree with her, she just put the thing in my hand and she burned me..." (C162).

Given her described experiences of physical violence understood in her broader sociocultural contexts, her reported psychological and interpersonal difficulties at the time of therapy are not surprising. At intake, CP3 indicated that she felt nervous and anxious, was angry much of the time, felt down and unhappy, experienced family difficulties, difficulty making or keeping friends, and was suspicious of others (Client Information Adult Form), which is consistent with existing literature that suggests that the exposure to violence is associated with post-traumatic distress (First et al., 2002). Also, repeated exposure to violence can result in complex or cumulative trauma presentations that involve disruptions in emotional and social functioning (Courtois, 2008).

Expressions of medical traumas. CP2's session included discussions of the client-participant's medical traumas. It was documented that CP2 had a traumatic stroke prior to the start of psychotherapy that contributed to ongoing medical crises including the onset of blindness and the near amputation of her foot, which were discussed in the transcribed session. CP2 described the experience of a threat to her physical integrity (e.g., infection and possible amputation) following an injury to her foot. She explained, "... I went to the foot doctor the next morning and I had been having fevers, I had been having, but low grade fevers. And he looked at it and wrapped it up. He said, 'Ok, you just need to go to [hospital] right now. You need to be prepared for whatever they tell you'..." (C115). She reported that after she was admitted to the hospital, "... Um, and they talked about amputation for the first five days" (C117) and explained the severity of

the overall infection on her physical health such that she was hospitalized for three and a half weeks. Although her foot was not amputated, the experience of the medical trauma was significant for her. She expressed, "... it kind of made me do a double take. I'm like, 'I can't believe I've gone through this.'..." (C128).

Childhood trauma. Notably, in addition to the specific trauma discussion described above, all of the client-participants in this study experienced some form of trauma in childhood. Although discussions of childhood traumas were not included in all transcribed sessions (e.g., Session 2), histories of childhood sexual, physical, and unspecified abuses were included in the available written documentation for all client-participants. Research has indicated that childhood abuse can have significant impact on psychological functioning in adulthood (Briere, 2004; Briere et al., 2008), including problems in interpersonal functioning (Stein et al., 2012). Moreover, multiple traumatic events in childhood have been observed to relate to later complexities in post-trauma symptoms (Briere et al., 2008).

Although the available information for each client-participant included in this study is limited in terms of examining the cumulative effects of childhood traumas, which is outside the scope of the study's purpose, understanding of the possible impacts of their histories of childhood traumas provides important context for analysis of their social support expressions in post-trauma psychotherapy. For example, it is significant to note that all three of the client-participants who described experiences of childhood sexual abuse indicated that it was perpetrated by trusted adults in their lives, which has been associated with poorer post-traumatic functioning and increased distress following the trauma (Leahy et al., 2003). Survivors of childhood sexual abuse may also be at risk for

later interpersonal problems (Stein et al., 2012). This pattern may be relevant for these client-participants such that they all were assigned Axis IV problems related to interpersonal functioning (i.e., social support problem and tense relationship with boyfriend for CP1; problems related to social environment for CP4; and abusive relationship with husband and loss of children for CP5). The results from this study support future research that would further focus on the context of social support experiences of trauma survivors in psychotherapy in ways outside the scope of the present study; for example, comparing social support expressions during trauma discussions versus non-trauma discussions.

Social Support Expressions Across and Within Participants

As previously discussed, many expressions of social support (n=827) were observed across the five psychotherapy sessions included in this study. This section discusses each of the coding categories (i.e., support content, received support, support functions, support needs, other support, extended support, and perceived support) presented in the frequency hierarchy established in the previous chapter with qualitative considerations from observations made across and within client-participant expressions of social support, and ties the results to the literature on social support and trauma.

Support content. The specific types of relationships in social support experiences can be described as “support content,” which refers to the interpersonal connections between people (Tolsdorf, 1976). The content of “natural support systems” (Besser & Priel, 2010, p. 167) fall into two broad categories, formal and informal, and include professional service providers as well as family and friends (Rieck et al., 2005). Tolsdorf (1976) identified the categories of support content that are most frequently cited

in the literature. For the purposes of this study, the types of support content put forth by Tolsdorf (1976) were adapted to the following categories: primary kin, secondary kin, primary friend, other friend, sexual/romantic, affiliative, mutual aid, service, and “not otherwise specified.” Although any one support relationship can fall into multiple content categories and can fulfill multiple functions (Cohen & Wills, 1985), identified support contents in this study were coded as only one type of support content, which was determined by the primary way in which the client-participant referred to the supportive individual. For example, CP3, CP4, and CP5 all referred to their husbands in the transcribed sessions; these relationships were coded as primary family (C1 [husband]) in order to maintain consistency in coding throughout the sessions.

Support content is not generally included in models theorizing the role of social support following trauma, which suggests that the type of support relationship may be considered less important than the quality and efficacy of the support experience with regard to trauma. In contrast, the majority of support statements across all participants were coded as support content in the present study; 70.73% of all coded expressions of social support fell into the *Support Content* categories. This result likely occurred because all mentions of support relationships, including those that occurred outside of detailed discussions of support experiences, were coded for support content. It is unknown, based on the methodological descriptions included in other studies (e.g., Sharpe, 2008; Tolsdorf, 1976) whether this approach has previously been done or not.

The other main finding related to *Support Content* was that the client-participants included in this study very frequently referred to support relationships but less frequently discussed specific experiences, beliefs, feelings, and needs related to social support. This

pattern indicates that clients may be likely to discuss interpersonal support relationships in therapy, but that therapeutic discussions may not be eliciting or including the quality and effects of support factors that have been hypothesized to impact post-traumatic functioning. Further discussion of the quality and effects of other social support constructs and structures is presented in the following sections in this chapter.

Family content: primary and secondary kin. Most of the expressions of support content across all client-participants were related to family relationships. That is, 63.59% of the expressions of support content fell into the two family categories. Primary kin relationships alone constituted 50.59% of the support content expressions and 35.79% of all social support expressions across participants. Primary family relationships were the most frequently observed type of support content and secondary family relationships were the third most often described type of support content across the five transcribed sessions. All client-participants referred to primary family relationships such as parents, siblings, spouses, and children. Only three of the five client-participants discussed secondary family relationships, such as grandparents, aunts, uncles, and cousins; CP2 and CP5 did not make any statements involving secondary family members. This finding is consistent with Sharpe's (2008) observation that informal supports, and family relationships in particular, are most likely to be used in coping following traumatic losses.

The findings of the current study suggest that there may be broader cultural or ethnic implications, as well as applications for various types of trauma, for the primary use of family relationships in coping. Whereas Sharpe's (2008) study focused on a sample of African American survivors of traumatic grief, the three client-participants

who made the most frequent references to family supports in the current study identified as El Salvadorian, multi-racial, and Caucasian. CP1, who identified as African American, and CP2, who identified as white European, made the fewest expressions of family support content. Therefore, no specific conclusions related to culture can be drawn from the current study. Thus, the use of family resources in coping may be further explored in future research in examining patterns across and within cultural groups.

All of the client-participants in the sample experienced some type of trauma in childhood (e.g., sexual or physical abuse) and CP2 experienced more recent medical traumas (e.g., stroke and loss of vision) in contrast to sample population of traumatic grief survivors in Sharpe's (2008) study. In regards to the types of trauma represented within this sample, only one client-participant discussed medical traumas and four client-participants discussed traumas that occurred in family relationships (i.e., sexual abuse, rape, and physical assaults). Therefore, future research should examine whether experiences of certain types of trauma may impact clients' experiences of family support in similar or different ways. Other factors such as client-participants' gender, experiences of migration and immigration, location of family and other supports in relation to the client-participants' locations that cannot be measured within the scope of this study may have impacted their support experiences and discussions of kin and non-kin relationships. However, because of the small sample size in this study, it is not possible to generalize any specific cultural or ethnic factors related to family supports or findings related to trauma types and other personal experiences that may influence relationships; the implications noted in the previous paragraph are offered as hypotheses for testing by future researchers.

Additionally, elements related to the therapeutic relationship (e.g., the therapists' gender, age, cultural and ethnic background, and theoretical orientation) may have some bearing on discussions of family relationships in psychotherapy discussions. For example, some existing literature indicates that the racial and ethnic "match" or "mismatch" in psychotherapeutic dyads do not significantly impact the course of treatment (i.e., number of session attended, treatment functioning, and retention of services; Shin et al., 2005). Conversely, other literature indicates that therapists' experiences with race and ethnicity and their own racial identity impact the degree to which they may discuss racial and ethnic differences with clients who are different from them (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003), which may include differing experiences with and beliefs about family relationships that could be influenced by ethnocultural factors (e.g., Sharpe, 2008), gender (e.g., Pulcino et al., 2003; Robertson et al., 2006), and other diverse dynamics. Because the archival database used in the current study did not include demographic information about the therapists involved in the sample, no hypotheses could be drawn related to the intersection of ethnic, racial, and cultural variables between the client-participants and their therapists.

Support content: service. Sharpe's (2008) study indicated that in addition to informal supports, professional, or formal, support contents are beneficial in coping with traumatic losses. Despite on the variance in diversity and trauma-related factors between Sharpe's (2008) study and the present one, it appears that the results of the current study support the significance of the role of professional support relationships in coping following traumatic events. That is, service relationships constituted the second most commonly expressed type of support content and represented 13.84% of the support

content codes. All of the client-participants in this study made some reference to professional support relationships, with a range from CP5 making one reference to her therapist to CP1 making 46 references to her therapist. Closer examination of the service relationships described by client-participants shed some light on the professional providers from whom client-participants received support.

The majority of client-participant references about service relationships were related to the therapists in the sessions. These expressions involved statements of “you” said directly to the therapists. CP1 repeatedly referred directly to her therapist because they played a therapeutic board game during the session which elicited direct communication between them. Conversely, CP5 referred directly to her therapist only once when discussing her desire to continue weekly individual therapy sessions when adding adjunctive couples therapy with another provider. Beyond their existing therapists, client-participants referred to a previous therapist (CP4) and a current physical therapist (CP2). Formal social support contents, and psychotherapists and mental health professionals in particular, have been observed to be an important resource for help (Barker & Pistrang, 2002). In fact, Rogers (1957) asserted that occurrences within the therapeutic relationship (e.g., unconditional positive regard) provide the basis for supportive helping. Since Rogers’ assertion in the 1950s, numerous researchers have provided support for the helping that occurs in therapeutic exchanges from the therapist to the client (Barker & Pistrang, 2002). Given that the client-participants in the current study engaged in direct communication with their therapists, it appears that the therapeutic relationships within the sample represented sources of help and support for the client-participants.

No other service providers were described as support resources across the five sessions. Although other service professionals were mentioned (e.g., unspecified medical professionals in Session 2 and Session 4), other professionals were not described as providing social support. Therefore, it appears that professional relationships that inherently involve the provision of support (e.g., emotional support and encouragement), as opposed to professional services alone, from providers such as psychotherapists and physical therapists represented an important area of support for the trauma survivors included in this study. At the same time, other service providers should not be overlooked when assessing available supports and support needs in therapy with individuals exposed to traumatic events. In fact, Barker and Pistrang's (2002) suggested that other types of formal supports (e.g., medical doctors) can learn from the helping exchanges in psychotherapeutic relationships in order to increase available help and support for individuals.

Support content: sexual/romantic. The *Support Content* code for sexual or romantic relationships was observed in only one transcribed session. CP1 referred to her current and previous romantic relationships so frequently that it was the fourth most commonly occurring content code across all five sessions, representing 9.05% of the support content codes. Other client-participants (CP3, CP4, and CP5) also referred to sexual/romantic relationships when discussing their spouses; however, these relationships were coded only as primary kin, which is consistent with the existing literature (e.g., Tolsdorf, 1976). As a result, the overall number of references to sexual/romantic relationships was reduced.

When examining the frequency of references to romantic relationships within CP1's session, which was significantly longer than any other session included in the study, as well as the other reference to spouses by CP3-5, it appeared that clients often discussed romantic relationships in psychotherapy sessions. Yet, romantic relationships were not explicitly stated as a common informal relationship that is likely to be relied upon in coping following trauma (Sharpe, 2008). This may be because spousal relationships are generally included in definitions of primary kin or, as indicated by Sharpe (2008), extended, or secondary, kin relationships are often loosely defined and may involve any number of relational types. Another reason why romantic relationships may not be commonly relied upon for coping resources is that such relationships may represent an important area of general stress, as evidenced by Constantine, Chen, and Ceesay's (1997) study that cited romantic problems as a highly common stressor among ethnic minority university students presenting for professional counseling services (20.4% of whom presented with sexual abuse history, and was most frequently observed in Native American students). The finding regarding CP1's frequent mention of romantic relationships suggested that such relationships were a salient issue in her life and represented an ongoing stressor. At any rate, this study suggests that it may be useful for therapists to discuss and be responsive to client expressions involving their sexual or romantic partners.

Friend content: other and primary friend. Social support literature indicates that friendships are often important support relationships (Rieck et al., 2005; Sharpe, 2008; Tolsdorf, 1976). Compared to the already discussed types of support relationships (i.e., family, service providers, and sexual/romantic partners), expressions related to

friendships among the sample population were relatively few (8.88% total friend expressions). According to Sharpe (2008), both primary and distal friends represent important types of informal support relationships. In the present study, “other” friends (i.e., those identified as friends but not clearly stated as primary or close friends) were mentioned by all of the client-participants (6.32%) and were coded more frequently than primary friends, which were mentioned by four of the five client-participants (2.56%; CP3 did not make any expressions of primary friendships).

CP2 discussed friendships more often than any other client-participants. Also, in contrast to some of the other client-participants (i.e., CP3, CP4, and CP5), CP2 appeared to rely more readily on friends for all types of support due to her medical needs, which may have resulted from her immigration experience and living far from her family in her country of origin. However, CP3 also lived far from her family due to immigration, but referred to distal friends only twice during her session and did not identify any close friendships during the session. Tolsdorf (1976) indicated that “relationship density,” or the total number of support relationships, is usually most weighted by kinship supports. Additionally, medically-admitted inpatients typically have more relationships that provide support functions (Tolsdorf, 1976). Because CP2 lived far from her family but had many medical problems and related hospitalizations, she may have developed primary friendships that provided relational density and support functions. Therefore, it is likely important for therapists to take the client’s context into consideration when exploring the role of friendships in the client’s experience, and clarify the strength of the relationship and support that may be available to the client within the friend relationship.

Support content: other. The code *Support Content: Other* was used to capture any expression of support content that did not clearly fit into any other specific content category. Statements of support content that were coded as “other,” which represented 4.61% of the total content codes, were examined to inductively identify any patterns that emerged. One pattern emerged across participants within the support content codes that were labeled as “other.” Four of the client-participants referred to relationships that were not categorized by any of the other content codes; CP3 did not make any expressions of support content that fell into the “other” category. All four of the client-participants who mentioned other types of support content made vague and unspecified references to supportive individuals using language such “people” and “everyone” and “someone.” This pattern highlights the type of words that may be used to describe general support relationships that may be helpful for therapists to further clarify.

No further patterns of “other” support content were observed across participants. The additional relationship types that fell into the “other” support content category represented supportive individuals who were unique to the client-participants and therefore occurred only within those sessions. For example, CP2 often referred to her roommate’s teenage son, who she identified as a supportive other but that did not clearly represent her own friend in order to be coded as either a primary or other friend. Therefore, the researcher-participants decided to code all references of that individual as “other” content. The other example of a support relationship that did not fit within any of the specific content codes was in Session 1. CP1 twice referred to her mother’s boyfriend, who was coded as “other” content. It should be noted that in one expression, CP1 referred to her “parents,” which was coded as primary kin. Although this

expressions may have included her mother and her mother's boyfriend (as opposed to her biological father), it was determined to represent a family relationship based on her descriptive language (i.e., "parents") in identifying the support content. CP2 and CP1's references to individuals in their lives who were not captured by any of the specific content codes, suggests that clients may participate in support relationships that do not fall neatly into any of the common relationship types but who, nonetheless, represent important support resources for clients.

Support content not identified: affiliative and mutual aid. As stated in the previous chapter, two *Support Content* codes were not used in any of the transcribed sessions: expressions involving affiliative and mutual aid relationships were not observed in any of the sessions included in this study. Affiliative support relationships refer to connections within an organization (e.g., religious community, political affiliation, recreational or professional group; Tolsdorf, 1976). Although two client-participants referred to workplace environments (CP1 and CP2), only CP1 discussed interpersonal interactions with co-workers. However, her descriptions of workplace relationships indicated that they did not represent social support content for her. For example, she stated, "... I'm very challenged by people at work. Because I don't want to be there with them..." (C41). In the overall context of CP1's discussions of workplace relationships, she did not provide any evidence that co-workers provided her with support; therefore, no mentions of workplace relationships in her session were coded as affiliative support content.

Notably, no other expressions of relationships with members of group organizations were mentioned across the five sessions included in the current study. This

may have been because such relationships and group participation were not part of the experiences of the five client-participants. Also, such discussion may not have come up in the sessions because most therapists did not ask specific questions about affiliative practices such as religious or spiritual community engagement. Although clinical recommendations, and those related to the treatment of trauma-related problems, vary in approaches to how to ask or assess for religious and spiritual factors, it remains a consistent treatment recommendation that religious and spiritual beliefs should be incorporated into treatment (Walker & Aten, 2012) because most therapists do not discuss religion with their clients, which may be due to lack of motivation for such conversations (Post & Wade, 2009) or hesitation to initiate discussion of religion (Cornish, Wade, & Post, 2012).

Session 4, which was an initial intake interview, represented the only session in which the therapist engaged the client in discussion of participation in an organizational community (i.e., religious affiliation). However, based on the client-participant's response, childhood involvement in a religious community and lack of current involvement in a spiritual community, no social support content was observed in relation to her religious experiences. Although participation in affiliations may be assessed at the time of intake, the results of this study suggest that it may also be useful for therapists to follow up and maintain open discussions of affiliative relationships over the course of therapy. This finding extends the previous clinical recommendations related to the development of new social ties in the form of support groups such as self-help or mentorship groups (Gottlieb, 2000) as well as the integration of spiritual factors into

treatment (Walker & Aten, 2012) to include other sources of meaningful support, such as religious and spiritual associations, for trauma survivors.

Whereas some discussions related to affiliative experiences (i.e., workplace relationships for CP1 and previous religious affiliation for CP4) occurred in some sessions, even though no affiliative relationships were mentioned, there were no mentions of experiences involving mutual aid support in any of the sessions. Tedeschi and Calhoun (2004) described “mutual support” as exchanges of support between people who have experienced similar events. Literature on post-traumatic growth has suggested that mutual support is useful following traumatic events in that it provides people with a sense of acceptance and hope as well as acknowledgement of one’s own strength (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2004). It is possible that certain types of trauma may lend themselves more to use of mutual aid, like disasters, than others (Kaniasty, 2011). It did not appear, based on the available written information or recorded sessions, that any of the client-participants in this study engaged in mutual support such as survivors groups or networks or that the therapists didn’t recommend group as adjunct treatment. It may be useful for therapists to collaborate with clients to determine if referral to adjunctive mutual aid support resources would be appropriate or beneficial for the clients and to continue discussion of mutual aid experiences.

Received support. Received support is cited as the support that is exchanged between people (Kaniasty & Norris, 1995) or “naturally occurring helping behaviors” (Norris & Kanisty, 1996, p. 498) during times of need (Joseph et al., 1995). For the purposes of this study, descriptions of helping behaviors that were provided to the client-participants were coded as *Received Support*, which represented 5.92% of all coded

expressions of social support. Received support has been correlated with psychological distress following traumatic events as both a protective factor (Cohen & Wills, 1985; Lyons, 1991) and a risk factor (Lepore et al., 2008; Norris & Kaniasty, 1996). Client-participant expressions of received support in this study were mostly coded as “not otherwise specified” or positive, with only two expressions coded as negative received support.

Received support not otherwise specified. The results of the current study indicated that most client-participant statements of received support did not clearly fall into either the positive (e.g., protective, helpful) category or the negative (e.g., risk, detrimental) category as was expected based on the existing literature (e.g., Cohen & Wills, 1985; Lepore et al., 2008; Lyons, 1991; Norris & Kaniasty, 1996). Despite the available information about the benefits and risks of received support, the majority of client-participant expressions of received support did not involve a clear statement of the quality of the support provided. Expressions that fell into the “not otherwise specified” category for received support were related to both neutral statements, or factual descriptions, about received support experiences as well as reflections of mixed feelings related to received support.

First, several client-participants described factual accounts of their experiences receiving support from others. For example, CP3 described receiving instrumental support from a friend who offered her a place to stay without qualifying the support as either positive or negative (C156, previously discussed). CP2 also expressed neutral accounts of the support she received such as her statement of assistance that a friend provided in helping her navigate an unfamiliar area (C92, already quoted).

Second, many expressions of received support illustrated mixed feelings for the client-participants. An example of CP4's mixed feelings about received support was previously quoted (C136) in regards to a therapy intervention to which she described feeling angry at her previous therapist but also understanding the purpose of the intervention. CP3 also expressed mixed feelings about accepting her husband's marriage proposal (C256, already discussed). As previously reported, most literature related to received support characterize support as *either* helpful *or* harmful; social support literature related to post-traumatic experiences does not include mixed, ambivalent, or unspecified qualifications of social support experiences, which may represent a limitation in the measurement or assessment of received support in existing research. However, literature on social support in the recovery experiences of women who abused substances suggest that mixed experiences of social support are common in the recovery process (Savage & Russell, 2005; Tracy, Munson, Peterson, & Floersch, 2010). Tracy and colleagues (2010) explained that while support may provide required functions of help, it may also encourage or facilitate ongoing substance abuse (e.g., providing shelter that leads to continued use within the provided place to stay). Although the existing research on mixed experiences of received support stems from populations related to substance abuse, the findings suggest that received support does not always fall neatly into labels of helpful or harmful, which has implications for a range of other populations experiencing social support. This study's findings (i.e., neutral and mixed expressions of received support) suggest that it would likely be beneficial for therapists to elicit further discussion of the quality of received support experiences in order to assess risk and protective

factors as well as to explore and foster areas of improvement in the efficacy and benefit of support that clients receive.

Positive received support. Beyond neutral and mixed descriptions of received support, most client-participants statements of support provided by others indicated that the received support was positive. Literature has suggested that received support, when adequate and appropriate to the individuals' needs, can protect against psychological distress following trauma (Cohen & Wills, 1985; Lyons, 1991).

In contrast to Gabert-Quillen and colleagues' (2012) study that suggested that emotional support was more beneficial following traumatic events than other types of support, the client-participants in the current study most frequently described positive received support that involved instrumental support (further discussion of the functions of support will be discussed later in this chapter). For example, CP1 discussed an experience in which a former romantic partner took her out for a meal (C362, discussed earlier). CP2 described several experiences in which friends provided her with assistance with her medical needs (e.g., C92, reported previously) as well as financial support (C197 previously discussed). Both CP4 and CP5 discussed receiving assistance from their husbands within the home environment. CP4 expressed the benefits of assistance from her husband in which he helped with making dinner and helping with the children (C83, described previously). Although CP5 did not describe all of the assistance she received from her husband as explicitly as CP4 did, her expression implied instrumental support when she stated, "He's offered to do stuff..." (C23). She also described, more specifically, help from her husband in buying a refrigerator (C297, previously discussed). This finding suggests that, although it may not be the most effective type of support

(Glass et al., 2007; Gabert-Quillen et al., 2012), experiences of received instrumental support represented salient factors for the client-participants in this study. However, it may also indicate that therapists can assist in eliciting expressions of other types of received support in discussions of social support experiences because clients may be more likely to discuss instrumental, task-related, or tangible support than other types of received support that may also have salience.

