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Qualitative analysis of expressions of gratitude in clients who have experienced trauma

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Graduate School of Education and Psychology

QUALITATIVE ANALYSIS OF EXPRESSIONS OF GRATITUDE IN CLIENTS WHO

HAVE EXPERIENCED TRAUMA

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Roxana Zarrabi, M.A.

September, 2015

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

This clinical dissertation, written by

Roxana Zarrabi

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

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TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGMENTS

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VITA

Roxana Zarrabi, M.A.

EDUCATION

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- Dissertation committee: Susan Hall, J.D., Ph.D., Edward Shafranske, Ph.D., ABPP & John Briere, Ph.D.

Pepperdine University
Master of Arts in Psychology   December 2009

University of California, Irvine
Bachelor of Arts in Psychology   June 2007

DOCTORAL CLINICAL TRAINING EXPERIENCE

Northwestern University Counseling Center
Doctoral Intern   August 2014-Present
Chicago, Illinois
Supervisors: Jod Taywaidtep, Ph.D., Rosy Magana, LCPC, Cynthia McKinzie, Psy.D.

Responsibilities:

- Provide short-term individual therapy to a diverse range of undergraduate and graduate students struggling with a variety of presenting problems including: mood and anxiety disorders as well as trauma, substance abuse and learning disorders
- Provide 3-4 hours of on-call crisis intervention per week
- Conduct 3 intake evaluations per week.
- Provide psychoeducational workshops on stress management to undergraduate students
- Present "QPR" suicide prevention training to undergraduate students
- Provide informal drop-in consultation and outreach to college students through "Let's Talk" program
- Co-facilitate a weekly process-oriented group for undergraduate students
- Participate in weekly intern seminar trainings on multicultural and diversity issues, crisis intervention, legal and ethical issues, psychiatric consult and professional development

Job Corps   September 2013-July 2014
Therapist/Assessment Trainee
Los Angeles, California
Supervisor: Joe Grillo, Ph.D.

Responsibilities:

•Provide individual therapy to economically disadvantaged youth between the ages of 16 and 24
•Write integrated psychodiagnostic and psychoeducational assessment reports for Job Corps
  students between the ages of 16 and 24.
•Administer, score, and interpret multiple tests including the WAIS-IV, WJ-III, VMI, BAARS-
  IV, MMPI-2, and Rorschach .
•Provide clients with feedback on strengths and recommendations for areas of improvement
  based on psychodiagnostic and psychoeducational assessment results.
•Participate in multidisciplinary case conference meetings to create individual educational plans
  and to provide reasonable accommodations for students.
•Conduct trainings and workshops for students and staff on a variety of topics such as: learning
  disabilities, conflict resolution, and stress management.

UCLA Adult Anxiety Disorders Clinic   July 2012- August 2013
Therapist Trainee
Westwood, California
Supervisors: Alexander Bystritsky, MD and Karron Maidment, MFT

Responsibilities:
•Conducted exposure response prevention with clients diagnosed with OCD, Panic Disorder and
  other anxiety related disorders .
•Co-led a coping skills group for clients diagnosed with OCD, Panic Disorder and other anxiety related
  disorders to enhance management of symptoms.
•Conducted intakes and diagnostic interviews with potential clients in order to assess suitability
  for clinic.

Santa Monica College Counseling Center   September 2011-July 2012
Therapist Trainee
Santa Monica, California
Supervisor: Alison Brown, Ph.D.

Responsibilities:
•Provided short-term individual therapy to a diverse range of college students.
•Conducted bi-weekly crisis walk-in sessions with college students.
•Conducted multiple intake evaluations and diagnostic interviews per week.
•Created individualized treatment plans for college students struggling with a variety of
  presenting problems including: mood and anxiety disorders as well as trauma, substance abuse
  and learning disorders.
•Participated in multidisciplinary team meetings with faculty members to discuss ways to help at-
  risk students.

Pepperdine Community Counseling Center   September 2010-December 2013
Therapist Trainee
Encino, California
Supervisors: Anat Cohen, Ph.D., Sepida Sazgar, Psy.D.

Responsibilities:
• Provide long-term individual therapy to a diverse range of adolescents and adult
  clients including Children of the Night (nonprofit organization that houses sexually exploited
  youth) clients.
•Conduct intakes and create individualized treatment plans for clients suffering from a variety of
  mood and anxiety disorders.
 •Administer, score and interpret outcome measures and provide feedback regarding results to
  clients.
 •Participate in on-call crisis duties.

LEADERSHIP EXPERIENCE

Pepperdine Community Counseling Center   September 2012-July 2014
Peer Supervisor
Encino, California

Responsibilities:
• Selected and trained to be a mentor for a 1st year doctoral student.
•Provide 1-2 hours of peer supervision per week to a 1st year doctoral student.
•Provide guidance to peer supervisee by viewing DVD's and providing feedback on strengths and
  areas of improvement.
•Audit peer supervisee's charts to ensure that charting guidelines are being adhered to.
•Participate in weekly supervision of peer supervisor duties by a licensed psychologist.

Pepperdine Community Counseling Center   September 2011-August 2013
Graduate Assistant
Encino, California

Responsibilities:
•Conducted orientation for new therapists on clinic procedures, assessment measures and crisis
  intervention.
•Coordinated marketing and outreach opportunities for clinic.
•Conducted interviews with the clinic director for MFT trainee positions.
•Audited charts for quality assurance purposes.
•Supported clinic director in promoting a professional environment to facilitate clinical training
  goals.
•Conducted telephone intakes with potential clients in order to assess suitability for clinic.

RESEARCH AND TEACHING EXPERIENCE

Pepperdine University, Graduate School of Education & Psychology   June 2011-August 2012
Research Assistant for Positive Psychology Dissertation Lab supervised by Dr. Susan Hall
Encino, California

Responsibilities:
•Responsible for creating research files for Positive Psychology Dissertation Lab.
•In charge of supervising data entry research assistants and coordinating monthly meetings to
 ensure quality assurance.
•Conducted orientation for data entry research assistants on PARC lab procedures, data entry
 guidelines, and creation of research files.

Pepperdine University, Graduate School of Education & Psychology   January 2010-April 2010
Teacher Assistant for Dr. Barbara Ingram
Encino, California

Responsibilities:
•Facilitated in-class clinical role-play exercises.
•Provided feedback to help students improve their clinical skills.
•Collaborated with Dr. Ingram in order to develop a lesson plan for each class.
•Responsible for conducting class if Dr. Ingram was not available to teach.
•Assisted with grading homework assignments and projects.

University of California, Irvine   January 2006-May 2008
Psychology Research Assistant for Dr. Mary Louise Kean
Irvine, California

Responsibilities:
•Provided research support to Dr. Mary Louise Kean.
•Responsible for recruiting participants for research studies.
•Responsible for conducting experiments and collecting data.

OTHER RELATED PROFESSIONAL EXPERIENCE

Drake Institute   March 2010-September 2010
Neurofeedback Trainer
Northridge, California

Responsibilities:
•Administered neurofeedback to children and adolescents with ADHD, stress, anxiety, Autism
 and auditory processing/language deficits.
•Provided feedback to parents regarding the client's progress, strengths and areas of
 improvement.
•Observed brainwave patterns during treatment session to ensure client was connecting with
 treatment**.**

Institute for Girls' Development   June 2010-August 2010
Leadership Intern
Pasadena, California

Responsibilities:
• Facilitated activities for the middle school mind, body, spirit summer program as well as the
  elementary summer program.
• Responsible for behavior management and resolution of conflict within the group.

UNDERGRADUATE CLINICAL TRAINING

University of California, Irvine Counseling Center   September 2006- June 2008
COACH Program Intern
Irvine, California

Responsibilities:
• Selected and trained to be a mentor for fellow students who needed to talk about personal issues,
  and/or needed motivation to achieve certain academic or personal goals.
• Provided outreach presentations to faculty and undergraduate students on utilizing counseling
  center services such as individual therapy, coaching, and group therapy.
• Trained and taught on topics such as learning disorders, academic pressure, eating disorders,
  motivation, goal setting, adjustment disorders, anxiety, depression, communication skills, and
  relationship skills.
• Carried a case load of 5-7 college students per quarter.

PROFESSIONAL AFFILIATIONS

Psi Chi, National Honor Society in Psychology, Member   February 2009-Present
    (Pepperdine University Chapter)
American Psychological Association, Student Affiliate   November 2012 – Present

CONFERENCE PRESENTATIONS

Zarrabi, R. & Hall, S.R. (2013, August). Expressions of gratitude in therapy with trauma survivors.
        Poster presented at the 121st Annual Convention of the American Psychological Association,
        Honolulu, HI.

ABSTRACT

Although gratitude may seem straightforward, it is a complex construct comprised of cognitive, emotional and behavioral elements. Gratitude has been presented as a positive psychological character trait, coping response, attitude, moral virtue, emotion, and habit (Emmons, McCullough, & Tsang, 2003), and significant overlap exists among these definitional presentations (Lambert, Graham, & Fincham, 2009). Despite definitional limitations, promising evidence indicates that gratitude can help survivors positively process and cope with trauma and contribute to the post-trauma recovery experience (Kashdan, Uswatte, & Julian, 2006; Vernon, Dillon, & Steiner, 2009). Yet, there is a lack of research examining how gratitude is expressed in psychotherapy with those who have experienced trauma.

The purpose of the current study was to qualitatively explore expressions of gratitude by psychotherapy clients who were trauma survivors. A deductive coding system was used, based on existing gratitude literature that allows researchers to comprehensively examine different types of gratitude. This study also compared gratitude expressions that took place during trauma and non-trauma discussions, which is an area of research that had not been examined.

In contrast to existing assessment and research, the findings from this study revealed that clients tended to express gratitude infrequently, in a *Narrow* manner or in a manner that was *Not Otherwise Specified*. Findings revealed that client expressions of gratitude were captured by four of the nine proposed coding categories: personal gratitude, gratitude for specific benefits received from a higher power, gratitude expressions that are not otherwise specified, and generalized gratitude as an attitude, in order of frequency.

It is hoped that the current study will contribute to the definition, understanding and measurement of gratitude in therapy. By demonstrating the extent that gratitude is utilized in

psychotherapy with clients who have experienced trauma, the results of this study can be used as a baseline from which to compare results of future studies that evaluate the effects of training therapists in gratitude interventions. This study may also help therapists develop a deeper understanding of a gratitude that emerges as a result of trauma, which can potentially inform their use of gratitude in future assessment and treatment.

Chapter I: Literature Review

There is a wealth of research that aims to understand the negative and positive effects traumatic experiences have on individuals (Joseph & Linley, 2008; Seligman, 2011). Consistent with the principles of positive psychology, more recent attention has focused on factors that contribute to positive outcomes, including posttraumatic growth. Results suggest that therapy can be a vehicle through which growth and change can be achieved (Vernon, Dillon & Steiner, 2009). For example, studies have demonstrated that therapy which focuses on developing an individual's character strengths such as hope, gratitude and spirituality contributes to adaptive coping and posttraumatic growth (Linley & Joseph, 2008; Tedeschi & Calhoun, 2004). Studies have also found that people's abilities to use their character strengths contribute to their capacity for growth and resilience (Seligman, 2011).

In particular, gratitude has been identified as a strength that can help trauma survivors deal with their experiences and potentially lead to positive effects as a part of the post-trauma recovery experience (Kashdan, Uswatte, & Julian, 2006; Vernon, 2012; Vernon, Dillon, & Steiner, 2009). Positive effects have also been found when using gratitude interventions with individuals dealing with medical issues such as low-back pain and neuromuscular disease as well as individuals dealing with clinical issues such as depression (Carson, Muir, Clark, Wakely, & Chander, 2010; Emmons & McCullough, 2003; Seligman, Rashid, & Parks, 2006; Seligman, Steen, Park, & Peterson, 2005). Given these benefits, research appears needed to explore the aspects of the therapeutic relationship that foster strengths such as gratitude in individuals who have experienced trauma. Thus, this study aimed to qualitatively examine trauma survivors' expressions of gratitude in the context of psychotherapy.

To accomplish this goal, the literature review begins with a review of the positive psychology movement and trauma from a positive psychology lens. Next, this chapter reviews different types of gratitude, the barriers to gratitude, and the effects of gratitude (i.e., psychological, physical and social), including research conducted on gratitude with people who have experienced trauma in particular. Next, gratitude assessment and various gratitude practices and interventions are discussed. This chapter concludes with the purpose of the study and its research question.

Positive Psychology and Trauma

This section reviews the history of the positive psychology field, its definition and relationship to character strengths, including gratitude, and criticisms of positive psychology. Next, the definition of trauma and critiques of the current DSM-IV-TR criteria are reviewed; then trauma trajectories are discussed, including positive and negative consequences that can result from trauma. This section concludes with a review of psychotherapeutic interventions typically used with trauma survivors.

Background and Definition of Positive Psychology

In 1998, Martin Seligman became the president of the American Psychological Association (APA) and ignited the field of positive psychology that aimed to revive the focus on the full spectrum of human functioning and ability to flourish that had been present in the field of psychology prior to World War II (Joseph & Linley, 2006; Seligman & Csikszentmihalyi, 2000; Wood & Tarrier, 2010). Prior to World War II, psychology had three main goals: alleviating pathology, identifying and enhancing strengths, and helping people lead more fulfilling lives (Seligman et al., 2005). Seligman argued that after World War II, the focus on fulfillment and enhancing strengths was de-emphasized and alleviating pathology became the focus of

practitioners and researchers in clinical psychology. This shift occurred in 1946 after the Veterans Administration was established and clinicians began to provide therapy to post-war veterans. Soon afterwards, the National Institute of Mental Health, established in 1947, supplied grants mostly for research focusing on pathology (Joseph & Linley, 2006; Seligman & Csikszentmihalyi, 2000; Wood & Tarrier 2010). As a result, the focus became the treatment and diagnosis of mental disorders, in a manner similar to a medical disease model (Gable & Haidt, 2005). Keyes and Lopez (2002) similarly have asserted that clinical psychology has traditionally focused on the etiology of and treatment modalities for disorders but there has been a lack of focus on protective factors that contribute to resilience and subjective well-being such as positive character strengths.

Positive psychology seeks to study the full spectrum of human functioning by not only examining factors that contribute to pathology but also focusing on the factors that contribute to adaptive coping and the ability to flourish despite the brain's natural negativity bias. Research has demonstrated from a biological perspective that evolutionary factors have contributed to the brain developing this tendency to protect individuals from potential threats in the environment (Gable & Haidt, 2005; Hanson & Mendius, 2009). In the book *Buddha's Brain*, the authors describe the brain's negativity bias as "velcro for negative experiences and teflon for positive ones" (Hanson & Mendius, 2009, p. 68), as negative memories are more likely to be processed faster and more in-depth than positive memories.

Positive psychology is referred to as the "scientific pursuit of optimal human functioning" (Lopez et al., 2006, p. 210). Positive psychology involves the scientific study of factors that contribute to the ability of individuals, institutions and groups to thrive and flourish

in the following 3 categories: (a) positive subjective experience, (b) positive character strengths (c) positive institutions (Seligman & Csikszentmihalyi, 2000).

A majority of positive psychology research has focused on the association between character strengths and overall well-being as well as the importance of developing and enhancing one's signature character strengths. Recognizing the importance of character strengths and their impact on optimal functioning, Peterson and Seligman created the Values in Action (VIA) Inventory of Strengths. Based on an investigation across cultures, the VIA consists of 24 strengths disseminated amongst 6 virtues: wisdom, courage, humanity, justice, temperance and transcendence (Seligman, Steen, Park, & Peterson, 2005). In 2004, Peterson and Seligman created a manual titled *Character Strengths and Virtues: A Handbook and Classification*, in order to classify these 24 character strengths in a way that was synonymous with the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM IV-TR; Seligman et al., 2005).

This study aimed to examine a construct within the second category of character strengths, specifically gratitude, and how it was expressed in therapy. Peterson and Seligman classify gratitude as a character strength that falls under the virtue of transcendence, as it contributes to an individual's ability to make meaning out of his or her experiences. According to Peterson and Seligman's (2004) manual, gratitude is defined as "a sense of thankfulness and joy in response to receiving a gift, whether the gift be a tangible benefit from a specific other or a moment of peaceful bliss evoked by natural beauty" (p. 554). This character strength is further discussed in the following section on gratitude.

The positive psychology movement has garnered a significant amount of interest due to its focus on enhancing individuals' well-being rather than solely focusing on alleviating

suffering. In recent years, universities such as Harvard have offered courses on happiness and well-being, and several institutions such as University of Pennsylvania and Claremont Graduate University have begun offering master and doctoral degrees in positive psychology.

Criticisms of Positive Psychology

Despite the interest and attention this burgeoning field has received, various criticisms of the movement have been identified. These critiques include: a lack of recognition for other orientations that contributed to the positive psychology movement, unrealistic perceptions of the world, lack of cultural applicability, and lack of agreement amongst researchers regarding positive psychology constructs (Joseph & Linley 2006; Wood & Tarrier, 2010). A major criticism of the positive psychology movement is the lack of credit given to the theoretical roots from which the movement was derived (Joseph & Linley, 2006). First, the positive psychology movement overlaps extensively with the humanistic/existential movement, which arguably laid the groundwork for positive psychology by focusing on character strengths as well as the factors that help human beings flourish and reach self-actualization (Wood & Tarrier, 2010). Psychologists such as William James, Carl Rogers, Abraham Maslow, and Gordon Allport emphasized the importance of focusing on positive character traits. In 1902, William James proposed the need to study healthy, positively functioning individuals rather than focusing on negative traits (Gable & Haidt, 2005). Carl Rogers, a humanistic psychologist who pioneered client-centered therapy in the 1940's, emphasized the importance of creating a therapeutic relationship aimed towards using the client's strengths to enhance optimal functioning through the therapeutic relationship. Additionally, in the late 1960's Gordon Allport began promoting the study of positive character strengths, and Abraham Maslow aimed to study

5

factors that contribute to an individual thriving, rather than focusing solely on psychopathology (Gable & Haidt, 2005).

Second, counseling psychology, which was developed in the 1950's, has also been identified as a major contributor to the field due to its focus on enhancing happiness as well as alleviating distress. In particular, counseling psychology highlights the importance of enhancing an individual's strengths rather than deficits, and building upon those strengths in therapy (Mollen, Ethington, & Ridley, 2006). Thus, research regarding what makes human beings flourish and the importance of developing character strengths has been conducted for many years, including placing an emphasis on the belief that every human being has the capacity to function at an optimal level (Wood & Tarrier, 2010). These psychologists and counselors set the foundation and paved the way for the positive psychology movement to come to fruition. Another major critique of the positive psychology movement is that it does not take into account the realistic side of life and adopts a "Pollyanna view of the world" (Gable & Haidt, 2005, p. 107). However the goal of positive psychology is not to invalidate pathology and suffering or the research conducted on those topics, but instead to build resilience and character strengths in order to enhance the current research (Gable & Haidt, 2005).

Similarly, Norem and Chang (2002) criticized positive psychology for adopting a "one size fits all" approach to positive thinking and optimism. What is considered "good" for one group of people may not be the same for others. Previous research has demonstrated that optimism can contribute to overall well-being and pessimism can contribute to negative affect and outcomes (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Based on these findings, researchers may have a tendency to conclude that optimism will contribute to positive outcomes for most individuals, but individuals are complicated and what is considered beneficial for one

person may not be the same for another. For example, research conducted by Norem and Chang (2002) demonstrates that defensive pessimism (exploring all possible negative outcomes before an event) is a strategy used by anxious individuals to prepare for upcoming events, and that it may not necessarily be beneficial for these individuals to use optimistic thinking as using defensive pessimism helps them prepare for the worst case scenario and cope with their anxiety. These results demonstrate that more positive psychology research needs to be conducted on how to apply findings to diverse populations and personalities.

Thus, a related critique of positive psychology is that its constructs and research findings are not culturally applicable to diverse populations. A majority of positive psychology research has been conducted on Western samples. Researchers emphasize the importance of positive psychologists examining how culture has shaped the meanings clients attribute to their character strengths because labeling something as "positive" requires that cultural norms be taken into consideration (Diener & Suh, 1997; Gable & Haidt, 2005). Additionally, the importance of particular character strengths and the meaning attached to them differ across cultures are not always universal (Gable & Haidt, 2005; Pedrotti, Edwards, & Lopez, 2009). Gable and Haidt (2005) support this point by asserting that even if a character strength holds the same value across cultures, it may be communicated or classified differently according to the culture. Wong (2006) illustrates how this concept could manifest in therapy, explaining that "a lack of assertiveness," which may be viewed by a clinician as "dysfunctional" (p. 139), may be valued highly as a virtuous form of humility by a client who is religious.

Research has also found that positive psychology interventions are more applicable to clients from individualist cultures rather than clients from collectivist cultures (Boehm, Lyubomirsky & Sheldon, 2011). Researchers argue that given this information, it is important for

therapists to examine the type of culture each client comes from when treating him or her and considering which (if any) positive psychology interventions to implement (Christopher & Hickinbottom, 2008; Sin & Lyubomrisky, 2009). Sin and Lyubomirsky (2009) provide an example that an individual from a collectivist culture may benefit more from writing a gratitude letter aimed at someone else rather than an intervention focused on the individual such as examining personal strengths. These criticisms indicate a need for positive psychology research to expand its focus on applicability of positive psychology interventions across cultures.

A final criticism of positive psychology is the lack of consistency in the definition of positive psychological constructs as there is a high degree of overlap between them (Mollen et al., 2006; Shogren, Lopez, Wehmyer, Little, & Pressgrove, 2006). Emmons and Shelton (2002) highlighted the significance of this issue stating ''greater attention needs to be paid to the overlap of constructs so as to ascertain shared operative processes and the shared variance in optimal functioning'' (p. 756). However, an attempt to create positive psychological constructs that are congruent across cultures creates a potential danger of adopting a one size fits all approach across different cultures because while one trait may be considered positive in one cultural context, it may not be regarded as positive in another cultural context. Therefore it is of significant importance that constructs be clearly defined according to cultural and socially derived values (Mollen et al., 2006; Norem & Chang, 2002; Shogren et al., 2006).

Trauma through the Lens of Positive Psychology

Approximately 40% of people living in the U.S. experience either one or several events (such as physical or sexual assaults, natural disaster, or combat) that can contribute to the development of Posttraumatic Stress Disorder (PTSD; Breslau, Chilcoat, Kessler, & Davis, 1999; Peterson, Park, Pole, D'Andrea, & Seligman, 2008). At the same time, positive effects in

8

the outcome of a traumatic event have been found to contribute to enhanced psychological well-being, decreased PTSD symptom severity (Joseph & Linley, 2008; Kashdan, Uswatte, & Julian, 2006; Linley, Joseph, & Goodfellow, 2008), and positive character changes (Linley & Joseph, 2004; Linley et al., 2008; Tedeschi & Calhoun, 2004). Accordingly, research that has been conducted in the application of positive psychology with trauma survivors does not focus solely on the negative effects of traumatic events and the maladaptive coping that may result, but also focuses on the growth that humans experience in response to such events and the ability to utilize their character strengths such as hope, gratitude and spirituality to deal with trauma and adversity (Joseph & Linley, 2008; Tedeschi & Calhoun, 2004). Positive psychologists acknowledge the importance of studying distress and negative effects of trauma in addition to the positive effects, as illustrated by Bonanno (2008) who stated that "dysfunction cannot be fully understood without a deeper understanding of health and resilience" (p. 110). Thus, psychotherapists should continue to develop skills and implement interventions to help reduce distress and enhance positive effects following trauma with their clients.

This section begins by discussing and critiquing the DSM definitions of trauma. Next the positive and negative trajectories in response to trauma are discussed. It concludes with a review of psychotherapeutic interventions used with trauma survivors, including positive psychology interventions and common therapeutic factors important in trauma treatment.