Negative received support. Although numerous studies have observed a positive correlation between negative received support and distress following trauma exposure (Lepore et al., 2008; Norris & Kaniasty, 1996), very few expressions of negative support (e.g., unhelpful, burdensome, or unwanted) were found in the psychotherapy sessions included in this study. Only two client-participants referenced negative experiences of support received from others; due to the few example of negative received support, no across participant patterns were identified. CP1 described receiving insufficient instrumental support from a previous boyfriend whereas CP4 described an angry emotional response to a therapy intervention by a previous therapist. In both cases, the client-participants described negative received support that had long since passed. Given that all of the client-participants had histories of trauma that occurred in childhood (in addition to more recent stressors), long before their current psychotherapy experiences, and several experienced interpersonal difficulties, the coders were surprised to not have encountered more statements that would have received this code. That is, the combined trauma histories and interpersonal problems for many of the client-participants did not lead to increased expressions of negative received support in the selected sessions. However, any reported interactions that involved abuse were not coded for received

support, which may have decreased possible coding of expressions negative received support. For example, CP1 reported that at the time of sexual abuse by her uncle, the perpetrator was babysitting her and her brother. Therefore, possible “support” within the provision of babysitting was not coded in expressions explaining the traumatic events.

Scholz and colleagues (2012) observed a negative correlation between received support and psychological distress that diminished across the lifespan with older populations. However, so few statements of negative received support were observed in this study, that a connection with Scholz et al.’s (2012) study could not be made. That is, descriptions of negative received support were observed in CP1, who was 28 years old, and CP4, who was 39 years old, among a sample population with a mean age of 32.6 years. Interestingly, neither CP3 (age 21), who was the youngest participant, nor CP2 (age 47), who was the oldest participant, made negative expressions of received support.

Support functions. “Support functions” refer to the types of services that are provided in exchanges of social support, and that comprise received support (Tolsdorf, 1976). The types of functions that are most commonly defined in existing literature (e.g., Cohen & Wills, 1985; Tolsdorf, 1976) were used to develop the *Support Functions* codes: esteem, emotional, advice/informational, feedback, instrumental, social companionship, and “not otherwise specified.” Because the functions are what actually occur within received support, it was anticipated that client-participants would most commonly include descriptions of the kinds of support provided when they reported on experiences of received support. Therefore, it would seem logical that the frequency of the *Support Functions* codes would be similar to the *Received Support* codes across the five sessions included in this study.

Indeed, the frequency counts for *Support Functions* and *Received Support* codes were the same (5.92% the total social support codes fell into both the *Support Functions* and *Received Support* categories). Although at times client-participants described received support without clearly indicating what support function had been filled, there were other times when client-participants described more than one support function occurring within a single experience of received support, in which case all functions were coded. As a result, the average number of support functions observed across all five transcribed sessions was generally similar to the average of received support expressions. For the purposes of this study, support functions were coded only in relation to support that was provided to the client-participants and not in regards to client-participants' stated needs for types of support, support from the client-participant to others, or beliefs about future support. Therefore, this subsection provides discussion of the support functions received by client-participants. Further, qualitative discussions of support functions pertaining to *Support Needs*, *Extended Support*, and *Perceived Support* are included later in the chapter.

Emotional support versus other support functions. Early social support literature did not hypothesize on any hierarchy of social support functions in terms of efficacy or benefits of various types of support functions. Rather, early literature such as Cohen and Wills' 1985 work and Tolsdorf's seminal 1976 work simply defined various types of support functions. More recently, some research has been conducted to explore and explain the benefits of support functions following different traumatic events (e.g., Glass et al., 2007; Rieck et al., 2005; Gabert-Quillen et al., 2012), with conflicting results. Rieck and colleagues (2005) suggested that both emotional and instrumental

support contributed to experiences of PTG in a sample of university students, whereas Glass and colleagues (2007) suggested that practical, or instrumental, support was more beneficial to urban women who survived sexual violence than cumulative social support experiences, and Gabert-Quillen and colleagues (2012) most recently identified emotional support as the most beneficial type of support for survivors of motor vehicle traumas. Another challenge in understanding the ways in which support functions may impact post-traumatic experiences is that there is a great deal of overlap in support functions in real-life social support experiences, such that many functions may occur simultaneously in any exchange of support (Cohen & Wills, 1985).

Similarly, the present study also found mixed results, with the most frequent amount of instrumental support (as previously discussed), but a low frequency of emotional support. In fact, only two other types of support functions (i.e., esteem support and feedback) of the seven function codes occurred less frequently than emotional support. One hypothesis for the discrepancy between emotional and instrumental support expressions observed in the current study is that instrumental support may be easier for clients to recognize as it represents tangible help whereas emotional support may present as more subtle and be harder to identify as it occurs and in later discussions of social support experiences. This section therefore first discusses the qualitative findings related to emotional support and continues with discussion of the other types of specific support functions identified in this study; expressions of functions not otherwise specified is discussed in the next section.

Emotional support. Only two of the five client-participants (CP2 and CP3) referred to experiences of receiving emotional support. Nearly all of the emotional

support expressions were also coded as positive received support experiences, which is consistent with Gabert-Quillen and colleagues' (2012) research. For example, both of CP3's emotional support expressions also represented positive received support. She described receiving comfort from her sisters when she felt distressed (C103, previously quoted) and assistance with calming down from husband when she was angry (C208, already discussed), both of which she described as positive experiences. The only client-participant's expression of emotional support that was not also identified as positive received support was made by CP2 when she described an experience in which a friend asked her why she was frightened of going to the hospital (C143, already reported) in which she did not provide a qualifier or specifier to describe this experience as either positive or negative, thereby falling into the "not otherwise specified category."

Although client-participants infrequently discussed emotional support in the current study, the expressions of emotional support that were identified were largely described as positive, which is consistent with existing evidence that suggests emotional support is helpful in the aftermath of traumatic events (e.g., Gabert-Quillen et al., 2012; Rieck et al., 2005).

Instrumental support. In contrast to emotional support expressions, statements involving instrumental support were the most frequently coded of the specific support functions codes, and were made by all client-participants. Existing literature has indicated that instrumental, or practical, support is also beneficial following trauma exposure (Rieck et al., 2005). As discussed earlier in this chapter, most expressions of positive received support were related to instrumental support, although instrumental support expressions also represented descriptions of negative received support, and

received support not otherwise specified because they were stated as neutral, factual accounts of support that occurred. This result suggests that instrumental support was commonly received by the client-participants in varying degrees of helpfulness. This finding offers some argument to Rieck et al.'s (2005) summary finding that instrumental support is beneficial and highlights the importance of assessing the quality of support experiences.

Advice/informational support. Although Gabert-Quillen and colleagues (2012) indicated that emotional support is more beneficial to trauma survivors than any other type of support, advice from others was discussed more frequently in discussions of received support than emotional support was. Advice or informational support has been observed to mediate negative outcomes of traumas by providing additional information or evidence that can change negative appraisals of the events and contribute to improved coping (Cohen & Wills, 1985). All transcribed psychotherapy sessions in this study included expressions of advice or information received from others. However, none of the expressions of advice support occurred in statements of positive appraisals or coping. All of the descriptions, across participants, of advice or information received from others fell into the *Received Support Not Otherwise Specified* category. Most expressions of advice were coded as not otherwise specified experiences of received support because they were stated in neutral terms. For example, CP3 described receiving instructions from her grandmother to leave the home following an attack by her mother (C155, already discussed). This and other expressions of advice, information, and instructions received from others suggest that client-participants acknowledged the receipt of information but were unlikely to describe it as either helpful or harmful or in any way

impacting their coping with traumas. Therefore, it may be useful for therapists to follow up with clients who describe advice functions occurring in their social support experiences to be aware of the impact of such advice on the client and her appraisal and coping with traumatic experiences, as suggested by Cohen and Wills (1985).

Social companionship. Like advice/informational support, experiences of social companionship were expressed more frequently than were experiences of emotional support. However, only three of the five client-participants referred to social companionship experiences. Companionship has been described as being beneficial at times when it is specifically sought or elicited for a specific need (e.g., due to loneliness; Cohen & Wills, 1985). The identified expressions of companionship mostly fell into the not otherwise specified received support category and generally referred to experiences of companionship that had occurred quite some time before the time of the sessions. Notably, most mentions of companionship were made CP1 as she recalled time spent with peers in adolescence (e.g., C192 and C193, already discussed). CP4 also reported on an earlier experience of companionship in which her stepmother accompanied her to an earlier therapy experience (C132), which she described as a difficult experience warranting a code for negative received support; this was the only expression of companionship that did not fall into the received support not otherwise specified category.

Although there were relatively few expressions of companionship by only three client-participants, one pattern that emerged was that client-participants appeared more likely to reflect on past experiences of companionship than recent companionship time. This is noteworthy given that all of the client-participants experienced traumas long

before the time of therapy. Therefore, experiences of supportive companionship may have occurred at times when it was specifically needed, as indicated by earlier literature (i.e., Cohen & Wills, 1985). Also, client-participants generally did not specifically describe companionship experiences as either positive or negative. However, other factors, such as the effects of the client-participants' complex trauma histories and current relationship difficulties may also have been contributing factors to experiences, and subsequent discussions of, companionship.

Esteem. Because emotional support (Gabert-Quillen et al., 2012) and, to some degree, instrumental support (Rieck et al., 2005) have been identified as important functions in experiences of received support, it was not surprising that esteem support occurred infrequently across participants. Esteem support is believed to mitigate post-traumatic distress by counteracting the injuries and threats to self-esteem that frequently occur following traumatic events (Cohen & Wills, 1985). Only two client-participants referred to esteem support functions. CP2 described made two statements of received support in which her physical therapist encouraged her to successfully try new movement activities (C104 and C106, already reported). She indicated that both experiences of receiving esteem support were positive. CP1 also described an instance of receiving esteem support from a previous romantic partner (C197, previously discussed) but did not indicate whether she experienced it as positive or negative. Esteem support functions were expressed so infrequently and by so few participants that it is difficult to identify any patterns in these expressions. This low frequency of expressions of esteem support was somewhat concerning given that all client-participants experienced traumas that are

associated with long-term negative sequelae but lacked support experiences that may have bolstered their sense of self following the traumas.

Feedback. Feedback was the least commonly type of received support that was mentioned and, like esteem support, occurred at a lower frequency rate than emotional support did. Only one expression of observed among the five transcribed sessions, which occurred in Session 4. CP4 described feedback provided by her husband on her ability to trust men (C113, already described). Although she acknowledged the support as feedback, she did not clearly state the received support as positive or negative; therefore, the statement was coded as *Received Support Not Otherwise Specified*. Because only one expression of feedback was made, there are no patterns to observe across participants. However, the infrequency of statements of feedback received from others suggests that clients may be unlikely to report on experiences with feedback. It is somewhat surprising that expressions of feedback were not observed in any of the other sessions as those sessions all occurred later in treatment than did Session 4, which was an intake session. That is, it was anticipated that some feedback related to client-participants' progress over the course of treatment, either from the therapist or other support resources, may have been discussed given that feedback support is used to inform the individual of progress towards goals or coping (Tolsdorf, 1976). Because all client-participants were in therapy due to psychological distress and involving treatment goals, it was surprising that they did not discuss any feedback received towards identified goals or improvement in general functioning. Also, taken in context with the frequency of advice/informational support expressions, it appeared that client-participants were more likely to discuss advice received from others than feedback on their progress.

Support functions: not otherwise specified. In addition to instrumental support, support functions most frequently fell into the “not otherwise specified” category of support functions. No clear across participant pattern emerged in this not otherwise specified category, even though all client-participants had some expression of support that fell into it.

One somewhat similar finding involving physical assistance occurred in Sessions 2 and 3. CP2 described receiving help from a friend who guided her by the arm due to her visual impairment (C92, previously discussed), and CP3 described physical protection provided to her by her aunts during attacks by her mother (C164; already reported); both were coded as not otherwise specified because they did not represent provisions of material assistance. Had the definition of instrumental support been broader, such as “practical” support (e.g., Rieck et al., 2005), these helping behaviors would have been coded as such. Therefore, our findings support expanding the definition of expressions of instrumental support to include physical or bodily assistance and protection.

The other occurrences of expressions of support functions that fell into the not otherwise specified category represented experiences described by only one client-participant each. CP1 described a time when her mother reached out to her due to concerns about her sexuality did not fit into any other specific support function (C195, previously quoted). CP2 described an experience in which an acquaintance told her to do something in a way that was not quite representative of encouragement and went against what her physical therapist told (C108, quoted earlier). CP3 made two statements about her husband’s marriage proposal (C254 and C256, explained previously). CP4 made

several references to a psychotherapy intervention by a former therapist (e.g., C132 and C174). Finally, CP5 described not clearly specified support from her husband that she referred to as the “stuff” that he did for her (C23, discussed previously). None of these statements were clearly captured by any of the other support function codes and also were not found to warrant any additional, inductively derived code. These varied descriptions of experiences with support functions that do not represent any shared theme or pattern support Cohen and Wills’ (1985) observation that support functions in practice, or actual experiences, may not clearly fall into any one category or concept.

Support needs. Although research has indicated that seeking support is beneficial in post-traumatic coping, research is lacking related to the ways in which the need for support might be expressed. Existing research (i.e., Putman et al., 2009; Wilder Schaaf et al., 2013) has suggested that support services should be geared towards meeting the specific need areas of trauma survivors (i.e., humanitarian aid workers and military families of veterans exposed to multiple traumas) but have not provided any specific recommendations for ways to assess to meet stated needs. The dearth of available literature and focus on support needs in existing research is surprising given that client-participant statements of social support needs became apparent in the qualitative coding process of the first practice coding session and were observed in across all five sessions included in this study. Consequently, an additional coding category was developed during the practice coding process in order to capture statements of needs related to social support including “support from others,” “support to others,” and “not otherwise specified.” Therefore, it appears that expressions of support needs represent a salient area of social support discussion in psychotherapy. In fact, expressions of support needs

represented 5.07% of all social support expressions across the sessions included in this study.

Support needs: to others. In contrast to the existing, albeit limited, literature that focused on the need for providing support *to* trauma survivors (e.g., institutional supports and peer support networks; Putman et al., 2009; Wilder Schaaf et al., 2013), all of the client-participants included in this study most commonly, although still infrequently (2.41% of all expressions of social support and 47.61% of all support needs statements), referred to their needs to provide *to others*. This finding extends existing literature that indicates that women may be more likely to provide support to others (Pulcino et al., 2003; Robertson et al., 2006) in that women, as the client-participants were, may feel significant need to give social support to others.

However, unlike other code categories related to the constructs of social support that examined the quality of support experiences in that area (i.e., received support, perceived support, and extended support), the *Support Needs* codes did not include analysis of the quality of the need but rather the directionality of the need. Therefore, both positive and negative feelings and beliefs related to the wish or desire to provide support to others were included in coded expressions of the need to provide support to others. For example, CP3 described the desire to provide support to her sisters who lived in her country of origin and continued to be exposed to family violence, which may have indicated a positive impact on her if she were able to help them or feelings of guilt related to being unable to help them. CP1 described difficult feelings related to needs about providing support to others such that she did not want to give a friend a ride and had difficulty providing support to her boyfriend's child. These mixed feelings related to the

desire to provide support to others is consistent with the finding that most expressions of actual extended support fell into the “not otherwise specified” category, which is discussed in the next subsection. This finding adds to the existing literature as it identifies a new area of support needs, the desire to provide support to others, which has not previously been included in literature.

Support needs: from others. It was expected that expressions of support needs *from* others to the client-participants would be the most commonly occurring Support Needs code based on the literature described previously (e.g., Putman et al., 2009; Wilder Schaaf et al., 2013). The need for support from others was stated infrequently when compared to the rest of the social support codes (1.45% of all social support expressions and 28.57% of all statements of support needs), although all five of the client-participants made statements of the need for support from others.

Also, all client-participants’ expressions of the need for support was for support from informal support relationships. CP1 expressed the need for support from her current boyfriend and the past need for support from her parents in childhood. CP4 described a specific need for support from her grandmother. CP3, CP4, and CP5 all described the need for support from their husbands. Only CP2 described the need for support from friends, which was related to the need for continuation of the support they were already providing. Such findings highlight the need for future research, given the split in the literature on this issue. On the one hand, the limited available literature on support needs suggests the need for support from service providers (Wilder Schaaf et al., 2013) and institutional supports (Putman et al., 2009) are more paramount. On the other hand, the current study’s finding is in line with research that indicates that informal supports

represent valuable support resources (e.g., Barker & Pistrang, 2002; Sharpe, 2008) such that their support is needed and desired in the aftermath of traumatic events. Other existing research found that 70% of African American women who experienced intimate partner violence discussed their first abuse experience with someone else, suggesting that their need for support was sought and found from either a formal or informal support resource (Fraser, McNutt, Clark, Williams-Muhammed, & Lee, 2002). Additionally, Fraser and colleagues' (2002) study observed that 90% of African American women surveyed indicated that they would be open to supporting a family member or friend who experienced violence; the authors suggested that this finding reflects openness within the African American community to providing support when it is sought. It may be hypothesized, then, that support needs may be related to availability and quality of support types over time. For example, the client-participants in the current study may have reported the need for support from informal relationships that were not sufficient in meeting their need areas, which may have led them to seek professional support. Once their primary or general need areas began to be met in professional support experiences, they may have begun turning to and stating their needs for informal supports. Tracking support needs over time may be useful in understanding how and when different types of support are sought or needed. Therefore, the stated need for support from informal supports observed in the current study supports the need to extend existing literature to include longitudinal analyses of the salient need for support from family and friends as well as formal providers.

When inductively examined, the types of support that the client-participants expressed fell into three categories: needs for support in other relationships, emotional

support for trauma disclosures, and instrumental support. First, the stated desire for support from others related to relationships with other people was observed in both Session 1 and Session 4. CP1 expressed the desire for her current boyfriend to introduce her to his child and involve her in that additional relationship. CP4 expressed the wish for her grandmother to keep her separated from her father due to her anger following allegations that he molested CP4's guardianship daughter. In both of these examples, the client-participants expressed the need for some supportive other to help them in regards to another relationship. This finding provides additional insight into the observation from this study that informal supports may, at times, be specifically desired for assistance with other relationships to mediate other relational stressors.

Second, expressions of the need for support from others were also observed in relation to the desire for emotional support from others related to disclosure of abuse. For example, CP1 described the previous wish for emotional support from her parents in childhood following her experiences of sexual abuse and rape by her uncle. CP1 indicated that she previously wished to be able to disclose the abuse to her mother and her mother's boyfriend (she collectively referred to both as her "parents"), indicating an earlier need for emotional support. CP4 described a more recent desire for emotional support from husband in regards to her need for support following the disclosure of the molestation of her guardianship daughter by her father. In both examples, the client-participants expressed need areas for support for their affective experiences. No previous literature has included the need for emotional support, and specifically emotional support related to trauma disclosure, as a primary need area. Therefore, the current study

provides additional understanding of the expressed needs for support that may occur among trauma survivors.

Instrumental support represented a third area of stated support needs. For example, CP5 described the need for financial support from her husband. CP2 made a general statement about the need for ongoing instrumental assistance from unspecified friends due to her continued physical and medical needs. This finding is consistent with a recent study that observed that the families of veteran trauma survivors had unmet needs for instrumental support (Wilder Schaaf et al., 2013). The observation within this study regarding the need for instrumental support suggests that survivors themselves may also have needs for instrumental support. Although future research is needed in this area in order to determine whether these findings could be generalized to all trauma survivors, the analysis of expressions for the need for support from others provides some insight into the ways in which clients may express needs or the types of support they may require.

Support needs: not otherwise specified. Some expressions of the need or desire for support did not clearly fall into either the need for receiving support from others or providing it to others. Therefore, *Support Needs: Not Otherwise Specified* was used to capture any expressions of stated needs for support that did not fall into either of the other two categories. Three of the five client-participants made statements that were not captured by the needs for support from or to others categories; CP3 and CP5 did not have any “not otherwise specified” category of support needs.

All of the expressions of support needs that fell into the “not otherwise specified” category represented the desire, wish, or need for some multidirectional, or mutual,

exchange of support. This finding was interesting given that the mutual aid code within the support content category was not used in any of the transcribed sessions. Examples of the desire for mutual exchanges of support were observed when CP1 described future plans for companionship with friends (C406, previously described) and when CP2 reported on her past desire for friendship with a childhood peer (C135, discussed previously). Support needs within the not otherwise specified category were also expressed for the desire for exchanges of communication, which is a specific example of mutual support interactions. For example, CP1 stated the wish to discuss an earlier therapeutic conversation with the therapist (C213, quoted previously) and CP4 reported on her desire for improved communication with her husband (C165, discussed earlier). In this way, client-participants expressed communication needs that are indicative of the desire for communication from others as well as to others, further extending the multidirectional relationship needs described above. Combined with the absence of expressions of mutual aid, this result suggests that clients may indeed need mutual exchanges of support whereas they may be less likely to discuss occurrences of such support, or others may not be adequately meeting such needs. This represents a new contribution to existing literature on support needs as the need for multidirectional communication was not identified in previous research on the need for support (e.g., Putman et al., 2009; Wilder Schaaf et al., 2013).

Social support not otherwise specified. In order to capture and account for expressions of social support that did not fit into any of the main categories of social support constructs and structures (i.e., received support, perceived support, extended support, support functions, and support content), the category *Expression of Social*

Support Not Otherwise Specified was included in the coding manual. Overall, 4.59% of all coded social support expressions fell into the general “not otherwise specified category,” which was consistent with the frequency rates of most of the coding categories, other than the *Support Content* category. Client-participant expressions that fell into this not otherwise specified category were examined for any themes that emerged across or within participants. This section discusses the two patterns that emerged across participants (i.e., relationship factors and planned future support activities) and the two themes that occurred within participants (i.e., past perceived support and past support that was absent).

Relationship factors. The primary across-participant theme observed in the content analysis of the *Not Otherwise Specified* category was about relational factors that impact social support experiences, but that do not explicitly represent social support constructs and structures. Such expressions were made by all client-participants in the sessions included in this study. Examples of the theme of relational factors that impact social support experiences include: difficulty trusting others; difficulty accepting support; general relationship descriptions (unspecified); communication problems; feeling understood and connected to others in relationships; and behaviors that may impact support experiences. For example, both CP1 and CP5 described having difficulty trusting others (Session 1: C126, previously discussed; Session 5: C68, already reported) which impacted their way of being in relationships. In C68, CP5 described how her difficulty trusting other negatively influenced her ability to depend on and accept support from others. CP1 also reported on having difficulty accepting support (C99, previously quoted). These expressions are consistent with earlier research that observed survivors of

childhood sexual abuse to have difficulty developing healthy, trusting relationships (Alexander, 1992).

Both CP1 and CP5 expressed general descriptions on relationships: CP1 described overall problems in her romantic relationship (C289, reported earlier) and CP5 provided an overall description of the quality of her relationship with her mother (C242, already discussed). CP1 also described having communication problems with her romantic partner (C261, discussed previously) that were stated as general relational factors rather than specific needs as was observed when CP4 who expressed the desire for improved communication with her husband. These relational difficulties, described by client-participants who experienced childhood sexual trauma support, recent research that indicated that women who experience sexual abuse in childhood are likely to avoid intimacy in adulthood and may be at risk for entering stressful romantic environments later (Liang, Williams, & Siegel, 2006).

In contrast to these factors that negatively impacted support relationship, other relational factors were described as more positive. For example, CP2 discussed the experience of feeling understood in support relationships by roommate and the roommate's son (C91, previously reported) that was not included in a specific example of received or perceived support. A sense of belongingness with others has been observed to mediate stress and enhance emotional experiences (Cohen & Wills, 1985). CP2's relational experience with two people who were quite close to her appears to have provided her with a sense of belonging.

CP4 described several positive factors related to her relationships with her daughters: vague reference to connecting with her guardianship daughter through their

shared trauma histories (C68, reported earlier); feelings of responsibility in her relationship with her guardianship daughter (C80, previously explained); and her relationships with her daughters as being very important to her (C120, discussed previously). CP4's expressions regarding relational factors provide some support for PTG literature, although they do not represent clear connections to an overall experience of PTG. That is, the positive focus on her relationships with her daughters appears to indicate improvement in relational experiences as she also discussed having shared in a generally negative relationship with her mother. A felt sense of relationship improvements has been identified as an important domain in the process of PTG (Tedeschi & Calhoun, 1996), which provides some context for CP4's relational experiences with her daughters.

Finally, CP3 talked about a belief that something negative she might do would have impact on people she cares about, which influenced her decision making in a positive way (C132, reported above). Just as appraisals of traumatic events influence coping (Weathers & Keane, 2007), it appears that appraisals of relationships can impact coping, decision making, and self-esteem. Cohen & Wills (1985) noted that enhanced self-esteem contributes to self-value and feelings of acceptance with others. For CP3, who appeared to struggle with self-value (i.e., suicidal ideation), a sense of being connected or impactful to others appeared to provide her motivation to make positive decisions for herself and contribute to developing improved self-esteem.

All of these expressions pertain to the client-participants' support experiences but do not represent specific statements of support exchanges or beliefs that fell into any

other coding category. This set of results suggests that the factors that impact relationships should also be considered in the context of social support experiences.

Future support activities. Whereas the literature related to received support describes the construct as support that has previously been provided (e.g., Joseph et al., 1995; Kaniasty & Norris, 1993; Scholz et al., 2012), two of the client participants referred to future, specific plans with supportive others that were coded within the not otherwise specified category. For example, CP2 referred to future specific plans with friends for friends to help her around an upcoming surgery (C87, previously quoted) and for brother to visit (C180, already discussed). Both expressions alluded to support that would occur in the foreseeable future. CP3 also made two references to plans with her mother-in-law related to an upcoming holiday (C274 and C276, discussed earlier) that was indicative of specific exchanges of support that would occur. These client-participant expressions of future support represented specific plans for support activities, as opposed to desired future companionship that was described by CP1 and coded as support needs not otherwise specified (discussed earlier in this chapter) or beliefs about the availability of future support (i.e., perceived support). Such expressions were coded as not otherwise specified because they fell somewhere between received and perceived support. Although few expressions were representative of the theme of future planned support, the emergent pattern suggests that it may be useful to revise current definitions or assessment measures and take future plans for received support into account as support resources for trauma survivors.

Past perceived support. Perceived social support has been defined as beliefs about the availability of future support that stem from previous experiences of past

received support (Clapp & Beck, 2009; Kaniasty & Norris, 1993; Norris & Kaniasty, 1996). For the purposes of this study, then, the perceived support codes were used to capture client-participant expressions of beliefs about future support. In contrast, one client-participant expressed *past* expectations and beliefs for support. CP2 described beliefs that she had related to the availability of support when she was a child. Specifically, she expressed: the belief that no one would visit her in the hospital when she sick as a child (C143, previously reported); the past belief that no one would want to help her with her need areas (C142, quoted earlier); and the past belief that she had to give to others to receive support in return (C136, discussed above). CP2 appeared to have a range of interpersonal experiences over time including unspecified childhood abuse, adoption, and highly supportive relationships in adulthood. This suggests that, as received support experiences change over time, perceived support may also change over time and it may be useful to explore perceptions of support over time. Although research has linked negative childhood interpersonal experiences and subsequent attachment styles with emotion dysregulation and negative perceived support in adulthood, the extent to which modifications to attachment and interpersonal relatedness may occur remains unclear (Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008). In fact, Cloitre et al. (2008) noted, “The question of whether attachment organization itself can be changed through therapy remains to be determined” (p. 287). The observed theme of past perceived support that changed over time in Session 2 provides some evidence that change is possible but the means through which it may be achieved is not known. Also, expressions of past perceived support were observed only in Session 2, which significantly limits the generalizability of the observed within-participant theme.

Past support that did not occur. Another within-participant theme was observed in Session 5 that was related to earlier absences of support. Although literature on received support following trauma indicates that it may vary in helpfulness (Cohen & Wills, 1985; Lyons, 1991; Norris et al., 2008), the very definition (i.e., “naturally helping behaviors that are being provided,” Norris & Kaniasty, 1996, p. 498) states that it must be present to be considered support. The same is true for extended support (Pulcino et al., 2003). However, one client-participant reported on experiences of received and extended support that did not occur at all. CP5 reported on things that her husband did not do (C25, previously quoted) and what she did not do for him (C77, already discussed). These expressions of the absence of past received and extended support were coded as *Not Otherwise Specified* because it was not that such support experiences were insufficient or lacking in some, it was that they did not occur and were totally lacking. Although the theme of support that did not occur was observed in only transcribed session, it does suggest that some attention may be warranted for assessing areas of unfulfilled support experiences.

Extended support. Although extended social support represents an important construct (Pulcino et al., 2003) in the overall social support experience (Simpson et al., 2002), little research has focused on the experience of providing support to others. In the current study, expressions of extended support represented 4.23% of all social support expressions.

Extended support experiences are said to be impacted by early experiences of received support and attachment style (Simpson et al., 2002). All of the client-participants in the current study experienced some type of trauma (e.g., sexual abuse,

physical abuse) during childhood that was perpetrated by family members (e.g., mother, uncle). Also of note, two client-participants experienced disruptions in primary attachment relationships through adoption; CP2 was adopted by another family at some time in her childhood and CP3 was adopted by a great-aunt and -uncle during her childhood. Although adoption experiences have been observed to contribute to lifelong factors of identity, different phases of the integration of adoption narratives represent a range of experiences (e.g., no acknowledgement of adoption factors, negative feelings related to adoption, and acceptance and peace; Penny, Borders, & Portnoy, 2007). As such, early experiences of adoption should not be assumed to contribute to later relational or attachment problems but should be considered in the context of the individual. Therefore, each client-participant presented with a history of early life experiences that may have impacted their experiences of providing support to others. However, CP3 did not make any statements related to experiences of extended support. Additionally, further research is required to determine any possible link between attachment style and later effects on extended support.

Extended support not otherwise specified. The majority (73.68%) of expressions of extended support observed across all transcribed sessions fell into the “not otherwise specified” category. Four of the five client-participants made statements of extended support that did not clearly fall into either the positive or negative *Extended Support* categories; CP3’s transcript did not include any statements of *Extended Support Not Otherwise Specified*. Interestingly, for the four client-participants who made statements of extended support, the majority of each of their extended support statements fell into the not otherwise specified category. As observed in the *Received Support Not Otherwise*

Specified codes, statements that fell into the *Extended Support Not Otherwise Specified* category were either impartial statements of facts or involved mixed feelings about extended support. For example, CP4 made several statements in which she factually described support she provided to family members, which was previously described in regards to C128 when she discussed taking her daughters to the movies and C49 when she explained starting therapy for her guardianship daughter.

An example of was observed in CP1's previously discussed statement of her resistance to providing support to others although she indicated that she did not mind extending support to others (C102). CP2 described mixed feelings related to a specific experience of providing support to someone else when she explained having conflicted feeling about offering a snack to a friend in childhood (C136, previously quoted).

However, in regards to extended support, the finding of a high number of "not otherwise specified" expressions, either neutral or mixed, is not as surprising as in the case of the *Received Support* codes because literature has infrequently focused the extension of support to others in social support experiences. Despite the lack of emphasis on extended support in existing literature, the observation of the "not otherwise specified" category as the most frequently occurring *Extended Support* code suggests that it may be a useful area for future inquiry. Also, therapists may wish to clarify and understand more about clients' experiences of providing support to others more specifically in the course of psychotherapy, as it may be related to previous support experiences and may contribute to a variety of feelings.

Negative extended support. All client-participants in the current study were women, and research has indicated that gender is a significant factor in the experience of

extended support (Pulcino et al., 2003). In particular, research has observed that women may be more likely to experience extended support as burdensome and distressing (Pulcino et al., 2003; Robertson et al., 2006). Three of the client-participants made expressions of *Negative Extended Support* perceptions and experiences. CP1 made two negative statements of extended support while CP4 and CP5 each made one negative expression of extended support; CP2 and CP3 did not make any expressions of negative extended support.

Two studies observed increased distress and post-traumatic symptomology among women with “traditional” gender roles (e.g., caretaking of others; Pulcino et al., 2003; Robertson et al., 2006). In both studies, women who had greater responsibility as primary caretakers experienced increased distress following exposure to traumatic events. Robertson and colleagues’ (2006) study focused on a sample of Somali and Oromo refugees, whereas the culture and ethnicity of participants in Pulcino and colleagues’ (2003) study was not specified. Therefore, this study’s analysis considered the influence of culture in a woman’s experience of providing support to others. CP4, who self-identified as multiracial, saw herself as a caretaker in her family and described herself as “... the show up girl for everybody” (C27) in her family. Therefore, her statement, “... I’m the one that does everything for you...” (C59) when she described feelings of anger at the support she provided for her grandmother can be viewed in the context of her role in the family. These quotes may indicate that she feels she had a lot of care taking responsibility that, during a time of increased family stress (i.e., disclosure of her guardianship daughter’s molestation), became quite burdensome for her. This example is consistent with the studies described above (Pulcino et al., 2003; Robertson et al., 2006).

CP5, was self-identified as Caucasian, described having to take on greater financial responsibility within her nuclear family due to her husband's inconsistent income. Her description of the burden she experienced (C100, previously described) is also consistent with research related to gender roles and extended support (e.g., Pulcino et al., 2003; Robertson et al., 2006) in that CP5 described the culture of financial contribution within her family of origin, which was recapitulated in her family with her husband. That is, she stated, "And then later my dad sat down and did nothing, and my mom went back to work, and he like totally did nothing" (C64). Recent literature suggests that traditional gender roles of women as caregivers and men as breadwinners has been slow to change in comparison to women's changing roles in the workplace in recent decades (Gaunt, 2012). Specifically, people who violate or cross these gender expectations have been held to "double standards" by samples of individuals with traditional and egalitarian beliefs about gender. Although CP5's family and cultural values around gender roles is not clearly identified in the available information, her expression highlight the belief about the gender roles and expectations within her family over two generations. This statement provided context for understanding the increased and burdensome instrumental support she extended to her family when her husband was unable to, just as her mother had previously. Examining CP5's experience of negative extended support within her cultural context is consistent with the recommendations put forth by Robertson and colleagues (2006).

Positive extended support. The client-participants in this study reported few positive perceptions and experiences related to providing support to others. In fact, CP1, CP2, and CP3 made only one expression of *Positive Extended Support* each; CP3 and

CP4 did not make any positive expressions of extended support. None of the client-participants described experiences of mutual support, which may relate to the limited number of positive extended support statements observed. Although it has been hypothesized that mutual support is related to positive perceptions of the self and therefore may be expected to contribute to positive perceptions of providing support in mutual exchanges (Calhoun & Tedeschi, 1999), no provisions of extended support described by the client-participants in the current study provide support for this hypothesis.

Whereas client-participants did not describe extending support in mutual support relationships, they did describe some beliefs about and experiences with positive extended support. No pattern or theme was observed across the three client-participant statements of positive extended support. Therefore, each of the three statements is discussed within the participants. First, CP1 described extending instrumental support to her romantic partner (C329, already discussed). Second, CP2 discussed a general belief about providing support to others as coming back around to benefit her when she needed support in her statement likening her help to others as “karma” (C145, previously quoted). Third, CP5, in response to the therapist’s question, described providing her husband with positive feedback (C30, discussed previously). Given Calhoun and Tedeschi’s (1999) hypothesis that mutual exchanges of support (which involves extending support to others) is rewarding and beneficial to the self, and the openness in some cultural communities to providing support when needed (e.g., African American women’s willingness to support others who experience violence; Fraser et al., 2002), the observation in the *Positive Extended Support* codes indicates that it may be useful for

therapists to discuss with clients the benefits they experience in providing support to others. In fact, one of the three expressions of positive extended support occurred in direct response to a therapist's question (i.e., CP5, C30).

Perceived support. Perceived support refers to beliefs about available support that stem from earlier support experiences (Clapp & Beck, 2009; Kaniasty & Norris, 1993; Norris & Kaniasty, 1996). Because it is often difficult to distinguish between perceived and received support (Laffaye et al., 2008), for the coding purposes of this study defined perceived support as beliefs about the availability of future support (Joseph et al., 1994; Kaniasty & Norris, 1995; Norris et al., 2008; Norris & Kaniasty, 1996) with the specifier that perceptions may develop out of previous support experiences (Clapp & Beck, 2009; Kaniasty & Norris, 1993; Norris & Kaniasty, 1996).

Although research indicates that perceived support, or beliefs about the availability of support, is more effective and beneficial to trauma survivors than received support (Norris & Kaniasty, 1996), and has been studied more extensively than received support (Norris et al., 2008), *Perceived Support* codes were used least frequently across all five participants (3.50%) when compared to received support (5.92%) and the other social support codes. But, statements of perceived support were observed in the majority, or four or the five, psychotherapy sessions included in this study; no expressions of perceived support were noted in CP3's session transcript. This finding suggests that despite the significance of support perceptions in post-traumatic functioning, perceived support represents an area of social support that may be discussed only minimally in psychotherapy. However, this finding stems from a limited sample of women only

client-participants from a community mental health clinic in which all therapists were trainees, which limits the generalizability of the results.

It is important to observe that expressions of perceived support were most frequently related to informal support relationships, which were the most frequently coded relationship types. This finding provides additional support for the important role of informal relationships in not only experiences with but also beliefs about social support. Although there is limited available research related to the role of informal supports (Barker & Pistrang, 2002), the observation from this study extends Sharpe's (2008) finding that informal supports are most likely to be used in coping and the suggestions of Fraser et al. (2002) that some cultural groups, such as the African American community, may be willing to provide support to family and friends during times of need. That is, not only are these supports used and available but they are also involved in perceptions and beliefs about support. It seems that clients may frequently describe perceptions of support from family and friends, more so than they do support anticipated or expected from professional help providers. Thus, clients may benefit from opportunities to share and explore beliefs and feelings about their perceived availability of support in relationships outside of the therapeutic experience.

Positive perceived support. The quality of support perceptions has been associated with levels of post-traumatic distress (e.g., Kaniasty, 2011; Norris et al., 2008; Widows et al., 2000). That is, positive perceptions of support have been associated with lower levels of distress (Norris et al., 2008) and fewer symptoms of PTSD (Widows, et al., 2000) whereas negative perceptions of support have been associated with interpersonal withdrawal and isolation (Kaniasty, 2011). Notably, most expressions of

perceived support within the sample population reflected positive beliefs about the availability of support. Three client-participants made references to general beliefs about positive and beneficial support related to current stressors, without specifically describing the support they anticipated receiving; however, given the nature of the present study, the relationship between such support and symptoms could not be examined (only CP5 received a PTSD diagnosis; CP3 had a PTSD “rule out” diagnosis at intake and termination). A general belief in future provision of support was exhibited in CP5’s description of ongoing support she anticipated receiving from her husband. She explained that she believed her husband would continue to provide support in her statement that he “... respects my space” (C24). Also, reflected that she continued to appreciate the ongoing support he provided when she said, “... I always appreciate [the little things]” (C30). In these statements, she expressed positive beliefs about ongoing support (i.e., implying that it would continue to be available) without specifically indicating what type or function of support she expected to receive. Given research that shows that spousal support frequently represents a range of relationship types (Cohen & Wills, 1985) and fulfills a range of support functions (Tolsdorf, 1976), CP5’s expressions may have represent any number of ongoing support factors. It may have been useful for the therapist to follow up such expressions of perceived support with questions or discussion of the support resources CP5 believed to be available within her relationship with her husband. Such clarification and exploration may be a useful clinical tool for assessing available resources as well as need areas related to perceptions of future support.

Another example of unspecified support was observed when CP4 described feeling “blessed” in regards to her support system (e.g., CP4, C93 and C155). As previously noted, the transcribed session for CP4 was the initial intake interview and represented the only session in which the therapist asked questions about and explicitly reflected on the client’s available supports. It has long been recommended that clinicians gather information pertaining to social support networks at the start of treatment in order to assess for the availability of supports (Lukas, 1993). In reviewing the initial intake paperwork that the client-participant completed, the therapist elicited discussion of available supports when she observed, “...I looked through your paperwork a little bit, looks like you have a strong social network?” (T65). As CP4 commented on positive perceived support later in the session, the therapist stated, “... we have established that you have a phenomenal social support system” (T155) and “... but you have some wonderful support system” (T92). This suggests that the initial clinical intake may provide opportunities to invite discussion of support perceptions into the therapeutic discussion of presenting problems, stressors, and coping. Early discussion of perceived support may provide the foundation for ongoing discussion of available support resources as therapy continues.

However, similar reflections of positive available supports were not observed in other transcribed sessions that occurred later in treatment. Gottlieb (2000) noted that social support represents an ongoing experiential process that requires ongoing attention in intervention settings. The establishment and maintenance of an environment that encourages improvement in support functioning must, therefore, involve ongoing discussion and integration of support experiences throughout the intervention period

(Gottlieb, 2000), rather than initial assessment only. Therefore, the therapeutic process may benefit from continued the discussions of perceived support over the course of treatment.

CP2 also made several statements of generalized positive perceived support. CP2 indicated positive beliefs about the availability of support both in her country of residence as well as her country of origin (e.g., CP2, C28 and C29). She also stated, "... they are still in my life, that they still want to help me" (C156), which referred to her belief about ongoing, unspecified support from people in her life. In addition, CP2, who made the most frequent statements of positive perceived support, was the only participant who required the support of others in her daily functioning due to her physical and medical needs. Therefore, her experiences of receiving support from others, on which perceived support is based, may have been somewhat different from other client-participants who did not require accommodation for day-to-day activities (e.g., CP2's visual impairment required the assistance of others for all activities outside of her home). Moreover, her medical needs may have heightened her awareness of the ongoing role of, and need for, support in her life as well as past experiences in which support was beneficial to her. For example, she stated, "... I have gotten used to this vision. But I don't like what it's done or how it has curtailed my activities that were already curtailed anyway..." (C9) and went on to discuss her initial planning for long term resources such as learning Braille, considering various living arrangements, and other specific support needs. Research suggests that individuals who face multiple medical traumas with resulting crises (e.g., loss of mobility) are at risk for the breakdown of interpersonal relationships, but that the openness and ability to receive support from others mediates

relational deterioration (Sells et al., 2009). CP2's reported experiences with accepting support from others during medical recoveries likely contributed to her positive perceptions of the availability of support.

Another expression of positive perceived support reflected a belief about the availability of instrumental support. As previously discussed, some research indicates that instrumental support is not as beneficial to trauma survivors as is emotional support (Gabert-Quillen et al., 2012) whereas other research shows that instrumental support is more beneficial (Glass et al., 2007). In the current study, perceptions of specific areas and types of support seemed to be related to beliefs about future instrumental support. No other specific types of functions of support were included in discussions of perceived support. Specifically, two client-participants made statements of positive perceived support that referred to future instrumental support from romantic partners. For example, CP1 described the belief that her boyfriend would be able to help her financially if needed when she stated, "... So if something happens and I do run out of money, he can send me money. It's just easier..." (C329). In this case, support for stressors related to basic need areas (e.g., financial resources) were valuable to these participants, which is in line with the basic needs outlined by Ingram (2006) that include tasks related to survival and safety (e.g., food and shelter). Although these statements by client-participants highlight tangible need areas related to daily functioning, it is important to note that the need for human contact is often cited as a "basic" need (Ingram, 2006; Joseph et al., 1995; Kanisty & Norris, 1995).

Negative perceived support. In contrast to the benefits of positive perceived support, negative perceptions about social support have been associated with decreased

social involvement (Kaniasty, 2011). Four of the five client-participants expressed negative feelings and beliefs about social support; CP3 did not make any statements of negative perceived support. Based on the available information, however, it did not appear that negative beliefs about the availability of support caused client-participants to withdraw from social relationships or to decrease social involvement as CP2 and CP4 expressed ongoing active engagement in interpersonal relationships. For example, in opposition to the findings of Kaniasty's (2011) study which indicated that perceived support deteriorates following distressing events and leads to withdrawal from support relationships, CP4 described a perception of inadequate emotional support from her husband but was able to maintain participation in supportive interactions with others. She stated that she planned to have lunch with a friend following the session for support after discussing her recent stressors and distress. At the same time, the quality of their relationships may have been impacted, as CP1 and CP5 described long-standing difficulties connecting and trusting others. Further, because all of these participants (i.e., CP1, CP2, CP4, and CP5) experienced disruptions in early relationships due to trauma, it cannot be determined from the existing information whether any changes in social involvement occurred previously in their lives.

Additional examination of the expressions that were coded as *Negative Perceived Support* revealed additional themes within participants. CP1 expressed generalized perceptions about future support from others due to her belief that received support occurs only when something is given in return. As a result of that belief, she described having difficulty accepting support from others. This is not surprising given that negative beliefs about expressing emotions (e.g., emotional expression as a sign of weakness)

inhibit the likelihood that an individual will seek support (Joseph et al., 1994). The thinking processes, or appraisals, related to coping with stressors and traumatic events impact the use of resources in the coping process (Joseph et al., 1995; Widows et al., 2000). For example, CP1 expressed the belief that anybody who is offering support wants something in return (i.e., C99, previously discussed) beliefs that she did not want to owe anyone for help they gave to her (i.e., C85 and C102, previously discussed). Due to these beliefs, she indicated that it was difficult for her to seek support from others (i.e., C115, previously discussed), which highlights global beliefs about support that impact her ability to receive support from others and her view of support as occurring at some cost. Because CP1 viewed support as occurring at a cost, her appraisal process decreased her openness to receiving support during times of stress and diminished her overall belief that support would be helpful and available.

Expressions of negative perceived support were also related to beliefs about future support functions being unavailable. Just as CP1 noted a positive perception about the availability of instrumental support that was discussed previously, CP5 described a negative belief about future instrumental support from her husband that was based on past experiences in their relationship, which may have also been related to culturally related expectations and values related to gender roles (e.g., Gaunt, 2012). For example, she expressed that she could not depend on him financially because he had been inconsistent with financial support over the course of their marriage. CP5 described their financial strain as a significant stressor within the relationship. She stated, "... I can't depend on him because he has contributed... over the course of our marriage, but not dependably and consistently..." (C84; C85). This was CP5's only expression of negative

perceived support and reflected a perception of the lack of available instrumental support based on previous experiences. Research has indicated that financial strain can threaten the quality and strength of marriages among African American populations (Cutrona et al., 2003). Therefore, it was recommended that interventions should focus on financial and employment issues and goals as well as communication and social skills. Although CP5 identified as Caucasian American, her expressions provide some support for the impact of financial difficulties on marital functioning in other racial groups that extend beyond the findings of Cutrona and colleagues (2003). There is no literature examining the relationship between support functions and beliefs about future support.

Another function of support was perceived as being lacking; two statements regarding the absence of emotional support were described in one transcribed session that stemmed from recent difficulties accessing received emotional support. This was somewhat consistent with existing literature that found that negative support perceptions have been linked to difficulties in sharing negative feelings about received support experiences (Kaniasty, 2011). CP4 noted a belief about emotional support not being adequate from her husband when she stated "... you are not getting it and you can't even fake it well, you know... me needing to be able to come to you is not there right now with this situation..." (C161; C163). One significant difference between CP4's experience and the findings of Kaniasty's (2011) study was that CP4 was able to share her feelings about the lack of support from her husband directly with him. In contrast, participants in Kaniasty's study who reported having difficulty disclosing feelings about negative received support were more likely to withdraw from interpersonal relationships. In this example, the client-participant was able to express her belief that emotional

support pertaining to the stressful event was not available directly to the individual from whom she wanted to the support. Although the problem was not resolved by expressing her feelings to her husband, and she sought additional support from the therapist (i.e., "... I could use some suggestions and input in that areas too" [C167]), it may have been beneficial to her ongoing perceptions about the availability of other types of support and support from other resources that assisted in maintaining her engagement in supportive interactions (e.g., support from friends and support within the context of therapy). Also, it may be helpful for clients to express feelings about negative support in therapy if they are not able to do so directly with the supportive other as CP4 was able to with her husband and to seek therapy interventions and modalities that specifically focus on emotions (e.g., emotionally focused therapy [EFT] for couples in which one partner experienced trauma; Greenman & Johnson, 2012).

In contrast to some research that indicated that people who received "more" support following stressful events having greater levels of perceived support later (Kaniasty, 2011; Norris & Kaniasty, 1996), CP2 expressed negative perceived support about the availability of support decreasing because she received so much of it. She stated, "... am I such a worthwhile cause for them to keep helping me if I need it?" (C158), which illustrated her fear that the support she had consistently received from friends and loved ones would eventually run out. However, this was CP2's only expression of negative perceived support and the majority of her perceived support statements were positive, which is fairly consistent with earlier research findings (e.g., Kaniasty, 2011; Norris & Kaniasty, 1996).