DSM Definitions of Trauma and Critiques

Traumatic events are defined by The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013), in order to diagnose PTSD or Acute Stress Disorder. The DSM-5 defines trauma as part of diagnostic criterion A for Posttraumatic Stress Disorder (PTSD):

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more)

of the following ways: 1) directly witnessing the traumatic event(s); 2) witnessing, in

person, the event(s) as it occurred to others; 3) learning that the traumatic event(s)

occurred to a close family member or close friend. In cases of actual or threatened death

of a family member or friend, the event(s) must have been violent or accidental; and 4)

experiencing repeated or extreme exposure to aversive details of the traumatic event(s)

(e.g., first responders collecting human remains; police officers repeatedly exposed to

details of child abuse; note: this criterion does not apply to exposure through electronic

media, television, movies, or pictures, unless this exposure is work related). (p. 271)

Although this new definition of trauma is currently used by researchers and mental healthcare

providers, it (as well as the previous definition of PTSD as defined in the DSM-IV-TR, which

was used in the current study as the DSM-5 was not published yet) has been critiqued for its

clinical utility and accuracy. In light of the fact that DSM-5 is a relatively new publication, the

majority of the arguments still relate with the prior definition of PTSD by the DSM-IV-TR and

are presented in the following section.

The DSM-IV-TR definition of trauma has been critiqued for not adequately designing a

framework from which to address the range of different events and circumstances that can

qualify as traumatic, thereby excluding potential patients or clients with trauma. Researchers

argue that expanding the PTSD criteria would accurately diagnose individuals who have suffered

from different types of events and are experiencing PTSD symptoms. One such researcher is

Seides (2010) who argued that while PTSD can occur as a result of one traumatic event, it can

also occur as a result of microtraumas, or multiple traumatic events that are less distressing, the

effects of which accrue over time. Microtraumas can include chronic emotional neglect in

childhood, harassment in the workplace, multiple lawsuits or repeated humiliation. Also, multiple traumatic events that occur during childhood (often of an interpersonal nature) are referred to as "complex trauma." Examples of such events include childhood sexual or physical abuse, chronic medical conditions, or domestic violence (Courtois, 2008). Disorders such as Complex Posttraumatic Stress Disorder (CPTSD) and Developmental Trauma Disorder (DTD) have been considered in order to properly diagnose and treat individuals according to the number and type of traumas experienced (Van der Kolk, 2002; Williams, 2006).

Taking the aforementioned factors into consideration, Seides (2010) proposed that the DSM expand the PTSD criteria (as defined in the DSM-IV-TR) to include microtraumas as events that can also lead to PTSD symptoms because although microtraumas don't meet the level of stress required for an event to be considered traumatic according to the DSM-IV-TR, the effect that accumulates over the years can surpass the required level of stress. Typically outside of the control of the individual, these events can result in anxiety, depression, humiliation, fear, difficulty sleeping or hypervigilance (Johansen, Wahl, Eilertsen, Weisaeth, & Hanestad, 2007). Wilson (1991) also argued that chronic exposure to multiple microtraumas such as bullying can cause more psychological distress than a life threatening event. According to the Cognitive Theory of Stress and Coping, PTSD symptoms can occur as a result of multiple traumatic events that are not life-threatening, further supporting the theory that microtraumas contribute to as significant level of stress over time (Jayasinghe, Giosan, Difede, Spielman, & Robin, 2006; Rubin, Berntsen, & Bohni, 2008).

Another criticism of the DSM-IV-TR's definition of trauma was the lack of applicability to diverse cultures. Although responses to trauma have similar elements across diverse populations, these responses are not considered universal (Antai-Otong, 2002). Tummala-Narra

(2007) argues that cultural differences in responses to trauma could be due to differences in emotional expression. For example, refugees from El Salvador and Central America perceive somatic symptoms such as headaches or stomach aches due to anxiety or anger as an "acceptable" way to communicate emotions than expressing them verbally. Additionally, individuals from diverse cultures may experience racism or discrimination that can be viewed as traumatic as it impacts one's relationships and sense of safety (Scurfield & Mackey, 2001; Sorsoli, 2010). The DSM-IV-TR definition of trauma did not include events such as racism or discrimination, despite the reported effects these events have had on individuals from different cultures. Lazarus and Folkman (1984) further supports these points by stating that "a stressful event does not occur in a vacuum, but in the context of the individual's life cycle and in relation to other events, be they distant, recent, or concurrent" (p. 108). Thus, a traumatic event needs to be viewed in the context of the individual's cultural environment, in order to best inform diagnosis and treatment. The new DSM-5 now contains the following information regarding culturally relevant diagnostic issues for PTSD (Hinton & Lewis-Fernández, 2011):

> The risk of onset and severity of PTSD may differ across cultural groups as a result of variation in the type of traumatic exposure (e.g., genocide), the impact on disorder severity of the meaning attributed to the traumatic event (e.g., inability to perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in post-conflict settings), and other cultural factors (e.g., acculturative stress in immigrants). (p. 272)

On the opposing side are researchers who argued that the DSM-IV-TR's definition of traumatic events needed to be narrowed. For example, McNally (2009) argued that Criterion A1 of PTSD be altered so that indirect exposure to a trauma (as defined in the DSM-IV-TR) could

be removed from the definition for the recently released DSM-5. McNally described that the definition of trauma (as defined in the DSM-IV-TR) includes individuals who directly experienced the traumatic event (e.g., combat veterans or assault survivor), individuals who were witnesses of trauma that occurred to others (e.g., witnesses of a stabbing), and individuals who are presented with information regarding threats to others (e.g., viewers of the September 11, 2001 terrorist attacks). Many have opposed such classifications as the trauma experienced by an individual who directly experiences it is different from trauma experienced by somebody who is presented with information regarding threats to others. McNally (2009) stated, "Even though both groups are reporting the 'same' symptoms, the meaning of the symptoms for television viewers and actual survivors is almost certainly very different" (p. 599). Andreasen (2004) also argued, ''this broadening should be reconsidered. Giving the same diagnosis to death camp survivors and someone who has been in a motor vehicle accident diminishes the magnitude of the stressor and the significance of PTSD'' (p. 1322). Additionally, researchers have argued that expansion of the definition of trauma will impact ability to assign "causal significance" to the traumatic event. Another concern is that clinicians may pathologize normal emotional responses to stressors.

In order to address these concerns, modifications to Posttraumatic Stress Disorder for the recently released DSM-V were proposed. For example, McNally (2009) recommended that DSM-V should eliminate PTSD of the virtual kind, which is referred to as "indirect, informational exposure" in Criterion A, and instead require that the individual was either a direct recipient of the trauma or a witness of the trauma experienced by others. Thus, McNally proposed that individuals who experience informational exposure regarding threats to others and

experience PTSD symptoms should be diagnosed with either Anxiety Disorder NOS or a new V code for "acute nonpathological reactions to a stressor" (McNally, 2009, p. 598).

Similarly, the APA Anxiety, OCD-Spectrum, Posttraumatic, Dissociative Disorders Work Group suggested that in order for a diagnosis of PTSD to be given the individual must have: 1) directly experienced the traumatic event, 2) witnessed the traumatic event personally, 3) learned that the violent or accidental death had happened to a close friend or family member, or 4) experienced extreme or repeated exposure to aversive details of the traumatic event (e.g., first responders collecting human remains; APA, 2012). The new Criterion A in the DSM-V excludes those individuals who witness the traumatic event indirectly through electronic means from receiving a diagnosis of PTSD. Additionally, the APA Anxiety, OCD-Spectrum, Posttraumatic, Dissociative Disorders Work Group suggested including a category such as Trauma or Stress Related Disorder Not Elsewhere Classified, for trauma related disorders that do not meet specific criteria for PTSD. The current DSM-V definition of PTSD is now included in the new Trauma- and Stressor-Related Disorders category in, rather than the anxiety disorders category (as it was placed in that category in the DSM-IV-TR).

The definition that will be used for the purposes of this dissertation is the predominant definition of trauma in the current DSM-5. As suggested by McNally (2004; 2009) and the APA Anxiety, OCD-Spectrum, Posttraumatic, Dissociative Disorders Work Group (APA, 2012) only individuals who have directly witnessed or experienced a serious threat to physical integrity or death will be included.

Examples of traumatic events as outlined by the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; First, Spitzer, Gibbon, & William, 2002) include, but are not limited to: serious accidents or fire, rape or physical assault, child sexual abuse, life threatening combat

experiences, seeing another person being killed or badly hurt, and life threatening major natural

disasters. Learning of an event indirectly (e.g., on television, talking to a friend) or experiencing

a traumatic event that did not involve a threat to physical integrity (e.g., a relationship breakup,

learning about the death of a family member) will *not* qualify as a traumatic experience for the

purposes of this dissertation. This definition will also include complex trauma resulting from

repeated traumatic events such as childhood abuse, domestic violence, and multiple traumatic

events that have accumulated over a person's lifetime. Additionally, this definition will include

trauma associated with cultural or race-based factors that have threatened the person's physical

integrity (e.g., hate crimes that involve actual or threatened physical assault). Finally, it is *not*

required for the individual to have a response that includes fear, helplessness, or horror as a

result of the trauma since many individuals vary in their responses to a traumatic event.

Trauma Trajectories

While positive psychology researchers have widely acknowledged that there are many

negative responses and consequences that occur in the aftermath of trauma, they also aim to

understand the positive responses that can occur after trauma survival, such as posttraumatic

growth and resilience. The reactions that occur as a result of a traumatic event are referred to as

positive or negative trajectories (Bonnano, 2008), which this section reviews.

Positive trajectories. Positive trajectories refer to the different methods that an

individual utilizes in order to "return to, or exceed pretrauma levels of functioning" (Joseph &

Linley, 2008, p. 40). Positive trajectories identified in the literature include posttraumatic growth

(PTG) and resilience.

Posttraumatic growth refers to "positive changes in individuals that occur as a result of

attempts to cope in the aftermath of traumatic life events" (Linley & Joseph, 2004, p. 406). In

15

order for growth to occur, the loss needs to have a significant impact on an individual's identity and framework of understanding the world. As a result of this impact, some survivors are able to make meaning out of their traumatic experience, which can cause them to view themselves, the world and others from a different perspective, and can simultaneously lead to growth.

A number of theorists have hypothesized that the variability of these responses may be due to how the survivor copes with the discrepancy between his/her global life meaning and the meaning he/she assigns to the traumatic event. Global world meaning consists of an individual's specific "beliefs, goals and subjective feelings" (Dittman-Kohli & Westerhof, 1999; Reker & Wong, 1988, as cited in Park, 2010, p. 258). These beliefs include perceptions about justice, control and predictability in addition to the individual's self-view (Janoff-Bulman, 1992; Leary & Tangney, 2003; Parkes, 1993, as cited in Park, 2010). These beliefs form the foundation from which the individual's core schemas develop and the lens through which individuals perceive their experiences in the world (Janoff-Bulman & Frantz, 1997; Mischel & Morf, 2003, as cited in Park, 2010). Thus, global meaning has a significant impact on an individual's thoughts, behaviors and emotional responses.

Situational meaning, on the other hand, refers to meaning that is assigned to a traumatic event by the survivor (Park & Folkman, 1997; Park, 2008, 2010). Initial appraisals of a traumatic event's meaning consist of several key components including: the degree to which the event is seen as threatening and controllable, the cause of the event and perceptions about how it will impact the individual's future. Additionally, appraised meaning may violate an individual's global belief. For example, an individual who experiences a brutal attack by a stranger may experience a violation of his/her global belief that the world is just and people are kind. A discrepancy such as this one that arises between an individual's appraised (situational) and

16

global meaning can contribute to an individual feeling a loss of control and predictability, which can lead to severe distress and an inability to cope.

According to the meaning-making model, the individual's level of stress and ability to cope are affected by perceptions of discrepancy (e.g., one's sense of control) between the appraised meaning of the traumatic event and their global meaning (Everly & Lating, 2004; Koss & Figueredo, 2004). The meaning-making model asserts that in order to reduce distress individuals often engage in meaning making in order to "restore" global meaning that has been disrupted. Meaning making consists of perceiving the event in a way that causes individuals to reform their beliefs to make them consistent. Individuals are able to do this by either altering the appraised meaning assigned to the traumatic event, altering their global beliefs, or both as a way of making sense of the tragedy (Brandtstädter, 2006; Joseph & Linley, 2005, as cited in Park, 2008). Thus, many changes can occur as a result of meaning making such as: changes to an individual's perception of the traumatic event, changes in an individual's global beliefs, and stress-related growth (Park & Edmondson, 2012, as cited in Shaver & Mikulincer, 2012). Furthermore, stress-related growth can contribute to an "increased appreciation for life", in addition to deeper relationships with significant others and an improved ability to recognize one's strengths (Park & Edmondson, 2012, as cited in Shaver & Mikulincer, 2012, p. 148).

According to research, posttraumatic growth contributes to an increase in psychological well-being, deeper compassion towards others, a desire to put more energy into relationships, and improved self-care (Calhoun & Tedeschi, 1999, as cited in Linley & Joseph, 2004; Ai & Park, 2005), and other benefits such as "heightened appreciation of life, more meaningful personal relationships, awareness of increased personal strength, changes in life priorities and

17

recognition of new possibilities and a deepening of engagement with spiritual or existential concerns and the enhancement of faith" (Joseph & Linley, 2008, p. 43).

Additionally, religion is also a significant factor of the meaning making process, due to the fact that religion plays an important role in many individuals' cultural identities, global beliefs and goals. Although these global beliefs and goals can be violated by stressful events, the majority of religions emphasize different ways of interpreting distress (Pargament, 1997; Park, 2005,, as cited in Shaver & Mikulincer, 2012). Thus if religion is an important component of a client's life, it may be detrimental to treatment not to address this aspect of the client's identity. Furthermore, religion may play a key role in the meaning making process by helping individuals to cope and experience positive consequences.

As noted above, positive changes occur for some, but not all, individuals after traumatic events or experiences. For example, an analysis of 39 studies by Linley and Joseph (2004) indicated that positive growth was found in approximately 30-70% of trauma survivors in the aftermath of a variety of traumatic events, including: transportation accidents, natural disasters, physical or sexual attacks, medical issues, and other traumatic events such as divorce and loss of a loved one. Various factors may impact people's abilities to experience PTG, in addition to those related to reconciling global and situational meaning-making. According to Joseph and Linley, positive growth is related with "higher socio-economic status, higher education, younger age, personality traits such as optimism and extraversion, positive emotions, and social support" (as cited in Joseph & Butler, 2010, p. 2). Thus, survivors' responses to traumatic events vary greatly.

Resilience refers to "the ability to maintain a stable equilibrium" (Bonanno, 2008, p. 102). Lepore and Revenson (2006) stated that resilience is comprised of 3 key components: (a)

18

recovery, (b) resistance, and (c) reconfiguration. Recovery refers to the response that occurs when a trauma survivor's functioning is negatively affected, but eventually returns to the prettrauma level of functioning. Resistance refers to the response that occurs when a trauma survivor's functioning is either not affected by the stressor or affected in a minimal manner. Reconfiguration refers to the response that occurs when a trauma survivor permanently adapts to changes that have occurred as a result of the event, which may also affect the manner in which this person responds to other traumatic or non-traumatic circumstances.

Research findings have suggested that resilience is more common than previously thought. For example, research conducted by Ozer and colleagues (2008) found that approximately 50-60% of the individuals in the U.S. have been exposed to a traumatic event but that only 5-10% are diagnosed with PTSD. Additionally, in a study conducted on Gulf War veterans, 62.5% did not exhibit psychological distress one year after returning to the U.S. (Sutker, Davis, Uddo, & Ditta, 1995, as cited in Bonanno, 2008).

Negative trajectories. Negative trajectories in response to trauma refer to "presentations that involve disturbance, decline and permanent disability" (Joseph & Linley, 2008, p. 40). Others have divided negative responses as a result of a traumatic event (as defined by the prior DSM-IV-TR) into 2 categories: (a) survival with impairment and (b) succumbing. Survival with impairment refers to a response in which an individual exhibits chronic impairment in functioning (Joseph & Linley, 2008). Succumbing refers to a response in which survivors cannot cope with the effects of the trauma (O'Leary & Ickovicks, 1995), and "take actions that result in their death by suicide or through physical injury secondary to maladaptive behaviors (substance abuse or recklessness), or when psychological events result in serious physical disturbances or

exacerbations of preexisting conditions that lead to death" (Kloner, 2006, as cited in Linley &

Joseph, 2004, p. 40).

Individuals who experience psychological distress related to trauma often experience

physical and psychological symptoms that negatively impact biological, psychological, and

social functioning. Included in the prior definition of trauma in the DSM-IV-TR, criteria for

PTSD are common symptoms that occur as a result of the body's fear and stress reactions to the

trauma including: "intense psychological distress at exposure to internal or external cues that

symbolize or resemble an aspect of the traumatic event," "hypervigilance," "difficulty falling or

staying asleep," "efforts to avoid thoughts, feelings, or conversations associated with the

trauma," and "recurrent and intrusive distressing recollections of the event" (APA, 2000, p. 468).

Some individuals may experience chronic impairment in any or all of these domains, depending

on factors such as the severity of the event and level of exposure, pre-trauma functioning,

previous trauma history, coping style, ability to make meaning from the experience and/or

identify any positive consequences (see spiritual bypass discussion below), and environmental

factors, such as lack of social support (Joseph & Linley, 2008). For instance, negative trajectories

have been examined as responses from individuals who have suffered from complex trauma,

such as childhood sexual or physical abuse, chronic medical conditions, or domestic violence

(Courtois, 2008).

Repeated exposure to trauma can have a significant impact on an individual's physical

and psychological well-being as well as their interpersonal relationships (Courtois, 2008). In

addition to these factors, research has demonstrated that early childhood exposure to trauma can

negatively impact self-regulation (Cassidy & Mohr, 2001). Joseph and Linley (2008) conclude

that trauma "does not appear to strengthen self-regulation, but instead causes a shift from

20

ordinary self-regulation to crisis-based regulation geared to achieve survival" (p. 301). Adult

survivors of childhood traumas are also at increased risk of developing PTSD, depression,

anxiety, addictive, psychotic and/or personality disorders (Heim & Nemeroff, 2001; Johnson,

Cohen, Brown, Smailes, & Bernstein, 1999; Kassam-Adams & Winston, 2004; Widom, 1999).

An increasing number of psychologists are incorporating their clients' spiritual beliefs

and practices into treatment (Bashan & O'Conner, as cited in Cashwell, Bentley, & Yarborough,

2007). However, while incorporating spiritual practices in treatment can be therapeutically

effective, it can also inhibit therapeutic progress if spiritual bypass occurs. Spiritual bypass is a

term developed by Charles Whitfield, who was a medical doctor and therapist specializing in

trauma, recovery, and codependence (Clarke, Giordano, Cashwell, & Lewis, 2013). Spiritual

bypass refers to "the use of spiritual experiences, beliefs, or practices to avoid (or bypass)

psychological wounds and other personal and emotional unfinished business, in essence rejecting

these experiences" (Welwood, 2000; Whitfield, 1987, 1991, as cited in Cashwell, Myers &

Shurts, 2004, p. 403). A spiritual bypass reflects a significant gap between the individual's

spirituality and personal development (Welwood, 2000, as cited in Cashwell et al., 2004). This

gap can be problematic as the integration of both spiritual and psychological development is

important for processing painful emotions (Kornfield, 1993, as cited in Cashwell et al., 2004).

Issues that occur as a result of spiritual bypass include: "compulsive goodness, repression of

undesirable or painful emotions, spiritual narcissism, extreme external locus of control, spiritual

obsession or addiction, blind faith in charismatic leaders, abdication of personal responsibility,

and social isolation" (Cashwell, 2005; Cashwell & Rayle [in press], as cited in Cashwell et al.,

2007, pp. 140-141).

Since spiritual bypass often contributes to negative effects and inhibits the progress of therapy, it is important for psychologists to understand how to identify, conceptualize and provide treatment to clients who use spirituality as a way to avoid processing psychological pain. This is particularly important for clients who are trauma survivors as they may utilize spiritual practices and activities as a way to avoid processing their underlying emotional pain from previous trauma and distress. Thus, in order to help the client process the trauma, it is important for the therapist to address all areas of the client's functioning (spiritual, cognitive, emotional, physical interpersonal), and be mindful of if the client is solely focusing on his/her spiritual functioning, as this will likely create barriers to psychological processing (Cashwell et al., 2007).

Psychotherapeutic Interventions Used with Trauma Survivors

Given the risk factors and potential outcomes in the aftermath of trauma, researchers and clinicians have been focused on finding interventions to use with trauma survivors that will help reduce their distress and facilitate potential growth. Treatments for trauma survivors may also utilize medical interventions as neurobiological pathways may become altered due to the traumatic event. Positive psychology theorists emphasize the importance of adopting a strengths-based approach when working with trauma survivors and creating an environment that help facilitates potential growth. This subsection provides a brief review of CBT, humanistic/existential, psychodynamic, and positive psychology interventions, as well as ones highlighting common factors.

Trauma-focused CBT is based on a CBT model of PTSD symptoms that has been developed from several different theories including: Beck's cognitive model, learning theory, and emotional processing theory. While the model is primarily intended for use with children, CBT interventions focused on trauma are also commonly utilized with adults. These

interventions include cognitive processing therapy, exposure therapy and stress inoculation training (Foa et al., 1999; Hembree & Foa, 2010; Woo & Keatinge, 2008). According to Beck's cognitive model, symptoms that impair functioning are not due to the events themselves but the individual's interpretation of those events which can then lead to symptoms. TF-CBT and adult CBT approaches attempt to work on the distorted thoughts that occur as a result of the trauma. Beck and colleagues (1985) hypothesized that "people with traumatic neuroses do not discriminate between safe and unsafe signals, and that their thinking is dominated by the concept of danger" (p. 71). In addition to restructuring distorted thoughts regarding the self and the world, the other key component is emotional processing. Thus, the goals of CBT treatment for trauma survivors are to: (a) help decrease PTSD symptoms by using cognitive restructuring to modify distorted thoughts and beliefs associated with the trauma, (b) reduce level of fear and anxiety through exposure techniques as well as stress inoculation training, and (c) to emotionally process the trauma in order to help the client distinguish the assault from other events (to prevent generalization), thus helping the client to recognize the world is not a dangerous place all the time.

CBT work that focuses on trauma can be offered in a group or individual format. CBT group therapy has also been shown to be effective with individuals suffering from traumatic medical issues. For example, a study was conducted in 2001 on 100 women starting treatment for Stage 0-II breast cancer over a 10-week period. Participants were administered group CBT. Results indicated that this intervention contributed to an increase in participants' recognition that being diagnosed with breast cancer had provided them with some positive consequences (Antoni et al., 2001).

Another CBT-related intervention is Eye Movement Desensitization Restructuring (EMDR; MacCulloch & Feldman, 1996; Shapiro, 1989). EMDR involves imaginal exposure with multi-saccaadic eye movements, with the goal being desensitization of the traumatic memory.

Humanistic/existential interventions utilize an experiential model of processing trauma in which the clinician aims to explore changes in the client's worldview, perception of others and themselves. This model is based on an emotional processing conflict theory that argues the symptoms that cause an individual to re-experience the traumatic event are an attempt for the individual to resolve significant emotional or adverse events (Greenberg, Rice, & Elliot, 2002).

Similarly, psychodynamic treatment for trauma survivors focuses on the meaning individuals ascribe to their responses and symptoms due to the traumatic event (Rose, 2002) Psychodynamic theory emphasizes the importance of examining the individual's internalized self-representations in relation with disrupted self-perceptions from early attachment by helping the client create a trauma narrative to make meaning out of their experience and process their emotions.

Taking into account aspects of CBT, humanistic and psychodynamic approaches, Joseph and Linley (2004) determined 4 key factors in treating trauma survivors from a positive psychology perspective (a) help the client to derive meaning from the event that occurred, (b) guide the client in developing awareness of insights gained as a result of the event, (c) help the client to use strengths to challenge "negative self-schemas" that occurred after the trauma event, and (d) help foster growth and the idea that the client can cope with the trauma and that positive aspects can occur. When guiding the client, Calhoun and Tedeschi (1999) emphasize that the concept of growth not be prematurely pushed onto the client. In other words, it is important for

the clinician not to convey to the client that there is an expectation for the client to experience growth and it is bad if they do not. The therapist's job is to attend to references clients may make in regards to their own growth and positive strengths that have emerged in the aftermath of the event and help clients navigate that process at a pace they are comfortable with.