Perceived support not otherwise specified. Whereas the literature on perceived support generally focuses on either positive or negative perceptions, the results of this study indicate that trauma survivors may also express neutral, ambivalent, or mixed beliefs about future support. Only three of the five client-participants in this study made statements of perceived support that did not clearly fall into the positive or negative *Perceived Support* categories; CP3 and CP4 did not make any expressions of *Perceived Support Not Otherwise Specified*. No clear themes emerged across participants who made expressions of perceived support that fell into the “not otherwise specified” category. CP1’s not otherwise specified expressions of perceived support were coded as such because they represented neutral beliefs about future support as observed when she described her belief about how her cousin or the therapist would respond to her (C302 and C338; previously discussed). CP2 described an ambivalent, or hesitant, hope for her future visual functioning based on previous experiences of independence (C6, already quoted and discussed above). Finally, CP5 expressed mixed feelings about future instrumental support from her husband (C97 and C98, described above). Although some expressions across participants did not clearly fall into either the positive or negative perceived support categories, no clear pattern emerged across participant expressions that fell into the not otherwise specified category.

Within-Participant Discussion of Models of Social Support

In addition to the information related to constructs and structures of social support gained from this study, some connections can be drawn between the client-participants’ post-traumatic experiences of social support and existing theoretical models of social support in the aftermath of traumatic events. Examples of some of the theoretical

models of social support described in the first chapter were observed in the sessions included in this study. Specifically, this section includes discussions of the network orientation model, the stress-buffering model, one of the deterioration models (i.e., the erosion model), and two etiological models (i.e., the social-cognitive processing and COR models) in the context of within-participant examples (1 client-participant example of each of the 5 models). The personality model is not included in this discussion because there was not enough available information about the client-participants' personalities and attachment experiences to examine this model. This section concludes with observations of the client-participants' expressed social support experiences and possible themes related to PTG.

Network orientation model in Session 2. Expressions related to network orientation, which is the model of social support that refers to an individual's beliefs about social support relationships and the degree to which they are used during times of need (Clapp & Beck, 2009), were observed in Session 2. Network orientation theory posits that the individual's perceptions of the social network develop from earlier experiences of social support (Clapp & Beck, 2009; Tolsdorf, 1976) and then contribute to later support seeking and acceptance (Tolsdorf, 1976). CP2 was the only client-participant in the current study who expressed past perceived support, which provided insight into her earlier network orientation.

Network orientations are generally characterized as either "positive" or "negative" (Clapp & Beck, 2009; Tolsdorf, 1976). CP2's network orientation at the time of the transcribed therapy session appeared to be largely positive as evidenced by her greater number of positive received, perceived, and extended support experiences, such

that she appeared open to accepting help and using a variety of support functions, including emotional, esteem, and instrumental help (Tolsdorf, 1976). In fact, she described only one negative perception of social support, and made no mention of negative received or extended support experiences. Her only statement of negative perceived support, that her friends would eventually reduce support provided to her (C158, previously discussed), appeared to stem from very early social support experiences, which aligns with the network model.

Throughout the course of the session, CP2 reflected on her network orientation as it changed over time and contributed to her current experience of receiving support from a variety of social resources. Although the network orientation model is generally described as a static approach to social support experiences (e.g., either positive or negative with no mention of change), CP2's experiences provide a valuable example of the ways in which previous experiences and beliefs about support impact the ways in which an individual may experience social support following traumatic events that supports Gottlieb's (2000) assertion that social support is a process rather than a static experience. Although the nature of CP2's childhood abuse and medical needs were not specified in the available information, she appeared to have experienced interpersonal difficulties and insufficient received support that contributed to the earlier belief that others would not want to help her (C142, previously reported) and that she had to give something in order to receive support (C136, quoted earlier). She discussed earlier worries that support would be unavailable at times of need in her expression that she thought no one would visit her in the hospital when she was a child (C143, previously quoted). However, she appeared to have some reparative experiences of support,

possibly through her adoption process and in her earlier work experiences as a nanny, over time that facilitated the shift from her early negative orientation later changed to a positive orientation. This shift may also have been related to the nature of her recent medical trauma resulted in an increased need for practical support, which may have provided further positive experiences of received support that contributed to the shift in her network orientation. At the time of the transcribed session, she described having significant amounts of support both in her country of residence and her country of origin (C28 and C29, previously explained) and she appeared highly open to receiving support from others. However, some of her earlier negative perceptions appeared to persist in her fear that the available support would run out. In this way, Session 2 provided an illustration of the role of network orientation over time, the ways in which it may change, and possible long term effects of early and significant social support experiences on network orientation.

Stress-buffering model in Session 4. The stress-buffering model suggests that positive social support prevents the development of stress related symptoms following distressing events (Clapp & Beck, 2009; Cohen & Wills, 1985). Expressions of social support observed in Session 4 illustrated the process of stress-buffering through supportive experiences following difficult events. For example, CP4 described having “wonderful” supports (e.g., husband, friends, stepmother; C65, C66, C92, previously quoted) that were beneficial to her in coping with traumatic and stressful experiences.

Cohen and Wills (1985) indicated that some functions of support in particular are associated with the buffering process in response to stressors. CP4 described experiences with some of the functions suggested by Cohen and Wills (1985) as contributing to the

buffering process: informational support (two expressions); companionship (1 expression); instrumental support (4 expressions); and esteem support (0 expressions). In particular, most of the functions CP4 described in experiences of received support directly related to responding to and coping with stressful events (e.g., referrals to therapy during times of increased stress [C90 and C181, already reported]; and assistance with home-based tasks from her husband [C83, previously discussed]).

The stress-buffering benefits of support for CP4 were highlighted in her response to her current stressor related to the disclosure of her guardianship daughter's molestation. Specifically, she discussed experiences of receiving support related to her appraisal of her responsibility for her guardianship daughter's abuse when she discussed messages she received from supportive others. She expressed that others told her that it was not her fault (C80, discussed earlier) and, although it did not change her belief outright, she did integrate such messages into her coping with the stressor. Additionally, she discussed the availability of support for times of stress such that a friend was meeting her for lunch "just as support" (C155) following the intake session. These examples illustrate the ways in which CP4's available support provided buffering against stressors that is consistent with the model proposed by Cohen and Wills (1985).

Erosion model in Session 5. Three deterioration models of social support, which hypothesize descriptions of the relationship between PTSD symptoms and social support experiences (Clapp & Beck, 2009; King et al., 2006), were described in the first chapter: the erosion model, the deterioration model, and the deterioration-deterrence model. Expressions of social support that are related to the erosion model were observed in

Session 5. Therefore, this qualitative discussion focuses on the erosion model as an example of the deterioration models.

The erosion model postulates that the protective benefits of social support diminish during the course of long term PTSD symptoms (King et al., 2006; Laffaye et al., 2008). That is, symptoms of PTSD, including detachment, isolation, and irritability, have a negative impact on the availability and quality of social support (King et al., 2006). Although the erosion model was developed from research with veteran populations, CP5's history and expressions in the transcribed session appear consistent with the theory of the erosion model. Based on the available information, it appears that CP5 had social support resources at one time that decreased over time as trauma-related symptoms emerged and persisted. At the time of intake, as documented in the Telephone Intake Form and the Intake Evaluation Summary, CP5 had few social support resources and had difficulty engaging in supportive relationships due to her history of traumatic experiences that began in childhood. CP5 informed the telephone intake staff that she had "ice in her veins" (Telephone Intake Form) when asked about irritability and losing her temper easily, which provided some evidence of the presence of irritable symptomology that may have impacted her interpersonal experiences and relationships. It was noted in the Initial Intake Summary that CP5 began feeling disconnected from herself and others during the time of sexual abuse by a neighbor when she was a child. At the time of intake, she was diagnosed with PTSD and Depersonalization Disorder, which reflected significant symptoms that impacted her daily functioning and ability to relate to and receive support from others. Additionally, one of the treatment goals at intake was to encourage client's use of a support system. Over the course of the

transcribed session, CP5 described having difficulty trusting others (C68, previously discussed). She described earlier experiences in friendships such that she drove nearly across the country in order to attend a weekend retreat with friends during her teenage years (i.e., “One of my friends, well actually several of my friends were gonna be there and it was at this really cool state park...”, C179). However, at the time of the transcribed session, when she was in her late twenties, she reported having few positive relationships with others such that she only would have been happy to see two close friends (i.e., “... [close friend] and [close friend] are the only two people I’d be happy to see...”, C164). This shift in her relational experiences indicates the erosion of social relationships over time that contributed to her limited support resources at the current time.

Research has indicated that veterans experiencing PTSD symptoms were more likely to seek support from veteran peers who experienced similar traumatic events than from family members or other friends (Laffaye et al., 2008). The support contents discussed by CP5 are somewhat inconsistent Laffaye et al. (2008), in that she often referred to supports consisting of family and friends, and she relied most heavily on friends who did not clearly share in her trauma history. CP5 referred only to five of the nine content types and most of her expressions of support content were related to primary kin relationships, with many references to her parents who contributed to her trauma history (e.g., physical and sexual abuse). She also referred to her brother who had somewhat similar trauma experience by being raised in the same house (e.g., physical abuse and abusive environment). She described receiving assistance from her brother, who may have been like a “veteran peer” (i.e., Laffaye et al., 2008) as they survived

similar family traumas, during their childhood but did not reflect on ongoing support from him in her adulthood.

She identified two close friends in the telephone and clinical interview intakes, as documented in the available information, as being her primary support resources; CP5 also referred to these two friends on one occasion during the current session. It is not known, based on the available documentation whether these friends shared similar trauma histories; however, CP5 was quite clear that these were the individuals to who felt the closest to and trusted the most. It was reported in the Intake Evaluation Summary that one of the friends was a “lifelong” friend while the other represented a more recently developed connection. However, unlike veteran populations, which were the focus on erosion model research, the nature of CP5’s traumatic experiences (e.g., sexual abuse by a neighbor and her father; physical and emotional abuse by her mother) were not likely to be directly shared by a peer group such as veterans who may have been in direct combat with their peers thereby sharing in the same traumatic event.

The erosion theory of social support also suggests that the functions provided within support exchanges are also related to the deterioration process of social support following traumatic events. Laffaye and colleagues (2008) observed that instrumental and emotional support were the most commonly received support types among their sample population and that such support decreased over time as PTSD symptoms persisted or increased, regardless of the type of relationship in which the support was received. In CP5’s case, her expressions of support functions were limited to only three of the seven support functions categories (i.e., instrumental, advice/informational, and not otherwise specified). She presented with symptoms of PTSD at intake that may have

been chronic due to her long trauma history and appeared quite severe such that she had difficulty going to work and interacting with others. At the same time, she reported on having few available support resources and mentioned few experiences of receiving only limited types of support. Therefore, it may be hypothesized that, by the time she sought treatment, her social support relationships had already eroded significantly.

Social-cognitive processing model in Session 3. One of the etiological models of social support presented in Chapter I was the social-cognitive processing model that hypothesized that the social environment is an important factor in cognitive processing after traumatic events (Lepore, 2001; Lepore et al., 1996; Widows et al., 2000). The social-cognitive processing model proposes that the quality of the social environment impacts the individual's ability to appraise, understand, and psychologically survive traumatic events (Lepore, 2001; Lepore et al., 2000). That is, positive and supportive social environments are likely to contribute to "successful" cognitive processing of traumas (Lepore, 2001; Lepore & Helgeson, 1998; Lepore et al., 1996) whereas negative and unsupportive environments impair the individual's ability to process traumatic events and may contribute to the onset of PTSD symptoms (Lepore et al., 1996). Given CP3's history, garnered from the available documents, and expressions of social support observed in the transcribed session, it may be hypothesized that her social environment significantly impacted her cognitive processing during and following her long history of trauma.

CP3 experienced repeated physical and emotional abuse by her mother and grandmother and two instances of unspecified sexual abuse, as reported in Intake Evaluation Summary. Based on the trauma discussions in the current session, her early

social environment involved traumatic experiences of physical and verbal abuse and resulted in an unsafe and unsupportive social environment in which she was repeatedly exposed to negative messages about herself (e.g., "... they used to tell me that I'm the ugly one in the family... and they used to tell me that I'm so angry...", C176). Even after her adoption by extended family members, she continued to be exposed to the negative social environment in other family interactions (e.g., C155, 164, previously discussed). Additionally, she grew up in El Salvador, which is an area with significant political and community violence that had long-lasting impacts on the population in (Radan, 2007). Although she was able to eventually leave the negative social environment, it seemed that CP3 continued to have difficulty processing earlier traumas due to limited support resources and difficulty expressing her feelings. Then, when she presented for psychotherapy sometime following her immigration to the United States, earlier traumatic events appeared to be a significant factor in her experience of depressive symptoms, possibly as a result of not having previously processed traumatic experiences, but also could be related to other factors such as culturally-based beliefs about trauma (Antai-Otong, 2002) or cultural expressions of distress (Ruchkin et al., 2005).

It was noted in the Telephone Intake Form that CP3 had difficulty expressing her reason for seeking therapy. Also, throughout the transcribed session, she appeared to have difficulty expressing herself (e.g., "I don't know [inaudible] I don't know, I'm just pretty upset with her." [C146]). Although this difficulty may have been related to language differences as therapy was facilitated in English (with some instances in which the client-participant and therapist clarified phrases using Spanish), whereas CP3's primary language was Spanish, it may also have illustrated her limited ability to

cognitively process her emotional experiences, which may have been impacted by other potential factors such as educational level, socialization to therapy, or possible stigma related to therapy participation. Thus, the impact of CP3's early social environment, as well as possible ongoing contributing factors to verbal expression in therapy, and limited opportunities the process early traumatic events appeared to have long-term impacts on symptoms of distress and her ability to express herself.

Conservation of resources model in Session 1. The COR model is another etiological model of social support that was discussed in the literature review. The COR theory suggests that resources such as social factors, personal qualities, and environmental elements are used in maintaining well-being and may be expended, without adequate renewal, during times of stress (Halbesleben, 2006; Hobfoll, 2001). Social support in particular represents a resource that can be useful in supporting or reinforcing other resources that may be strained or depleted following traumatic events (Halbesleben, 2006; Hobfoll, 2001). However, resource losses that are not sufficiently regained, contribute to psychological distress (Hobfoll, 2001; Johnson et al., 2009). Session 1 provided an example of the process of resource expenditure involving social support.

CP1 presented with a number of resources, consistent with the COR term (e.g., Hobfoll, 2001). For example, it was reported in the Telephone Intake Form and Intake Evaluation Summary that she had moved independently from her hometown in another state to a large city, where she was quite self-sufficient despite financial challenges, suggesting that her personal characteristics were useful in her own survival and successes. Also, throughout the transcribed session, she reported on various relationships

over the course of her life, which likely provided her with some social resources, particularly following her experience of sexual abuse in childhood. Even though she had difficulty disclosing the sexual abuse to her mother, she described the availability of support, albeit in a way that was rather avoidant of difficult topics that may have represented earlier resource losses from her mother (e.g., C193). Despite the personal resources she demonstrated, her social resources appeared to decrease with her move to her current city, such that she referenced only one primary friend relationship in her current city during the session (C100). Also, she reported having difficulty accepting support from others (e.g., C99, C117), which may have impacted her overall support resources within the COR frame.

CP1's available but limited social resources by the time of the session were then expended during the stressor of her current romantic relationship. Although the stressor within her relationship (i.e., her partner had a child with a former girlfriend) was not "traumatic" per se, it represented a significant problem for her that impacted her expenditure, or use, of and availability of resources. Because she had limited other supports, exchanges of support within the relationship were likely strained as there were few other social resources to reinforce the support within that relationship. Then, when this stressor occurred, which she identified as a major problem and disruption within the relationship (C289, previously quoted), the support within the relationship was drained. The depletion of support resources from the COR perspective was illustrated in her description of communication problems with her partner due to the stress of his child with another person (C261, reported previously). With few other support resources to bolster and regenerate the resources within the romantic relationship, CP1 experienced a

resource loss in her relationship that did not appear to be regained. Therefore, CP1's experiences of social support represented an example of resource depletion within the context of the COR model.

Observations of social support and PTG across sessions. Although this study hoped to also gain understanding into the relationship between social support and PTG, there was not enough information available within the study to determine if the client-participants experienced PTG. Measurement of PTG within the sample population was outside of the scope of the current study because the archival database did not contain a PTG measure and only consisted of closed cases. No expressions of PTG were observed in the single transcribed sessions for each client-participant. Also, the available documents for each client-participant were not indicative of PTG experiences (e.g., available Termination Summary forms did not describe treatment outcomes consistent with PTG).

Despite the limitations related to assessing and analyzing PTG, one notable pattern emerged that has implications for possible PTG experiences: the absence of expressions of mutual aid. As noted previously, none of the client-participants referred to experiences of mutual aid, or support from others who had experienced similar traumas, such as occurs in self-help. Also, as reported earlier in this chapter, there was no evidence within the available information for each client-participant to indicate that any of them participated in any survivor support networks, groups, or relationships. This finding is significant given that mutual support experiences have been cited as contributing to the process of PTG (e.g., Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2004).

Mutual support, specifically related to support between trauma survivors, has been observed to benefit the process of PTG such that survivors can share in the “been there” experience and that survivors with similar trauma histories can motivate and model growth after the event(s) (Tedeschi & Calhoun, 1996). It has also been suggested that survivors find an experience of acceptance with each other (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2004) that can facilitated vicarious, or shared, PTG (Tedeschi & Calhoun, 2004). Some of the client-participants described the need and desire for exchanges of support with important others in their lives (e.g., CP1, CP2, and CP4 expressed the desire for multidirectional support exchanges, discussed above), which reflects “mutual” support but does not include the element of “mutual support” related to support from other trauma survivors (e.g., Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2004; Tolsdorf, 1976). Therefore, it may be hypothesized that the absence of mutual aid with other trauma survivors may have some impact on the client-participants’ possible experiences (or lack of experiences) of PTG.

Limitations

There were at least ten methodological limitations inherent to the qualitative directed content analysis design as well as the coding system developed for use in this study. The primary limitation was related to the use of pre-existing theory, which impacted the researcher’s ability to maintain a neutral frame when analyzing the data. The influence of existing theories can cause researchers to overlook elements or contextual factors of a given phenomenon (Hsieh & Shannon, 2005). Also, the researcher may have been influenced to find supportive, rather than unsupportive, evidence related to the theoretical guide for analysis. However, the codes that were used

in this study represent a range of elements related to the conceptualization of social support in post-traumatic experiences that are included in a variety of theoretical models (as described in the previous chapter). The codes that were used for this study were developed from a range of theoretical and empirical literature in an effort to increase understanding of the social support phenomenon rather than a specific model. Also, an additional set of codes was developed that emerged from client-participant statements of social support experiences (i.e., support needs) that was not clearly delineated in existing literature. Despite this effort in designing codes, coded material from recorded sessions did not, at times, fall specifically into one category or another which increased the chance for researcher bias to impact coding decisions and data analysis (Hsieh & Shannon, 2005). The use of the audit trail in this study was intended to increase awareness of, and correct, possible researcher biases.

Second, the coding system and its application were limited in other ways. Although useful in generating a clear and consistent system for identifying and coding expressions of social support, the use of explicit verbal markers for categorizing statements of social support may have limited the researchers' ability to capture the full experience of the client-participants. For example, it did not include client-participant expressions that were not explicitly stated to indicate social support. Also, as previously noted, all client-participant expressions of social support, those occurring both within and outside of trauma discussions, were coded. Therefore, this study cannot make generalized inferences about social support experiences and beliefs specific to trauma experiences.

Third, this study may also be seen as limited by the small, purposefully selected sample of participants that is suggested for this type of design (Creswell, 1998). The approach to sampling limited the generalizability of the results, such that the 5 selected cases, and including only one psychotherapy session from each case, were not representative of a wide range of demographic and cultural backgrounds. Furthermore, only Session 4, which was an intake session, indicated the point in therapy at which the session occurred; no data was available for the other sessions to indicate when in therapy they were conducted. As a result, the study was not able to determine how and when social support experiences may have been discussed at various points in therapy, and the impact of the timing of such discussions on variables such as the development of the therapeutic relationship and any possible ruptures in the therapeutic alliance. Still, qualitative approaches to research focus on the unique experience and perspective of the individual (Creswell, 1998; Merriam, 2002), which were represented in the client-participant expressions and discussion in the psychotherapy sessions included in this study.

Though small, the participant sample did include members from varied demographic groups. However, the information garnered from the clinical documents included in the research database offered limited descriptions of important demographic and cultural variables and may not have fully captured an individual's identity and experience (Schwartz, Unger, Zamboanga, & Szapocanki, 2010). Despite attempts to vary potential client-participants to represent a range of demographic factors, all of the selected client-participants were women. This gender imbalance could be seen as further limiting the generalizability of the results, but others may argue that this is not the focus

of qualitative inquiry. In addition, due to the database's content and the desire of the researcher to limit inferences about demographic and cultural variables when viewing videotapes, no information was collected about the therapists or the interactions between the clients and therapists. The ethnocultural similarities and differences between therapists and clients, and the transactional nature of the therapy relationship itself, could have impacted client-participant expressions of social support, but were not able to be assessed in the present study. Although there have been longstanding debates in the field of qualitative research related to the usefulness and appropriateness of generalizability of qualitative findings, no shared consensus has emerged to outline the process by which generalizations may be made (Chenail, 2010). Despite the debate surrounding generalizability in qualitative research, Myers (2000) asserted that qualitative research contributes to knowledge about complex human experiences that provides a depth of understanding within small samples that may be missed in large samples even though findings may not be widely generalizable. Therefore, insights can be garnered from the current study, although they may not be applicable to a broad range of people, and may be limited due to a lack of full knowledge of contextual data in the psychotherapy relationship.

A fourth limitation for this study was that its sample was comprised of archival data, namely, psychotherapy cases that were terminated prior to the start of the study. This limited the researcher's ability to directly interview client-participants about any of the study's variables or themes or patterns that emerged during the analysis. However, this qualitative approach to analysis of the data provides an opportunity for in-depth understanding of the constructs and structures of social support that are reported by

clients in psychotherapy that is currently missing from self-report measures used in non-therapy-related samples. Additionally, the use of previously completed psychotherapy cases was useful in gaining awareness into how clients may discuss social support experiences in general sessions. That is, this study did not attempt to manipulate or influence the natural course of therapeutic discussions or content that client-participants brought into the sessions.

Another limitation that emerged during the course of the coding process related to coding only client expressions of social support; therapists statements were not coded, nor client-therapist interactions. That is, only spontaneous client-participant expressions of social support were coded in an attempt to capture only client-participants' expressions of social support. That is, coding did not always capture responses to therapist-initiated questions, prompts or reflections, which may have been influenced by therapists' biases, theoretical orientation and other factors that were not known to the researchers. As such, coding may not have accurately represented client-participants' thoughts, feelings, or beliefs or other transactional factors in the exchange between client and therapist (e.g., related to the therapists' gender, ethnicity, or other contextual factors and the clients' perceptions or experiences thereof).

For example, CP3 seemed to have some difficulty, which may have been due to language, level of insight and self-awareness, or other factors, in describing her experiences and feelings. Therefore, at times when the therapist asked her direct questions pertaining to her thoughts and feelings, her responses of "yes" and "no" were not captured by the codes. Also, the therapist in Session 3 frequently asked CP3 to repeat back what the therapist had said, which did not clearly represent the *client-participant's*

social support expression. This represents a methodological limitation in that any salience or resonance the client-participants may have experienced in responding to therapist prompts and questions was not included in the results, as such responses could not be inferred or assumed by the coders.

The sixth limitation within the current methodology involving archival psychotherapy sessions was related to variability of the length and focus of sessions included in the sample with the number of talk turns in the session ranging from 184 (CP4) to 418 (CP1) and the number of social support expressions ranging from 119 (CP2) to 220 (CP1). For example, Session 1 was longer than the other sessions both in terms of the time of the session and the number of talk turns that occurred in the session, which may be attributed to different factors, such as the client-participant's fast speaking pace and the use of a therapeutic game that led to many changes in discussion topics over the course of the session. As a result, the number of talk turns in Session 1 represented 30.5% of the overall number of talk turns across all five sessions and 26.6% of all expressions of social support across the sample. However, the percentage of social support expressions within the transcribed session (52.6%) was generally consistent with most other transcribed sessions. In contrast to Session 1, Session 4 had the fewest number of talk turns (13.4% of the total number of talk turns across all sessions) but the second highest number of social support expressions (24.3% of the total number of social support expression across all participants). Therefore, the number of social support expressions varied by client-participant with some participants over-representing or under-representing statements of social support in general and in specific areas (e.g., CP1

was the only participant who referred to sexual/romantic support content; CP3 did not make any statements of perceived or extended support).