Regarding fostering PTG and coping, positive psychotherapists should aim to help trauma survivors pay attention to and enhance positive emotions that may occur in the aftermath of trauma, such as humor, gratitude, and appreciation (Tedeschi & Calhoun, 1996). For example, when a trauma survivor attempts to make meaning out of the event that occurred, he/she may experience stress-related growth which can lay the foundation for experiencing gratitude and an increased appreciation for life (Park & Edmondson, 2012, as cited in Shaver & Mikulincer, 2012)

Linley and Joseph (2008) stated that "the experience of gratitude and appreciation may serve to undo the effects of negative emotion following trauma" (p. 345). For example, perceiving benefits (similar to the positive psychology intervention "Counting Blessings") has been associated with positive psychological adjustment 18 months after bereavement (Davis, Nolen-Hoeksema, & Larson, 1998), and a decreased likelihood of death 8 years after the first heart attack in patients (Affleck, Tennen, Croog, & Levine, 1987). Attending to these PTG constructs and using positive psychology interventions may help clients cope with the negative emotions that arise and buffer against development of chronic negative emotions associated with posttraumatic stress.

Regardless of what interventions are used, research has demonstrated that the strength of the therapeutic alliance impacts the therapeutic outcome (Gaston, Piper, Debbane, & Bienvenu, 1994; Krupnick et al., 1996). Similarly, Shapiro (2010) argues that the clinician's ability to build

rapport is the "best therapeutic tool" that can be used in trauma therapy (p. 47). Shapiro explains that if a clinician is unable to connect with a client, it will be difficult, if not impossible to help the client because in order for the client to undergo trauma therapy it is imperative that he/she feels understood and cared for by the clinician. Since the therapeutic alliance is so important, Shapiro (2010) recommends a few verbal and nonverbal gestures that clinicians can use to build rapport with the client including: sitting close to the client (but respecting the client's personal space and not sitting too close), making eye contact but not forcing the client to do the same, and being transparent by disclosing one's own feelings (e.g., expressing sadness about what happened to the client or physical symptoms experienced by the therapist that may be similar to what the client is experiencing).

Positive psychologists also emphasize the importance of using empathy to create a strong therapeutic alliance which will facilitate an environment in which the client feels supported and trusts the therapist is imperative to the treatment (Joseph & Linley, 2008). Therefore, therapists who are treating trauma survivors should convey unconditional positive regard, genuineness, and empathy to their clients in order to strengthen the therapeutic alliance and create opportunities for growth and positive change.

Gratitude

Gratitude is derived from the Latin *gratia*, meaning grace, graciousness, or gratefulness, and has been celebrated in ancient religious texts through modern social science research as a desirable human characteristic with the capacity for making life better for oneself and for others (Emmons & Shelton, 2002). Since the 1930's, social scientists have noted the importance of gratitude and the implications of expressing gratitude on a societal level. For example, gratitude has been described as essential for facilitating reciprocity between individuals (Gouldner, 1960;

26

Simmel, 1950). By engendering a prosocial response to perceived benefits from others, it is adaptive in an evolutionary sense (Trivers, 1971, as cited in Linley & Joseph, 2004). Additionally, recent research has demonstrated that gratitude can act as a protective factor against mental illness (Frederickson, Tugade, Waugh, & Larkin, 2003; Kendler et al., 2003; Linley & Joseph, 2004), which has relevant implications for the use of gratitude interventions in psychotherapy.

This section begins with a review of the different ways in which gratitude is conceptualized and defined. Next, research demonstrating the social, physical and psychological benefits of gratitude is discussed. Then, research on the relationship between gratitude and trauma survivors as well as factors that contribute to coping are discussed. Next instruments used to measure gratitude are presented. Finally, this section concludes with a review of interventions that can be used to strengthen gratitude in the context of psychotherapy.

Defining Gratitude

Despite its enduring nature, there has been discrepancy in agreement on a unitary definition of gratitude. Gratitude has been presented as a positive psychological character strength and trait, coping response, attitude, moral virtue, emotion, and habit (Emmons, McCullough, & Tsang, 2003). It has also been divided into narrow and broad conceptualizations (e.g., benefit-triggered vs. generalized gratitude); yet overlap exists and future research is needed to clarify definitions (Lambert, Graham, & Fincham, 2009). This subsection examines gratitude broadly (as a character trait, attitude, and as dispositional and generalized gratitude), and more narrowly (as a habit and an emotion), and concludes with the definition that will be used in this study.

Gratitude broadly defined. Broad definitions of gratitude all appear to refer to a general tendency and characteristic of an individual to approach and respond gratefully to most circumstances. Overlapping labels used within this categorization include trait gratitude, dispositional gratitude, an attitude, and generalized gratitude.

Gratitude as a trait appears to be synonymous with dispositional gratitude. The *Oxford Handbook of Positive Psychology* defines trait gratitude as "one's disposition for gratitude" (Watkins, Van Gelder, & Frias, 2009, p. 439). More specifically, Peterson and Seligman (2004) state that trait gratitude "is expressed as an enduring thankfulness that is sustained across situations and over time" (p. 555). Similarly, dispositional gratitude was conceptualized in 2001 by McCullough and colleagues as "a generalized tendency to recognize and respond with grateful emotion to the roles of other peoples' benevolence in the positive experiences and outcomes that one obtains" (p. 112).

Dispositional gratitude has been described as being comprised of 4 main facets: (a) gratitude intensity, (b) gratitude frequency, (c) gratitude span, and (d) gratitude density (Peterson & Seligman, 2004). Gratitude intensity refers to the tendency of an individual with dispositional gratitude to experience gratitude to a more intense degree as a result of a positive event when compared with an individual who does not have a strong gratitude disposition (Peterson & Seligman, 2004; McCullough, Emmons, & Tsang, 2002). Gratitude frequency refers to the tendency for an individual with a grateful disposition to experience gratitude (even in response to small favors) on a more regular basis, than an individual who does not have a strong gratitude disposition (Peterson & Seligman, 2004). Another aspect of gratitude frequency has been described as the effortless manner in which gratitude is provoked (McCullough et al., 2002). Gratitude span refers to the amount of blessings (including people, events and other

circumstances) that an individual is grateful for during a given time disposition (Peterson & Seligman, 2004). Relatedly, 3 aspects of trait gratitude are: (a) sense of abundance, which refers to the individual's gratitude for benefits received, (b) simple appreciation, which refers to appreciation for simple pleasures such as nature and sunsets as opposed to luxurious pleasures such as vacations, and (c) social appreciation, which refers to appreciation towards others for benefits received (Linley & Joseph, 2004; Watkins, Woodward, Stone, & Kolts, 2003). Gratitude density refers to the amount of individuals that a person feels gratitude towards for a specific positive event or benefit disposition (Peterson & Seligman, 2004). An individual with a strong grateful disposition is more likely to be grateful towards a wide variety of people and for more blessings, as opposed to an individual with a weaker gratitude disposition.

Dispositional gratitude has also been referred to as an attitude of appreciation (Lambert, Graham, & Fincham, 2009). In his book *Thanks! How Practicing Gratitude Can Make You Happier*, Emmons (2008) defines gratitude as an attitude that is "a chosen posture toward life that says, "I will be grateful in all circumstances" (p. 180). Emmons differentiates between gratitude as an emotion that naturally occurs as a result of events or benefits, and "being grateful" which is an attitude one adopts towards life. Emmons (2008) further supports this point by stating that a "grateful stance toward life is relatively immune to both fortune and misfortune" (p. 181).

Similarly, generalized gratitude refers to the tendency to be appreciative of others, events or things that people consider meaningful and valuable, regardless of particular benefits perceived (Lambert, Graham, & Fincham, 2009). Adler and Fagley (2005) and Steindl-Rast (2004) define generalized gratitude as being "grateful for something or someone" (as cited in Lambert et al., 2009, p. 1194), as opposed to being grateful to someone for a benefit received.

Adler and Fagley (2005) also referred to broad gratitude as, "acknowledging the value and meaning of something—an event, a person, a behavior, an object—and feeling a positive emotional connection to it" (p. 81).

A component of generalized gratitude is transpersonal or universal gratitude, which is defined as "a gratefulness to God, to a higher power, or to the cosmos" (Peterson & Seligman, 2004, p. 555). Transpersonal or universal gratitude typically results from peak experiences that can include nature or spirituality and are often accompanied by a sense of undeserved kindness (Peterson & Seligman, 2004). Lambert and colleagues (2009) further note that "the object of celebration may be a thing, a person, an activity, an event, a situation, or a state" (p. 1194). Finally, definitions of this broad sense of gratitude have also referenced its effects, namely gratitude cognitions, feelings, and/or behaviors. In their most recent review chapter, Emmons and Mishra (2011) defined trait gratitude as a "stable affective trait that would lower the threshold of experiencing gratitude" as emotions or mood states (p. 249). In other words, "if an individual is high in trait gratitude, then they should experience gratitude more easily and more frequently than one who is not a grateful person" (Watkins et al., 2009, p. 439). Similarly, when Roberts (2004) defined dispositional gratitude as a trait, he noted that it makes an individual "prone to respond with gratitude to a wider range of beneficent actions, and more likely to notice beneficence on the part of others" (Roberts, 2004, p. 60). Roberts (2004) also elaborated that individuals who have a disposition to experience gratitude are more likely to respond to benefits with gratitude rather than negative emotions such as resentment or shame.

Gratitude as a habit. In the book *Thanks! How Practicing Gratitude Can Make You Happier*, Emmons (2008) explains that although individuals may not naturally have dispositional gratitude, gratitude can be acquired as a habit through consistent practice. In recent years,

numerous gratitude exercises such as "count your blessings" and "the gratitude visit" aimed at increasing one's tendency to experience gratitude, have been tested with both clinical and non-clinical samples (Carson, Muir, Clark, Wakely, & Chander, 2010; Emmons & McCullough, 2003; Seligman, Rashid, & Parks, 2006; Seligman et al., 2005; Sheldon & Lyubomirsky; 2006). Watkins and colleagues (2009) theorized that a consistent practice of gratitude will likely contribute to "long-range increases in happiness" (p. 443). Consistent with this hypothesis, research has demonstrated the positive effects of cultivating gratitude consistently (Sin, Della Porta, & Lyubomirsky, 2011; Seligman et al., 2005).

Although gratitude has been conceptualized as a habit, the literature on this definition does not appear to be specific as to what aspects or experiences of gratitude are to be practiced: feelings, thoughts, states and/or behaviors. Perhaps Frederickson's (1998) theory about how the experience of gratitude as an emotion can contribute to specific action tendencies and prompt reciprocity behavior could be used to further understand gratitude as a habit. As it stands, however, this definition is limited and is in need of refinement. Lambert, Graham and Fincham (2009) asserted that in order for such definitions to become specific, research studies need to be more clear regarding the specific type of gratitude being studied.

Gratitude as a narrow state and emotion. Researchers tend to focus more on the narrower definitions of gratitude, including gratitude as a state, emotion, and mood appearing as a response to receiving gifts or benefits from others, as opposed to broader definitions (Lambert, Graham, & Fincham, 2009). Some define gratitude simply as the cognitive awareness that a person is a recipient of a benefit received from an external source; others explicitly explain how the emotion of gratitude is connected to a preceding thought, meaning or attitude; and others focus more on its behavioral outcome.

31

The emotion of gratitude is often referred to in the literature as a state that arises temporarily when an individual acknowledges that he/she has received a benefit and recognizes that an external source is responsible for providing this benefit or gift (Watkins et al., 2009). Finally, gratitude has been identified as an empathic, positive and moral emotion that serves prosocial functions, and has been identified as an important component of coping. This subsection explores these views to elucidate how gratitude as an emotion has developed.

Gratitude as an emotion. Gratitude has been conceptualized as an emotion that serves prosocial and moral functions. In other words, gratitude is comprised of vital cognitive-emotional components that contribute to prosocial and moral behavior.

Initial psychological writings on gratitude examined how the feeling of gratitude was prompted through benefit-finding or benefit-perceiving. For example, Fritz Heider, a prominent social psychologist, asserted that individuals experience gratitude when a benefit is bestowed by somebody who the individual believes was intended to provide him or her with benefits (as cited in Emmons & McCullough, 2004). Currently, this understanding of gratitude as an emotion is referred to as personal gratitude or benefit-triggered gratitude. It is defined as "thankfulness toward a specific other person for the benefit that the person has provided" (Peterson & Seligman, 2004, p. 555). Similarly, Lambert and colleagues (2009) identified this type of gratitude as an "emotion that results from an interpersonal transfer of a benefit from a beneficiary to a benefactor" (Lambert et al., 2009, p. 1194). Thus, personal gratitude pertains to specific contexts in which benefits were received (Steindl-Rast, 2004).

Research by Lambert and colleagues (2009) examined in two studies whether individuals are more likely to experience gratitude in a narrow or broad manner. They found that individuals are more likely to express gratitude in a narrow manner rather than a broad manner. Their first

study was conducted with a sample of 208 undergraduate students (157 females, 51 males, ages 18-30). Participants were asked to write a paragraph about an experience when they felt grateful and to describe some thoughts and feelings they experienced during that time. Findings indicated that 58% of responses were benefit-triggered gratitude, while, 22% were generalized gratitude, and 20% were responses that contained both benefit-triggered and generalized gratitude. In a second study conducted by Lambert and colleagues (2009), they asked a sample of 55 undergraduate students (34 females, 21 males, ages 18-30) to think back to a time when they felt grateful and write a paragraph about the experience. Results from the second study indicated 53% of their responses were deemed benefit triggered gratitude, 22% as generalized gratitude, and 25% included both.

Other current theorists also explain gratitude through the cognitive-emotional appraisal of events. According to Weiner's (1985) attributional theory, the emotional reactions individuals experience are due to causal appraisals of situations. Secondary emotional responses such as gratitude are considered attribution-dependent as attribution to an outside source due to benefits received elicits gratitude. According to this theory, gratitude is a cognitive process with 2 main components: (a) acknowledging receipt of a benefit and (b) acknowledging that the benefit was received from an outside source.

Similarly, according to Lazarus and Lazarus (1994), individuals who receive benefits experience the emotion of gratitude as a result of being aware that the benefactor has taken the time and effort to provide them with benefits. In their theory, every emotion is attached to a personal meaning which becomes a frame of reference for how individuals perceive events. Accordingly, they define gratitude as an empathic emotion that occurs as a reaction to benefits

received (Lazarus & Lazarus, 1994). The meaning attached to gratitude is the awareness of benefits received from an outside source.

Gouldner (1960) posited that the emotion that develops from this awareness of or reactions to transferred benefits prompts individuals to engage in reciprocity behavior, which is prosocial and moral in nature. Frederickson (1998) expanded on this work by asserting that gratitude is a positive emotion capable of helping an individual build psychological and social resources. Frederickson theorized that beyond eliciting specific action tendencies, positive emotions such as joy, interest, pride, contentment and gratitude "broaden people's momentary thought-action repertoires, widening the array of the thoughts and actions that come to mind" (Frederickson, as cited in Emmons & McCullough, 2004, p. 147). Since gratitude prompts individuals to explore different methods of reciprocating the benefits they have received, their momentary thought-action repertoires are broadened. As a result, the individual's skills for showing love and care to others are strengthened, and they are more likely to also feel supported and loved by others. Thus, from this viewpoint, the emotion of gratitude serves as a vehicle for strengthening social relationships.

Gratitude as a moral emotion and virtue. Other theories focus on gratitude as a moral emotion and/or virtue. Gratitude has been defined as a virtue that serves moral, secular purposes such as prompting reciprocity behavior (e.g., gift giving; McCullough, Kilpatrick, Emmons, & Larson, 2001), as well as a non-secular virtue that emphasizes the importance of giving thanks to God both generally and for specific benefits received (Emmons, 2008; Emmons & McCullough, 2004; Frederickson, 2004). This subsection reviews both the secular and non-secular definitions of gratitude as a virtue.

Gratitude as a secular virtue. McCullough and colleagues (2001) defined gratitude as a moral emotion comprised of 3 key components: (a) gratitude as a moral barometer, (b) moral motive, and (c) moral reinforcer. Gratitude as a moral barometer has been defined as recognition of a change that occurs when a benefit is received and gratitude is experienced (McCullough et al., 2001). McCullough and colleagues (2011) support this theory by explaining as a moral barometer, gratitude is dependent on social-cognitive input, people are most likely to feel grateful when:

> (a) they have received a particularly valuable benefit; (b) high effort and cost have been expended on their behalf; (c) the expenditure of effort on their behalf seems to have been intentional rather than accidental; and (d) the expenditure of effort on their behalf was gratuitious (i.e., was not determined by the existence of a role-based relationship between benefactor and beneficiary). (p. 252)

In this way, gratitude serves as a moral barometer because the extent to which some or all of these 4 factors are met contributes to the social-cognitive input a person receives and the likelihood that he/she will acknowledge this change and feel gratitude as a result.

Second, gratitude can act as a moral motivator because it encourages individuals to respond to an act of kindness by reciprocating with kindness. For example, if an individual is given a gift from another person, he may feel motivated to repay this act of kindness with a gift or some other benefit. Similarly, Smith (1976) conceptualized gratitude as an emotion vital for serving prosocial functions, claiming that "the sentiment which most immediately and directly prompts us to reward, is gratitude" (Smith, as cited in Peterson & Seligman, 2004, p. 556). Smith also asserted that "Beneficiaries are most likely to feel and express gratitude toward benefactors who (a) intend to benefit them, (b) succeed in benefiting them, and (c) are capable of

sympathizing with the beneficiary's grateful feelings" (as cited in Emmons & McCullough, 2004, p. 124).

Third, gratitude as a moral reinforcer indicates the increased likelihood that a benefactor will respond with kindness based on the recipient's grateful reaction; thus it acts as a reinforcer. For example, if the recipient of the benefits expresses gratitude, the benefactor's behavior is reinforced and he/she is more likely provide benefits again (Emmons & McCullough, 2004; McCullough et al., 2001).

Gratitude serves as a motivator that elicits an action tendency which prompts reciprocity behavior for benefits received (Lazarus & Lazarus, 1994). This action tendency, labeled as the *gratitude imperative* by social psychologist Barry Schwartz (1967), may motivate individuals to reciprocate in different ways. One of the most common ways is expressing gratitude through gift giving.

Across cultures, giving a gift is considered a common way to express emotions such as gratitude, as well as appreciation and love (Knox, Hess, Williams, & Hill, 2003). As such, a gift in the context of psychotherapy should also be interpreted through a cultural lens as the significance of the gift can vary across cultures (Brown & Trangsrud, 2008). Not accepting the gift may contribute to a rupture as clients may feel disrespected if their culture emphasizes reciprocity and views gifts as a significant tradition (Spandler, Burman, Goldbert, Margison, & Amos, 2000).

Gift giving in the context of psychotherapy can occur due to a variety of reasons, including boundary pushing or dependency (Spandler et al., 2000) and may have varied meanings depending on the client's gender and culture. Additionally, gifts in psychotherapy can lead to a host of ethical dilemmas and difficult interpersonal dynamics that may rupture the

36

therapeutic relationship (Lyckholm, 1998, as cited in Emmons & McCullough, 2004). On the other hand, gifts can also be an expression of gratitude and appreciation by the client or a way to strengthen the therapeutic alliance. Research has demonstrated that while there may be a variety of reasons for giving gifts in therapy, many clients give therapists gifts as a sign of their gratitude and appreciation (Knox et al., 2003; Knox et al., 2009). Small or symbolic gifts have been perceived as strengthening the therapeutic alliance and have been linked with positive therapy outcomes (Spandler et. al., 2000). These types of gifts may occur during the holiday season, during termination, or after an emotionally exhausting time period (Borys & Pope, 1989).

 Gratitude as a non-secular virtue. Gratitude has also been identified as a virtue that is a key component of religious/spiritual traditions and practices (Emmons, 2008; Emmons & McCullough, 2004; Frederickson, 2004). As a positive psychological character strength, gratitude falls under the virtue of transcendence and is an aspect of spirituality. Historically many religions including Judaism, Christianity, Islam, Buddhism, and Hinduism have perceived the expression and subjective experience of gratitude as having many benefits both on an individual level and societal level (Emmons, 2008). Gratitude is a virtue emphasized repeatedly throughout religious texts and teachings, which emphasize that regardless of circumstance, individuals are supposed to maintain an awareness of benefits received from God and provide thanks to God for those gifts.

 The emphasis on gratitude as a virtue in religious teachings may be the reason why research has found that people who have a higher level of dispositional gratitude tend to score higher on measures of religiosity and spirituality than individuals who have a lower level of gratitude (Linley & Joseph, 2004). Emmons (2008) supports this finding through his research that demonstrates in individuals who report that they are religious or spiritual have an increased

37

likelihood to experience more gratitude than individuals who report being neither religious nor spiritual.

Christianity. In 2005, Emmons and Kneezel stated,

Christian gratitude is not merely a sentimental feeling in response to a gift, but is a virtue that entails an obligation or sense of indebtedness. An indebtedness to others enables followers of Christ to share a common bond, which shapes not only emotions and thoughts, but actions and deeds. (p. 140)

A common theme emphasized in Christian teachings is the necessity to cultivate gratitude towards God despite adverse circumstances, due to God's generosity. This theme is present in the following scriptures, "give thanks in all circumstances" (1 Thess. 5:18, as cited in Emmons, 2008), and "Give thanks to God the Father for everything" (Eph. 5: 19-20, as cited in Emmons & Kneezel, 2005). Additionally, Christianity emphasizes the knowledge that the gift of eternal life was made possible by the death of God's son, Christ. Recognition of this gift and gratitude towards God for this gift is woven into many Christian teachings and texts.

Islam. Traditionally the main text in Islam from which teachings are derived, is The Holy Koran. The Holy Koran has chapters referred to as "suras" in which gratitude towards God is strongly emphasized. Additionally, the purpose of prayer in Islamic tradition is to provide praise to God for his mercy and the gift of life, regardless of the circumstances. This theme is consistent with the following Islamic prayer, "The first who will be summoned to paradise are those who have praised God in every circumstance. If you are grateful, I will give you more" (14:7, as cited in Emmons, 2008).

Judaism. Emmons (2008) also explains that gratitude is a key component in worship contained in the Jewish religion. Many prayers indicate gratitude towards God, such as "I will

give thanks to the Lord with my whole heart" (Ps.9:1, as cited in Emmons, 2008). Additionally, Jewish individuals typically practice over one hundred blessings daily, referred to as "berakhot" (Emmons, 2008). Traditionally, sacrifices offered in the temples in Jerusalem include gratitude and thanks, such as the "bikkurim ceremony," which consists of providing first fruits to the priests (Emmons, 2008).

    Buddhism. Although belief in one God is not present in Buddhism, gratitude takes on the form of a virtue in Buddhism. One type of Buddhism referred to as Nichiren Buddhism emphasizes 4 debts of gratitude (Emmons, 2008). The first is debt is owed to all other living beings, the second to one's parents, the third to the ruler of an individuals' country, and the fourth to the Buddha, the Dharma and the Sangha. For each of these debts, the teachings emphasize the importance of repaying each debt to the appropriate benefactor. Gratitude, therefore, is felt in regards to existence of life among all forms including oneself.

    Gratitude as a coping response. According to Lazarus and Folkman (1984), coping is comprised of "cognitive and behavioral efforts to master, reduce, or tolerate the internal and/or external demands that are created by a stressful event" (p. 226). Research has demonstrated that positive emotions can contribute to the ability to cope with a stressful event in an adaptive manner (Emmons & McCullough, 2004, Fredrickson, 1998). Gratitude, in particular is one of the positive emotions that has been considered an important component of coping.

    According to the broaden-and-build theory, when individuals experience the emotion of gratitude they become aware of the kindness bestowed on them from others, which motivates them to think and act in ways that will help strengthen their psychological resources (Fredrickson, 2001). This awareness can shape the perspective that others can be relied on for support, which may be a contributing factor to seeking social support as a means of coping when

facing adversity (Fredrickson, 2001; Wood, Joseph, & Linley, 2007). Emmons and Shelton (2002) also supported this point by expressing that gratitude "may be one means by which tragedies are transformed into opportunities for growth, being thankful not so much for the circumstances but rather for the skills that will come from dealing with it" (as cited in Watkins et al., 2009, p. 467).

Research has demonstrated that the relationship between gratitude and coping is consistent with this concept. For example, Wood, Joseph, and Linley (2007) tested the relationship between gratitude and coping with 236 undergraduate students from 2 different samples. The first sample consisted of 149 participants (115 females, 33 males, one participant did not report gender), between the ages of 18 and 22. 92% of the sample was Caucasian (other ethnicities not specified). The second sample consisted of 87 people (75 females and 12 males) between the ages of 18 and 30. 81% of this sample was Caucasian and 9% was Indian (other ethnicities not specified). Participants in the first sample were administered measures assessing trait gratitude (GQ-6; McCullough et al., 2002), coping skills (Brief COPE; Carver, 1997), satisfaction with life (SWLS; Pavot & Diener, 1993), and level of stress (PSS; Cohen & Williamson, 1988). Participants in the second sample were administered measures assessing trait gratitude (GQ-6; McCullough et al., 2002), coping skills (COPE; Carver, Scheier, & Weintraub, 1989), depressive symptoms (CES–D; Radloff, 1977) and happiness (SDHS; Joseph, Linley, Harwood, Lewis, & McCollam, 2004). The results indicated that trait gratitude was associated positively with adaptive coping strategies such as pursuing social support and utilizing positive reinterpretation (Wood, Joseph, & Linley, 2007).

For the purposes of this dissertation, gratitude was defined as a broad trait experienced generally (i.e., gratitude for something or someone, God/higher power, life or nature, not

40

directed towards a specific individual) and/or as a narrow cognitive-emotional state experienced specifically (i.e., directed toward particular individuals, God or another higher power for benefits received), which may manifest in a desire to engage in reciprocity behavior or in other specific actions.

Barriers to Gratitude

In his book *Thanks! How Practicing Gratitude Can Make You Happier*, Emmons (2008) emphasizes the importance of recognizing the barriers to gratitude during one's effort to cultivate gratitude. This section reviews the following gratitude barriers: the negativity bias, the inability to acknowledge dependency, inappropriate gift giving, comparison thinking, perceptions of victimhood, the business of life, ingratitude, and narcissism.

Negativity bias. Emmons (2008) asserts that "without a conscious intervention, we are held hostage by an information-processing system that appears bent on maximizing our emotional distress and minimizing positive experience" (p. 128). Without specific practice and intention, therefore, people may find it easy to attend to negative stimuli or perceive events through a negative lens, which would contribute to difficulty experiencing gratitude.

The inability to acknowledge dependency. Gratitude results from the awareness and knowledge that many things in life wouldn't be possible without the help of others. In order to experience gratitude, one needs to develop an awareness that positive accomplishments occur as a result of help from others not just one's own actions. Recognizing this interdependence signifies acceptance of dependence and contributes to the ability to feel gratitude. This assertion may be particularly relevant for individuals who have survived trauma, particularly sexual trauma, as research indicates these individuals frequently feel powerless in interpersonal relationships, which contributes to reluctance to depend on others (Alexander 1992; Beth, 1999;

41

Cloitre, Scarvalone, & Difede, 1997; Ray & Jackson, 1997, as cited in Kallstrom-Fuqua, Marshall, & Westin, 2004).

Inappropriate gift giving. Emmons (2008) indicates that some gifts are given as a form of control or to gain favor, which can impede the experience of gratitude. Emmons asserts that "a gift that is lavishly disproportionate to what is appropriate to the relationship between the giver and receiver will produce resentment, guilt, anger, a sense of obligation, or even humiliation" (p. 135).

Comparison thinking. Emmons (2008) explains that a significant barrier to gratitude is social comparison. In an experiment conducted by Emmons and colleagues (n.d.), a comparison condition was created in which participants were instructed to record 5 things daily they didn't have that they wish they did. Results indicated that the participants in this group exhibited a significantly less level of gratitude and joy than participants in the other groups. Emmons recommends that since social comparison is a natural tendency, it is important to be aware of it and counteract it with effort to cultivate gratitude.

Perceptions of victimhood. Emmons (2008) believes that a significant barrier to gratitude is a perception of victimhood because "when one's identity is wrapped up in the perception of victimhood, the capacity for gratitude shrinks" (p. 137). When one experiences a tendency to blame external sources, recognition of benefits cannot occur and gratitude is impeded.

The business of life. The practice of reflecting on gratitude takes concentrated time and effort. As daily life is increasingly frantic, frazzled, and fragmented, gratitude can be crowded out. As such, it is easy to take events, significant others or situations that would usually elicit gratitude, for granted, as one tries to manage with the hassles in daily life.

Ingratitude. Ingratitude occurs when an individual finds fault with the benefit, misreads the benefactor's motives, and responds negatively rather than positively to the benefit received. Ingratitude goes beyond an absence of responding with gratitude and facilitates a response with a harmful intention towards the benefactor.

Narcissism. In 2008, Emmons conducted a study which found that people characterizes as narcissists tend to list fewer daily blessings than those who are not classified as narcissistic. Narcissistic characteristics such as lack of empathy and extreme self-focus are seen as obstacles to gratitude as they make it difficult for the individual to experience this emotion. Emmons (2008) describes that "An overly high opinion of oneself is the chief cause of ingratitude. …the ungrateful person appears to be characterized by a personality….that manifests narcissistic tendencies, characterized by excessive self-importance, arrogance, vanity, and an unquenchable need for admiration and approval" (pp. 148-149).

Effects of Gratitude

Research has demonstrated that experiencing gratitude can not only lead to psychological benefits, but physical and social benefits as well (Emmons & Shelton, 2002; Frederickson, 2001; Linley & Joseph, 2004; Wood, Joseph, & Maltby, 2008). This section reviews each of these effects, by first describing benefits followed by research demonstrating neutral or negative effects.

Psychological Effects

This subsection begins with a review of the psychological benefits of gratitude including an increase in well-being (both subjective and psychological) and an increased ability to cope with difficult or traumatic events (Emmons & McCullough, 2003; Seligman et al., 2005). Next, a review of the effects of gratitude on negative emotions and psychopathology is discussed. This

section concludes with a review of studies that have demonstrated neutral psychological effects of gratitude.

Psychological benefits: Well-being. Well-being is a broad concept that many researchers have classified as either subjective or psychological. However, similar to gratitude, researchers have had difficulty measuring these aspects of well-being as there is a substantial amount of overlap between these two categories. Research has demonstrated that subjective and psychological well-being are connected, but distinct constructs comprised of components that have loaded on different higher order factors in studies (Biaobin, Xue, & Lin, 2004; Keyes, Shmotkin, & Ryff, 2002). Despite these findings, some argue that these 2 aspects of well-being are more related than is believed (Kashdan, Biswas-Diener, & King, 2008).

The following definitions are provided with these considerations in mind. Subjective well-being, as defined by Diener and colleagues (1999) is typically referred to as a "broad category of phenomena that includes people's emotional responses, domain satisfactions, and global judgments of life satisfaction" (p. 277). In other words, as a multidimensional construct, subjective well-being refers to frequency of positive emotions and overall life satisfaction (Diener, 1984). Psychological well-being refers to "self-acceptance, positive relationships with others, personal growth, purpose in life, environmental mastery, and autonomy" (Ryff, 1989; Ryff & Keyes, 1995; as cited in Wood, Joseph, & Maltby, 2009, p. 443). This section reviews the relationship between gratitude and subjective well-being and then the relationship between gratitude and psychological well-being.

Research has demonstrated a significant relationship between dispositional gratitude and subjective well-being (McCullough, Emmons, & Tsang, 2002; McCullough, Tsang, & Emmons, 2004). For example, in a study conducted by McCullough, Emmons, and Tsang (2002), 1,228

44

participants who were online users drawn from several different websites regarding health, spirituality and religion (age range = 18–75 years; 80% women, 15% men; 91% Caucasian, other ethnicities not reported) were instructed to complete questionnaires regarding their level of gratitude, overall life satisfaction, which is a significant component of subjective well-being, personality traits and affect: the gratitude questionnaire (GQ-6; McCullough et al., 2002), the positive and negative affect scales (PANAS; Watson, Clark, & Tellegen, 1988), the satisfaction with life scale (Diener, Emmons, Larsen, & Griffin, 1985), and the Big Five Mini-Markers scale (Saucier, 1994). Results indicated that individuals whose scores reflected a higher level of dispositional gratitude also had higher levels of positive affect and subjective well-being.

An expanding area of research are studies that have demonstrated the significant relationship between psychological well-being and gratitude (Kashdan et al., 2006; Wood et al., 2009). In one such study, Wood et al. (2009) sought to examine the relationship between gratitude and psychological well-being in relation to the big 5 factor model. The sample consisted of 201 undergraduate students (128 females and 73 males) between the ages of 18 and 26. 75% of the participants were Caucasian and 13% were Indian. Participants were instructed to fill out questionnaires assessing gratitude (the GQ-6; McCullough et al., 2002), psychological well-being (Psychological well-being scales; Ryff & Keyes, 1995) and facets of the Big Five personality traits such as extraversion, agreeableness, neuroticism, openness and conscientiousness (NEO-PI-R; Costa & McCrae, 1992). Results demonstrated that gratitude was correlated with the following components of psychological well-being: environmental mastery, personal growth, positive relationships, purpose in life, and self-acceptance. These correlations were demonstrated outside of the effects of the five factors, providing support for the theory that gratitude may be a key component to psychological well-being.

45

Psychological benefits: Coping. Many studies have also found promising evidence indicating that gratitude is a strength that can help trauma survivors deal with their experiences (Kashdan et al., 2006; Vernon, 2012; Vernon et al., 2009). Emmons (2008) further supports this point by explaining that "an attitude of gratefulness permits a person to transform a tragedy into an opportunity for growth" (p. 164).

One area of focus concerns the role of gratitude in adaptive or proactive coping (Fredrickson, 2003; Vernon et al., 2009). As noted previously, Lazarus and Folkman (1984) state that coping is comprised of "cognitive and behavioral efforts to master, reduce, or tolerate the internal and/or external demands that are created by a stressful event" (p. 226). Among the various types of coping, proactive coping may be particularly beneficial in helping individuals deal with trauma. Proactive coping is defined as "thoughts and behavior aimed at general resource building to facilitate future goal attainment and personal growth" (Green-glass et al., 1999, as cited in Vernon et al., 2009, p. 117). Proactive coping is a preventive measure as opposed to reactive coping which focuses on dealing with an event that has already taken place (Aspinwall & Taylor, 1997; Schwarzer & Taubert, 2002, as cited in Vernon et al., 2009). Vernon et al. (2009) examined the connection between proactive coping, gratitude, positive emotions and posttraumatic stress among 182 undergraduate women with a history of trauma. 84.7% of the participants were Caucasian, 11.4% African-American, 2.5% were Asian-American, .5% were Hispanic, and 1.0% reported a multiracial ethnicity. The results indicated that proactive coping style and posttrauma gratitude were negatively related with existing PTSD symptom degree (Vernon et al., 2009). The results suggest that gratitude may be a protective factor for women who are trauma survivors. Due to this finding, the authors also suggest that the results indicate a

need for further research on the different aspects of gratitude and the relation of posttrauma gratitude to coping and resilience.

Research has also consistently reflected how gratitude strengthens social resources as a component of coping (Emmons & McCullough, 2004; Wood, Joseph, & Linley, 2007; Frederickson, 2001). Algoe, Haidt, and Gable (2008) argue that relationships with individuals who take into consideration an individual's specific needs can serve as a resource to help people cope with difficult times and thrive during better times.

Furthermore, Algoe et al. (2008) conceptualized gratitude as "an emotion that serves the social function of promoting (such) relationships" (p. 429). Similarly, the broaden-and-build theory of positive emotions is based on the hypothesis that positive emotions enhance individuals' thought-action repertoires and lay the foundation for developing personal resources (Emmons & McCullough, 2004; Fredrickson, 1998). According to the broaden-and-build theory, when an individual experiences gratitude, he/she recognizes the kindness of others, which strengthens thought-action repertoires, motivating individuals to behave in ways that will help strengthen his/her psychological resources (Fredrickson, 2001). This recognition of others' support and kindness can contribute to the belief that others can be relied on for support, which can promote utilizing social support as a means of coping through stressful times (Fredrickson, 2001; Wood et al., 2007).

Accordingly, research has demonstrated that gratitude is one of the positive emotions associated with adaptive coping strategies such as increasing social support and utilizing positive reinterpretation (Fredrickson, 2001; Wood et al., 2007). For example, Frederickson et al. (2003) examined the frequency of positive and negative emotions experienced by a sample of undergraduate students prior to and following September 11, 2001). Although approximately

72% of the participants exhibited depressive symptoms that were clinically relevant, participants who experienced a moderate level of positive emotions had a higher degree of resilience and were at lower risk for depression. Results indicated that positive emotions played a crucial role in helping resilient people cope with the tragedy. Of the 20 positive emotions studied, results indicated that gratitude was the most common emotion experienced, after compassion, which was the first.

While results of studies like these are promising, the majority of studies conducted in this area have been with undergraduate students, which limits generalizability and applicability to other populations. Overall, these results suggest that gratitude can play a pivotal role in coping with adversity and can help enhance one's well-being. However, more work is needed to conduct these studies across diverse populations so that the results can be applicable across different cultures and age groups.

Psychological effects of gratitude on negative emotions/psychopathology. Numerous studies have examined the psychological effects of gratitude on negative emotions and the development of psychiatric disorders (Frederickson, 2001; Kendler et al., 2003; Linley & Joseph, 2004). According to McCullough and colleagues (2002), gratitude is contradictory with negative emotions. Thus, it may decrease or inhibit emotions of greed, jealousy, anger and bitterness (McCullough et al., 2002).

To test this theory, other researchers have examined the relationship between negative emotions and gratitude. For example, Watkins and colleagues (2008) conducted a study on 128 undergraduate students (race/ethnicity not mentioned) who were randomly assigned to one of three writing conditions: writing about a neutral topic, writing about a negative event, or writing about perceived positive consequences of the event that they are grateful for. Participants in the

latter 2 groups were instructed to reflect on a memory that felt was unresolved and triggered sadness, loss, rejection, anger, anxiety, or frustration. Results indicated that participants who were part of the gratitude group demonstrated more closure and a lower level of unpleasant emotions in relation to the memory than participants in the neutral topic group or the negative event group.

In addition, positive psychology research has demonstrated how particular character strengths such as gratitude, hope and spirituality can serve as protective factors against negative affect and psychopathology (Frederickson et al., 2003; Kendler et al., 2003). An example of how gratitude may serve as a protective factor against psychopathology was demonstrated in a study conducted on 2,616 male and female twins in which a measure of 78 items assessing different dimensions of religiosity (including items focused on gratitude) was associated with decreased risk for internalizing and externalizing disorders (Kendler et al., 2003). More specifically, results indicated that increased levels of thankfulness were related with lower risk for psychiatric disorders such as depression, phobias, and substance abuse (Kendler et al., 2003).

Research has also demonstrated that the higher an individual's level of gratitude, the lower his or her level of risk for developing disorders related to depression, anxiety and substance use (Linley & Joseph, 2004). For instance, Seligman et al. (2005) conducted a study demonstrating that gratitude may also decrease depressive symptoms. This study tested the efficacy of positive psychology interventions, including two gratitude exercises ("gratitude visit" and "counting your blessings exercise") through a large randomized controlled trial (RCT) using a random-assignment placebo-controlled design. The sample consisted of 577 adults, 77% Caucasian (other ethnicities not reported) between the ages of 35 and 54 who were recruited from a pool of visitors to the website for Seligman's book Authentic Happiness (2002).

Participants who were assigned to the gratitude visit condition were given one week to write a gratitude letter and deliver it to somebody who had impacted their life but had not been thanked. Participants in the count your blessings condition were required to write down 3 things that went well and the perceived causes on a daily basis for one week. Participants in the placebo condition were required to write about early memories nightly for one week. Results indicated that these interventions increased the participants' happiness (measured with the Steen Happiness Index (SHI; Seligman et al., 2005), and decreased their depressive symptoms (as measured by the CES-D; Radloff, 1977), when compared with participants in the placebo group. The results demonstrated that the impact of the blessings exercise lasted for six months (Seligman et al., 2005).

Neutral or negative psychological effects of gratitude. While some research has demonstrated that there is a relationship between gratitude and well-being, other studies have not. Four such studies were located. After relating those studies, this subsection discusses other negative effects of gratitude, namely a sense of deprivation and gratitude fatigue.

First, Henrie (2006) conducted a study examining the impact of using a gratitude journal on divorce adjustment and overall well-being. The sample consisted of approximately 136 participants who were divorced, middle-aged female members of The Church of Jesus Christ of Latter-day Saints. Participants were randomly assigned to 1 of 3 different groups. The groups consisted of (a) a gratitude condition during which participants were instructed to record 5 things they were grateful for daily, and (b) a condition in which participants were required to read educational materials including articles on how to enhance happiness and well-being. The third group was a control group in the wait-list condition, that received no treatment but completed the

pretest and posttest measures as the other groups did. The results indicated that the gratitude intervention did not have a significant effect on divorce adjustment or overall well-being.

Similarly, Ozimkowski (2007) conducted a study on the "gratitude visit" among children and adolescents in order to examine its effects on subjective well-being, depressive symptoms and state gratitude. The sample included 89 participants from 3rd, 8th and 12th grade (gender/ethnicity not reported) who were randomly assigned to 1 of 2 intervention groups: the gratitude group or control group. Each participant in the gratitude condition was instructed to pick somebody who had been kind to him/her but had never been properly thanked, and instructed to write a letter of gratitude expressing how this person impacted his/her life and to deliver this letter personally during a gratitude visit to this individual. Participants in the control group were told to write about the activities they engaged in the previous day and how they felt while engaging in these activities. Although it was found that participants of the gratitude condition experienced an increase in life satisfaction 4 weeks after the intervention, results demonstrated that participants in the gratitude condition did not experience an elevation in happiness or state gratitude, or a reduction in depressive symptoms (Ozimkowski, 2007).

Third, Sin, Della Porta, and Lyubomirsky (2011) conducted an 8 week study testing the relationship between the "gratitude letter" exercise, its expected efficacy, and impact on well-being with a dysphoric (non-clinically depressed) sample of 58 undergraduate students (gender & race/ethnicity not reported). The sample was randomly assigned to 1 of 2 conditions: a gratitude condition in which participants were required to write a gratitude letter, or a placebo condition in which they were instructed to list to classical music and write about it. Additionally, participants in each condition were either presented with fake articles from New York Times discussing how the exercise has been linked to improvement in well-being as well as articles

discussing how the exercise has not been linked to improvement in well-being. Results demonstrated that the dysphoric participants in the gratitude group who did not expect for the intervention to work demonstrated a decrease in well-being prior to the intervention and right afterwards (Sin et al., 2011). This research demonstrates that there are certain conditions or populations with which there may not be a relationship between gratitude and well-being.

In addition to motivation, frequency of the exercise may have an effect on the outcome. For example, in 2005 Lyubomirsky and colleagues conducted a study examining the effectiveness of the "Count your blessings" gratitude exercise. This study examined the relationship between gratitude and well-being over 6 weeks. This study found that the group who practiced the exercise once a week demonstrated an increase in well-being. However, the group who practiced the exercise 3 times a week did not experience an increase in well-being.

Finally, negative effects of gratitude have been measured in other ways than impact on well-being. A sense of deprivation is a negative effect that can occur if gratitude is not present. Deprivation refers to resentment that occurs in response to a perceived dearth of benefits received, as opposed to a sense of abundance (Linley & Joseph, 2004; Watkins et al., 2003). Another negative effect that can occur as a result of practicing gratitude is "gratitude fatigue" (Emmons, 2008). Gratitude fatigue occurs as a result of continuous repetition of the same blessings which contributes to a loss of gratitude for those benefits over time. Emmons (2008) described that when people practice gratitude by counting their blessings, it is important for them to continue to revise their blessings and gratitude lists on a weekly basis in order to prevent gratitude fatigue.

Physical Effects

  Research has demonstrated that in addition to psychological benefits, gratitude can contribute to physical benefits such as enhanced cardiovascular and immune system functioning, a longer life span, increased exercise frequency, and decreased pain and physical illness (Affleck et al., 1987; Danner, Snowdon, & Friesen, 2001; McCraty & Atkinson, 2004; McCraty, & Childre, 2004, as cited in Linley & Joseph, 2004; Shipon 2007). After reviewing these findings, this section concludes with a review of studies that have demonstrated neutral physical effects of gratitude.

  One of the earliest studies finding positive physical effects of gratitude was conducted by Affleck and colleagues in 1987 with a sample of 287 (race/ethnicity not mentioned) male heart attack survivors between the ages 30 and 60. The participants were interviewed 7 years after the attack and then again 8 years afterwards. This study found that cardiac patients who attributed the reason for the heart attack on external factors such as family members, were at a higher risk of experiencing another heart attack sometime over the next 8 years. Results also showed that individuals who recognized the benefits that were reaped as a result of the heart attack such as appreciating life more, were less likely to experience another heart attack and exhibited reduced morbidity at 8 year follow-up (Affleck et al., 1987). Since data collection for this study began in the 1960s, the clinical prognostic instruments typically used now were not validated at the time. Additionally, causal attributions of the heart attack were measured by participants rating the degree to which they perceived that 13 typical causes of heart attacks were responsible for their own attack. As such, a diverse variety of measurement methods may have been more useful for strengthening reliability and validity of this study. Therefore the results should be interpreted with consideration of these limitations.

A more recent study also looked at how gratitude was related to heart health. Shipon (2007) examined 82 low-income (average income was $8,400 per year) African American (2% of the sample was biracial) participants (62 women and 20 men, from 26 to 84 years old) who were suffering from hypertension. Participants were randomly assigned to 1 of 2 groups: (a) gratitude condition or (b) control condition. In the gratitude condition, 41 participants were instructed to record 5 blessings through a voicemail system once a day for 10 weeks and were administered treatment as usual for hypertension. Participants in the control group were administered treatment as usual for hypertension. Results indicated that participants in the gratitude condition experienced significant decreases in blood pressure when compared with participants in the control condition (Shipon, 2007). However, a limitation in this study is that it did not control for other possible reasons for a decrease in blood pressure, such as compliance with medication. Additionally, only 57% of participants completed measures at follow-up.

Research has also demonstrated that gratitude can contribute to the physical benefit of exercise frequency. For example, in a study conducted in 2003 by Emmons and McCullough demonstrated that gratitude can also lead to increased frequency of exercise. The sample consisted of 201 undergraduate students (147 women, 54 men; ethnicity not mentioned), who were randomly assigned to 1 of 3 different conditions, (a) gratitude, (b) hassles, and (c) events. The first group was instructed to recount 5 things they were grateful for that week; the second group was instructed to recount 5 daily hassles from the prior week; and the third group was instructed to recount 5 events that impacted them over the prior week for a period of 10 weeks. Results indicated that compared to the other 2 conditions, participants in the gratitude group experienced less physical illness symptoms than participants in the hassles and events conditions. Additionally, participants in the gratitude group spent approximately 1.5 hours more per week

exercising when compared with the subjects in the hassles group. However, this study does not address the longevity of these effects and whether they were maintained long-term. Lastly, this sample is not generalizable as it consists of undergraduate students in a health psychology class, who could be intrinsically interested in these factors already and not necessarily representative of the general population.