A seventh limitation was also observed in coding support content relationships that may have changed over time. As the literature on network orientation indicated, perceptions about the supportiveness of relationships changes over time based on factors that include experiences with the supportive individual, earlier influential experiences with others, the type of support relationship, and functions provided within the relationship (Tolsdorf, 1976). In the current, study, all client-participants described reports of people who provided support at one time with later changes in the quality of support provided and the overall context of the relationship. For example, four of the client-participants (i.e., CP1, CP3, CP4, and CP5) described family members who at times represented support content and at other times represented perpetrators of physical or sexual abuse. Thus, a limitation of the codes, and the *Support Content* codes in particular, was that it was difficult to capture the negative aspects within a relationship that did not fit with the definition of support (e.g., abuse) and were salient factors within the sample population of trauma survivors. Specifically, the *Support Content* codes did not capture changes within relationships such that all mentions of a person who at one time provided support were coded as support content.

A further limitation related to coding *Support Content* was in quantitatively examining the number of and inter-rater reliability for *Support Content* codes when multiple occurrences of a *Support Content* code occurred within a single talk turn. Three of the *Support Content* codes (i.e., C1, C2, and C4) were used multiple times within a single talk turn; no other codes presented this issue. However, two of the repeating codes

were codes related to family relationships (C1 and C2); these occurred hundreds of times across all five sessions with multiple codes occurring in single talk turns approximately 25% of the time. For example, when CP3 referred to both her mother and her sisters within a single talk turn, C1 [mother] and C1 [sisters] were coded for that talk turn. Unfortunately, when calculating inter-rater reliability, it was not possible to account for both C1 codes in one talk turn. The problem of multiple *Support Content* coded occurred most frequently for the last three participants who were generally discussing single family issues when mentioning multiple family members, which were coded individually.

Two final limitations were observed that were also related to a *Support Content* code. The code for *Support Content: Service* (C8) was used to capture client-participants' relationships with service providers. "Formal" social support resources refer to professional service providers (Rieck et al., 2005) and "service" represents a common type of support content (Tolsdorf, 1976). Additionally, formal support resources have been found to be beneficial in supporting the grieving process among African Americans who traumatically lost family members to homicide (Sharpe, 2008). However, two problems were encountered in coding expressions of *Support Content: Service* (C8). First, the researcher-participants had difficulty determining when services provided by professionals represented social support or "naturally occurring helping behaviors." That is, many expressions of assistance from professional service providers reflected provisions of services that aligned only with the nature of the professional relationships. For example, CP1 referred to calling for roadside assistance and CP2 frequently reported on medical services provided by unspecified professionals. Because

the services exchanged in these relationships occurred only within the context of the professional interaction without any clear statement of social support that would be observed in other types of relationships, the researcher-participants determined that such professional relationships should not be coded as service contents (C8). However, other types of professional relationships were described that did evidence a more supportive nature within the context of the relationship. Some professional relationships described by the client-participants included an inherent element of social support that extended beyond simple service provision. For example, CP2 described receiving support and encouragement from her physical therapist, who she described as “wonderful.” Also, CP4 reported on a supportive relationship with a former therapist and stated, “...I loved her...” (C174). In both of these examples, the client-participants described relational experiences that represented social support rather than basic service provision. As a result, the researcher-participants decided that C8 should be coded for professional relationships that were explicitly described as supportive by the client-participants.

Finally, the second limitation related to coding C8 was observed in coding client-participant mentions of the current therapists within the transcribed sessions. Based on the coding decisions made by the researcher-participants described above, it was determined that expressions involving mention of the client-participants’ therapists should be coded as C8 [therapist]. That is, direct statements to the therapist (e.g., “you” specifically implying the therapist) were coded as C8 [therapist]. All client-participants made at least one reference to their current therapist. Due to the nature of the therapeutic board game played by CP1 and her therapist in the identified session, CP1 directly referred to her therapist 46 times; Session 1 also represented the longest session with the

most number of talk turns. The researcher-participants also decided to include the CP4's mentions of the therapist in Session 4 in C8 even though the transcribed session was the initial clinical intake. Because CP4 was seeking support in referring herself for therapy following a significant stressor, the researcher-participants determined that the developing therapeutic relationship indeed represented a support relationship. Coding all mentions of the therapists in the transcribed sessions increased the overall number of C8 codes as only two other service relationships were clearly identified as being supportive (i.e., CP2's physical therapist and CP4's former therapist). By including all mentions of the current therapists, C8 was the second most frequently observed *Support Content* code. In sum, the frequency may have reflected only some supportive professional relationship or included references to service providers (i.e., the therapists) outside of specific support experiences, instead of clearly capturing all formal support contents related to experiences of social support.

Contributions

Although social support is often considered an important factor in post-traumatic experiences (e.g., Bonanno, 2008; Lyons, 1991) and has been studied extensively in populations of trauma survivors (Clapp & Beck, 2009), the literature on the clinical implications of social support with individuals who have experienced trauma is largely based on theories that stem from non-psychotherapeutic research (Goldsmith, 2004; Gottlieb, 2000). Also, whereas numerous theoretical models of social support have been articulated in the literature, there is no single model that captures the multifaceted experience of social support following traumatic events (Clapp & Beck, 2009). This study aimed to contribute to existing literature by examining identified constructs and

structures of social support as expressed in therapy with clients who have experienced trauma. The qualitative coding system developed for and used in the current study sought to contribute to existing literature by comprehensively assessing factors that cross theories and models by examining several constructs and structures of social support, including positive and negative experiences with and beliefs about support as well as space for inductive analysis of “not otherwise specified” support experiences. Indeed, based on the qualitative analysis of the five psychotherapy sessions included in this study, it appears that clients are likely to discuss social support experiences in therapy sessions.

More specifically, the study’s findings suggest that clients are most likely to refer to the construct of support content in therapy, but that other constructs and structures identified in social support literature are also likely to be included in therapy discussions, but at a lower frequency. Particularly, client-participant expressions of support content, received support, support functions, extended support, and perceived support, which are often discussed in social support literature, were observed in the qualitative analysis. Notably, this study observed that client expressions of social for received support, extended support, and support functions were most often coded as “not otherwise specified,” which indicated that expressions of these support factors were not clearly stated in regards to the quality or type of support experienced. In addition, inductive analysis of the psychotherapy sessions indicated that support needs also represent a salient area in the discussions of social support, which is not often included in theoretical models or identified constructs and structures in the social support literature. Factors that may impact social support experiences and beliefs, but do not fit into existing theoretical constructs and structures of support, emerged in further inductive analysis. Specifically,

relationship factors, planned future support activities, past perceived support, and past support that did not occur represented salient expressions observed across and within participants. In this way, the current study provides support for continued assessment of the elements of social support (i.e., received support, perceived support, extended support, support functions, and support content) that are already discussed in literature, but also highlights an additional area for clinical and research attention (e.g., support needs; planned future support activities; past support that did not occur; revising definitions of perceived support to include past and present support).

This study also provided a comprehensive literature review regarding the range of models used to conceptualize ways in which social support impacts post-traumatic experiences (e.g., stress-buffering, erosion, social-cognitive processing, and COR models). Although the study did not focus on examining models of social support following trauma exposure, examples emerged within all sessions to provide support for various models. This analysis suggests that the theoretical models continue to provide useful frameworks for understanding the role of social support after trauma, and further asserts that no one model fully captures the range of social support experiences following traumatic events. Therefore, the availability of multiple models is helpful in conceptualizing the varying ways in which social support may be experienced by individuals, and future work is needed to discern how they can be used together.

Overall, this study presented a unique perspective on the psychotherapeutic treatment of individuals who have experienced trauma, which was a useful addition to existing social support literature and the clinical application of social support interventions. Next, clinical implications identified in the current study are discussed.

Clinical implications. Social support is cited as both a protective and a risk factor in a range of theoretical and research literature pertaining to post-traumatic experiences (e.g., Bonanno, 2008; Ellis et al., 2009; Lyons, 1991). However, despite the mixed effects of social support evidenced in the literature, most treatment recommendations involving social support appear to focus on the positive impacts, or benefits of, social support following trauma (Goldsmith, 2004). The current study observed that while clients may discuss the positive attributes of social support experiences, they are also likely to discuss negative aspects and, to a greater degree, mixed or unspecified feelings and beliefs about support experiences.

Existing recommendations for support-focused interventions are largely related to group and couples work (e.g., Calhoun & Tedeschi, 1999; Cohen et al., 2000; Gottlieb, 2000; Helgeson & Gottlieb, 2000; Lepore 2001; Lepore et al., 2000), which inherently involves support relationships outside of the client-therapist dyad and provide areas of focus for support within the therapeutic context. Research that focused on individual psychotherapy indicated that therapists are likely to overestimate the effects of social support on the individual and that social support actually had limited effects on clinical outcomes (Roehrle & Strouse, 2008). Although the current study did not examine therapist variables (e.g., perceptions; theoretical orientation; gender; ethnicity) or measure therapy interactions or outcome, the finding that the therapists did not ask about or clarify client-participants' frequent mentioned of mixed or unspecified support experiences and beliefs may signal a need to change therapists' views, expectations, or assumptions about social support and how they assess and talk about it with clients. Thus, it appears that social support is a widely accepted factor that is assumed to impact

post-trauma functioning, but that the bridge between understanding of social support and its applications in psychotherapy and its relation to explicit trauma discussions is incomplete. By examining client-participants' descriptions of social support in a naturalistic therapeutic context, this study increased awareness of possible clinical implications for how clients discuss social support in psychotherapy with individuals who have experienced trauma and potential new areas for individual therapists to consider.

Perhaps the primary finding of the current study is that client-participants indeed brought expressions of social support into psychotherapy sessions and frequently referred to support relationships in therapeutic discussions. In fact, the results suggest that clients frequently talked about the supportive others in their lives but that discussions of the actual exchanges of support, beliefs and perceptions of support, and the need for support were expressed much less frequently. This finding is somewhat surprising given that few models of support include relationship types as significant factors in the mediating effects of support, and instead focus on factors such as perceived support, received support, and support functions as the meaningful agents of change (e.g., Clapp & Beck, 2009; Cohen & Wills, 1985; Kaniasty & Norris, 1993; King et al., 2006; Laffaye et al., 2008). Also, relationships represent dynamic constructs that are likely to change over time (Tolsdorf, 1976), impacting support experiences. For example, CP1 described experiences of receiving support from her uncle but later being sexually abused by him. Also, CP2 described perceptions of support that changed, and became more positive, over time as relational experiences changed. They may also be affected by the nature of the psychotherapy relationship. Thus, when clients bring discussions of support resources into psychotherapy sessions, therapists are encouraged to more deeply explore the roles

and impacts of those relationships on the individuals' post-trauma experience, the therapy relationship, and to generate discussion of relational factors over time. Yet, in the present study, therapists often did not follow up on client-participant expressions of support experiences, such that "not otherwise specified" codes were frequently used across participants.

Additionally, the study's findings further extend Wilsey and Shear's (2007) observation that social support cannot be examined only in terms of "positive" and "negative" descriptions without additional follow up to understand qualitative experiences of social support. Many of the identified social support expressions in the study fell into the "not otherwise specified" categories across the coding groups for social support constructs and structures. Notably, the majority of received support and extended support expressions were coded as not otherwise specified, and the not otherwise specified category for support functions was one of the two most frequently used functions codes. Additionally, the general "other support" code was used with relative frequency when compared to the specific coding groups, and was used more frequently than the extended support and perceived support codes. As discussed earlier in this chapter, expressions in all categories were coded as not otherwise specified when they did not clearly fall into any other category within the coding group and were generally coded as such when expressions were vague, ambiguous, or unspecified. Therefore, consistent with the findings of Wilsey and Shear's (2007) qualitative study of survivors of complicated grief, the results of the current study suggest that it may be beneficial for therapists to follow up on clients' spontaneous expressions of social support in order to clarify and understand the role of support experiences across constructs and structures to

see what is helpful, what is not, and what is needed. Such work may help contribute to the development of resilience and PTG, in that social support, when appropriately and adequately provided (e.g., Norris & Kaniasty, 1996) can be beneficial following trauma exposure.

Interestingly, perceived support is cited as perhaps the most significant element of social support. That is, having the belief that support will be available and effective when needed is, in itself, beneficial to trauma survivors (Norris & Kaniasty, 1996). However, perceived support expressions were the least common social support expressions observed in the current study. Therefore, it may be helpful for therapists to discuss beliefs and perceptions about support with clients. The results of this study suggest that clients may not spontaneously initiate discussion of perceived support, which indicates that therapists may have to invite the conversation and elicit the clients' reflection and exploration of beliefs about support. That is, therapists' theoretical orientations (e.g., interpersonal psychotherapy; Talbot et al., 2011) and other factors may influence the degree to which clients may be encouraged to discuss support experiences or beliefs and adapt their approaches to incorporate such discussions. Additionally, it may be useful to clinicians to use an expanded definition of perceived support to fully understand clients' beliefs about the availability of social support. That is, rather than examining only beliefs about the availability of support when it will be needed (e.g., Joseph et al., 1994; Kaniasty & Norris, 1995), which implies the *future* availability of support, the results from this study support new ways of defining perceived support, including past and current beliefs about support, which would more thoroughly capture and understand clients' expectations of support experiences.

Finally, it is important to note that two areas of support content, mutual aid and affiliative relationships, were not mentioned by any of the client-participants in this study. This finding was particularly unexpected because all of the client-participants had some focus of treatment (e.g., diagnosis or treatment goals) related to interpersonal or support experiences. For example, CP1 was assigned the v-code of Partner Relational Problem and one of CP5's treatment goals was to increase her use of her support system. Thus, it would have been logical to anticipate some discussion of how the client was engaging in mutual aid or affiliative relationships to meet treatment recommendations. Such recommendations are indicated as mutual support among survivors of similar traumas has been identified as a contributing factor in PTG experiences (Tedeschi & Calhoun, 2004), and mutual aid refers to trauma-specific support relationships (e.g., support groups), which overlap with affiliative relationships (e.g., religious, political, recreational groups) that may themselves offer support groups related to traumatic events (e.g., grief groups). Moreover, most existing psychotherapy recommendations for social support interventions include multiple-client treatment formats (e.g., Calhoun & Tedeschi, 1999; Cohen et al., 2000; Gottlieb, 2000; Helgeson & Gottlieb, 2000; Lepore, 2001; Lepore et al., 2000). However, of the available information for the client-participants, it appeared that only CP5 was recommended to engage in multiple-person therapy (i.e., couples therapy with her husband) and no client-participants were referred or encouraged to engage in affiliative support resources. Therefore, therapists for clients in individual psychotherapy may seek to encourage their clients to engage in adjunctive mutual aid or affiliative support groups in order to develop additional social supports for

post-trauma functioning, which is consistent with recommendations made by Gottlieb (2000).

In conclusion, the current study found that client-participants in psychotherapy after experiencing traumas frequently referred to support resources in therapy sessions but that further, more specific discussion of the benefits or detriments of social support beliefs and experiences occurred at a much lower frequency. Therefore, given the expansive body of research related to the role of social support following traumatic events, it appears that therapists should engage clients in dynamic discussions involving their beliefs about and experiences with social support in order to address any risk factors related to support experiences and to encourage the benefits and efficacy of social support in the healing process.

Directions for Future Research

Given that this study was one of the first to raise awareness about the ways in which social support is expressed in psychotherapy sessions with trauma survivors, future research is encouraged to further enhance understanding of the ways in which social support experiences are discussed and the theories and models in the existing social support literature. Directions for future research are also encouraged to address several of the limitations observed within the present study. Examples of ways to address many of these limitations in future research are illustrated in the following discussion.

First, researchers should expand the populations examined beyond the present study's purposeful sampling of a small sample of all female client-participants. Future research that includes gender balanced samples and/or samples of male participants may be one way in which the findings of the current study could be extended. In such work, it

may be useful to explore any similarities or differences that may occur in expressions of social support between female and male trauma survivors both within trauma discussion and in other, general psychotherapy discussions. For example, that women are more likely than men to seek social support after crises (Swikert & Hittner, 2009), or that women may experience or perceive more burden or strain in providing support to others (Pulcino et al., 2003; Robertson et al., 2006). Additional research that examines expressions of social support in psychotherapy in female and male populations may provide insight into how such gender differences may be addressed in therapy.

Changes in sampling procedures would address limitations to hypotheses and generalizations related to other demographic factors such as ethnic and cultural background related to both the client-participants and therapists in the sessions included in this study. To that end, future research should gather demographic and cultural information about the therapists such as their gender, age, and ethnic, racial, or cultural identities, which would be useful for exploring factors related to demographic match and mismatch in the therapeutic dyad. For example, a future research study could employ the use of purposeful sampling of clients and therapists in order compare and contrast social support expressions among particular ethnic or racial groups (e.g., African American, European American, Latino American, Asian American) and to then examine expressions within and across cultural groups when the clients and therapists identified within the same or different groups. Such research would expand upon existing but varied hypotheses already represented in literature (e.g., Fraser et al., 2002; Knox et al., 2003; Shin et al., 2005) pertaining to cultural practices and norms related to social support and

the potential effects of race and culture on discussions of social support within the therapeutic dyad.

Second, future research could address the current study's limitation of sole use of archival data by directly collecting data from new psychotherapy cases and tracking social support expressions over the course of therapy. This process would allow for improved methodological rigor through the use of multiple forms of data in qualitative and quantitative analysis, including the active role of clients and therapists in the triangulation process. Assessing expressions of social support over the course of treatment would be useful in determining how and when in therapy discussions of social support may be likely or unlikely to occur and could elicit valuable clinical implications for fostering discussion of social support factors. Assessments of social support can be incorporated into the psychotherapy process as it currently is lacking in existing research (Brissette et al., 2000). For example, future research involving ongoing psychotherapy cases that incorporate self-report measures such as the ISSB (Barrera et al., 1981 as cited in Wills & Shinar, 2000), the MSPSS (Zimet et al., 1988; Zimet et al., 1990), and the SNI (Cutrona & Russell, as cited in Wills & Shinar, 2000) may be useful in gathering retrospective accounts of social support experiences that would produce quantifiable results. Additionally, interview protocols such as the UCLA-SSI (Wills & Shinar, 2000) may be beneficial in consistently measuring integrative reports of social support experiences of client-participants.

Whereas these interview protocols are used with client-participants, it may also be useful to interview therapists about discussions of social support in psychotherapy sessions. For example, the development of a semi-structured interview to assess therapist

perceptions of the quality of clients' reported social support experiences would be helpful in gathering information about clinical discussions of support. Such instruments or methods could be used to further develop the coding system developed for this study. Further research may also incorporate the findings of the current study and other existing literature in order to develop targeted, semi-structured interviews with clients to gather information specific to social support experiences with follow up questions to clarify vague, ambiguous, mixed, and "not otherwise specified" responses. Finally, additional research that includes direct behavioral observation of support relationships such as the SSBC (Cutrona & Suhr, 1992) and daily diaries (Lakey, 2007; Reis & Collins, 2000), which can both examine support within the relationship and outside of therapy, is encouraged. Such behavioral observation methods are currently missing from existing social support resources and therefore represent an important area for future research.

A third limitation observed in the current study was related to coding only client-participants' spontaneous expressions of social support. As a result, client-participant responses to therapist questions and statements were not adequately captured in the study's results. Since this study focused on client-participant expressions of social support, the therapists' roles and interventions in facilitating discussion of social support and addressing social support as a protective or risk factor were not captured in the coded material. A possible area for further study to address this limitation would be to examine all statements of social support made by the client and the therapist. Then it would be possible to conduct a qualitative analysis examining factors such as: comparison of spontaneous client expressions and client responses to therapist questions/reflections; questions asked by therapist to elicit expressions of social support; client responses to

therapist-initiated social support discussions; and therapist responses to client expressions of social support. This approach could also be used to address the limitation of coding all expressions of social support (within and outside of trauma discussions) by comparing the results of coding client and therapist expressions of social support with trauma discussions to expressions made in general therapy discussions. Additional information in these areas would provide greater insight into themes and patterns in social support discussions in psychotherapy and further extend the clinical implications identified by this study.

As noted above, future research methods could also incorporate interviews with therapists to provide insight into therapists' clinical thinking and decision-making around when and why they asked, or did not ask, questions about social support experiences. This approach would gain information related to therapists' expectations and beliefs about social support (e.g., assumptions may be that social support is helpful) which could lead to recommendations for training and resources for psychotherapists that may improve the assessment of and interventions for enhancing social support for clients. For example, therapists' theoretical orientations may impact the likelihood that they will initiate discussion of social support with clients. For example, interpersonal psychotherapy (IPT) involves direct exploration of early attachment experiences and ongoing relationships with others and has been associated with reduced levels of depression and PTSD in a randomized trial with women with histories of sexual abuse (Talbot et al., 2011). Therefore, a study involving two groups, one receiving treatment as usual and one receiving a treatment in which social support is more likely to be discussed, such as IPT, may be useful in comparing the frequency and quality of social

support discussions in therapy. Other factors such as gender, race/ethnicity, experience, timing of the sessions could also impact the therapists' and clients' comfort with and likelihood of discussing social support with each other.

A fourth limitation that emerged in the current study was related to capturing relationships that changed over time, which is a common phenomenon in support relationships (Tolsdorf, 1976). All of the client-participants in this study referred to supportive others who were not consistently supportive over time and, at times, even contributed to traumatic experiences. One possibility for addressing this limitation in future research would be the inclusion of a sub-code to rate the relationship each time it is mentioned to capture instances of variable interactions or other changes over time. For example, in the current study, each time a social support content area was mentioned, it was assigned a content code and the specific relationship was recorded in brackets following the assigned code. A future study may take this approach a step further and assign a secondary code (e.g., helpful, unhelpful, harmful) to each coded support content. The additional codes could then be examined for trends in relationship changes.

Additionally, each mention of support contents was coded in the current study. A suggestion for future research would be to only code support content when mentioned in expressions involving another element of support (e.g., received support, perceived support) in order to generate a more balanced account of relationships within expressions of other dimensions or support as opposed to a high frequency of stand-alone support codes. This would provide additional understanding of the types of relationships involved in actual support experiences or beliefs about support. This approach may be useful in identifying patterns and connections of formal and informal supports in received

and perceived support experiences, which would extend the currently available, but limited, literature in this area (e.g., Barker & Pistrang, 2002).

Another area of limitations was observed within the service provider content of social support. For the purposes of this study, coding decisions were made to code only professional service relationships that were explicitly stated as being supportive and to include all mentions of the current therapists as service content. Because formal support relationships have been observed to benefit support coping (Sharpe, 2008), future research should specifically examine formal support relationships in social support experiences. For example, existing measures of social support could be adapted to target experiences with and beliefs about support from professional service providers.

A limitation was also observed in capturing support functions were only in relation to received support. Although this chapter provided a qualitative discussion of support functions in other structures of support (e.g., perceived support), would also be helpful to quantitatively count functions expressed in perceived, extended, and need areas. This would provide additional information related to consistencies and discrepancies in the types of support received when compared to the types of support believed to be available, needed, and given to others.

Finally, the qualitative analysis included in the current study identified that support needs represent a salient area of social support experiences and were observed in all five of the psychotherapy sessions. However, there is little existing research that examines the role of support needs in social support experiences or that postulates recommendations for meeting stated need areas within the psychotherapy process. Thus,

it appears that further exploration and understanding of expressions of support needs in an important area for continued research.

Conclusion

Although social support is commonly discussed in relation to post-traumatic functioning (e.g., Bonanno, 2008; Ellis et al., 2009; Leahy et al., 2003; Lyons, 1991), and has been cited to be a factor in the PTG process (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 2004), current literature does not clearly define the ways in which the constructs and structures of social support impact post-traumatic experiences. Existing models of social support theorize the process and means in which social support experiences both help and hinder functioning following trauma exposure, but, to date, no single, integrated explanation for the potential influence of social support has been identified. Similarly, clinical implications have been suggested in existing research, but limited focus has been given to studying social support experiences in the context of psychotherapy. To address these limitations in previous social support and trauma literature, the current study sought to explore client expressions of social support as they occurred in psychotherapy sessions.