Next, research has demonstrated the potential impact of gratitude on symptoms of pain. For example, Carson and colleagues (2005) examined the effectiveness of a loving-kindness meditation on lower back pain with 43 chronic low-back pain patients who were between the ages of 26 and 80. 61% of the participants were female; 63% were Caucasian; and 35% were African American. Participants were randomly assigned to either a loving-kindness treatment group or treatment as usual group. Participants in the meditation group were instructed to practice loving-kindness meditation over a period of 90 minutes once a week, for 2 months. During this exercise participants were instructed to focus on positive feelings towards an individual they care about and then gradually work on applying those feelings towards themselves and significant others in their lives. In this study, positive emotions were also directed towards a neutral person, a person who had previously hurt the client, and eventually towards all living beings. An additional component to this exercise was a "body-scan exercise." This exercise instructed participants to accept their bodies and feel grateful for what their bodies have allowed them to achieve thus far in life. Results demonstrated that patients in the meditation group experienced a significant reduction in pain and psychological distress as opposed to the treatment as usual group, which did not exhibit any changes (Carson et al., 2005). However, generalizability is limited due to the small sample size in this study. Additionally, it would be beneficial to add multiple measurements in addition to self-report such as observational or

physiological measures. Lastly, since the loving-kindness meditation focuses on different positive emotions (including gratitude), more research needs to be conducted on the specific role of gratitude in this intervention and its impact on physical pain as well as psychological distress.

Gratitude has also been linked to a longer lifespan. For example, Danner and colleagues (2001) analyzed the relationship between positive emotional content exhibited in nuns' autobiographies written when they were between the ages of 18 and 32 and likelihood of death in later years. At the time of the follow-up, the sample consisted of 180 nuns between the ages of 75 and 95. Results indicated that the more positive emotional content found in the autobiography such as gratitude, hope and love, the greater likelihood that the nun would be alive over 60 years later. The nuns who had the least positive emotional content were twice as likely to die when compared with the nuns who used the most positive emotion content. However, since this study was conducted with a specific population, it may be difficult to apply these results to the general population. Additionally, an increase in sample size would contribute to more statistical power in future studies, and the ability to further examine the relationship between longevity and various positive emotions such as hope and love.

Neutral physical effects of gratitude. Although a majority of studies have shown that gratitude is linked with physical benefits, two studies were located that demonstrated that gratitude did not contribute to any health benefits. First, Emmons and McCullough (2003) studied 157 undergraduate students (originally 125 women and 41 men, before 9 participants dropped out during the course of the study), who were assigned to 1 of 3 conditions during a 2 week period: (a) gratitude, (b) hassles, or (c) downward social comparison. Participants in each condition were asked to track amount of time spent exercising strenuously versus moderately, hours of sleep received, and to rate quality of sleep. Participants in each condition were also

asked to fill out daily experience rating forms that assessed positive and negative affect through daily mood ratings according to approximately 30 affect terms (e.g., excited, thankful, appreciative sad, stressed). Although it was found that participants in the gratitude condition had increased positive affect during the 2 week intervention, no changes in health behaviors or physical symptoms were demonstrated.

Similarly, Emmons and McCullough (2003) examined the effectiveness of a gratitude intervention with 65 participants (44 women and 21 men; aged 22 to 77; race/ethnicity not reported) who had neuromuscular diseases. Over a period of 3 weeks, participants were randomly assigned to either a gratitude condition during which they had to record 5 things they were grateful for that week and fill out a daily experience rating form, or a control condition during which participants were required to fill out only the affect, well-being and global appraisal sections of the same daily experience rating form given to the gratitude group. The daily experience rating form indicated the degree to which people experience 32 affects (including gratitude and appreciation) on a 5-point Likert-type scale. Results indicated that participants in the gratitude condition displayed higher levels of positive affect and life satisfaction, in addition to lower negative affect, when compared to those in the control group. However, while participants in the gratitude group reported more hours of sleep than those in the other group, there were no changes in other physical health symptoms, such as quality of sleep, pain, and exercise habits.

Social Effects

Research has demonstrated that gratitude plays a significant role in cultivating social bonds and strengthening social resources by prompting individuals to reciprocate benefits received (Bartlett & Desteno, 2006; Frederickson, 2004; Tsang, 2006a). This section reviews

how gratitude enhances social resources by prompting reciprocity behavior and strengthening social bonds.

  Reciprocity behavior. Two studies have demonstrated that gratitude prompts reciprocity behavior (Bartlett & DeSteno, 2006; Tsang, 2006a). First, Bartlett and DeSteno (2006) examined the impact of a gratitude intervention on the prosocial behavior of reciprocity. The sample consisted of 105 undergraduate students (70 females and 35 males, race/ethnicity not reported) who were randomly assigned to 1 of 3 emotion conditions: (a) gratitude, (b) amusement, (c) neutral. All participants believed that they were part of a team with one other individual (a confederate). Participants were told that the study was examining individual versus group problem solving, and they completed tasks designed to test hand-eye coordination. In the gratitude condition after this task was completed, the screen went blank. The participant was then informed that he/she needed to start the entire task over. At this point, the confederate (whose task is finished and is free to leave), chose to stay and help the participant resolve the problem by plugging in the computer. The participant was then informed that he/she does not need to start the task over. After each task, participants in all conditions were asked to complete a questionnaire assessing current emotional state and feelings towards partner. At this point, the confederate asks the participant if he/she would be willing to fill out a problem solving survey that will take at least half an hour. Results demonstrated that individuals who were in the gratitude condition were more likely to feel grateful towards the confederate and take time to fill out the survey when compared with participants in other conditions. Although these results provide support for the theory that gratitude promotes reciprocity behavior, it is also possible that indebtedness motivated the helping behavior rather than the emotion of gratitude. Therefore, it

would be important in future studies to distinguish between feelings of indebtedness and gratitude.

Second, Tsang (2006a) studied how gratitude prompts reciprocity behavior with a sample of 40 undergraduate female psychology students (race/ethnicity not reported). Participants were told that another participant would work with each of them to complete 4 segments of a resources distribution task. Participants were not allowed to interact with one another except for through writing during certain tasks. Additionally, participants were under the impression that $10 would be dispersed between each dyad during each segment. In some segments, the participant would be required to disperse the money; in other segments the resources were assigned by chance. For the first round, all participants were given $3 and told that the other participant was provided with $7. Afterwards, participants were randomly assigned to 1 of 2 conditions either the favor condition or the chance control condition. Those in the favor condition were informed during the second round that the other participant had opted to give the participant $9, and keep $1 for herself. In the chance condition, the participants were informed that they were given $9 by chance and that the other participant received $1. During the third round, participants from both conditions were given the option of dispersing the $10. After the decision was made, participants filled out a questionnaire regarding the reasons that motivated this particular decision such as expressing appreciation or getting money.

The results demonstrated that individuals in the favor condition experienced more gratitude than participants in the chance condition. Participants in the favor condition reported that gratitude motivated them to repay benefits by allotting their partner more money as opposed to participants who received extra resources by chance. However, similar to the previous study,

59

one of the limitations in this study is that it did not differentiate between gratitude and other possible motives for reciprocity behavior such as indebtedness and the norm of reciprocity.

Social bonds. Research has also demonstrated that in addition to prompting reciprocity, gratitude also serves to strengthen social bonds (Algoe et al., 2008; Emmons & McCullough, 2003; Emmons et al., 2003). One such study supporting this theory was conducted by Algoe et al. (2008) with 160 female members from 3 different sororities, who were between the ages of 18 and 22. 82 of the participants were little sisters and 78 were big sisters. 92.4% of the participants were Caucasian, 3.8% were Asian American and 3.9% were from other racial backgrounds. During big sister week, little sisters receive typically gifts from their big sister who remains anonymous until the end of the week. The little sisters were instructed to complete an online questionnaire after each gift from their big sister was received. Instructions included providing a description of the event when the benefit was received, describing feelings in relation to the benefit and rating the benefit as well as the big sister. After the identity of the big sister was revealed, little sisters were instructed to fill out an online questionnaire the morning after regarding their feelings towards the big sister. At one month follow-up with big and little sisters, participants were asked to record their feelings regarding the big sister and recent interactions with her.

Results demonstrated a significant relationship between gratitude and relationship formation (Algoe et al., 2008). This study found that relational perception of the benefit predicted gratitude. Perceived responsiveness such as degree to which little sister perceived thoughtfulness of her big sister, and the degree to which she liked the benefit were determined to be robust predictors of gratitude. During big sister week, the little sister's gratitude was a predictor of her feelings towards her anonymous benefactor. Both big and little sisters' gratitude

60

scores from big sister week also predicted both sisters' ratings of the relationship at 1 month

follow-up. While this study provides evidence gratitude is a key element of building and

developing relationships, there are also some limitations to consider. This study was conducted

with a specific sample so it may not be generalizable to other populations. Additionally, the

study was correlational, so it was not determined whether gratitude is a direct cause of

strengthening dyadic and group relationships.

Another study also demonstrated the impact of gratitude on interpersonal relationships

(Emmons & McCullough, 2003). Undergraduate students (125 women and 41 men, however 9

subjects were removed from the study due to incomplete data; race/ethnicity not reported) were

assigned to 1 of 3 conditions: gratitude, hassles or downward social comparison, all were asked

to record daily whether they had helped somebody else with a problem or offered another person

emotional support. Results indicated that participants in the gratitude group had a higher

likelihood of offering emotional support to others when compared with participants from the

hassles or social comparisons group. Participants in the gratitude group also had a higher

likelihood of helping someone else with a problem when compared with participants in the

hassles condition. It is important to note that the emotional support offered to others in this study

was not offered in exchange to a direct source that had provided the individual with a benefit, but

rather as a way to help others, which was found to be related with the gratitude exercise.

In sum, all of these studies provide evidence that gratitude promotes prosocial behavior

and strengthens social bonds, in addition to helping individuals develop personal resources to

utilize in times of stress. These studies are limited, however, because they were conducted with

undergraduate students, which is a specific sample that may not be generalizable to other

populations. Additionally, there are other possible motives for reciprocity behavior besides

gratitude (e.g., indebtedness; norm of reciprocity), and a majority of the studies discussed did not differentiate between gratitude and these other possible motives. Therefore, it would be important in future studies to examine indebtedness as well as other possible motives for reciprocity behavior and their relationship with gratitude.

Neutral or negative social effects of gratitude. Although much research has demonstrated that there are prosocial benefits to gratitude, there are certain factors that appear to inhibit these benefits, such as indebtedness or if there is a perceived expectation that the beneficiary has to reciprocate benefits received, and helper intention. Some researchers have considered gratitude and indebtedness as two constructs that overlap (Greenberg, 1980; Komter, 2004), while others have argued that these are two separate constructs (Watkins et al., 2006). Receiving benefits may also trigger guilt, as noted by Bono, a prominent gratitude researcher, who asserted that guilt can be related with or even inhibit gratitude in a situation that involves "inequity" in a relationship that builds up over time (Kennelly, 2014).

Regarding the first area Watkins and colleagues (2006) administered a vignette to 107 undergraduate students (ethnicity/gender not reported) randomly assigned to 1 of 3 conditions: expectation condition, moderate expectation condition, high expectation condition asking each participant to imagine that he/she was moving and that a friend volunteered to help without being asked. In the first group, the vignette explains that the benefactor does not expect reciprocity. In the second group, the vignette describes that the benefactor expects an expression of thanks either in person or in a written note. In the third group, the vignette describes that the benefactor expects an expression of thanks in addition to a favor back. After each vignette was presented, participants were then instructed to complete emotion questionnaires with questions pertaining to various emotional states, such as gratitude, resentment, guilt, and pride. Gratitude was measured

by the GQ-6 (McCullough et al., 2002), and the GRAT (Watkins et al., 2003). The results demonstrated that indebtedness and perceived expectation of a benefactor contributed to beneficiaries being less likely to help the benefactor or repay benefits. A limitation in this study is the use of vignettes rather than an experiment where actual tangible benefits were provided to participants. Findings could reflect participants' estimation of gratitude and not how he/she would actually feel in a given situation.

In another study assessing the impact of helper intention on gratitude, Tsang (2006b) instructed a sample of undergraduate students (76 females and 16 males) to recall and write about a situation which occurred in the last year. Participants were randomly assigned to either the benevolent condition or the selfish condition. In the benevolent condition, participants were instructed to think of a situation where the other person did a favor for the participant for unselfish reasons. In the selfish condition the participant was instructed to imagine a situation where a benefit was received for selfish reasons. Participants were instructed to think and feel the feelings and thoughts that were experienced during the actual situation and record them as well as current emotions regarding the memory. Results demonstrated that participants reported significantly more feelings of gratitude in response to the benefit received when the favor was received for unselfish reasons when compared with participants who perceived that a benefit was received for selfish reasons. A limitation in this study is that there was not a measure of the amount of time since the situation happened. As a result, recall biases may have impacted the findings.

Gratitude Assessment

The assessment of gratitude has been challenging as researchers have conceptualized gratitude so differently (as described earlier: as an emotion, an attitude, a moral virtue, a habit, a

personality trait, a coping response). As a result, gratitude assessment measures do not assess the same types of gratitude. Also, most rely on self-report.

This section begins with a review of general self-report measures and those specifically focused on gratitude (i.e., The Gratitude Questionnaire, The Gratitude, Resentment and Appreciation Test, The Gratitude Adjective Checklist, the Posttrauma Gratitude Scale), and concludes with other qualitative methods used in gratitude research.

Self-report rating scales. Rating scales are the most frequently used way of measuring gratitude in research (Peterson & Seligman, 2004). One area of research using self-report surveys has examined gratitude frequency in the general population. In one such survey, Sommers and Kosmitzki (1988) found that 10% of Americans reported that they consistently and frequently experience the emotion of gratitude, whereas 30% of Germans reported experiencing gratitude consistently and frequently. A national gratitude survey conducted on behalf of the John Templeton Foundation (Kaplan, 2012) found that 51% of 2,000 (18-6+) participants reported that they think about the things they are grateful for on a daily basis.

Other studies asked people to rate themselves and/or others on rating scales. Saucier and Goldberg (1988) worked with an adult sample as well as their peers who were required to rate the participant according to how thankful he/she appeared to be, in addition to other personality traits. Results indicated that the adjectives, "grateful" and "thankful" were positively correlated with agreeableness (big Five), (r=.31). In another study conducted by Gallup in 1998, participants were asked gratitude related questions such as if he/she knew individuals who appeared grateful for no particular reason and the frequency with which he/she gives thanks to others or God. Other studies have included the use of vignettes that require the participant to rate the level of gratitude he/she would feel if such events occurred in real life or how the protagonist

of the story would feel (Lane & Anderson, 1976; Rodrigues, 1995; Tesser, Gatewood, & Driver, 1968).

Additionally, the daily experience rating form has been used as a supplemental measure of gratitude with undergraduate students and adult samples (Emmons & McCullough, 2003). The daily experience rating form indicates the degree to which people experience 32 affects (including gratitude and appreciation) on a 5-point Likert-type scale. In addition to assessing mood ratings, this form assesses physical symptoms, responses to social support, health behaviors such as amount of hours spent exercising, and 2 "global life appraisal" questions (asking how participant feels about his/her life on a scale of -3 to 3, and rating expectations for the following week on a scale of -3 to 3). In one such study, Emmons and McCullough (2003) utilized the daily experience rating form to test the effectiveness of a gratitude intervention with 65 participants (see neutral physical effects section) who had neuromuscular diseases over a period of 3 weeks. Results indicated that participants in the gratitude condition displayed higher levels of positive affect and life satisfaction (as measured by the daily experience rating form in addition to other measures) in addition to lower negative affect, when compared to those in the control group.

In addition to such general ways of assessing gratitude, measures specific to gratitude have been developed. This subsection describes 4 such measures: The Gratitude Questionnaire, The Gratitude, Resentment and Appreciation Test, The Gratitude Adjective Checklist, the Posttrauma Gratitude Scale.

The Gratitude Questionnaire. The Gratitude Questionnaire (GQ-6) is a six-item, unidimensional self-report questionnaire developed by McCullough, Emmons and Tsang in 2002 to measure trait gratitude. Items are based on a 7-point Likert scale from 1 (strongly disagree) to

7 (strongly agree). Examples of some of the items included are: "I have so much to be thankful for;" "If I had to list everything that I felt grateful for, it would be a very long list;" and "I am grateful to a wide variety of people." This measure also tests the following four facets of dispositional gratitude: gratitude intensity, gratitude frequency, gratitude density, and gratitude span.

Research conducted on the GQ-6 with adults has demonstrated the questionnaire's adequate level of internal consistency (α=.82) in addition to a robust one-factor solution in adult samples (McCullough et al., 2002). The GQ-6 has been used with adults, children and adolescents (Froh et al., 2011; Kashdan, Uswatte, & Julian, 2006; McCullough et al., 2002; Wood et al., 2008). A few studies have also utilized the GQ-6 with trauma survivors including male combat veterans or undergraduate students (e.g., Kashdan, et al., 2006; Vernon, 2012; Vernon et al., 2009). Research has also demonstrated that modified versions of the GQ-6 can be used to measure gratitude in Chinese, Taiwanese and Portuguese populations, indicating that this measure is correlated with life satisfaction and different components of well-being such as happiness and optimism, similar to American samples (Chan, 2010; Chen, Chen, Kee, & Tsai, 2009; Chen & Kee, 2008; Neto, 2007).

Studies using the GQ-6 with children and adolescents have demonstrated that gratitude has positive benefits for youth as well. In a study conducted with 2 different samples, Froh and colleagues (2011) tested the effectiveness of the GQ-6 and other gratitude measures with children and adolescents. The GQ-6 demonstrated adequate internal consistency across all age groups in this study (r's ranged from .76-.85). Additionally, GQ-6 scores were positively correlated with positive affect and life satisfaction in all of the age groups (r's ranged from .28-.59). GQ-6 scores were also negatively correlated with negative affect for participants from 12-

19 years old (r's ranged from-.16 to -.35). The GQ-6 was negatively correlated with depression in all age groups (r's ranged from -.24 to -.44). However, no significant correlation was found between the GQ-6 and negative affect for 10-11 year olds, indicating that the GQ-6 may not be a valid measure of gratitude with this age group.

The GQ-6 is unique in that it also includes an observer questionnaire. This measure is the same as the GQ-6, except that the raters are instructed to answer questions based on how they believe the participant would respond (Peterson & Seligman, 2004). These questions are the same ones presented earlier and include: "I have so much in life to be thankful for," "If I had to list everything that I felt grateful for, it would be a very long list," "When I look at the world, I don't see much to be grateful for," "I am grateful to a wide variety of people," "As I get older I find myself more able to appreciate the people, events, and situations that have been part of my life history," and "Long amounts of time can go by before I feel grateful to something or someone."

Although many studies utilize the GQ-6 without the observer version, the scores from this measure converged adequately with the GQ-6 scores of an undergraduate sample (McCullough, Emmons, & Tsang, 2002). Participants who filled out the GQ-6 self-report version were instructed to give the informant-report scales to an individual who knew them well. Although the GQ-observer version has provided promising preliminary results, an examination of literature regarding this measure revealed that it has not been used in recent research.

The Gratitude, Resentment and Appreciation Test. The Gratitude, Resentment and Appreciation Test (GRAT; Watkins et al., 2003; Watkins, Grimm, & Hailu, 1998) is a 44 item self-report scale that measures trait gratitude. The GRAT consists of a larger item pool than the GQ-6, so it may not be immediately obvious to participants that gratitude is being assessed

during the administration of the GRAT, as is typically the case with the GQ-6. Additionally it aims to measure 3 specific aspects of trait gratitude such as: sense of abundance, simple appreciation, and social appreciation, as opposed to the GQ-6 that measures trait gratitude generally based on 6 items. Sample items include: "I couldn't have gotten where I am today without the help of many people", "I think that life has been unfair to me", "It sure seems like others get a lot more benefits in life than I do", "I never seem to get the breaks or chances that other people do", "Often I'm just amazed at how beautiful the sunsets are."

The GRAT was developed through a study with 237 undergraduate psychology students (gender and ethnicity not reported) using a preliminary GRAT that consisted of 53 questions originally created to address the following four components of gratitude: sense of abundance, simple appreciation, appreciation for others, and significance of gratitude expression. Because 9 items received less than .20 correlations, they were removed and the final measure included 44 items. Results indicated that items regarding social appreciation and the importance of gratitude expression clustered under one factor, which lead to the GRAT testing the following 3 components: sense of abundance, simple appreciation, and appreciation for others. Results demonstrated good reliability and internal consistency in this population ($\alpha = .92$). Research has demonstrated that the GRAT has good internal consistency with samples of undergraduate students ($\alpha = .91$; Peterson & Seligman, 2004; Watkins et al., 2003), and was found to be related with life satisfaction and positive affect in undergraduate samples (race/ethnicity not specified; Watkins et al., 2003). Additionally, the GRAT correlated strongly ($r = .77$) with the GQ-6 in another undergraduate sample, which provided evidence for concurrent validity (Watkins et al., 2006).

GRAT short-form. A revised short-form version of the GRAT (GRAT-R; Thomas &

Watkins, 2003) contains 16 items related to dispositional gratitude based on the following 3

components: (a) lack of a sense of deprivation or sense of abundance, (b) appreciation, and (c)

appreciation for others. Sample items include: "I really don't think that I've gotten all the good

things that I deserve in life;" "I think it's important to appreciate each day that you are alive;"

and "I couldn't have gotten where I am today without the help of many people" (Froh et al.,

2011).

Internal consistency for the GRAT-R with undergraduate populations is strong (α = .92;

Thomas & Watkins, 2003); however, it is noteworthy that this result was reported in a

conference presentation and not published as its own article. More recently, Diessner and Lewis

(2007) examined the relationship between the GRAT-R and spiritual transcendence and

materialism with a convenience sample of 206 undergraduate students (58% women and 42%

men; ethnicity not reported) who were between the ages of 16 and 47. This study found that the

GRAT-R scores were positively correlated with the spiritual transcendence scores (*r* = .31), and

negatively correlated (*r* = −.44) with the Material Values Scale scores. Although the α scores

found in this study were lower than what was found in previous studies, internal consistency was

still adequate for all 3 of the components measured by the GRAT-R (lack of a Sense of

Deprivation or Sense of Abundance; (*α* = .80), Appreciation for Simple Pleasures (*α* = .87), and

Social Appreciation (*α* = .76).

The GRAT-R has also recently been tested for use with children and adolescents aged 10

to 19 in a school setting (Froh et al., 2011). In a study conducted with 2 different samples, Froh

and colleagues (2011) tested the effectiveness of the GRAT-R as well as other gratitude

measures with children and adolescents. The participants in the first sample consisted of 411

middle-school students (from ages 10-13). 71.5% of the sample was Caucasian (other ethnicities not reported) and 52.1% of the sample was female, while 47.9% of the sample was male. In the second sample participants were 994 high school students (from ages 14 to 19). 63.8% of the sample was Caucasian (other ethnicities not reported). Additionally, 50.5% of the sample was male and 49.5% of the sample was female. After parental consent forms were completed, teachers gave all student participants questionnaires assessing their level of gratitude, affect, life satisfaction and presence of depressive symptoms. Results demonstrated internal consistency for this measure as indicated by the α scores for all 3 subscales of the GRAT-R (lack of sense of deprivation, simple appreciation, appreciation of others), which ranged from .70-.83 for all age groups. However, results also indicated that the GRAT-R scores demonstrated low correlation with the GAC (discussed next) and GQ-6 (discussed previously) with participants between the ages of 10 and 13, which indicates that this form is not measuring the desired trait as the GQ-6 and GAC has with this population. Additionally, the GRAT-R was found to be mildly to moderately positively correlated with positive affect and life satisfaction among 14 to 19 year olds (*r* range =.30 - .46) and 12 to 13 year olds (*r* = .16 and .19), but no significant correlations between gratitude and positive affect or life satisfaction were found among the 10 to 11 year olds. Additionally, the GRAT-R was negatively correlated with negative affect scores among 14 to 19 year olds (*r* = -.17 to -.25); consistent with other findings, no significant correlation was found between the GRAT-R and negative affect among 10 to 13 year olds. Thus, these results indicate that the GRAT-R is a valid and reliable measure to use with adolescents from ages 14 to 19. However, the results also suggest that the GRAT-R may not be applicable to youth ages 10 to 13. This may be due to the developmental stage 10 to 13 year olds are in and the cognitive limitations that accompany this stage. Some of the questions contained in this measure require

the participant to evaluate internal and external causes for the events that have occurred in his/her life, which may be difficult for a child in this age group to do if he/she has not yet been able to think in an abstract manner.