A qualitative content analysis was conducted to review the ways in which five female client-participants expressed social support experiences and beliefs in actual, un-manipulated therapy sessions. The results of the current study provide support for some existing constructs, structures, and models of social support, call for the need to expand understanding of support needs and definitions of perceived support, and suggest that clinicians support more in-depth discussion of social support experiences within the psychotherapeutic context that extended beyond simple mention of support relationships.

Thus, with the conclusion of the study, the primary researcher hopes that the qualitative analysis conducted with the five selected client-participants and therapy sessions contributed to, and expanded upon, the existing body of work related to social support in the aftermath of traumatic experiences. It is the hope of the researcher that the contributions of this study add bridges between existing theoretical frames and clinical work with trauma survivors. In this way, it is hoped that this study will encourage clinicians to be open to exploring and eliciting client reflections and expressions of social support that may enhance survivors' beliefs about support and engagement in supportive relationships in order to promote positive post-traumatic functioning.

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APPENDIX A

IRB Approval Form

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

November 8, 2011

Celine Crespi-Hunt

Protocol #: P1011D19

Project Title: *Expressions of Social Support: A Qualitative Analysis of Psychotherapy with Clients Who Have Experienced Trauma*

Dear Ms. Crespi-Hunt:

Thank you for submitting your application, *Expressions of Social Support: A Qualitative Analysis of Psychotherapy with Clients Who Have Experienced Trauma*, 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/ohsr/site/guide/ines/45cfr46.htm>) 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/>).

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jean Kang". The signature is fluid and cursive, with the first name "Jean" and last name "Kang" clearly distinguishable.

Jean Kang, CIP
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cc: Dr. Lee Kats, Associate Provost for Research & Assistant Dean of Research, Seaver College
Ms. Alexandra Roosa, Director Research and Sponsored Programs
Dr. Yuying Tsong, Interim Chair, Graduate and Professional Schools IRB
Ms. Jean Kang, Manager, Graduate and Professional Schools IRB
Dr. Susan Hall
Ms. Cheryl Saunders

APPENDIX B

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

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

OR

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

Fees: The fee for the initial intake is nonrefundable.

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

collect fees. In most collection situations, the only information released is your name, the nature of services provided and amount due.

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

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

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

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

- If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

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

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

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

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

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

Treatment & Evaluation of Minors:

As an 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.

Signature of client, 18 or older
(Or name of client, if a minor) and/or _____
Signature of parent or guardian

Relationship to client

Signature of parent or guardian

Relationship to client

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

Clinic/Counseling Center
Representative/Witness

Translator

Date of signing

APPENDIX C

Therapist Consent Form

INFORMED CONSENT FOR THERAPIST PARTICIPATION IN PEPPERDINE CLINICS RESEARCH DATABASE PROJECT

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

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

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

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

- I understand and agree that the following information will be included in the Research Database (check all that apply).
_____ Written questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures

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

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

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

OR

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

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

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

OR

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

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

- necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).
9. I understand that the investigators will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project.
 10. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. I understand there is a possibility that information I have provided regarding provision of clinical services to my clients, including identifying information, may be inspected and/or photocopied by officials of the Food and Drug Administration or other federal or state government agencies during the ordinary course of carrying out their functions. If I participate in a sponsored research project, a representative of the sponsor may inspect my research records.
 11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access. In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.
 12. I understand I will receive no compensation, financial or otherwise, for participating in study.
 13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at (310) 506-8559, Dr. Meshia Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.
 14. I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness to continue in the study.
 15. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have

received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

Participant's signature

Date

Participant's name (printed)

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

Researcher/Assistant signature

Date

Researcher/Assistant name (printed)

APPENDIX D

Coding Manual

RESEARCH PROJECT CODING MANUAL

This training manual is intended to describe the methods of participant selection, transcription, and coding that will be utilized for the team's dissertation research projects. The specific videotaped therapy sessions will be of clients and therapists at Pepperdine University GSEP clinics selected based on inclusion/exclusion criteria (e.g. individual adult clients representing diverse ethnicities, genders, religions, and presenting issues). Rebecca Dragosits, Celine Crespi-Hunt, and Christopher Ogle will be using this data for their respective dissertations to gain a more in-depth understanding of how clients who have experienced a trauma express/discuss humor, social supports, and cultural worldviews in psychotherapy. Research assistants will also assist in the participant selection and transcription processes, including the identification of discussions of trauma within videotaped psychotherapy sessions.

I. PARTICIPANT SELECTION AND IDENTIFICATION OF TRAUMA DISCUSSION: INSTRUCTIONS

Participant Selection Procedures

Step 1: Obtain a list of potential participants. The researchers should first obtain a comprehensive list of research records for clients who are no longer receiving therapy services and whose clinical records are already de-identified and entered into the research database.

Step 2: Narrowing the list based on demographic inclusion criteria. Next, researchers should narrow down the list to include clients who are at least 18 years of age, are English-speaking, and have engaged in individual therapy.

Step 3: Narrowing the list based on experiences of trauma. The list of potential research participants should then be limited only to those individuals who have experienced trauma, as noted in clinical records included in the database. For the purposes of these studies, traumatic events will be defined as:

direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or [directly] witnessing an event that involves death, injury, or a threat to the physical integrity of another person. (APA, 2000, p. 463)

In order to meet these criteria, an individual must have directly witnessed or experienced a traumatic event and responded in fear, horror, or helplessness, as indicated on clinical records/instruments described below. Common examples of traumatic events include serious accidents or fire, life threatening combat experiences, rape or physical assault, life threatening major disasters, and seeing another person being killed or badly hurt (First et

al., 2002). This definition also includes forms of trauma related to cultural or race-based factors (e.g., hate crimes involving threatened or actual assault).

Several data instruments should be used to help determine whether a potential participant has experienced a traumatic event that meets the above definition. The researchers should first look at the information presented under the Family Data section of the Client Information Adult Form (Appendix D). In this section, the client is asked to indicate “Which of the following have family members, including yourself, struggled with,” and is provided with a comprehensive list of distressing and potentially traumatic situations. The researchers should look to see if the client marked “Yes- This Happened” in the “Self” column for stressors such as discrimination (e.g., hate crimes), death and loss, physical abuse, sexual abuses, rape/sexual assault, injury, debilitating illness, or disability.

Additional information from the Telephone Intake Form (Appendix E), the Intake Evaluation Summary (Appendix F), and the Treatment Summary (Appendix G) will be used to determine whether clients have experienced trauma. On the Telephone Intake Summary, for example, the Reason for Referral portion describes the client’s rationale for seeking therapy; the researchers should examine this portion to see if the client reports seeking therapy for reasons associated with the experience of trauma. Various sections of the Intake Evaluation Summary will also be examined for any reference to a trauma history, including: Presenting Problem/Current Condition (Section II), History of Presenting Problem and Other Psychological Conditions (Section III), Psychosocial History (Section IV), DSM-IV-TR Multiaxial Diagnosis (Section VIII), and Treatment Recommendations (Section X). In addition, the Treatment Summary will also be reviewed for any indication that a trauma-related diagnosis had been considered or that the course of therapy involved discussing or processing trauma. The researchers must all agree that at least one of these forms clearly indicate the experience of trauma for a given client before moving on to the next step. The researchers will also use an Excel spreadsheet to track information regarding a client history of trauma found on clinic forms (see Appendix H).

Step 4: Narrowing selection based on discussions of trauma. To be included in this study, clients must openly discuss their traumatic experience(s) with their therapist in at least one recorded therapy session. The researchers for these studies should review each video recording of potential participants’ therapy sessions to determine whether such a discussion took place. Based on definitions used in the literature regarding disclosures, discussions of trauma will be classified as client verbalizations that consist of the following: (a) descriptions of a traumatic event; (b) evaluative content about the traumatic event (e.g., beliefs, thoughts, attitudes); and (c) affective content (e.g., feelings and/or emotions regarding the traumatic event; Chelune, 1979; Cozby, 1973; Jourard, 1971; Omarzu, 2000; Pennebaker, Zech, & Rimé, 2001). Sessions in which discussions of trauma did take place will later be transcribed and coded. If there is more than one recorded therapy session in which a client participant engages in a discussion of trauma, only one should be chosen for transcription and analysis. That session should be selected based on the length of time in session spent discussing the trauma; that is, the session in

which the client discussed the trauma for the longest length of time (compared to other sessions in which trauma was discussed) should be chosen.

Step 5: Narrowing selection based on cultural diversity. The researchers should attempt to choose culturally and demographically diverse participants who vary in age, gender, religion, and race/ethnicity. Specifically, there should be no more than four clients that identify with each of these demographic categories/groups. The researchers will determine participant's demographic and cultural characteristics using multiple clinic forms. Specifically, the researchers should check clients' age and gender that are indicated in the Telephone Intake (Appendix E). Clients may self-indicate religion/spirituality, ethnicity or race, and disability status in the Social Cultural (Optional) section of the Client Information Adult Form (Appendix D); researchers should examine this section for information about the client's identification in these areas. Finally, researcher should look at cultural information that may be included in the Cultural Factors & Role of Religion in Client's Life portion (section F) of the Intake Evaluation Summary (Appendix F).

Procedures for Identifying Trauma Discussion

The start time should be noted on the transcription by writing the word Start and then the time in bold, highlighted (in green) brackets. When the discussion changes to a topic other than a trauma discussion, again pause the video and write the word Stop and then the time in bold, highlighted (in red) brackets.

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

Introduce following sample transcription

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
Client: Ms. M.

Session Number: 1
Date of Session:

Introduction: This session was included in a training video for APA, entitled, "Series II-Specific Treatments for Specific Populations," and was hosted by Jon Carlson, PsyD, EdD. The session that follows was transcribed verbatim, for the purposes of coder training for Pepperdine University as a part of the Positive Psychology PARC Lab supervised by Susan Hall, JD, PhD. This format will be followed for future transcribed sessions to be utilized in the actual research.

CONFIDENTIAL VERBATIM TRANSCRIPT

Verbatim Transcript of Session	Initial Coding Impressions
<p>T1: Ms. M, I want to start by thanking you for being here this afternoon. And we talked a little bit before the cameras came on about what you want to talk about with me today. So, why don't you tell me about that, let's start from there [therapist used open hand gesture inviting client to share].</p>	
<p>C1: Well, um, [client scratching under nose as talking], I have, um [client looking down], I have dealt with a lot of issues in therapy, um, but one of the issues that I really haven't talked about or really dealt with in therapy [client briefly looking off] is my relationship with my sister. She's my younger sister, um, she's three years younger than me. Um, we really are not talking. We haven't been talking [client briefly looking up] since, I think, the year 2000, since my mother passed away. We haven't, we haven't really spoken. We talk but it's very business-related when things have to get done but I really don't talk to her and I [client looking down], um, I really don't have any desire to have a relationship with her. I liked to, a part of me wants to but a part of me, um, doesn't want to because she is, um, she gets really angry, and I sense that I really can't be myself around her, um, that she, for some reason, I don't know, it might be the past that she's angry and I have no idea because I don't know [client clearing throat] and I have a sense that she doesn't know either why she's angry with me. But, um [client looking down and taking a deep sigh], she was, um, we never really got along when we were growing up. We fought a lot [client looking away and down]. I spent a lot of time with her. I grew up in a family of seven. And, um, she was very, she was always fighting with all of us. She was very angry.</p>	

T2 : [therapist nodding] Fighting physically or verbally or both?	
C2: Start [1:42] Sometimes it was physical with my brothers, and, but it was verbal with me because I wouldn't I wouldn't get into fights with her because I was afraid of her because I watched how angry she would get with my brothers and my brothers were (2) they were pretty, violent too, and, um, one of my brothers, one of my younger bothers was in a gang, was a gang member, and she would fight with him. [therapist nodding] She, I saw her one time, um, put an iron right to his chest and when I saw these things happening, I just I grew really afraid of her. And so when we would argue I knew what she was capable of so, I I would stay clear of any like physical, anything physical with her. I would try to talk my talk my way out of it.	
T3: [therapist nodding] Mm-hmm. Were there ever times where she was physically violent with you?	
C3: Well, there was one time when we got into it and my mom was there and my father was there. Um [client sighs deeply], my mother immediately got between us [therapist nodding] and she just got us both together and said she was going to hit both of us. Um [client pressed lips], that was the only time that we were rolling on the floor and really nothing happened.	
T4: Mm-hmm [therapist nodding]	
C4: She just was, we were pulling each other's hair, and actually I was mo—I was mostly like trying to get her away from me, trying to get her off of me.	
T5: Mm-hmm [therapist nodding]	
C5: Um, but that was the only time that we got into it. I never, after that, wanted to get into any physical. I don't, I don't know why I just-she really scared me.	
T6: Yeah I kind of get a sense, and tell me if I'm reading this accurately, that it's like you saw her as having no fear...	
C6: Right [client slowly nods]	
T7: ...as having no limits [slowly nodding] to	

what she would be willing to do.	
C7: Right [Client nods]. And that scared me.	
T8: Mm-hmm [therapist nodding]	
C8: And the verbal things that she would say to me were really scary. Like, “I’m gonna stab you, I’m gonna—” she would tell me all these things that she was gonna do to me.	
T9: Mm-hmm [therapist nodding]	
C9: And they were very detailed.	
T10: Mm-hmm [therapist nodding]	
C10: And that scared me. And the things that I saw I mean I saw her doing [client takes a deep breath in and out] being a, not being afraid of my brothers who were violent themselves. Um who were gang members who fought with weapons and that didn’t scare her [client swallows]. They didn’t scare her. So to me I thought she would, she would, there would be no limits to what she would do. That she...	
T11: So it sounds like [therapist scrunches up her face and squints] she feels dangerous to you [therapist nodding].	
C11: Yeah [client nods]. To this day she feels dangerous to me. And [licks lips] I had— I would go back and forth with having relationship with her. My sister has a really sweet personality. And then on the other hand, when you say something, and she interprets it as being, like she has to get on the defense...	
T12: Mm-hmm [therapist nodding]	
C12: ...she, she can get really violent. And it happened more with me [client scrunches up face inquisitively] I sensed, than with more-- I, I she was real sensitive with me. Um, well that’s what my nieces say that it was something historically with us.	
T13: Mm-hmm [therapist nodding]	
C13: [Client looks down] Um, but she recently had an altercation with my [client points to the side] my niece. And my niece confirmed to me that [client looks up at therapist] it wasn’t me that it was my sister. And my sister has had a past with [client scratches chin] violence, like she has had a past with her husband with, with um, hitting her husband [client nods]. And I’ve seen her doing it.	

T14: So you know she's capable of being physically violent.	
C14: Mm-hmm	
T15: You know she has these really violent fantasies about what [client nods] she might do to you. She's had them over the years...	
C15: Mm-hmm [client nodding]	
T16: ...and you experience her as not having any internal limits [therapist's hands gesture toward middle of her body], no sense of [therapist nodding] something that will stop her even when she might actually be in danger.	
C16: Mm-hmm [client nods] that's right, that's correct.	
T17: So it does sound like she's a pretty scary person.	
C17: [client nodding] Yeah, although, um, for a lot, [client looks up at ceiling] for a long time and still [client looks down at floor], other family members, um, that were close to her [client looks back up at therapist] didn't want to believe that about her. And so I always thought that it was me. I always felt that it was me because I, we were really close [client looks down at ground], um,	
T18: Thought that it was you like [therapist scrunches up face, squints, and puts hand up in the air] you were overreacting or—	
C18: Yeah that I was overreacting or that my sister just didn't like me for whatever reason...	
T19: Mm-hmm [therapist nodding]	
C19: ...and it was— but I also sensed that they kind of protected her too. Um, (3) the, she can be really sweet she has a nice she has a really good disposition. Um, but once you get to know her she gets pretty scary and (3) [client gazes up in the air] we don't— she doesn't have a relationship really with any of my brothers [client gazes towards the floor] and my sister- my older sister who passed away they didn't get along either (3) so—	
T20: So it's not as if she really relates to anybody in the family [therapist gestures at middle of body with both hands as speaks]	
C20: [client nodding] Right, right now she does, she's not— [client gestures with both	

hands as speaks] she's kind of isolated, um, each family member throughout the years and for me it happened very early because I grew up with her and I had experience with her.	
T21: So, it seems like what you're saying is [therapist gestures with both hands as speaks] so here you are now today an adult and this person is still being really scary for you. [therapist nodding]	
C21: [client nods head in agreement] Yeah, she is and that bothers me. [both therapist and client nod heads in agreement]	
T22: It bothers you because—	
C22: It bothers me because [client gazes down toward the floor away from the therapist] uh, she can't hurt me. [client looks directly at therapist] I mean, she can't do anything to me now. I mean, if she laid a hand on me, [client looks around the room] I know that I'd be able to call the co- call the police or— [therapist nodding] um, there'd be somebody there to defend me or I could defend myself. Stop [7:52]	

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

Research assistants will transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of therapist and/or client statements to then be coded. Attached at the end of this section is a template that you will use for your transcriptions. After reading this manual and discussing questions during training, you will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the practice, we will review with you a completed transcript to check your work and address any questions.

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

When identifying who is speaking, use a "T" to indicate the therapist is speaking and a "C" to indicate the client is speaking. In addition, please use numbers to indicate how many times each person is speaking. For example, the first time the therapist speaks

represent it as T1: and the second time as T2, T3, etc., and vice versa for the client (C1, C2, C3, etc.)

In addition to capturing the actual words, speech patterns and thought patterns of the speakers, we would like to try and capture some of the more important non-verbal behaviors/communication taking place between the therapist and client. In order to do so, please use parentheses with numbers inside of them to indicate pauses in a speaker's response. For example, use (3) to represent a three second pause or (10) for a ten second pause. Use this whenever there are significant pauses or moments of silence between the speakers.

When attempting to capture non-verbal behaviors/movements that are significant to the therapeutic interaction taking place, use brackets [] to indicate these movements and clearly state which person—the therapist or client—is performing the movement and what specifically he/she does. For example, [Client turned away from the therapist and looked down at the ground] or [Client laughs] or [Therapist sighed deeply and looked away briefly]. Only note hand gestures that have meaning. For example, the therapist gestures toward her heart when asking about how the client feels, or gestures hands toward self when asking client to say more. Do not note hand gestures that do not carry meaning, such as simply moving hands in the air while talking. Also use brackets to indicate the inability to hear/understand a word or sentence: [Unintelligible] or [Inaudible]. Please make every effort to hear and understand what is said. Sometimes you can figure out a word by the context of what the speaker is saying. If you can make an educated guess, type the closest possible approximation of what you hear, underline the questionable portion, and add two question marks in parentheses. Example: I went to school in Maryville (??) or Maryfield (??).

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

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

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

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

While there is some merit in having an absolutely verbatim tape, which includes all the feedbacks (such as Um-hm and Yeah), too many interruptions in the flow of the therapist's remarks make for tedious transcribing now and exhaustive reading later. Knowing when to include feedback sounds and when to omit them calls for very careful judgment. Usually the therapist's noises are intended to encourage the client to keep talking. Look at your transcript. If every other line or so is a therapist's feedback, go back and carefully evaluate the merit of each feedback. Don't include every feedback, especially if it interrupts the client's comments in midstream. Only if the feedback is a definite response to a point being made by the client should you include it. When in

doubt, please ask the research team.

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

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

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

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

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

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

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

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

Example: Interruption

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

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

Interruption and continuation

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

C2: Scared?
T2: ...scared and confused.

Quotation Marks:

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

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

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

Example: They said, What are you doing here?

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

Example: I thought, Where am I?

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

TRANSCRIPTION TEMPLATE

CONFIDENTIAL VERBATIM TRANSCRIPT

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

Session Number:
Client #:

Coder:
Date of Session:

C = Client
T = Therapist

Verbatim Transcript of Session	Initial Coding Impressions
T1:	
C1:	
T2 :	

C2:	
T3:	
C3:	
T4:	
C4:	

VERBATIM TRANSCRIPT FOR CODING TRAINING

William Miller Therapy Session from APA Series III-Behavioral Health and Counseling

Therapist: Dr. William Richard Miller
 Client: Ms. S

Session Number: 1
 Date of Session: xx/xx/xxxx

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

T = Therapist; C = Client

Verbatim Transcript of Session	
T1: Ok, Well now that we're settled in just a little bit, um, I understand that what you wanted to talk about was alcohol and perhaps some other drugs and how that fits into some of the other things that you are dealing with in your life, so fill me in a little, what's happening?	
C1: Well, as far as the alcohol and drugs I've been in and out of recovery since 1995. I used to be basically a social drinker. I lived in Chicago 32 years and moved to California and that's when the heavy use started.	
T2: Uh-huh. [Head nodding]	
C2: A lot of that had to do with, I think, the change in lifestyle. Out there, especially where I lived, it was the Palm Springs area. A lot of people, a lot of partying, a lot of drugs. And I just kind of got into it because the people were	

<p>in the environment where I was living, it—um, that’s what everybody did.</p> <p>C2.1: I actually started cuz I was going to college, and I wanted, a girl who I was a neighbor suggested I try speed to keep me awake. She used it as a waitress and it helped her and I thought, well, and that’s how I got started into that part of it.</p> <p>C2.2: I had been smoking marijuana for the longest time, since the eighties, but I had done nothing else. And then when I moved to California, I started drinking because I hung out with younger people, and we would drink, I don’t mean just beers, we’d drink hard liquor.</p>	
<p>T3: Yeah, you get thrown along with the lifestyle</p>	
<p>C3: Exactly, and that was also a problem because I have an addictive personality and it’s, I believe it’s hereditary and it’s part of other problems that I have.</p> <p>C3.1: It just manifested itself very quickly. I did in perhaps one year, what some people would do 3, 4, 5 years. I just crammed it all together. I got started with the speed, and then I switched to cocaine. Now, people call it crack or rock, whatever you want to call it. Free, the freebasing. You buy the, buy it in the rock form or in the powdered form, and I spent, I spend \$7000 in 3 months on that.</p>	
<p>T4: So you’re very efficient about the drug use, packing it into a short period of time.</p>	
<p>C4: Well I packed it in, unfortunately, I don’t know if it’s good or it’s bad, I went from buying it from people I didn’t really, trying to get what I could from wherever, to climbing up the ladder to finding the main source, so to speak.</p> <p>C4.1: And I was one of those people, who I’m always proud to say, I never did any sex or anything for drugs or anything like that. Now, I didn’t do any, anything... prostitution, or there was a lot of girls that would, a lot of women that would do that.</p>	
<p>T5: [Head nodding] So it was very common.</p>	
<p>C5: And, I was the kind of person, I got my nose broken because I wouldn’t sleep with</p>	

<p>somebody's; this one fella wanted me to sleep with him when his girlfriend was at work and I wouldn't do it so he busted my nose. That's the kind of person I am. I don't believe in, that the two have to meet. My love was drugs. I didn't need a man, I didn't need relationships. If I had the money, if I didn't have the money, I had a way to get, you know, get it through people. I had, I didn't just party you know. I partied with uh--</p>	
<p>T6: Contacts.</p>	
<p>C6: Yeah, people who used to be in the show business industry, so to speak. You know, or who were related, A girl that was related to a guitarist in a famous rock star's band, and I'm not gonna name names, and she unfortunately—she died of AIDS but she had the money and she had, always, there was always partying going on with her. We'd go to the hotel and party, party, party.</p>	
<p>T7: And you got caught up in that very quickly.</p>	
<p>C7: Oh, very quickly, and it's easy to I guess, if you have the personality for it, you know. And I didn't have any, and I was at a point in my life where I didn't really care about anything. And I wasn't young either. I was 32.</p>	
<p>T8: So it sort of felt natural to you.</p>	
<p>C8: It felt fun, it felt, actually, it felt good, you know. I was trying to, as they say, chase that next high. It got fun, but when I started running out of the money and I don't know how I had the stamina for it because I actually still worked, paid rent, kept a job, I did everything, well, which a lot of people can do, but for the amount of drugs and drinking I did--</p>	
<p>T9: Pretty remarkable--</p>	
<p>C9: Some people would probably not even be able to get out of bed. I'm not bragging about it. C9.1: Now, ten years later, I feel like I'm physically, I'm just kind of burnt out, you know, C9.2: I stopped doing cocaine in '95, and then I admitted myself into rehab in California that same year, and I've done it still on occasion,</p>	