The Gratitude Adjective Checklist. The Gratitude Adjective Checklist (GAC) is a 3 item scale that was created by McCullough, Emmons, and Tsang in 2002. The GAC is comprised of 3 gratitude-related adjectives (i.e., grateful, thankful and appreciative), and requires participants to rate the intensity of each adjective experienced (according to different time frames such as daily or weekly for example) based on a 5-point Likert scale that ranges from 1 (*very slightly* or *not at all*) to 5 (*extremely*). Unlike the previous two measures, it was designed to measure gratitude as an emotion/mood based on the period of time indicated in the instructions (Froh et al., 2007). Additionally, dispositional gratitude can be assessed through this measure by instructing participants to rate how accurately these 3 adjectives characterize them (McCullough, Emmons, & Tsang, 2002).

Adequate internal consistency has been demonstrated with the GAC in adult samples (α=.87, McCullough et al., 2002; α =.91, Emmons & McCullough, 2003). In a sample of undergraduate students, the GAC was also found to be associated with positive affect (r=.57), life satisfaction (r=.38), spiritual transcendence (r=.47), and negatively correlated with negative affect (r=-.23) and neuroticism (r=-.31; McCullough et al., 2002). Additionally, in a sample of veterans with and without PTSD, daily gratitude was measured by an adjective check-list (based on the GAC) that included 2 adjectives: "grateful" and "appreciative." This measure was positively related to well-being among both groups and demonstrated adequate internal consistency (α= .84; Kashdan, Uswatte, & Julian, 2006).

The GAC has also been used with children and adolescents and has demonstrated strong internal consistency (α's ranged from 0.80–0.84; Froh et al., 2009). Additionally, in the study previously discussed that was conducted by Froh in 2011 (see GQ-6 subsection), the effectiveness of the GAC and other gratitude measures was tested with children and adolescents from ages 10 to 19. Results indicated that GAC scores were positively correlated with positive affect and life satisfaction with all age groups (r's ranged from .32-.56), and negatively correlated with depression scores of all age groups (r's ranged from -.15 to -.41), except for 12 to 13 year olds, with which no significant correlations were found. Thus, these results indicate that the GAC is a valid and reliable measure to use with adolescents aged 14 to 19; however, it may not be applicable to children ages 10 to 13. Further studies need to be conducted using the GAC with this age group to consider validity and reliability factors.

Posttrauma Gratitude Scale. Vernon, Dillon, and Steiner (2009) created a 4 item posttrauma gratitude scale in their research with undergraduate students. The scale asks participants to rate the degree to which each gratitude related emotion (i.e., fortunate, grateful, appreciate life and relieved) was felt shortly after the trauma he/she experienced on a 5 point scale from 1 (very slightly or not at all) to 5 (extremely).

Vernon, Dillon, and Steiner (2009) used this measure when examining the connection between proactive coping, positive emotions and posttraumatic stress among 182 undergraduate women with a history of trauma. The results indicated that proactive coping style and posttrauma gratitude were negatively related with existing PTSD symptom degree (Vernon et al., 2009). This scale demonstrated adequate internal consistency (α=.82) in this initial study.

Similar internal consistency was found ($\alpha = .83$) when Vernon (2012) used the posttrauma gratitude scale to examine the role posttrauma gratitude plays in proactive coping

with PTSD and anhedonic depression with a sample of 169 undergraduate students between the ages of 17 and 35 (86 men and 83 women; 80.5% of the sample was Caucasian, 9.5% was African American, 3.0% was Asian American, 3.0% was Hispanic and 4.2% identified as a multiracial ethnicity). Results demonstrated that proactive coping and posttrauma gratitude were negatively related with PTSD symptom severity. Additionally, proactive coping was also found to be negatively related with anhedonic depression.

Qualitative methods used in gratitude research. Qualitative methods are also used in research to assess gratitude. Some studies have examined overt behaviors in order to measure gratitude. For example, Becker and Smenner (1986) conducted a study which examined the frequency with which a sample of 250 children (121 boys, 129 girls) verbally expressed gratitude (i.e., Thanks, thank you) following a prize they received for guessing a color correctly. Results from this study indicated that 37% of the children verbally expressed gratitude after receiving the reward.

Other research has examined individuals' responses (saying "thank you" or smiling) to another person holding the door open for them (Okamoto & Robinson, 1997; Ventimiglia, 1982). Other studies have also used observer reports to assess factors related to gratitude such as well-being and prosociality (Emmons & McCullough, 2003; McCullough et al., 2002).

More frequently, methods involving the assessment of written documents are used to measure gratitude. These include open-ended personal stories, such as those obtained from autobiographies, and personal interviews, as well as more directed narratives, reactions to a gratitude related vignette, and written accounts of success, specifically related to recognizing that help received from others contributed to the success.

Regarding open-ended stories, Danner and colleagues (2001; see Physical Effects of Gratitude subsection for more details), reviewed nuns' autobiographies written when they were between the ages of 18 and 32. Results indicated that the more positive emotional content found in the autobiography such as gratitude, hope and love, the greater likelihood that the nun would be alive over 60 years later. The nuns who had the least positive emotional content were twice as likely to die when compared with the nuns who used the most positive emotion content.

Similarly, personal interviews have been directly coded for grateful verbal and physical expressions (Reibstein, 1997), and open coded, in which gratitude themes emerged. For example, Coffman (1996) found that gratitude was a consistent theme of Hurricane Andrew survivors. Liamputtong and colleagues (2004) conducted personal interviews with 30 women from Thailand regarding motherhood. Interviews were coded for various themes, one of which was the appreciation of love and gratitude participants felt towards their own mother once they had their own child.

Other researchers use specific directions and questions to elicit responses of gratitude. Sometimes researchers directly ask their participants to write about gratitude experiences. For instance, Kashdan and colleagues (2009) instructed participants in 2 samples (sample 1: 77 older adults from ages 59 to 85, 47 women and 29 men, 98.7% Caucasian; sample 2: 214 undergraduate students, aged 18 to 48, 155 women and 59 men, 55.4% Caucasian, 18.8% Asian American, 8.5% Hispanic American, 8.5% African American, 4.7% Middle-Eastern, 2.8% identified as mixed or other ethnicity and 1.4% did not indicate an ethnicity) to record a narrative of a "personally meaningful experience of gratitude" that occurred in the last week, as well as the GQ-6 (McCullough et al., 2002). Then, participants were asked to answer questions regarding their gratitude experience assessing the intensity of gratitude, degree of pleasant or unpleasant

emotion attached to experience, any sense of burden and whether the person was motivated to do something good for other individuals after the gratitude experience.

Other researchers use indirect methods. Attributional measures can be used to indirectly measure gratitude as "it can be inferred that attributing one's own success to another person measures gratitude in a certain sense, as gratitude is the emotion felt when success is attributed to other people" (Weiner, Russell, & Lerman, 1979). Several studies have used this measure (Baumeister & Ilko, 1995; Farwell & Wohlwend-Llyoyd, 1998). For example, Baumeisteand and Ilko (1995) instructed participants to write about a successful experience, and the frequency of gratitude to others was coded throughout the essay. In approximately half of these stories, individuals recognized that help received from others partly led to the success they experienced. Similarly, researchers use prompts about receiving benefits. Algoe et al. (2008; see Social Effects of Gratitude) studied female members from 3 different sororities, and instructed little sisters to answer questions after every gift from her big sister was received, such as describing her feelings regarding the gift and providing a description of the event when the gift was received. In another study, Tsang (2006b; see Social Effects) instructed a sample of undergraduate students to recall and write about a situation that occurred in the last year. Depending on what group the participant was assigned to, he/she was instructed to either think of a situation where the other person did a favor for the participant for unselfish reasons or imagine a situation where a benefit was received for selfish reasons. Participants were then instructed to think and feel the feelings and thoughts that were experienced during the actual situation and record them as well as current emotions regarding the memory.

Finally, some studies use informant reports that assess factors related to gratitude such as well-being and prosociality, often in conjunction with self-report gratitude measures, such as the

GQ-6, GRAT and GAC. For example, Emmons and McCullough (2003) used observer reports of well-being in a study with 65 adults (44 women, 21 men; from ages 22-77) who were randomly assigned to either a gratitude group or a control group (see Physical Effects section for further details). Participants were instructed to give the Positive and Negative Affect Scales (PANAS; Watson et al., 1988) and the Satisfaction With Life Scale (Diener et al., 1985) to their significant other. Observers were then instructed to answer the questionnaires based on how they believed their significant other would respond. Results indicated that members of the gratitude group were perceived as having higher positive affect and life satisfaction when compared with observer reports of participants in the control group.

In another study conducted by McCullough, Emmons and Tsang (2002) with 238 undergraduate students (174 women, 57 men, 7 not reported; from 19 to 44 years old; ethnicity/race not reported), participants were administered the GQ-6 (McCullough et al., 2002) in order to measure dispositional gratitude and instructed to administer a questionnaire to somebody who knew him/her well that required observers to rate the frequency of times the participant had engaged in a prosocial action towards the observer (e.g., providing emotional support, loaning money, cheering the person up). These answers were rated on a 5-point Likert-type scale that ranged from 1 (not at all) to 5 (frequently). Observers were also instructed to answer questions regarding their perception of the participant's overall prosocial behavior such as how often the participant helps others or has volunteered to do so on a scale of 1 (not at all characteristic of the participant) to 5 (extremely characteristic of the participant). Results indicated that the gratitude scores were positively correlated with observer reports of participants' prosocial tendencies. Additionally, participants who were perceived as more grateful by themselves and observers were rated as engaging in more prosocial actions (i.e.,

76

providing emotional support or loaning money) towards the observers when compared with participants who were less grateful.

Gratitude Interventions

Given the purported benefits of gratitude, a variety of practices and interventions have been introduced. Some have been studied, with generally positive results. For example several experiments have consistently demonstrated that practicing grateful thinking on a weekly basis can lead to an overall increase in positive affect and well-being (Emmons & McCullough, 2003). Although most of these exercises have been promoted for use by the general public in lay or religious settings, some of these interventions have also been used in studies testing the effectiveness of gratitude exercises within a psychotherapeutic context (Carson et al., 2010; Seligman, Rashid, & Parks, 2006; Seligman et al., 2006; Wood, Froh, & Geraghty, 2010). Thus, this subsection begins with a review of 12 gratitude interventions and supporting research findings, and is followed by a review of other therapeutic practices that are relevant to gratitude. Next, research on the use of gratitude practices with adults, including those with clinical issues or disorders is discussed.

Gratitude exercises / practices / interventions.

Three Good Things in Life or Count Your Blessings (Emmons, 2008; Seligman, 2002; Seligman et al., 2005). This exercise involves an individual reflecting about and writing down three things that went well each day and providing causes for each of those items. Emmons (2008) recommends setting aside time daily to recount blessings. When individuals focus on and write down things they are grateful for each day, gratitude can become a habit and lead to an increased sense of appreciation for the blessings in one's life.

As previously noted in the effects section, this gratitude exercise has been researched with adult populations. Seligman et al. (2005) tested the efficacy of the "counting your blessings exercise" and found that this intervention increased the participants' happiness (as measured with the Steen Happiness Index (SHI; Seligman et al., 2005), and decreased their depressive symptoms (as measured by the CES-D (Radloff, 1977), when compared with participants in the placebo group. The results demonstrated that the impact of the blessings exercise lasted for six months (Seligman et al., 2005).

Also, Emmons and McCullough (2003) asked one of their 3 groups of undergraduate students to recount 5 things they were grateful for that week over a period of 10 weeks, and that group felt more optimistic about their lives and reported fewer health problems as well as more time spent exercising than those in the control group. Lyubomirsky and colleagues (2005) also found that frequency of engaging in this exercise affected its impact on ratings of well-being over a 6 week period. Results showed that the group who practiced the exercise once a week demonstrated an increase in well-being; whereas the group who practiced the exercise 3 times a week did not experience an increase in well-being.

Lastly, a study conducted by Smith, Friedman, and Nevid (1999) compared African American and European patients with panic disorder and results indicated that African Americans used counting their blessings (as measured by Revised Ways of Coping Checklist [WCCL]; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985) in addition to religiosity as coping strategies to manage their symptoms.

Gratitude Letter (Seligman, 2002). The gratitude letter is an exercise in which individuals take time to reflect on somebody they believe has benefited them in some way, and whom they've never expressed gratitude towards for their actions. The individuals are then

78

instructed to write a letter to this person detailing how the benefits they received from him/her impacted their lives, and the feelings that have developed towards this person as a result. The individual can choose to mail the letter, deliver it in person, or not send it. There is no recommended time frame for this exercise, although most of the studies testing this exercise (excluding Carson et al., 2010) have required participants to write no more than one gratitude letter.

In 2006, Sheldon and Lyubomirsky conducted two studies on the "gratitude letters" exercise and found that motivation and effort to practice the interventions affected its effectiveness. This exercise was also tested in 2 gratitude workshops with 9 patients/service users (gender/ethnicity not reported) in a recovery group at a community mental health center (Carson et al., 2010). The participants presented with a variety of clinical issues including bipolar I disorder, anxiety, depression and psychosis. Participants attended two 2 hour workshops examining the meaning of gratitude and the importance of gratitude in their lives. During one of the workshops, participants were required to choose 5 people to write a gratitude letter to. A comparison between pre- and post- measures administered 2 weeks after the last workshop indicated that after the gratitude letter and other gratitude interventions were implemented, participants were more grateful for different aspects of their lives (the Life Thankfulness Review (cite not provided) and experienced a higher level of life satisfaction (Lambeth Well-being Indicator, New Economics Foundation, 2008).

Finally, Froh and colleagues (2009) tested the effectiveness of the "gratitude letter" exercise with 89 students from 8 to 19 years old (50.6% girls, 49.4% boys; 67.4% Caucasian, 12.4% Asian American, 9.0% African American, 9.0% Hispanic, and 2.2% reported "other" as their ethnicity). After parental consent was obtained, participants were matched according to

79

grade level and randomly assigned to 1 of 2 conditions: (a) gratitude condition or (b) control

condition. Participants in the gratitude condition were instructed to think of a person in his/her

life that has been kind to them but hasn't been thanked and to write a gratitude letter to that

individual (including what this person specifically did that impacted his/her life) and bring it to

them in person. Participants in the control condition were instructed to record the activities they

engaged in the previous day and the emotions experienced during these activities. Results

indicated that participants in the gratitude group who scored low on positive affect reported a

higher level of gratitude and positive affect at post-treatment and higher positive affect at follow-

up 2 months afterwards, when compared with participants who were in the control condition.

Gratitude Visit (Emmons, 2008; Seligman, 2002). The gratitude visit is an extension of

the gratitude letter exercise in which individuals are asked to write a letter expressing their

gratitude to somebody who has impacted their lives. In this exercise, participants are instructed

to deliver the letter personally to the recipient and read the letter out loud to them.

Seligman et al. (2005) conducted a study testing the effectiveness of this exercise with an

adult sample. Participants who were assigned to the gratitude visit condition were given one

week to write a gratitude letter and deliver it to somebody who had impacted their life but had

not been thanked. Results indicated that this interventions increased the participants' happiness

(measured with the Steen Happiness Index (SHI; Seligman et al., 2005), and decreased their

depressive symptoms (as measured by the CES-D (Radloff, 1977), when compared with

participants in the placebo group.

Gratitude Journal (Emmons, 2008; Seligman, 2002). This exercise includes the practice

of writing down benefits or blessings, including people, things, events or feelings for which an

individual is grateful. Emmons (2008) indicates that the daily practice of using a gratitude

journal can serve as a reminder of all the blessings in one's life, even those related to ordinary events. Additionally, Emmons emphasizes the importance of continuously revising one's list of blessings so as not to achieve "gratitude fatigue," which can have the opposite effect. If the benefit is received from another person, Emmons recommends taking time to focus on the specific aspects of the benefits received rather than a generalized view of gratitude towards the individual (e.g., "I'm so grateful for all the hours my mother has spent cooking for me, providing me with support and driving me to my appointments," as opposed to "I'm so grateful for my mother").

This exercise was also tested in Carson et al.'s (2010) previously mentioned study of 2 gratitude workshops with 9 patients/service users (gender/ethnicity not reported) in a recovery group at a community mental health center (see Gratitude Letter). During the first workshop, participants were instructed to implement a gratitude journal in which they wrote down 3 things they were grateful for every day and the reasons why over a period of 4 weeks.

Remember the Bad (Emmons, 2008). This exercise involves the practice of recalling negative events and contrasting the past with how the individual is doing now in an effort to highlight his/her strengths. Emmons does not recommend a time frame for this exercise and emphasizes that remembering the bad can serve as a reminder of the personal growth an individual has experienced through his/her ability to cope. Emmons indicates that this reminder can lead to an experience of gratitude for getting through the difficult situation. Emmons (2008) further emphasizes this point by explaining that "when we remember how difficult life used to be and how far we have come, we set up an explicit contrast in our mind, and this contrast is fertile ground for gratefulness" (p. 191).

Ask Yourself 3 Questions (adapted from Naikan therapy, as discussed in *Thanks! How Practicing Gratitude Can Make You Happier*, Emmons, 2008). Emmons discusses this Buddhist mediation technique adapted from Naikan therapy (discussed in more detail in the next subsection) and recommends practicing this exercise daily. This exercise consists of reflecting on these 3 questions (Emmons, 2008, p. 192):

What have I received from _____?

What have I given to _____?

What troubles and difficulty have I caused_____?

The purpose of this exercise is to facilitate an awareness of the give and take in social relationships, benefits received from others, and the awareness of pain caused to others. This exercise can be used to meditate on events of the day for approximately 20 minutes (Emmons, 2008) or a specific relationship (either chronologically or in the present) for approximately 50 to 60 minutes (Emmons, 2008). Emmons (2008) described that this practice focuses on 2 elements: "(1) the discovery of personal guilt for having been ungrateful toward other people in the past and (2) the discovery of feelings of positive gratitude toward those persons who have extended themselves on behalf of the person in the past or present" (p. 194).

Gratitude Prayers (Emmons, 2008). As noted in the definitions section, gratitude is a virtue strongly emphasized throughout most religions. Therefore, prayers expressing gratitude are quite common. Additionally, gratitude prayers can also be incorporated spiritually, such as the prayer by Buddhist teacher Thich Nhat Hanh, which is a combination of meditation and nonviolent civil disobedience:

Waking up this morning, I see the blue sky.

I join my hand in thanks

For the many wonders of life;

For having twenty-four brand-new hours before me (p. 196).

Emmons does not indicate a recommended time frame for using gratitude prayers. Additionally, Emmons (2008) suggests, that even if an individual finds it difficult to engage in a gratitude prayer, Emmons (2008) suggests that it may be beneficial to pray for the "ability to be grateful" (p. 196).

Breath of Thanks (Luskin, 2002, as cited in Emmons, 2008, p. 198). Emmons indicates that according to his research, health is a common expressed reason for gratitude. Studies have demonstrated that common health-related themes eliciting gratitude are: an individual's body, recovery after illness, being alive, or gratitude for one's senses (Emmons, 2008).

To engage in the Breath of Thanks exercise, individuals are instructed to pay attention to their breathing and practice taking deep breaths, while noticing how their breath flows in and out easily, for about 3 to 5 deep breaths. For the next 5 to 8 breaths, individuals are instructed to say "thank you" for each breath they take in order to remind themselves of their gratitude for breathing and the gift of being alive. Luskin (2002) recommends that this exercise be practiced 2 to 3 times a day, at least 3 times a week (as cited in Emmons, 2008).

Visual Reminders (Emmons, 2008). Emmons (2008) emphasizes that "awareness is a precondition for gratitude" (p. 199). An obstacle identified as a barrier to gratitude is a lack of awareness. Visual reminders can help prevent this barrier by facilitating recognition of gratitude, which can serve as a reminder to be grateful. Emmons suggests listing blessings on post-it notes and placing them around the house in places that can be easily seen on items that are frequently used such as the phone or mirror. Additionally, Emmons suggests setting a phone alarm as a daily reminder to recount one's blessings.

Gratitude Affirmations (Emmons, 2008). Emmons recommends using positive affirmations to practice gratitude such as: "I have so much to be grateful for," "My life is a gift," and "I am truly blessed." He suggests that these affirmations can also be used with visual reminders.

Accountability Partners (Emmons, 2008). Partners can help other people cultivate gratitude by providing another perspective on aspects to be grateful for, assisting in exploring barriers to gratitude and helping in finding gratitude for challenging situations in one's life. Having an accountability partner or group also serves as a way to spend time with a grateful individual(s), which can help enhance gratitude as emotions can be contagious (Emmons, 2008).

Make a Vow to Practice Gratitude (Emmons, 2008). Research has demonstrated that commitment techniques such as vows and written contracts can have significant impacts on behavior change (Dean 2001; Kanfer, Cox, Greiner, & Karoly, 1974; Kiesler & Sakamura, 1966; Pardini & Katzev, 1983; Prochaska & Velicer, 1997; Putnam et al., 1994). Studies have consistently shown that those who make vows to engage in a specific behavior have a higher likelihood of following through with that behavior than those who do not make a vow (Dean, 2001; Katzev & Wang, 1994). Emmons (2008) asserts that the act of making a vow signifies greater likelihood that an individual will carry out the vow due to: fear of consequences (internal or external), moral failure if the vow is public in front of others, or knowledge that a vow to God is one that won't be forgotten.

Emmons (2008) suggests that a vow to practice gratitude can take on different forms, including a desire to practice gratitude more regularly (e.g., "I vow to pause and count my blessings at least once each day"), or a promise to express gratitude to loved ones or a person who has had an impact on one's life (e.g., "I vow to express gratitude to someone who has been

influential in my life and whom I've never properly thanked"; p. 203). Additionally, Emmons (2008) recommends posting a gratitude vow somewhere that can be easily seen as a constant reminder to oneself, or for sharing it with one's accountability group or partner.

Relaxation exercises. Although relaxation exercises are intended for different purposes, they can contribute to changes in gratitude. According to Smith's attentional behavioral cognitive (ABC) relaxation theory (Smith, 1990; Smith, Amutio, Anderson, & Aria, 1996), relaxation exercises are associated with "independent relaxation state factors or R-States" which consist of states such as mental relaxation, awareness, joy, love, thankfulness and prayerfulness (p. 409). Additionally, a study conducted by Khasky and Smith (1999) found that the group who had participated in progressive muscle relaxation exercises experienced increased positive emotions of thankfulness, as measured by the Smith R-State Inventory.

Mindfulness. Mindfulness is a practice, exercise, and/or intervention based on Buddhist philosophy that aims to bridge the gap between mind and body, which can strengthen an individual's sense of gratitude by intentionally focusing one's attention on positive aspects in his/her environment, such as what is going right (Shapiro, Schwartz, & Santerre, 2002). An important component of mindfulness is meditation that consists of "intentional non-judgmental awareness and acceptance of the present moment" (as cited in Sin et al., 2011, p. 86). In other words, one of the basic tenets of mindfulness is developing an intentional awareness of one's surroundings by being present in the moment.

Another component of mindfulness is referred to as "vipassana" by Buddhists, and means insight meditation. This type of meditation is aimed to help individuals develop awareness of their passing thoughts and bodily sensations. Individuals are encouraged to pay attention to the starting and passing of their thoughts instead of becoming attached to them, which is the

85

foundation from which the concept of "cognitive defusion" was developed in mindfulness based therapies such as ACT and DBT.

This awareness directly relates to the concept of "impermanence," which is emphasized in Buddhist teachings. Just as an individual's thoughts are impermanent, so is life and every passing moment. Thus, the aim of insight meditation is to help individuals become aware of impermanence, which will make them less susceptible to cravings and attachments, which are often the root of suffering. This awareness of impermanence lays the foundation for gratitude as Nelson-Jones (2004) noted that "shedding the illusion of personal permanence and gaining increased awareness of death can lead to heightened appreciation of life" (p. 113).