<p>but I'm on medication which, thank goodness, doesn't make it where the drug has addictive properties.</p>	
<p>T10: Really?</p>	
<p>C10: Ya, I found it very interesting. I could do cocaine and put it down and not go back to it.</p>	
<p>T11: Which was new?</p>	
<p>C11: Which is something new to me, I mean, this is as recent as moving back to Chicago. [Therapist's head nodding] You know, I haven't been able, I've struggled in and out of sobriety, you know, I feel like Robert Downey, Jr. sometimes. [Therapist laughs]</p> <p>C11.1: It's like okay, but I've not, I've never gotten arrested for drugs, or for selling, you know, one of those people who was too smart to keep it in the house and you know, I even though I never had money I had the common sense of well, you don't keep it in the house, don't drive around with it, you don't drink and drive, you don't drink and use. You know, why ask yourself for trouble?</p> <p>C11.2: One time I had drank and drove, and that was because I was at my boyfriend's, we were out, I had an argument, and we both went our separate ways. So, I ended up having to go home inebriated. And, um, fortunately nothing happened so I was pretty lucky.</p> <p>C11.3: And um, I've been in and out of recovery with AA and NA and, although I love the program and I espouse to do it, they say anonymity in AA, but I think that the condition in a situation like this, it's...well, it's part of talking about recovery and addiction. And, I've worked in and out of the program, I was clean, and sober for 3 years until I moved back to Chicago. Because I had gotten myself surrounded by people in recovery. Yet, when I moved back here, I was not surrounded by people in recovery and I discovered that I was staying clean and sober for the wrong reasons. I was doing it for other people, not for myself. I was doing it to help my mother, because my mother was dying of cancer, so I tried to, I wanted to...</p>	
<p>T12: So the change again of, of moving--</p>	

<p>C12: Right, they say geographics, you are running away from yourself. But I left California for many reasons. And uh.</p>	
<p>T13: And coming back here in a way set off--</p>	
<p>C13: It set off, right. It set off everything because I felt like I had the freedom. There was nobody there, I had no sponsor, no clean and sober neighbor, nobody checking up on me so to speak to make sure I was still, I was still smoking pot. I hadn't quit marijuana and, but the alcohol was the one that really got to me. I had been, I had quit marijuana for about a 7-8 months after I got out of recovery, but ended up getting back into that situation when I moved in, uh, out of sober living and I ended up eventually moving in keeping a roommate who was a friend of mine from my drinking and using days who was dying of AIDS. But he needed someone to take care of him. And I was going back to school at night plus working, so basically, my drug use was limited to marijuana and alcohol, sometimes doing coke or whatever. I never liked speed really because I saw people, the more they did that their teeth would rot out and, you know, it's Drain-o or rat poison, it comes in so many different colors. I've noticed it's not that big here in Illinois, in Chicago.</p>	
<p>T14: So when you say your in and out of recovery now, its alcohol and marijuana your talking about—and every now and then cocaine.</p>	
<p>C14: Right, ya, well the cocaine, basically I've stopped, ah, pretty much avoided that because the individual who introduced me to that again, I avoid seeing him at all costs...which I do for my own well being. I don't want to ride the dragon again. I don't want to go there, even though I know that if I do, I'm not going to be going there again every day. I won't be getting loaded every day because of the medication I take. But, and, he was paying for it, but I realized it was just something that I wasn't even enjoying.</p>	
<p>T15: So why do it?</p>	
<p>C15: Right, you know, to me, everybody, I</p>	

believe has an addiction. We all have addictions be it food, sex, drugs, alcohol, gambling, family life, work. You know, whatever it may be, I think everybody has one, one thing at least that they crave and that in the back of their mind that they focus on and they really desire.	
T16: And you said you think you have an addictive personality--someone who easily gets drawn into things	
C16: Yeah, well right, I have been. I'm an artist, freelance artist as well, and my addiction used to just be drawing. As a child, I would just come home and draw, you know.	
T17: So whatever you do like that you do it intensely	
C17: Yeah, I wish I could do it to make money and do it, you know. [Therapist laughs] Get a money making idea and do like that, I'd probably be rich, it's just um, but not able to find a proper substitute, you know. At this time, I'm trying to get back into drawing and being more creative, and my personal life, though I feel so mentally, emotionally, and physically exhausted after all I've been through in my life, that all I want to do is almost not do anything. I'm trying not to focus on any addictions. I'm at the point where I'm getting tired. You almost get tired of it physically. Like, if I drink I feel, I don't get the hangovers cuz I won't even allow myself to drink enough, but physically the next day, I feel, I ache, you know I feel the hangover with the headache would manifest itself with my body aches, and I don't want to, want to get up on the...you feel as vital and I've just done so much that I'm burning out.	
T18: And you've used up your chances, huh?	
C18: Yeah, pretty much. And being single all my, which, since 1990 and not having...being blessed without having children, which I never wanted, thank God, I'm not a kid lover. I chose not to have kids also because of my husband and that was one of the reasons we also parted ways. I was happy. I'm lucky enough to where I've had my own life and I've not had to drag	

<p>anybody, drag anybody down with me, you know. It did affect family members. Anytime you're, you have an addiction, people who care about you, it will, but eventually they turn you away too.</p>	
<p>T19: Now what is recovery for you besides not using alcohol or marijuana?</p>	
<p>C19: To me recovery would be going to meetings, having a sponsor, working a twelve step program, um, I still try to incorporate 12 step beliefs and behaviors in my life as far as, "Let go, Let God," the use the steps, resentment, a lot of people say if you're drinking and using you cannot work the steps, but I think you can use them in a behavior, method of behavior modification if you're, instead of turning to getting loaded or anger or what have you, when you have a problem in life, try to do something positive, call somebody, read if you have an AA Big Book or an NA Big Book, pick something up in there and try to read it. Try to keep yourself as close to the, that behavior as you can because it helps you to get...the closer I try to stay to meetings, even if I'm drinking, if I go to meetings it helps me from not wandering too far off track to where I'll say drink more, or just stop totally leaving in that whole lifestyle or that whole belief process.</p>	
<p>T20: There's a piece here which were missing before we go, which is what are you wanting to move toward? What do you--</p>	
<p>C20: What I want to move toward is to just be able to totally not have to drink or use. And at this point--</p>	
<p>T21: Which is doing nothing.</p>	
<p>C21: Right. Well, at this point I still enjoy my pot. I'll be the old person sitting out there smoking a joint on the steps with all my cats around me, you know, and that's okay with me, but I don't want to drink. That's what I'm trying to avoid, and I'll be, I'll go a couple weeks without drinking and then maybe I'll drink again. But it's getting to where I want it less and less again.</p>	

III. Coding Overview

The third step of the process involves the researcher-participants engaging in the coding processes, specifically for expressions of humor (A), social support (B), and cultural worldviews (C). Operational definitions and relevant codes are discussed in this section.

A. Expressions of Humor

The first step of the coding process involves the researcher-participants coding client expressions of humor. Humor will be defined broadly to refer to “anything that people say or do that is perceived as funny and tends to make others laugh, as well as the mental processes that go into both creating and perceiving such an amusing stimulus, and also the affective response involved in the enjoyment of it” (Martin, 2007, p 5). For the purposes of the current dissertation, verbal expressions of humor and laughter (a behavioral expression of humor) will be coded in the context of psychotherapy sessions in which a discussion of trauma occurs. Verbal expressions of humor can include, but are not limited to, jokes, anecdotes, wordplay, or use of irony.

Verbal Expressions of Humor

Humor codes and their definitions and examples are presented in the table below for the researcher-participant to use in coding transcribed sessions. Due to the complex and multidimensional nature of humor, expressions of humor will be coded along various dimensions. For example, each humorous verbalization should first be coded as either (a) Reactive or (b) Productive. Expressions of humor should then be further coded as one of the following: (a) Benign; (b) Aggressive; (c) Self-deprecatory; (d) Dark; or (e) Expression of humor not otherwise specified. Additionally, these categories are not completely mutually exclusive and it may be possible for an expression of humor to be assigned to multiple categories (e.g., aggressive *and* dark humor).

Coding System for Identifying Verbal Expressions of Humor

	Reactive Humor (Code F1) <i>The client recognizes and responds to humorous stimuli in the environment (e.g., reaction to therapist humor or situational/unintentional humor in environment).</i>	Productive Humor (Code F2) <i>The client deliberately produces and uses humor in a situation that does not appear to be inherently humorous.</i>
Benign Humor (Code H1) <i>The client uses humor in a playful, benign manner, containing no apparent aggressive, self-deprecatory, or dark elements.</i>	Example: [Session takes place on a stormy day; client walks in with an umbrella] T: “Beautiful day out, huh?” C: “Oh yes, days like this really make me appreciate living in Southern California!”	Example: C: “I’m sorry for crying so much today.” T: “No need to apologize, I think it’s important for you to freely express your emotions in here.”

		C: “Yeah, well, thank goodness the red-eyed look is totally in this season.”
<p>Aggressive Humor (Code H2) <i>The client expresses humor in a way that is hostile or demeaning to others, including the therapist or regarding another person not present in the therapy room (e.g., sarcasm, satire, ridicule, teasing).</i></p>	<p>Example: C: “My wife and I have been getting along better because we have decided to put aside our differences and focus on being responsible for the kids’ sake.” T: “Maybe you should share some of your secrets with Congress.” C: “I think my kids have a better shot at raising themselves than that group of idiots does at learning to cooperate.”</p>	<p>Example: T: “So is this [activity/intervention] something you want to try? C: “Oh, <i>definitely</i>, doc, I’m sure it will totally cure me. You’re a genius.</p>
<p>Self-Deprecatory Humor (Code H3) <i>The client uses humor in a way that is self-disparaging or appears to attempt to entertain the therapist by saying or doing things at his or her own expense. Client targets his or herself as the object of humor or makes fun of him/herself (e.g., to put listener at ease or ingratiate him or herself to listener, to demonstrate modesty). This form of humor can range from subtle and/or playful mocking of oneself to more obvious and/or self-disparaging expressions.</i></p>	<p>Example T: “So the prostitution- I mean prosecution- is going well?” C: [a lawyer, in the midst of an important case] “Prosecution is going well, but prostitution is probably not an option for me- I don’t think women would sleep with me even if I offered them money.”</p>	<p>Example T: “So you were hurt when your wife called you two-faced?” C: “Well, maybe more confused than hurt- if I were two-faced, do you really think I’d choose to wear this one?”</p> <p>Example of multiple codes (H4 & H3): C: “I certainly have a lot of work to do in therapy! I’ll have lots of material to keep us busy with, that’s for sure [client laughter].”</p>
<p>Dark Humor (Code H4) <i>The client uses humor in a way that makes fun of situations ranging from difficult/challenging to</i></p>	<p>Example: T: “So how was your recent hospital stay? Just delightful, I’m sure.” C: [recently diagnosed with a</p>	<p>Example: T: “So how was your trip home?” C: “Well, as disasters go, it was better than</p>

<p><i>terrifying/life-threatening; humor is used to treat serious, dark, or painful subject matter in a light manner. Furthermore, the situation/topic/context in which humor is used should be clearly identified as being difficult, challenging, serious, dark, or painful. Humorous expressions in reference to a client's presenting problem(s) will generally fall under this category.</i></p>	<p>terminal form of cancer] “Oh yes, a total blast. It’s a shame I couldn’t stay longer. You know, I’ve decided that I’m no longer afraid to die- I just don’t want to be there when it happens.”</p>	<p>the Titanic, but worse than the Hindenburg. My brother is back in rehab, my parents are getting divorced, and my favorite family dog just died.”</p> <p>Example of multiple codes (H4 & H3): C: “I certainly have a lot of work to do in therapy! I’ll have lots of material to keep us busy with, that’s for sure [client laughter].”</p>
<p>Expression of Humor Not Otherwise Specified (Code H5) <i>The client uses a form of humor or refers to humorous stimuli in a way that is not captured by any of the aforementioned codes. Second-hand and vague references to humorous expressions also generally fall under this category.</i></p>	<p>Example: T: “You have a unique sense of humor, you know that?” C: “Oh yeah? You’re pretty funny yourself.”</p>	<p>Example C: “I have been getting along with my roommate much better lately” T: “Really?” C: “Yeah, the other day he told me this joke about this duck who crossed the road. He totally cracked me up.”</p> <p>Example C: “It’s funny that he was in my dream, because I haven’t thought about him in years!”</p>

Laughter/Behavioral Expression of Humor

In addition to verbal expressions of humor, laughter (a behavioral expression of humor) will also be coded as either: (a) Laughter Accompanied by a Coded Verbal Expression of Humor or (b) Laughter not Accompanied by a Coded Verbal Expression of Humor. Expressions of laughter will further be coded as occurring either: (a) In the Context of a Serious or Difficult Topics; or (d) In the Context of Benign or Positive Topics. All

Instances of therapist laughter, regardless of context, should also be identified and coded. Please refer to the following coding systems for definitions and examples.

Coding System for Laughter

	<p>Laughter in the Context of Serious or Difficult Topics (Code D1)</p> <p><i>Client’s laughter occurs in the context of subject matter ranging from serious/difficult to painful/traumatic. The topic/context in which laughter is evident should be clearly identified as being serious, difficult, challenging, dark, traumatic, or otherwise explicitly regarded by client as eliciting negative emotions or as being difficult, challenging, etc. Laughter accompanied by verbal expressions of humor that are coded as H2, H3, or H4 will generally fall under this category.</i></p> <p>Examples of D1 topics:</p> <ul style="list-style-type: none"> • Daily stressors • Ruptures or conflict within the therapeutic relationship • Traumatic event(s) (e.g., physical or sexual abuse) • Uncertainty with regard to client’s coping abilities • Discussions of therapy that are directly related to issues/topics that are clearly identified by client as being distressing or problematic. 	<p>Laughter in the Context of Benign or Positive Topics (Code D2)</p> <p><i>Client’s laughter occurs in the context of subject matter ranging from neutral/benign to positive. Laughter accompanied by verbal expressions of humor that are coded as H1 will generally fall under this category. Laughter in the context of topics that don’t appear to elicit any negative emotions from the client will also generally fall under this category. If a topic is not explicitly regarded as being negative, difficult, or challenging by the client, or cannot be clearly identified as being serious, difficult, challenging, dark or traumatic, then it should be coded D2.</i></p> <p>Examples of D2 subject matter:</p> <ul style="list-style-type: none"> • Client successes • Client hobbies (e.g., discussion regarding a television show) • Stories about benign, daily activities (e.g., cooking dinner) • Second-hand stories or vague discussions about others. • General discussions of therapy
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<p>Laughter Accompanied by a Coded Verbal Expression of Humor (Code L1)</p> <p><i>Client's laughter is accompanied by a (coded) verbal expression of humor.</i></p>	<p>Example: T: "So how was your recent hospital stay? Just delightful, I'm sure." C: [recently diagnosed with a terminal form of cancer] "Oh yes, a total blast [client laughter]. It's a shame I couldn't stay longer."</p>	<p>Example: [Session takes place on a stormy day; client walks in with an umbrella] T: "Beautiful day out, huh?" C: "Oh yes [client laughter], days like this really make me appreciate living in Southern California!"</p>
<p>Laughter not Accompanied by a Coded Verbal Expression of Humor (Code L2)</p> <p><i>Client's laughter is not accompanied by a (coded) verbal expression of humor</i></p>	<p>Example: [Client is in the middle of a messy divorce] C: "I just don't understand how he could leave me [client laughter]. You know?"</p>	<p>Example: C: "I wish I had a vacation planned for this summer, but I don't think I have the time! Plus I might just prefer to relax at home [client laughter]."</p>

<p>Therapist laughter (Code TL)</p>	<p>All instances of therapist laughter, regardless of context, should be coded as TL.</p>
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B. Social Support

The next step in the coding process consists of the researcher-participants coding client-participant expressions of social support. For the purposes of this study, which focuses on clients' trauma experiences, social support can be defined as the interpersonal networks that are experienced, sought, or needed by an individual during or in the aftermath of traumatic events that provide, or attempt to provide, that person with tangible and/or emotional help and that are expected to contribute, either positively or negatively, to his or her post-traumatic experience. Expressions of social support are

those explicit verbal statements made by client-participants to describe, discuss, explain, or reflect on their personal experiences of social support. Because this study will include only psychotherapy sessions in which discussions of trauma occur, all expressions of direct social support experiences (those experienced personally by the client) within the selected sessions will be coded and analyzed in the context of the session. Therefore, for the purposes of coding client expressions of social support in this study that may not concern a threat to physical integrity, social support will also be defined as personal/direct client experiences within or beliefs about interpersonal networks and relationships that are anticipated, needed or desired, offered or received to provide him or her with either positive or negative helping behaviors. Thus, all statements that clients make about their own social support experiences (e.g., types and functions of support) will be coded. Additionally, each instance of coded support content should be followed by brackets containing the identified individual discussed.

Social support codes and their definitions and examples are presented in the table below for the researcher-participant to use in coding transcribed sessions. However, given the conceptual overlap that occurs amongst constructs of social support, it is likely that many expressions of social support may be coded in more than one category. Once identified, expressions of social support should be placed in any of the applicable following categories (they are not mutually exclusive): (a) Received support; (b) Perceived support; (c) Extended support; (d) Support needs; (e) Support functions; (f) Support content [including identified support resource]; (g) Other.

**Coding System for Identifying Client Expressions of Social Support
In Psychotherapy Sessions that Involve Discussions of Trauma**

Client Expressions of Social Support: *Received Support*

Codes	Descriptions	Examples
<i>Positive received support:</i> (Code RS1)	The client reports on support (naturally occurring helping behaviors) that was given or provided to the client from another person(s) or entity (an exchange took place) and describes it as positive (e.g., helpful, beneficial, or useful).	C: "My sister's help was such a blessing!" C: "It was so helpful to hear those comforting words from my rabbi."
<i>Negative received support</i> (Code RS2)	The client describes support (naturally occurring helping behaviors) that was given or provided to the client from another person(s) or entity (an exchange took place) and describes it as negative (e.g., unhelpful, unwanted, or damaging).	C: "My brother said he would take care of the kids but he never showed up." C: "She was supposed to help but what she said really offended me."

<i>Received support: Not Otherwise Specified</i> (Code RS3)	The client discusses support (naturally occurring helping behaviors) that was given or provided to the client from another person(s) or entity (an exchange took place) and describes it as neither positive or negative (e.g., ambivalent, impartial).	C: "The church gave us food and clothes." C: "My social worker called to check in on me."
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Client Expressions of Social Support: *Perceived Support*

<i>Positive perceived support</i> (Code PS1)	The client speaks about beliefs about support to be received, that are positive and may stem from previous support experiences (e.g., expectations for future support to be available and effective).	C: "I just know my friends will always be there for me, ready to help me out."
<i>Negative perceived support</i> (Code PS2)	The client describes beliefs about support to be received, that are negative or lacking and may stem from previous support experiences (e.g., expectations that future support will not be available or will not be effective).	C: "I can't rely on anyone and I doubt I ever will."
<i>Perceived support: Not Otherwise Specified</i> (Code PS3)	The client reports beliefs about support to be received, that are neither positive nor negative or unspecified beliefs about future support that may stem from previous support experiences.	C: "Sometimes you can count on your friends and sometimes you can't."

Client Expressions of Social Support: *Extended Support*

Codes	Descriptions	Examples
<i>Positive extended support:</i> (Code ES1)	The client reports on an explicit indication of support (e.g., doing something for someone else), or beliefs about support, that he or she provided, or will provide, to others and describes the experience as positive (e.g., beneficial, fulfilling, meaningful) for the client.	C: "It felt so good to be needed for once! I was the person she talked to and counted on." C: "I'm good at taking care of people. It just comes naturally to me."
<i>Negative extended support</i> (Code ES2)	The client describes an explicit indication of support (e.g., doing something for someone else), or beliefs about support, that he or she gave to others, or will give to others, and describes it as negative (e.g., unhelpful, burdensome, or stressful) for the client.	C: "Everyone is always relying on me for everything. I have to do everything! I'm so sick of constantly taking care of everyone else." C: "She is too sick. I'm just not cut out to take care of

		her. I'll mess everything up!"
Extended support: Not Otherwise Specified (Code ES3)	The client discusses an explicit indication of support (e.g., doing something for someone else), or beliefs about support, that he or she provided to others, or will provide to others, and does not distinctly specify the quality of the experience (e.g., mixed feelings, ambivalence, vague descriptions, factual or non-emotional descriptions) for the client.	C: "I got so annoyed that I had to help him but I felt better after doing it." C: "I took over the childcare duties for them." C: "I see myself as the caretaker in my family. I'll always take care of them."

Client Expressions of Social support: Support Needs

Codes	Descriptions	Examples
Support needs: From others (Code SN1)	The client discusses the need, desire, or longing for support from others (as opposed to actual support experiences; e.g., the need for information rather than received information, or beliefs about such support). This may also include clear statements of what is <i>not</i> needed, wanted, wished for, or desired from others.	C: "I just wish someone would tell me what will happen." C: "Please just tell me it will get better." C: "I don't want those church ladies coming around here and getting involved in my business!"
Support needs: To others (Code SN2)	The client notes the desire, wish, longing or need to provide others with support instead of actual support rendered to others. This may also include clear statements of what the client does <i>not</i> need, want, wish, or desire to provide others with.	C: "I knew I would feel better if I helped them in some way." C: "I wanted to be able to tell them it would be ok." C: "I just don't want to have to cook for everyone."
Support needs: Not otherwise specified (Code SN3)	The client reported on some need, wish, longing, or desire for support that is ambiguous, hypothetical, or is not better characterized by perceived support, and is not clearly subsumed by support needs <i>from</i> others or <i>to</i> others. This may also include clear statements of what is <i>not</i> needed, wanted, wished for, or desired.	C: "I went to the church because I just needed to be around people." C: "I would feel better if I had someone to talk to." C: "I just can't stand to be around anyone right now."

Client Expressions of Social Support: Support Functions

Codes	Descriptions	Examples
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Support function: Esteem (Code F1)	The client reflects on words of encouragement or communication from others intended to enhance self-esteem, self-efficacy, or self-worth.	C: "Receiving that card from her let me know how special I am."
Support function: Emotional (Code F2)	The client shares that others acknowledged or otherwise were responsive to his/her affective experience and expressions.	C: "He was just so understanding when I cried."
Support function: Advice/informational (Code F3)	The client acknowledges/listens to or discusses guidance, instructions, directions, or specific information received from others.	C: "She told me that what happened was illegal and I should talk to a lawyer." C: "He told what happened while I was in the hospital."
Support function: Feedback (Code F4)	The client talks about others' evaluations of his/her progress.	C: "My best friend told me I'm getting better every day."
Support function: Instrumental (Code F5)	The client reports on material aid or task offered and/or provided by others.	C: "My mother let us stay at her place and borrow her car."
Support function: Social companionship (Code F6)	The client describes the affiliation, belongingness, or time spent with others.	C: "When we were at the beach and laughing together, I totally forgot about how bad everything has been."
Support function: Not otherwise specified (Code F7)	The client describes relationship functions that are not captured by any of the aforementioned support content codes.	C: "I talked and she listened."

*Note: support functions should be coded in instances where the client-participant discusses functions that were provided to or experienced by the client.