Because research has demonstrated that the key to cultivating gratitude is to continuously reflect and develop awareness about blessings and gifts received from others (and forgetfulness is identified as a major obstacle to gratitude), gratitude should be able to be cultivated through consistent practice of meditation and mindfulness. Frederickson, Cohn, Coffey, Pek, & Finkel (2008) tested the effects of practicing a loving-kindness meditation (LKM), an exercise in which individuals focus on an individual they care about and then work on applying those feelings towards themselves and significant others in their lives, which presumably should increase compassion towards the self and others (Salzberg, 1995). Loving kindness is one of the four Divine Abodes of Buddhism, which includes sympathetic joy, compassion and equanimity. Loving kindness is an important quality discussed in Buddhist teachings that emphasizes the importance of cultivating good will towards others.

Results indicated that participants who had practiced LKM experienced increased levels of gratitude as well as other positive emotions such as: love, joy, contentment, hope, pride, interest, amusement, and awe, as measured by the Modified Differential Emotions Scale (mDES;

86

Fredrickson et al., 2003). Additionally, these positive emotions appeared to contribute to further development of personal resources such as social support, decreased symptoms of illness, and mindfulness (Frederickson et al. 2008), consistent with Frederickson's broaden-and-build theory (Frederickson, 1998). Additionally, regular practice of LKM was associated with reduced pain in patients with chronic low back pain (Carson et al., 2005).

Similarly, research has demonstrated that mindfulness can be useful for decreasing depressive and anxious symptoms (Kuyken et al., 2008). Given its usefulness, mindfulness (and the other components discussed above including vipassana/defusion and LKM) is a key part of third-wave CBT approaches, including mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT; Baer, 2005).

Research on gratitude interventions in psychotherapy. As discussed in the Effects of Gratitude section above, some research has been conducted on the effectiveness of gratitude interventions with adults and youth, including those dealing with medical and clinical issues to enhance physical, psychological and social functioning. Such research has contributed to positive psychology resources such as *Positive Psychology in Practice* (Linley & Joseph, 2004), which is a book that can guide clinicians in using positive psychology interventions during the course of therapy to help enhance clients' character strengths. Only a few studies have examined the effectiveness of a gratitude intervention in the context of psychotherapy. This section reviews 4 such studies and the implications for utilizing gratitude exercises in therapy, followed by research regarding certain cultural and religious practices involving gratitude that have been incorporated into psychotherapies, namely Naikan therapy, Cognitive Humanistic Therapy, and mindfulness-based therapies.

The first set of two psychotherapy studies involving gratitude were conducted as part of the development of Positive Psychotherapy (PPT) with people struggling with depression (Seligman, Rashid, & Parks, 2006). Positive psychotherapy (PPT) strives to enhance positive emotion, engagement and meaning in clients' lives. In the first study, Seligman et al. (2006) created a positive psychotherapy program (PPT) during which 2 of the 6 sessions group therapy sessions included the use of 2 gratitude interventions, the "gratitude visit" and "3 blessings". Participants were 40 University of Pennsylvania students (method of recruitment not reported) who scored on the mild-to-moderate range of depression on the BDI-II, and were assigned to the PPT group (42% were female, 58% were male; 26% were Caucasian, other ethnicities not reported) and a control group (43% were female, 57% were male; 52% were Caucasian and percentages of other ethnicities were not reported). Results indicated that over the span of 6 weeks, participants in the PPT group exhibited significant reductions of their depressive symptoms and an increase in life satisfaction when compared with the control group (Seligman et al., 2006).

In the second study, Seligman and colleagues (2006) examined the effectiveness of individual PPT with 45 clients (gender & race/ethnicity not reported) who were seeking treatment at the University of Pennsylvania Counseling Center and were diagnosed with Major Depressive Disorder. They were randomly assigned to either an individual PPT group (n=13) or treatment as usual group (TAU, n=15). In addition to these two groups, a third nonrandomized matched group was used (TAUMED, n=17) in order to compare results with the PPT group. This third group received treatment as usual in addition to antidepressant medication at the same time (TAUMED, n=17). The individual PPT group consisted of approximately 14 sessions across 12 weeks and included 2 gratitude exercises, "count your blessings" and "gratitude letter" in

addition to a discussion of the role of gratitude in good and bad memories (explanation of this discussion was not provided in the article). Results demonstrated that individual PPT was associated with greater reduction in depressive symptoms, increased happiness and higher level of remission from MDD when compared with the randomized group (TAU) and nonrandomized group (TAUMED; Seligman et al., 2006).

While the results of these two studies are promising, there are some limitations to consider. Both studies used small samples consisting of university students. As such, these factors reduce the generalizability of PPT to other populations of different ethnicities, ages, and socioeconomic statuses. Additionally, these studies only examined depression and not other clinical issues such as trauma. Lastly, gratitude was not examined separately in a majority of the studies presented.

Most recently, as previously discussed, Carson and colleagues (2010) conducted 2 gratitude workshops with 9 patients / service users (gender/ethnicity not reported) in a recovery group at a community mental health center. Presenting with a variety of clinical issues including bipolar I disorder, anxiety, depression and psychosis, participants attended two 2 hour workshops examining the meaning of gratitude and the importance of gratitude in their lives. During the first workshop, participants were instructed to implement a gratitude journal in which they wrote down 3 things they were grateful for every day and the reasons why over a period of 4 weeks. Additionally, participants were instructed to write 5 thank you letters to people to whom they were grateful. During the second workshop, participants were encouraged to discuss their experience monitoring their gratitude and bring items that reminded them of gratitude. A comparison between pre- and post- measures administered 2 weeks after the last workshop indicated that after gratitude interventions were implemented, participants were more grateful for

different aspects of their lives (the Life Thankfulness Review (cite not provided) and

experienced a higher level of life satisfaction (Lambeth Well-being Indicator, New Economics

Foundation, 2008).

Although this study provides promising results that may be useful for gratitude

interventions within the context of psychotherapy, there were some limitations. First, there were

only 9 participants, which limits generalizability to the greater mental health population. Second,

the participants were picked by the first author, which could be indicative of a selection bias.

Additionally, there were no comparison or control groups or follow-up of long-term effects.

Lastly, the study did not report whether any of the participants had experienced trauma.

Naikan therapy. Naikan therapy is utilized in several centers located across the U.S. as

well as Germany, Austria and Japan (Linley & Joseph, 2004). Naikan therapy, which means

"looking within," originated in Japan and was created by Ishin Yoshimoto, a Jodo Shin Buddhist

minister. The goal of Naikan therapy is to increase an individual's awareness and insight into

his/her significant relationships. Naikan therapy aims to shift the individual's awareness from

his/her own problems and tendency to blame others, to awareness of benefits bestowed upon

them by others and the impact of their own actions towards others (Hedstrom, 1994; Linley &

Joseph, 2004; Reynolds, 1983). The ultimate goal of Naikan therapy is for individuals to derive

meaning from their lives by engaging in altruistic behavior and reciprocating the benefits they

have received (Hedstrom, 1994). Whereas western therapy generally focuses on individual

growth and self-actualization, Naikan therapy is focused on alleviating the individual's suffering

through improvement of social relationships and reciprocity (Hedstrom, 1994). The primary

intervention used in Naikan therapy is meditation through which an individual explores 3 main

questions (see Gratitude Exercises) in order to achieve the aforementioned goals (Sengoku, Murata, Kawahara, Imamura, & Nakagome, 2010).

Studies have demonstrated that Naikan therapy has been used successfully to treat a variety of people with anorexia nervosa, alcoholism, and personality disorders (Morishita, 2000, as cited in Bono, Emmons, & McCullough, 2004; Sengoku et al., 2010). Additionally, Naikan therapy has been found to be particularly effective with prisoners, as in the 1970's, Naikan therapy was used in 60% of Japanese prison settings (Reynolds, 1980). A study conducted in 1972 to evaluate the effectiveness of Naikan therapy with male prisoners, indicated that prisoners who had utilized Naikan therapy were less likely to be repeat offenders than those who did not (Tanaka-Matsumi, 1979).

Cognitive Humanistic Therapy. Cognitive Humanistic Therapy (CHT) is a type of therapy created by Richard Nelson-Jones that integrates principles from cognitive-behavioral therapy and humanistic therapy with Christian and Buddhist teachings. Cognitive Humanistic Therapy has been influenced by psychologists from humanistic and cognitive behavioral backgrounds as well as important religious figures such as the Buddha, the Dalai Lama, Albert Ellis, Aaron Beck, Abraham Maslow and Carl Rogers.

CHT is based on the belief that all human beings have the potential for goodness as well as for aggressive or evil actions (Nelson-Jones, 2004). A component of the Buddhist teachings that is emphasized in CHT is the significance of strengthening positive qualities such as gratitude and sympathetic joy while simultaneously reducing negative qualities, such as greed and craving. Furthermore, individuals have the capacity to train their minds to cultivate the four Divine Abodes of Buddhism: loving kindness, sympathetic joy, compassion, and equanimity. Sympathetic joy refers to celebrating another person's good luck or successes (Nelson-Jones,

2004). Furthermore, "people who show sympathetic joy rise beyond the confines of everyday negativity in ways that enhance both their own and others' happiness" (Nelson-Jones, 2004, p. 178). The purpose of cultivating the aforementioned qualities is to become "fully human," which means that an individual cares for other peoples' well-being as much as his/her own. Nelson-Jones (2004) further illustrates the meaning of being "fully human" by noting that "clients and therapists alike can learn to become strong enough to liberate themselves further from the prisons of their separate existences by cultivating skills of thinking and communicating more benevolently towards others" (p. 175).

Gratitude is an important component of loving kindness and is closely associated to an individual's capacity to experience, think and demonstrate sympathetic joy. Thus, the more an individual is able to cultivate a sense of gratitude, the more likely he/she is to experience and demonstrate gratitude towards others and consequently improve his/her relationships. CHT therapists work with clients on overcoming factors that may inhibit their ability to experience gratitude, such as rigid beliefs or a tendency to focus on negative qualities of the self or others.

Additionally, Nelson-Jones (2004) notes that there are other ways that therapists can help clients cultivate their gratitude skills. One such intervention includes the practice of helping the client identify several important people for each stage of his/her life thus far (i.e., infancy and childhood, adolescence, young adulthood, middle age, and post-middle age). For each individual listed, clients are instructed to specifically record how these significant figures changed their life in a positive way. The therapist then helps the client to determine whether he/she has properly thanked that person for the positive impact that was made. If not, the therapist assists the client in creating a plan for how to thank the person. Another practice suggested by Nelson-Jones (2004) includes an intervention in which therapists help clients to imagine that they are about to die and

92

assist them in identifying what they would be thankful for and what they wish to say to significant others in those last moments.

A final gratitude exercise includes the therapist helping the client to create a list of people he/she wishes to demonstrate gratitude towards. The client is then instructed to consciously focus on feeling, thinking and expressing gratitude towards the people on the list. After the client tries this experiment, the therapist assists the client in exploring how the exercises went as well as the positive and negative results of feeling, thinking and expressing him/her self in a different manner.

Mindfulness-based therapies. This subsection reviews three mindfulness based therapies: Mindfulness-based stress reduction (MBSR), Mindfulness-based cognitive therapy (MBCT), Dialectical Behavior Therapy (DBT), and Acceptance and Commitment Therapy (ACT). MBSR is a structured group program created by Jon Kabat-Zinn in that includes weekly sessions which implement mindfulness by teaching different types of meditation (i.e., body scan and sitting), as well as mindful yoga to be utilized as a coping strategy for managing painful physical and emotional symptoms (Fjorback, Arendt, Ørnbøl, Fin, & Walach, 2011). The aim of MBSR is for participants to change their relationship with their thoughts, feelings and sensations by learning to focus on them with a nonjudgmental attitude of acceptance. MBSR has been found to be useful for reducing stress and alleviating anxious and depressive symptoms (Fjorback et al., 2011). Additionally, MSBR has been shown to increase pain tolerance and improve psychological functioning in individuals suffering from a wide range of medical disorders including chronic pain and insomnia (Rosenzweig et al., 2010; Wong et al., 2011).

MBCT is a structured group program developed by Segal, Williams and Teasdale which incorporates components of CBT and MBSR. MBCT was designed for use with depressed

93

patients, in order to prevent relapse (Fjorback et al., 2011). Like MBSR, the goal of MBCT is change an individual's relationship to his/her thoughts, emotions, and sensations. Thus, MBCT teaches individuals to develop an awareness of their ruminative thought patterns and to "decenter" themselves. The aim of MBCT is to help the individual recognize his/her automatic thought patterns and feelings and to focus on cultivating a decentered, nonjudgmental perspective towards cognitions, feelings and sensations in the present moment by practicing meditations focused on the body and/or breath (Fjorback et al., 2011; Fresco, Segal, Buis, & Kennedy, 2007, as cited in Felder, Dimidjian & Segal, 2012). MBCT has been found to be most effective for preventing relapse in formerly depressed patients, particularly those with 3 or more previous episodes of depression. Additionally, several studies have found promising results for the effectiveness of MBCT in reducing symptoms of anxiety and depression in patients diagnosed with cancer as well as patients with bipolar disorder (Tan, 2011).

DBT is a treatment that Marsha Linehan developed particularly for use with clients with borderline personality disorder. DBT emphasizes using the technology of change and acceptance through skill building in four areas: emotion regulation, distress tolerance, improvement of interpersonal relationships and acceptance/mindfulness. The mindfulness portion of DBT focuses on 3 different states of mind: reasonable mind, emotional mind, and wise mind (Tan, 2011). Wise mind refers to the part of one's mind that makes decisions. Logical mind refers to the part of the mind that utilizes knowledge when performing concrete tasks. Emotional mind is the state of mind that causes people to experience the full range of their feelings and to take action based on those feelings. DBT also teaches clients to utilize their "how" and "what" skills with regard to mindfulness. "What" skills are designed to help clients observe events as well as their feelings and actions without trying to change them. Additionally DBT teaches clients to recognize that

their feelings and thoughts are not facts. The "how" skills that are taught to clients include implementing a nonjudgmental perspective by not perceiving something as either good or bad and recognizing the consequences of actions instead of judging situations. Lastly, DBT helps individuals to practice acting in a way that reflects their commitment to their goals instead of their judgments (Tan, 2011). DBT has been found to be particularly effective for patients with Borderline Personality Disorder, as well as for patients with depression (Tan, 2011).

ACT is a type of therapy developed by Steven Hayes and colleagues that is based on relational frame theory. ACT includes six main components: acceptance, cognitive defusion, being present, focusing on a transcendent sense of self, as well as values and action reflecting commitment to those values (Hayes, Strosahl, & Wilson, 1999). ACT emphasizes mindfulness by helping individuals grasp the importance of learning to accept their painful emotions and physical sensations, rather than trying to avoid or control them (Harris, 2009). ACT also emphasizes the importance of defusion which teaches clients to observe their thoughts and feelings in a nonjudgmental manner instead of overidentifying with them, since having a thought doesn't mean that it's true (Harris, 2009). ACT also teaches clients the importance of living a life that reflects one's values. ACT has been found to be effective for a variety of issues including: anxiety, depression, chronic pain, and stress (Tan, 2011).

Purpose of the Study and Research Question

Research has demonstrated that gratitude can help survivors positively process difficult events and cope adaptively with their traumas in addition to serving as a protective factor against the development of posttraumatic stress disorder (PTSD; Kashdan et al., 2006; Vernon et al., 2009). Despite these promising findings, there is limited research examining gratitude expression by trauma survivors in the context of psychotherapy. Additionally, researchers have had

95

difficulty agreeing on a unitary definition of gratitude, as it has been presented as a positive psychological character strength and trait, coping response, attitude, moral virtue, emotion, and habit (Emmons et al., 2003). Significant overlap among these categories exists and future research is needed to clarify definitions (Lambert et al., 2009) and assessment methods.

Thus, this study aimed to examine expressions of gratitude by trauma survivors in psychotherapy. In order to achieve this goal, qualitative analysis was used to examine these gratitude expressions through the use of videotaped psychotherapy sessions. The research question this study sought to answer was: How do clients who have experienced trauma express gratitude in the context of psychotherapy?

Chapter II: Method

The purpose of this chapter is to describe the methods that were used for this study. This section begins with the research design and rationale, then reviews the participants involved in this study as well as data collection and coding procedures. This chapter concludes with data analysis procedures.

Research Design

This study implemented a qualitative analysis which is useful for examining "How" or "What" questions instead of "Why" questions (Morrow, 2007). This method is typically used when conducting research relevant to clinical or counseling psychology as it is synonymous with the method of approach utilized in clinical practice (Mertens, 2009). This approach is also applicable when the aim of the study is to examine individuals' unique experiences, particularly when coping with adversity, and the process through which these individuals create meaning out of such circumstances (Creswell, 2009; Glazer & Stein, 2010; Morrow, 2007). This method can also be useful in examining specific variables in regards to a construct that has not been clearly defined or adequately covered by existing literature.

This study examined expressions of gratitude communicated by trauma survivors in the context of psychotherapy. Qualitative analysis can shed light on a diverse range of contextual factors that impact the course and effectiveness of treatment (Mertens, 2009). Qualitative analysis is also particularly helpful when analyzing a target issue as it relates to the therapeutic alliance and the context of psychotherapy (Mertens, 2009). This study was based on a treatment process approach. This approach is typically used to label, categorize, identify and track specific client and therapist behaviors, and can be dispersed across categories (Stiles, Honos-Webb, & Knobloch, 1999). These categories included:

97

(a) size of the scoring unit, such as single words, phrases, topic episodes, timed intervals

of various durations, whole sessions, phases of treatment, whole treatment, and series of

treatments,(b) perspective, or view point of the therapist/client, (c) data format and access

strategy, such as transcripts, session notes, and audio/videotapes, (d) measure format,

such as coding used to classify data into nominal categories, rating, or Q-sort, (e) level of

inference, distinguishing the *classical strategy* in which only observable behavior is

coded, from the *pragmatic strategy* in which the coders or raters make inferences about

the speaker's thoughts, feelings, intensions, or motivations based on the observed

behavior, (f) theoretical orientation, ranging from specific orientations to broader

applicability, (g) treatment modality, such as individual adult, child, family, group

therapy,(h) target person, including the therapist, client, dyad, family, or group as the

focus of measurement, (i) communication channel, such as verbal, paralinguistic, or

kinetic, and (j) dimension of verbal coding measures, including *content categories* which

describe semantic meaning (e.g., "fear"), *speech act categories* which concern the

manner in which the speech was conveyed (e.g., reflections, interpretations, questions,

and self-disclosures), and *paralinguistic measures* which describe behaviors that are not

verbal but accompany speech(e.g., hesitations and tonal qualities). (Stiles et al., 1999,

pp. 389-390)

The treatment process approach described above is comprised of specific categories that can be

found through an intensive examination of each case. These categories are typically cumulative

in nature as they build up over time across sessions (Stiles et al., 2009). As a result, this allows

the researcher to identify the frequency of each category occurring in every session and/or across

sessions (Stiles et al., 2009). A review of how this approach specifically was used to analyze the data as well as measures and categories used is provided in the following section.

Participants

This section first reviews the steps taken in choosing the sample for the present study. Next, summaries for each of the chosen client-participants are provided, including demographic information and presenting problems (see Table 1). Then a review of therapist and researcher participants is provided. Then this section presents a review of instrumentation and the coding categories used in the present study. Finally, this section concludes with a description of the procedures and data analysis steps used in the study.

Client-participants. For this study purposeful random sampling was used to choose 5 clinical cases from the archival database of videotaped sessions from a Southern California University's community counseling center. First, the researcher obtained approval from the Institutional Review Board (IRB) of the researcher's university. In order for potential client-participants to be included, it was required that they previously provided consent to allow their videotaped sessions/written materials to be a part of the research database prior to receiving psychotherapy treatment. All videotaped/written materials were redacted and de-identified before being included in the university database, ensuring that date(s) of birth, names, and exact locations are not mentioned so that clients are protected and cannot be identified. This data was recorded on the participant tracking sheet (see Appendix A).

Client-participant 1. Client Participant 1 was an African American, Christian, female. When the transcribed session took place, she was 28 years old. She sought therapy to deal with adjustment issues related to relocating to Los Angeles from Kentucky four years before starting treatment as well as difficulties with expressing her emotions to members of her social support

system. At the time, she reported that she was in a long-distance relationship with a man who resided in her hometown. Upon intake, CP1 disclosed that she was employed as a travel agency accountant, but that she was experiencing financial difficulties. She reported that her difficulty expressing her emotions to her friends and boyfriend might be connected to being raped by her uncle when she was in third grade. She disclosed that her uncle tried to rape her a second time, but that he ceased because she threatened to let her mother know about the sexual abuse. CP1 did not report her history of childhood sexual abuse to anyone before seeking therapy, and her uncle was deceased. Upon intake, CP1 reported that she remains in contact with her mother, but that she had no contact with her father since she had never met him. She stated that her brother and older cousin were both included in her social support system.

On the clinic intake form, CP1 listed the following presenting issues as being the primary reasons she sought treatment: lack of self-confidence, difficulty communicating and expressing her feelings, feeling inferior to other people, and difficulty managing her thoughts. She also reported that she was suffering from the following symptoms to a lesser degree: feeling angry, guilty and unhappy, feeling isolated and lonely, difficulty managing emotions and being open with others, being suspicious of other people, and worry about finances. Upon intake CP1 was diagnosed with a V-code of Partner-Relational Problem and a GAF of 75. CP1's termination summary indicated that she attended therapy for 21 sessions, which were focused on assisting her to explore her childhood trauma and to effectively express her emotions.

Client-participant 2. Client participant two was a single, Caucasian, female. She reported that she was originally from England. When the transcribed session took place, she was 47 years old. CP2 reported that she immigrated from England approximately fourteen years ago. Upon intake, CP2 reported that she was unemployed due to her disability status, as a result of her

health complications. One year prior to starting therapy she experienced a stroke which caused her to lose her eyesight and contributed to other health issues. She sought therapy to address frequent crying and problematic scratching that was triggered by stress and her loss of eyesight. CP2 also disclosed that she had other medical complications including: neuropathy, diabetes, and balance difficulties. The client reported that although she suffered from numerous health complications, she had a stable support system.

On the clinic intake form, CP2 reported the following presenting problems as being the primary reasons she sought therapy: feeling down or unhappy, feeling anxious, needing to learn to relax, concerns about emotional stability, feeling lonely, difficulty making decisions, experiencing guilty feelings, and concerns about physical health. The client-participant's records indicated that no diagnoses were assigned to the client and that her therapy goals consisted of addressing her emotions related with her loss of eyesight in addition to emotions from her childhood that were being triggered as a result of her health complications (i.e., needing to be dependent on others and feeling abandoned). Since there was no Termination Summary for this client, the duration of her treatment was not determined. However, the appointment log included in her chart indicated that treatment duration was 12 sessions.

Client-participant 3. Client participant three was a married, Hispanic, Christian female. She was 21 years old when the transcribed session took place. Her highest level of education was high school, and she immigrated from El Salvador when she was 19 years old. At the time this session took place, CP3 was living with her husband and was employed as a sales representative. Her husband referred her to therapy. The client sought therapy to address depressive symptoms she was experiencing which included: anhedonia, feelings of sadness, worthlessness, and guilt, and suicidal ideation. CP3 also reported that she had conflict with her husband, difficulty

managing her anger and impulsivity, and a limited social support system. The client reported a history of childhood abuse that occurred physically, sexually, and emotionally. She reported that her mother and grandmother physically abused her from the ages of 11 to 17 and that her mother used a knife to threaten her numerous times. Additionally, the client reported that she experienced two sexual assaults in her past (age not specified).

On the clinic intake form, CP3 indicated that the following presenting issues were the primary reasons she was seeking treatment: difficulties with her family, feeling nervous or anxious, and needing to learn to relax. She also reported that she was experiencing the following symptoms to a lesser degree: feeling down or unhappy, feeling guilty, thoughts of taking your own life, concerns about emotional stability, difficulty making or keeping friends, feeling angry much of the time, difficulty controlling your thoughts, being suspicious of others, and difficulty in sexual relationships.