Client Expressions of Social Support: Support Content

Codes	Descriptions	Examples
Support content: Primary kin (Code C1)	The client describes experiences with members of his/her family of origin, adoptive family, spouse/partner (coded	C: "I have a hard time talking to my parents about it."

	as C1 only rather than C5), or children.	C: "My husband is my biggest support."
Support content: Secondary kin (Code C2)	The client speaks about experiences with members from his/her extended family system (e.g., aunts, uncles, cousins, in-laws).	C: "My wife's parents stayed with us after the accident."
Support content: Primary friend (Code C3)	The client discusses platonic relationships which he or she considers to be significant (e.g., close friends).	C: "My three closest friends are the guys I grew up with." C: "My best friend just 'gets' me."
Support content: Other friend (Code C4)	The client discusses experiences in platonic relationships that are distal, unspecified, or not otherwise stated (e.g., acquaintances).	C: "It was nice to talk to a friend." C: "I never really talked about personal stuff with the other moms at the playgroup."
Support content: Sexual/Romantic (Code C5)	The client talks about experiences in relationships that are sexual or romantic (note that spouse/partner is coded only as C1).	C: "I've been dating this girl for about six months." C: "My boyfriend was always the person I went to when things got bad."
Support content: Affiliative (Code C6)	The client reflects on experiences in relationships that stem from group organizations and affiliation (e.g., religious, political, recreational, professional).	C: "The people in my hiking group have been so understanding when I've had to cancel."
Support content: Mutual aid (Code C7)	The client reports on experiences in relationships that were established specifically to exchange support (e.g., support/self-help groups; relationships with other survivors that did not pre-exist the traumatic event(s)).	C: "The women in my support group have shared so much."
Support content: Service (Code C8)	The client describes experiences in relationships with professional service providers.	C: "I just didn't connect with my previous therapist."
Support content: Not otherwise	The client describes experiences in relationships that are not captured by	C: "This guy just listened to me and let

<i>specified</i> (Code C9)	any of the aforementioned support content codes.	me cry.” C: “I told the woman that I didn’t care.”
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*Note: all mentions of support content should be coded as indicated by a direct relationship to the client (e.g., all mention of “friends” should be coded whereas “my sister’s friend” would not be coded unless the client stated a clear relationship between her/himself and the other individual).

*Note: when the same individual/group support content is referenced multiple times within a single talkturn, that support code should be coded only once. However, the same content code may be used multiple times within a talkturn when various support contents from the same category are referenced within the talkturn. For example, when only one cousin is referenced multiple times within a talkturn, “C2 [cousin]” would be coded whereas when more than one cousin are clearly stated and referenced as support content, it would be coded as “C2 [cousin A], C2 [cousin B], C3 [cousin C]” or “C2 [cousin A], C2 [cousins], ect.”

*Note: in cases where only pronouns are used to reference support content in a talkturn, the content should be coded if it is clear who the participant is referring to from the context of the transcript. In instances where it cannot be clearly determined to whom the participant is referring, no content should be coded. For example, C1: “My mom never came to visit me in the hospital.” T1: “That must have been hard.” C2: “Yeah, well, she could never really deal with seeing me sick or hurt, so it wasn’t surprising.” C1 would be coded as C1 [mom] (content only) and C2 would be coded as C1 [mom] (content only). Whereas, C: “They only care about themselves.” would not be coded for content unless the context of the discussion indicated who “they/themselves” were. However, unspecified individuals/groups that are indicated by words or phrases other than pronouns (e.g., “people,” “others,” “nobody,” “the fellow,” ect.) should be coded as C9. At times when a client uses “you” and it is clearly in direct reference to the therapist, it should be coded as C8 [therapist]. At other times, it may be used euphemistically or not in clear and direct reference to the therapist, in which case it would not be coded.

Client Expressions of Social Support: *Other*

Codes	Descriptions	Examples
<i>Expression of social support not otherwise specified</i> (Code SS)	The client expresses or discusses experiences of social support in a way that is not captured by any of the aforementioned codes (may be positive, negative, factual statements, mixed feelings, ambivalence, or unclear expressions).	C: “Even though my mother passed away, I still get so much strength from thinking of and talking to her.” C: “We get along well.” C: “Even though he’s my brother and I love him, we’ve really never gotten along.”

C. Cultural Worldviews

The third step of the coding process involves the researcher-participants coding client discussions of cultural worldviews. In this study, *Cultural Worldview* is defined as: A humanly constructed symbolic conception of reality that imbues life with order, permanence, and stability; a set of standards through which individuals can attain a sense of personal value; and some hope of either literally or symbolically transcending death for those who live up to these standards of value (Pyszczynski, Greenberg, & Solomon, 1999, p. 835).

Cultural worldview codes and their definitions and examples are presented in the table below for the researcher-participant to use in coding trauma discussions in the transcribed sessions: (a) Religion, (b) Ethnicity, (c) Political Affiliation, (d) Nationality, and (e) Other.

Coding System for Identifying Client Discussions of Cultural Worldviews

Identifying Discussions of Cultural Worldviews: Religion

Codes	Descriptions	Examples
<i>Religious Group or Denomination</i> (Code R1)	The client refers to his or her religious identification	C: "As a Christian, I feel that giving to charity is important."
<i>Religious Practice</i> (Code R2)	The client discusses an event or practice that he or she engages in for religious purposes	C: "I am fasting because it's Ramadan."
<i>Vague Reference to Religion</i> (Code R3)	The client uses a generic term when referring to his or her religious ideology	C: "I am thankful for my faith because I feel like it has helped me get through this hard time."
<i>Others' Religion</i> (Code R4)	The client discusses the religious identification or practices of others in a neutral or positive manner	C: "My friend and his family believe in reincarnation."
<i>Religious Derogation</i> (Code R5)	The client speaks negatively about the religious views or practices of others	C: "I think people who believe in God are just unintelligent and easily manipulated."
<i>Religious Discussion Not Otherwise Specified</i> (Code R6)	The client discusses religion in a way that is not captured by any of the aforementioned codes	C: "Lately, I have found myself intrigued by various religions."

*Note: This study is interested in discussions concerning religion rather than spirituality. However, some statements could be considered discussions of beliefs or

practices that are both spiritual and religious (e.g. prayer). Client statements that seem to convey a belief or practice that is both religious and spiritual will be coded with the appropriate religious code.

Identifying Discussions of Cultural Worldviews: *Ethnicity*

Codes	Descriptions	Examples
<i>Ethnic Identification</i> (Code E1)	The client references his or her ethnic group or identification	C: “Since I am an African American, I feel like I have had to work hard to overcome certain stereotypes.”
<i>Ethnic Cultural Practice</i> (Code E2)	The client discusses an event or practice that he or she engages in because he or she is a member of a specific ethnic group	C: “I am excited to visit my family for our annual Chinese New Year celebration.”
<i>Vague Reference to Ethnicity</i> (Code E3)	The client uses a generic word or term when referring to his or her ethnic group	C: “My people have been through so many struggles that continue to affect our behaviors.”
<i>Others’ Ethnicity</i> (Code E4)	The client discusses other ethnic populations in a neutral or positive manner	C: “I visited my friend, and she is Native American and makes really good traditional fry bread.”
<i>Ethnic Derogation</i> (Code E5)	The client speaks negatively about an ethnic group or groups that are different from the client’s ethnic identification	C: “Those people (referring to an ethnic group) are responsible for most of the crime in this country.”
<i>Ethnic Discussion Not Otherwise Specified</i> (Code E6)	The client discusses ethnicity in a way that is not captured by any of the aforementioned codes	C: “I wish people could see past the color of a person’s skin.”

Identifying Discussions of Cultural Worldviews: *Political Affiliation*

Codes	Descriptions	Examples
<i>Political Party or Identification</i> (Code P1)	The client references his or her political party or identification	C: “As a libertarian, I think the government should be limited.”
<i>Political Action or</i>	The client discusses an event	C: “I am planning to attend the

<i>Practice</i> (Code P2)	or practice that he or she engages in for political purposes	governor’s rally this weekend.”
<i>Vague Reference to Political Affiliation</i> (Code P3)	The client uses a generic word or term when referring to his or her political affiliation	C: “All of us on the left are upset over the plan to decrease spending on education.”
<i>Others’ Political Affiliation</i> (Code P4)	The client discusses the political identification of others in a neutral or positive manner	C: “My dad is an independent so he doesn’t really tend to have extreme political views.”
<i>Political Derogation</i> (Code P5)	The client speaks negatively about the political parties or affiliations of others	C: “If it wasn’t for the democrats trying to corrupt the values that we group up with, this country would be in a better place.”
<i>Political Affiliation Discussion Not Otherwise Specified</i> (Code P6)	The client discusses politics in a way that is not captured by any of the aforementioned codes	C: “I have been arguing with my wife a lot because I am very pro-life and she is pro-choice.”

Identifying Discussions of Cultural Worldviews: Nationality

Codes	Descriptions	Examples
<i>Nationality Identification</i> (Code N1)	The client references his or her nationality	C: “I am proud to be an American and to have certain freedoms that people in other countries might not have.”
<i>Nationalistic Practice</i> (Code N2)	The client discusses an event or practice that he or she engages in because he or she seems connected to a particular country	C: “I will visit my family in Mexico to celebrate Cinco De Mayo.”
<i>Vague Reference to Nationality</i> (Code N3)	The client uses a generic word or term when referring to his or her nationality	C: “It will be nice to go home and spend time with some other Kiwis.”
<i>Others’ Nationality</i> (Code N4)	The client discusses other nationalities in a neutral or positive manner	C: “In general, I found the Canadians to be very polite and friendly.”
<i>Nationalistic</i>	The client speaks negatively about	C: “After the terrorist

<i>Derogation</i> (Code N5)	nationalities that are different from the client's nationalistic identification	attacks, I don't think we should let anyone from Afghanistan into our country."
<i>Nationality Discussion Not Otherwise Specified</i> (Code N6)	The client discusses nationality in a way that is not captured by any of the aforementioned codes	C: "I love watching the Olympics and seeing most of the world's countries come together in sport."

Identifying Discussions of Cultural Worldviews: Other (Explicit)

Codes	Descriptions	Examples
<i>Geographic Region</i> (Code OE1)	The client refers to a region within a country as a cultural characteristic	C: "I'm from the South, so I was raised to always hold the door for women."
<i>Occupational Affiliation</i> (Code OE2)	The client refers to a job, career, or occupation as a cultural characteristic	C: "Us psychologists always seem to have a hard time avoiding treating our loved ones like clients."
<i>Institutional Affiliation</i> (Code OE3)	The client refers to an affiliation with and organized institution as a cultural characteristic	C: "All the students at State University are only in school for the parties."
<i>Gender</i> (Code OE4)	The client refers to gender as a cultural characteristic	C: "I was taught from a very early age that men are supposed to be strong and not cry."
<i>Sexual Orientation</i> (Code OE5)	The client refers to sexual orientation as a cultural characteristic	C: "Since I'm gay, I am expected to be more sensitive and effeminate."
<i>Cultural Affiliation Not Otherwise Specified</i> (Code OE6)	The client refers to any cultural characteristic not captured by any of the aforementioned codes as a way of seems consistent with the study's definition of a cultural worldview	C: "People on my planet think it's ridiculous that you earthlings feel the need to work 40 hours a week."

* Note: Other (Explicit) codes are to be used only when the client refers to an affiliation as a cultural characteristic rather than simply mentioning a demographic variable that does not imply shared cultural experiences with others. For example, if a client says, "Being a full time student has ruined my marriage" no OE code would be assigned

because this is simply a statement of a personal experience rather than a cultural characteristic.

Identifying Discussions of Cultural Worldviews: *Other (Implicit)*

Codes	Descriptions	Examples
<i>Physical Universe</i> (Code OI1)	The client refers to a belief about the ontology or purpose of the physical universe or the cosmos	C: "I was walking outside on a clear night and felt very small as I looked up at the stars and thought about how we all started from the same cosmic event."
<i>Communalism</i> (Code OI2)	The client refers to a belief about the roles of individuals and their communities or families in influencing each other's welfare or that of society at large	C: "It's my responsibility to succeed in as much as I can so I can honor my family." C: "Families are only expected to be supportive until the child turns 18, and then he or she should be independent."
<i>Mortality</i> (Code OI3)	The client refers to a belief about the afterlife or the spiritual soul after life on earth	C: "Even though she passed away, I know my mother is looking down on me from somewhere and she is proud of me."
<i>Human Nature</i> (Code OI4)	The client refers to a belief about the essence of human nature	C: "People are born good, and they learn evil ways from the world around them."
<i>Meaning of Life</i> (Code OI5)	The client refers to a belief about life's purpose or an explanation of the nature of the world	C: "I think life is just a series of random events, and I don't believe in destiny."
<i>Implicit Cultural Worldview Not Otherwise Specified</i> (Code OI6)	The client refers to any implicit cultural beliefs not captured by any of the aforementioned codes	C: "Any negative or evil energy in the world is originally created by kittens."

*Note: Other (Implicit) codes are not to be used when a code from any of the other coding categories is assigned.

IV. Coding Steps for Researcher-Participants

1. Watch the selected videotaped session containing a trauma discussion(s) and read the transcript entirely to make sure that the transcript is accurate. Familiarize yourself with the content and process of the session.
2. When coding, 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. While coding and analyzing the data, the researchers should provide a detailed account of the analysis process so that the auditor can best assess the reliability of the study (Lincoln & Guba, 1985). This meticulous description of the research process, or audit trail, should include accounts of the decision processes regarding the research design and data collection procedures as well as the actions taken when analyzing and reporting the data. The following information should be included in the audit trail as recommended by Halpern (1983; as cited in Lincoln & Guba, 1985): raw data, products of data reduction and analysis (e.g. notes and qualitative summaries), data synthesis and reconstruction notes (e.g. definitions and themes of emerging categories), reports on literature supporting decisions, process notes (e.g. methodological notes and rationale), and trustworthiness notes.
4. Each of the researchers should also record their personal expectations and potential biases using a technique for qualitative research known as bracketing. Bracketing is used to minimize the influence of personal assumptions on the data collection and analysis processes by reflecting and recording potential foreseen biases (Ahern, 1999). As part of the bracketing process, the researchers should keep reflective journals which may include the following: (a) potential assumptions regarding demographic variables such as race, gender, age, and socioeconomic status; (b) his or her personal values that are thought to potentially interfere with objectivity; (c) issues regarding potential role conflict; (d) his or her interests in the data and the extent to which these interests may dispose him or her to interpret findings favorably; and (e) personal feelings that may suggest a lack of neutrality (Ahern, 1999).
5. Depending on whether you are coding expressions of humor, social support, or cultural worldviews, familiarize yourself with the corresponding coding system(s). Then, begin the coding process, simultaneously reading the written session transcriptions and watching the corresponding session videotape.
6. Individually, read the transcript again in detail by looking at each statement (C1, C2, 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 adequately captured by the coders. Also provide the auditor with audit trail materials and reflective journals (described in steps 3 and 4). The auditor will facilitate discussion with the coders regarding discrepancies that arise with the team's judgment and any potential biases that have been noted in reflective journals and will provide suggestions for changes.

APPENDIX E

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: _____

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

HOUSEHOLD INCOME:

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

OCCUPATION: _____

Family Data

IS FATHER LIVING?

Yes If YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

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

CAUSE OF DEATH: _____

IS MOTHER LIVING?

Yes If YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

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

CAUSE OF DEATH: _____

BROTHERS AND SISTERS

NAME	AGE	OCCUPATION	RESIDENCE	CONTACT HOW OFTEN?

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

NAME	RELATIONSHIP TO YOU	STILL IN CONTACT?

THE FOLLOWING SECTION WILL HELP US UNDERSTAND YOUR NEEDS AND FACTORS THAT MAY IMPACT YOUR LIFE OR TREATMENT. BELOW IS A LIST OF EXPERIENCES WHICH MAY OCCUR IN FAMILIES. PLEASE READ EACH EXPERIENCE CAREFULLY. PLEASE INDICATE WHETHER ANY OF THESE EXPERIENCES HAVE HAPPENED TO YOU OR YOUR FAMILY. SOME OF THESE MAY HAVE BEEN TRUE AT ONE POINT FOR YOU OR IN YOUR FAMILY BUT NOT TRUE AT ANOTHER POINT. IF THE EXPERIENCE NEVER HAPPENED TO YOU OR SOMEONE IN YOUR FAMILY, PLEASE CHECK THE "NO" BOX. IF YOU ARE UNSURE WHETHER OR NOT THE EXPERIENCE OCCURRED FOR YOU OR IN YOUR FAMILY AT SOME TIME, PLEASE CHECK THE "UNSURE" BOX. IF THE EXPERIENCE HAPPENED TO YOU OR IN YOUR FAMILY AT ANY POINT, PLEASE CHECK THE "YES" BOX.

	SELF			FAMILY			
	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	PLEASE INDICATE WHICH FAMILY MEMBER(S)
WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, INCLUDING YOURSELF, STRUGGLED WITH:							
SEPARATION/DIVORCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT RE-LOCATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EXTENDED UNEMPLOYMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADOPTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FOSTER CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FINANCIAL STRAIN OR INSTABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEATH AND LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DRUG USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADDICTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PHYSICAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMOTIONAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RAPE/SEXUAL ASSAULT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIAGNOSED OR SUSPECTED MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SUICIDAL THOUGHTS OR ATTEMPTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SELF HARM (CUTTING, BURNING)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEBILITATING ILLNESS, INJURY, OR DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PROBLEMS WITH LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT FIGHTS AND ARGUMENTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INVOLVEMENT IN LEGAL SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CRIMINAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INCARCERATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Current Difficulties

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

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

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

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

Social/Cultural (Optional)

1. RELIGION/SPIRITUALITY: _____

2. ETHNICITY OR RACE: _____

3. DISABILITY STATUS? _____

APPENDIX F

Telephone Intake Form

ID# _____

A copy of this form should be included in the client's chart

Pepperdine Community Counseling Center
Telephone Intake Interview

Caller Information

INTERVIEWER: _____ DATE OF TELEPHONE INTAKE: _____ TIME: _____

WHAT IS YOUR NAME?: _____

WHO IS THIS APPOINTMENT FOR? _____ M F DOB: _____ AGE: _____

_____ M F DOB: _____ AGE: _____

IF THE POTENTIAL CLIENT IS NOT THE CALLER, ASK, "WHAT IS YOUR RELATIONSHIP TO (CLIENT'S NAME)?: _____

WHAT IS (CLIENT'S) ADDRESS?: _____

WHAT IS (CLIENT'S) PHONE NUMBER(S): _____ (H) _____ (W) _____ (CELL OR PAGER)

IS IT OK THAT WE LEAVE A MESSAGE AT ANY OR ALL OF THE NUMBERS, IDENTIFYING OURSELVES AS BEING FROM THIS COUNSELING CENTER? Y N

HOW DID YOU HEAR ABOUT US? (LIST NAME AND NUMBER): _____

MAY WE CONTACT THEM TO THANK THEM FOR REFERRING YOU? Y N

WHO DOES (CLIENT) LIVE WITH? SELF OTHERS -

LIST: _____

DOES (CLIENT) HAVE CHILDREN?: _____

WHO IS INCLUDED IN (CLIENT'S) SUPPORT SYSTEM? _____

sample

ADDRESS CONFIDENTIALITY AND LIMITS TO CONFIDENTIALITY BEFORE PROCEEDING WITH THE PHONE INTAKE:

"I'd like to find out about your situation and for what reason you're seeking help. This will help me figure out how our counseling center might be of assistance/service. But before we begin I need to explain about confidentiality and its limits. Here at the Pepperdine Counseling Center we pride ourselves on guarding our clients' privacy, and on creating an environment where people can feel comfortable about discussing very personal matters. With that said, we want you to know that everything you describe to me is confidential, however, if I begin to understand that your's or someone else's life is in danger, or when there are significant concerns about a child or elder person's safety, I may need to break that confidentiality and take steps to assure that everyone is safe. Do you have any questions about this?...if not, let's proceed"

Type of Service

What type of appointment is being requested? Check all that apply

- Therapy
- Assessment
- Don't know or unsure
- Child
- Adolescent
- Adult
- Don't know or unsure
- Individual
- Couple (Ask if there has been any domestic violence)
- Family
- Group
- Don't know or unsure

ID# _____

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

Why? _____

Reason for Referral

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

sample

ARE THERE ANY PAST OR CURRENT LEGAL PROBLEMS?: Y N _____

IS THERE A COURT ORDER THAT REQUIRES TREATMENT? Y N _____

FOR WHAT REASON? _____

CLIENT TOLD LIMITS REGARDING COURT ORDERS? Y N _____

ARE THERE ANY PAST OR CURRENT DRUG AND/OR ALCOHOL PROBLEMS?: Y N _____

ANY CURRENT THOUGHTS OF HURTING YOURSELF?: Y N _____

ANY PREVIOUS THOUGHTS OR ATTEMPTS AT HURTING YOURSELF?: Y N _____

IF SO, WHEN WAS THE LAST TIME YOU THOUGHT ABOUT HURTING YOURSELF?: _____

WHEN WAS THE LAST TIME YOU ATTEMPTED TO HURT YOURSELF?: _____

DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOU HAVE A "BAD TEMPER" OR THAT YOU GET MAD EASILY?: Y N _____

IF SO, PLEASE PROVIDE EXAMPLES: _____

ANY PAST VIOLENCE TOWARDS OTHERS?: Y N _____

ID# _____

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

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

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

IF SO, LIST: _____

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

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

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

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

IS THERE DOCUMENTATION AVAILABLE (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 THE LIMITS OF CONFIDENTIALITY FOR THE PHONE INTERVIEW

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

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

ID# _____

- I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT VIDEO AND
~~SOMETIMES AUDIO TAPES DURING 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 G

Intake Evaluation Summary Pepperdine Psychological and Educational Clinic Intake Evaluation Summary

Client: _____ Intake Therapist: _____
Intake Date(s): _____ Date of Report: _____

I Identifying Information

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

II Presenting Problem/Current Condition

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

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

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

IV Psychosocial History

A Family History

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

B Developmental History

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

C Educational/Vocational History

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

D Social Support/Relationships

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

E Medical History

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

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

(Cultural group identification/identity, acculturation issues relevant to presenting problems/therapy) (Religious affiliations, strength of commitment to and/or involvement in religion, view of spirituality and its role in emotional problems/suffering and intervention)

G Legal History

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

V Mental Status Evaluation

Hygiene & grooming:

Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

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

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

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

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

Thought Content (appropriate; delusions; odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

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

VI Client Strengths

(Intelligence, personality, internal resources, coping skills, support system, talents and abilities, motivation, education/vocational skills, health)

VII Summary and Conceptualization

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

VIII DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

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

Current GAF:

Highest GAF during the past year:

IX Client Goals

X Treatment Recommendations

Be as specific as possible. Note: suggested therapy modalities and frequency of contact, issues to be addressed, adjunctive services such as psychological testing or medication evaluation.

Recommendations should be connected to presenting problem and diagnoses.

Intake Therapist

Supervisor

Date

Diagnosis at Termination:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

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

sample

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

Student Therapist

Supervisor

Date

Date

APPENDIX J

Protecting Human Research Participants Certification



APPENDIX K

Research Assistant Confidentiality Agreement – Transcriber

As a research assistant (RA) appointed by Susan Hall, J.D., Ph.D. and co-supervised by her dissertation students, Rebecca Dragosits, Ed.M., Celine Crespi-Hunt, M.A., and Christopher Ogle, M.A., I understand that I am expected to abide by specific principles and responsibilities to ensure effective and proper participation in the research program designed to investigate trauma disclosure in psychotherapy.

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

I will commit to _____ hours per week and attend all relevant coding meetings. First, I will complete human subjects and HIPAA training required by Pepperdine University's Graduate and Professional Schools Institutional Review Board, and submit my certificates of completion to Dr. Hall. Subsequently, I will learn a transcription procedure and/or coding system so that I can use it reliably. Then, I will observe and transcribe tapes and/or code them for research purposes. Due to the intensity of training, I agree to remain a RA on the research project for _____ months.

By signing this Confidentiality Agreement, you are stating your commitment to upholding research participants' privacy and confidentiality and your RA responsibilities, which involves a commitment to maintaining professional demeanor and adhering to the highest ethical standards. The expectations of my position as a RA with the Pepperdine Applied Research Center at Pepperdine University, Graduate School of Education and Psychology has been explained to me by Dr. Hall, her dissertation student(s), or another research assistant working with her. Should I have any questions whatsoever regarding

my position and its expectations; I agree to discuss these with Dr. Hall. I understand the expectations outlined above, and agree to abide by them.

Printed Transcriber Name: _____

Transcriber Signature: _____

Date: _____

Witness Signature: _____

Date: _____

APPENDIX L

Researcher Confidentiality Statement - Coder

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

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

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

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

Coder Signature: _____

Date: _____

Witness Signature: _____

Date: _____