Upon intake, CP3 was diagnosed with Major Depressive Disorder (Recurrent, Severe, Without Psychotic Features) and both PTSD and Dysthymic Disorder were indicated as diagnostic rule-outs. During treatment, Dysthymic Disorder was ruled out and the client was diagnosed with Borderline Personality Disorder. The Termination Summary indicated that CP3 was treated for 31 sessions and that the majority of treatment focused on addressing the client's suicidal ideation and assisting her in managing her emotions, improving her communication skills, and developing distress tolerance. Additionally, the Termination Summary indicated that CP3 terminated therapy prematurely, and that she was provided with outside referrals.

Client-participant 4. Client participant four was a married female of African American, American Indian, and Caucasian descent. She was 39 years old when the transcribed session took place. The client reported that she has four daughters, two of whom moved away from home due

to college. At the time when this session took place, she was residing with her husband and two of her daughters. At the time this session took place, CP4 was a stay-at-home mother in addition to being the power of attorney conservator for her paternal grandmother who resided in an assisted living facility. She reported that she was previously employed as a paralegal on a part-time basis for 16 years.

CP4 sought therapy to address feelings of guilt and anger that had been triggered as the result of discovering that her father sexually abused one of her daughters (whom she and her spouse had guardianship of, but were not related biologically to her) approximately four years ago. The client reported that this discovery was difficult for her due to her history of being sexually abused by her paternal grandfather when she was about seven years of age. CP4 reported that her grandfather threatened her in order to prevent her from telling her mother about the abuse.

Upon intake, she disclosed experiencing emotions of sadness, anger, anxiety, and guilt. The client also reported having difficulty sleeping, concentrating and trusting others. She stated that her difficulty managing her emotions was contributing to problems with her husband. CP4 reported that she had a stable support system which consisted of her friends and husband. On the clinic intake form, CP4 reported that she was experiencing the following symptoms to a lesser degree: concerns about emotional stability feeling under pressure and feeling stressed, feeling angry much of the time, feeling down or unhappy, difficulty making difficulty controlling your thoughts, feeling confused much of the time, being suspicious of others, financial concerns, trouble communication sometimes, family difficulties, and feelings related to having been abused or assaulted.

Upon intake CP4 was assigned a diagnosis of Adjustment Disorder with Mixed Anxiety and Depression and a V-code of Sexual Abuse of a Child. Based on the intake form, CP4's goals included reducing feelings of anger and resentment and improving her ability to trust others. No Termination Summary was provided for this client, therefore the duration of treatment is unknown. However the amount of DVDs contained in the research file (i.e., three) suggested that therapy as likely short-term.

Client-participant 5. Client participant five was a Caucasian female who identified as Protestant. She was 28 years old when the transcribed session took place. The client reported that she had two children and that she was separated from her husband, whom she had recently reconciled with. The client reported that she was employed as an administrative assistant. CP5 reported that she married her husband when she was 21 years-old, but that she separated from him due to him being physically and verbally abusive towards her. The client reported a history of physical and sexual abuse. The client also disclosed that when she was four years old she was sexually abused by her neighbor until she was 8 years-old. The client also reported that when she was 14 years-old her father tried to persuade her to have intercourse with him, but that she was uncertain if she engaged in any sexual activity with him. She also reported that she was physically abused by her father when she was 16 years-old. The client stated that when she was 13 years-old she made one suicide attempt.

She sought therapy in order to manage her feelings of fear and confusion. On the clinic intake form, the client endorsed "needing to learn to relax" as the primary reason for seeking treatment, however she also identified the following items as reasons for seeking treatment: feeling nervous or anxious, feeling inferior to others, feeling down or unhappy, feeling under pressure and feeling stressed, trouble communication sometimes, afraid of being on your own,

difficulty expressing emotions, lacking self-confidence, concerns about emotional stability, feeling confused much of the time, concerns about finances, concerns with weight or body image, feeling controlled/manipulated, marital problems, difficulties in sexual relationships, feelings related to having been abused or assaulted, and concerns about physical health.

Upon intake, CP5 was diagnosed with Posttraumatic Stress Disorder, Depersonalization Disorder, and Dysthymic Disorder. No Treatment Summary was included in CP5's chart, but the intake form indicated that treatment goals were to assist the client in exploring her history of abuse, to identify and link her physical and emotional experiences, and to utilize her social support system. No Appointment Log was found for this client, however 13 DVDs were included in the research file, which suggested that the duration of therapy was approximately 13 sessions.

Table 1

Client-Participant Demographic Information

C-P	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	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

Therapist-participants. Similarly, all therapists (master's or doctoral level psychology students) consented to both written and audio/video recording procedures (see Appendix B), and their inclusion in the archival database. All therapist materials were redacted and de-identified prior to being placed in the archival database, so that names, date(s) of birth, and exact locations were unavailable and therapists could not be identified. Individual research files were each given a unique code to maintain organization throughout the database.

The client and therapist participants included in this study were required to meet the inclusion and exclusion criteria described below. There were 6 inclusion criteria. First, potential participants needed to be at least 18 years old at the time of intake. Second the participants must speak English. Third, informed consent from the participants and the therapists allowing written and videotaped materials to be included in the database were required. Fourth, cases were required to provide data that indicated the client has experienced trauma (see Procedures section for definition) through written materials such as the Telephone Intake Summary, Client Information Adult Form, Intake Evaluation Summary, and Treatment Summary (see Procedure section) as well as videotaped sessions of psychotherapy. Fifth, it was required that each case chosen included at least one videotaped session of psychotherapy during which the client discussed a previous trauma that occurred. Finally, all therapists included needed to be trainee therapists who were masters-level or doctoral-level students.

There are two exclusion criteria in this study. The first was that researchers could not personally know the therapist and/or client. This exclusion criterion was used to ensure confidentiality and prevent potential research bias that may impact coding procedures. Additionally, couples, family and children receiving therapy were not included. Only adult

participants receiving individual psychotherapy were considered for this study. There are no exclusion criteria pertaining to race/ethnicity, gender, socioeconomic status, or religiosity.

Researcher-participants. The researchers in this study consisted of three clinical psychology doctoral students who coded the collected data (Coders 1, 2, and 3) as well as one auditor. The dissertation chair who is a clinical psychologist acted as an auditor for the study and guided the researchers through the process of data collection, coding and analysis.

This study included multiple researchers in order to prevent potential individual bias due to the various perspectives that the data can examined through (Hill, Thompson, & Williams, 1997). All 3 coders individually categorized and analyzed the codes prior to meeting to discuss their codes and come to a consensus. This section reviews background information regarding each of the researchers, including professional views and demographics, in order to establish any potential factors that may have contributed to bias.

Coder 1, the primary researcher and dissertation author, is a 28-year-old, Caucasian female who is a doctoral student in clinical psychology. Coder 1 was raised in a middle-class family in the western part of the United States. Coder 1 does not identify with a particular religion but considers spirituality an important presence in her life. Coder 1 tends to treat clients from an integrative framework that includes cognitive-behavioral, humanistic and positive psychology interventions. Coder 1 believes that empathy and unconditional positive regard are vital for creating a safe environment, trust between the therapist and client and a strong therapeutic relationship. In particular, coder 1 believes that the therapeutic relationship is the vehicle through which change can be achieved. Coder 1 believes that every client has potential for growth and aims to help them navigate through this process. Coder 1 believes that in addition to exploring the impact of thoughts on mood and behavior, using a strengths-based approach can

improve the client's self-perception by helping the client to acknowledge his/her strengths and utilize them accordingly. Coder 1 also believes that the character strength of gratitude can potentially help trauma survivors to cope and achieve posttraumatic growth, which is why she is particularly interested in examining the expression of gratitude in the context of psychotherapy with trainee therapists.

Coder 2 is a 29 year-old Caucasian female who is a clinical psychology doctoral student. Coder 2 was raised by a working class family in the northeastern part of the United States. Coder 2 generally treats clients with cognitive-behavioral interventions, while also including strengths-based interventions when providing therapy to clients. She believes that the relationship between thoughts, feelings and behaviors can have a significant impact on an individual's mood and relationships. Additionally, she values using a strengths-based approach, which contributes to a strong therapeutic alliance. In regards to this study, she believes that the therapeutic relationship is a significant aspect of the relationship between the client and therapist, which is impacted either negatively or positively depending on the trainee therapists' responses to the client. She also feels that gratitude is an important and powerful emotion to express, and although she hasn't used it in specific therapy interventions, she has consistently recognized it to be salient with clients who have a low socioeconomic status. Coder 2 is particularly interested in trainee therapists' expression of self-disclosure during treatment of trauma survivors, including generally and as a reaction to client self-disclosure.

Coder 3 is a 27-year-old, Caucasian female who is a doctoral student in clinical psychology. She was raised in a middle-class family in the northeastern part of the United States. Coder 3 generally provides therapy from an integrative framework consisting of cognitive-behavioral, relational, and positive psychology interventions. Coder 3 believes that examining

and modifying thoughts will have a significant impact on mood and behavior. Additionally, she believes that a strong therapeutic relationship and empathy are factors that will significantly impact the progress and growth that occurs in therapy. She believes that change and growth can occur as a result of a strong therapeutic alliance and a positive response to the discussion of trauma can reduce distress and enhance relationships. She perceives the response of the trainee therapist as potentially enhancing the alliance and fostering posttraumatic growth. In regards to gratitude, coder 3 believes that gratitude is an important part of an individual's life and tries to incorporate gratitude into her daily life as well. While coder 3 recognizes the potential benefits of gratitude for trauma survivors, she believes that trauma survivors who incorporate gratitude may have a better outlook in general than those who do not. Coder 3 is primarily interested in the potential benefits of positive responses to trauma disclosures.

The auditor of this study also serves as the dissertation chair. She is a European-American, Christian female who is married. She has a doctoral degree in psychology as well as a terminal law degree. As a tenured, associate professor of clinical psychology who is primarily interested in researching positive and forensic psychology, she generally conceptualizes cases from a cognitive-behavioral framework informed by systems and strength-based approaches. Accordingly, she believes that the response of the therapist can assist individuals who have experienced trauma, including those who share such experiences in psychotherapy, in examining their experiences from different perspectives, which in some cases can lead to resilience and growth. She believes that constructs studied within positive psychology, including gratitude, can and/or should be a part of this process.

Instrumentation

The primary researcher developed a coding system in order to analyze verbal expressions of gratitude in psychotherapy by clients who have experienced trauma; it did not code therapist-participant verbal content. This coding system was based on the different types of gratitude defined and measured in the positive psychology literature.

As described in the literature review, there has been discrepancy in agreement on a unitary definition of gratitude. Gratitude has been conceptualized as a positive psychological character strength and trait, coping response, state, attitude, moral virtue, emotion, and habit (Emmons et al., 2003). In an attempt to encompass the overlap among these definitions, for the purposes of this study, gratitude was defined as a broad trait experienced generally (i.e., gratitude for something or someone, for God or other higher power, life or nature, and is not directed towards a specific individual) and/or as a narrow cognitive-emotional state experienced specifically (i.e., directed toward particular individuals, God, or other higher power for benefits received (material or nonmaterial), which may manifest in a desire to engage in reciprocity behavior or in other specific actions (e.g., helping behavior that is not directed towards the benefactor). Of note, when this study was proposed "gratitude for relationships" was listed as a part of the broad code definition; however, since this example was not consistent with the definition in the coding manual based on Adler and Fagley's (2005) definition, it was removed. Thus, every verbal expression of gratitude was coded under one of three main categories, which contained subcategories: (a) Gratitude as a broad, general tendency or trait (GB), (b) Gratitude as a narrow state, and (c) Expressions of gratitude that are not otherwise specified (G-NOS/Other).

To assess gratitude in the context of recorded and transcribed psychotherapy sessions, only verbal expressions of gratitude were examined. Words that are typically used to signify

110

gratitude include grateful, fortunate, thankful, lucky, blessed and appreciative, and were required to code for the categories described below. Coders carefully considered whether a gratitude code should be given if the client used a gratitude word (e.g., "I should be feeling appreciative, but I'm not") or its opposite/converse (e.g., "unlucky", "unfortunate"). Statements that indicated insincere gratitude were coded as NOS/Other since they did not fit any of the other categories. In addition, words that described a desire to reciprocate included but were not limited to: repay, reciprocate, and owe. Similarly, coders carefully considered whether a word that indicated reciprocation should be given a reciprocation code, given the context in which it was discussed (e.g., "My gratitude for the favor you did for me does not mean that I owe you").The coding system described next includes operational definitions and examples of each code that together attempted to identify a range of expressions of gratitude in psychotherapy by clients who have experienced trauma.

Gratitude as a broad, general tendency or trait (GB). Gratitude as a broad tendency or trait (GB) was operationally defined as a general tendency and characteristic of an individual to approach and respond to most circumstances with appreciation and thankfulness. This code included the concepts of trait or dispositional gratitude, gratitude as an attitude, generalized gratitude and transpersonal gratitude discussed in the literature review.

Generalized gratitude as an attitude (GB-1) is referred to as a component of trait or dispositional gratitude and is "a chosen posture toward life that says, "I will be grateful in all circumstances" (Emmons, 2008, p. 180), and includes a tendency to be "grateful for something or someone" generally (Adler & Fagley, 2005; Steindl-Rast, 2004). Examples of verbal expressions that would reflect generalized gratitude as an attitude are as follows: "I have so much in life to be thankful for," "When I look at the world, I see much to be grateful for," "I

111

always appreciate the little things," "I just really try to be grateful for everything," "I am so grateful for my mother, she is amazing," and "I am so grateful that I live in such a safe neighborhood."

Transpersonal gratitude (GB-2) is defined as "a gratefulness to God, to a higher power, or to the cosmos" (Peterson & Seligman, 2004, p. 555). Transpersonal or universal gratitude typically results from peak experiences that can include nature or spirituality and are typically characterized by a sense of undeserved kindness (Peterson & Seligman, 2004, p. 555). From a religious perspective, some belief systems emphasize the necessity to cultivate gratitude towards God despite adverse circumstances, due to God's generosity, the mercy of God and the gift of life (e.g., "give thanks in all circumstances" (1 Thess. 5:18, as cited in Emmons, 2008). Examples include: "It took a long time for me to acknowledge my higher power in AA, but I'm so glad/thankful I got there;" I feel grateful that I have the opportunity to enjoy this beautiful mountain;" "I suddenly felt overcome by gratitude during my hike, that I had the opportunity to enjoy such beauty," and "I am so grateful that God has been there for me through this difficult time period."

The subcode GB-2u was created to capture client statements that indicate a sense of undeserved kindness. . Examples of GB-2u include: **"**I feel so grateful for all that I've been given, I did nothing to deserve all of this, and "During the trip I felt overwhelmed by thankfulness that I had the opportunity to enjoy all these wonderful things without even deserving too."

The subcode GB-2p was created to capture client expressions of gratitude for the present moment. Examples of GB-2p included: "I am grateful to be experiencing this moment right

112

now," "I feel grateful that I have the opportunity to enjoy the present moment" and "No moment is like another and because of that I am grateful for this moment right now."

Gratitude as a narrow state (GN). Gratitude defined narrowly referred to gratitude as a state, emotion, and mood that arises temporarily as a response to receiving gifts or benefits from a specific person (Lambert, Graham, & Fincham, 2009), or from God (Emmons, 2008; Emmons & McCullough, 2004; Frederickson, 2004). It also included the experience of gratitude arising as a result of people recognizing the ways in which others have supported them, which prompts specific action tendencies such as reciprocity (Gouldner, 1960; McCullough et al., 2001; Simmel, 1950), and/or utilizing their psychological resources (Frederickson, 2001; Wood et al., 2007).

Personal gratitude (GN-1) or benefit-triggered gratitude was defined as "thankfulness toward a specific other person for the benefit that the person has provided" (Peterson & Seligman, 2004, p. 555). Examples included: "I am so thankful to Sarah for taking the time to tutor me in math; otherwise I would have failed the calculus exam," and "I feel blessed that Martha wrote that letter of recommendation for me."

Gratitude for specific benefits received from a higher power (**GN-2).** Examples included**:** "I am so thankful to Allah for blessing me with such an amazing family;" and "God has provided me with a wonderful social support system, for which I am so grateful."

Gratitude outcomes (**GN-3).** According to the broaden-and-build theory, when individuals experience the emotion of gratitude, they recognize the ways in which others have supported them, which prompts them to think and act in ways that leads them to return the favor (Gouldner, 1960; Simmel, 1950; McCullough et al., 2001), and/or help enhance their

113

psychological resources (Fredrickson, 2001) by changing their views of themselves and others (e.g., "I am worthy"). Thus, there are 3 subcodes for GN-3.

Subcode 1: Reciprocation (Secular) (GN-3-RECIP). Gratitude acts as a prosocial and/or moral motivator because it prompts reciprocity behavior by encouraging individuals to respond to an act of kindness by reciprocating with kindness. For example, if an individual is given a gift from another person, he may feel motivated to repay this benefit with a gift or some other benefit. Thus, this code was created to capture instances when an individual expressed gratitude towards the benefactor for a benefit received as well as a desire to engage in reciprocity behavior. It was decided by the team that this code would supersede GN1 or GN2, as the whole phrase would receive a GN-3-RECIP code. Additionally, following practice coding, it was decided that this category would require the client to use a gratitude related word in addition to expressing a desire to engage in reciprocity behavior in order for coding decisions to be consistent as all the other codes in the manual required a gratitude related word.

Examples of GN-3-RECIP included: "I'm so grateful that Emily spent hours helping me with my homework, so I'm going to repay her by bringing her favorite dessert to school," "Rachel saw how swamped I was at work and offered to audit the rest of my files so I could finish my other tasks, without which I never would have made it to the wedding. I'm so grateful for what she did that I'm going to return the favor by offering to cover her shift one day next week because she was so kind."

Subcode 2: Prosocial behavior (GN-3-PROSOC). Gratitude can act as a prosocial and/or moral motivator because it can prompt people to engage in altruistic behavior towards others (and not just one's benefactor; Emmons & McCullough, 2003). Following practice coding, the team decided to add a code to capture such instances (e.g., offering emotional support to others,

helping others with personal problems), not directed towards the benefactor. Examples included: "I am so thankful for the support my therapist has given me that it motivated me to volunteer at a crisis hotline so I can help others in need", "I am grateful for all of the mentoring I received through the job search process, so I'm going to help mentor other students through the process."

Subcode 3: Changed perceptions of self and others (GN-3-POS). Experiencing gratitude can also result in changed perceptions of self. Emmons and Shelton (2002) argued that experiencing gratitude "may be one means by which tragedies are transformed into opportunities for growth, being thankful not so much for the circumstances but rather for the skills that will come from dealing with it" (p. 467). Thus, this subcode referred to the awareness that that occurs due to recognition of skills that have developed as a result of coping through difficult times.

During the coding process, several gratitude statements that involved social support were identified; however, none of them were captured by the previous definition that included "seeking social support as a means of coping." Thus, the team decided to remove this part of the definition; instead, statements that indicated gratitude related to seeking or receiving social support from one or more individuals (which may include benefits received) would be coded as G-NOS/Other. Examples included: "The divorce was very difficult but without it I would have never realized how strong I am on my own, so I'm thankful for that," "Although moving to a new city was really challenging for me, I learned about skills I never knew I had, which I'm grateful for."

***Expressions of gratitude that are not otherwise specified* (G-NOS/OTHER).**
Expressions of gratitude that did not include a gratitude related word and were not included in any of the aforementioned categories received this code. Examples included: "My friends have been such a great support that words cannot express how much their support has meant to me,"

"Without the difficult times I've experienced recently, I never would have realized how resilient I am, which is a realization that is so touching and valuable to me, it is hard to explain it in words," "Steve was able to talk with his employer and get me an interview at ABC. I really want him to know how much that meant to me, so I'm going to take him out to dinner this week," "He told me I looked thin and I thought gee thanks, what did I look like before?"

Procedure

     Sample selection. Purposeful sampling was used in the study based on general guidelines to choose participants who met the research criteria (Creswell, 1998; Mertens, 2009). All three researchers reviewed the list of pre-screened cases with transcribed sessions (those that have been used in former PARC research teams) for inclusion criteria (See Step 1 of Coding Manual). Following review of the list of pre-screened cases, it was decided that all five cases were appropriate for inclusion in the present study based on the criteria previously described. Since all five pre-screened cases satisfied inclusion criteria for the current study, Steps 2-4 as outlined in the preliminary proposal for the present study were eliminated.

     Coding. The primary coders for this study were the three doctoral-level students discussed in the researcher-participants subsection. Their dissertation chair was responsible for acting as auditor of this study. Before the coding process of selected cases began, every coder engaged in training on the coding procedures relevant to this study and client-participants' expressions of gratitude during psychotherapy sessions. Instructions on training procedures for coding are described in Appendix C.

     Prior to coding the transcribed sessions, the researchers practiced coding sessions with the intention of reaching 66% agreement (two out of three coders in agreement), which is the highest possible rate of agreement outside of 100% agreement. Typically 80 percent agreement

among coders is required for this type of study (Miles & Huberman, 1994). After all three researchers reached an agreement on the codes, the dissertation chair audited the codes, with the aim of reaching 75% agreement (three out of four coders in agreement).

Human Subjects/Ethical Considerations

The researchers for this study maintained the confidentiality of all participants included in this study and adhered to ethical guidelines required for their participation. Non-invasive methods of obtaining data for this study were implemented by gathering data from an archival database instead of having direct contact with participants.

In addition to these methods, researchers took extra precautions in order to maintain ethical treatment of all participants included in this study by reviewing informed consent forms (see Appendix D) in order to ensure that all of the client and therapist participants chosen to be a part of the study provided consent for all written, audio, and videotaped materials related to their case to be included in the database prior to starting psychotherapy services. These research files were not created until the client was no longer being seen at the clinic and the case was closed. Once therapy was terminated these research files were created by research assistants who de-identified all materials by redacting any identifying information (i.e., names, locations, date (s) of birth) of clients and therapists, in order to protect all participants' confidentiality prior to entering their data into the archival database.

All participants that are part of the database were assigned a research identification number in order to categorize files without relying on identifying information. Before beginning the process of data entry, each researcher and research assistant participated in an Institutional Review Board (IRB) online certification class as well as an online certification training on the Health Insurance Portability & Accountability Act of 1996 (HIPAA; see Appendix E).

117

Additionally, each researcher signed confidentiality agreements in order to ensure that all client and therapist participant information was kept confidential. The researchers also ensured that cases which were selected did not include client or therapist participants with whom the researchers were familiar in order to maintain confidentiality.

Data Analysis

This study qualitatively examined expressions of gratitude in therapy through a naturalistic, directed content analysis (Hsieh & Shannon, 2005). This approach was useful for qualitatively analyzing significant components that define the construct being studied. This analysis was conducted in a deductive manner to "validate or extend conceptually a theoretical framework or theory" (Hsieh & Shannon, 2005, p. 1281). This approach helped make the research question more specific which aided in the creation of codes (Hsieh & Shannon, 2005). The focus of this present study was to examine expression of gratitude by trauma survivors in the context of psychotherapy. In order to achieve this goal, an in-depth review of the existing literature was conducted and integrated for the purpose of determining main themes to develop initial coding categories. This process laid the foundation for the operational definitions of gratitude that were used for coding in this study.

Due to the nature of this dissertation and that each coder brought a unique perspective to this study, analysis of the data was seen through the perspective lens of each individual. For example, preference for a particular theoretical orientation or differences in demographic factors could affect the way in which a coder perceives expressions of gratitude in therapy (Ahern, 1999). Throughout the coding process, researchers regularly discussed and reviewed any potential or actual biases that arose during the coding process with one another and their auditor. Additionally, coders used a reflective journal to keep track of any biases or discrepancies that

rose during the coding process. To further maintain reliability the use of an "audit trail" was implemented. This audit trail allowed the auditor to effectively analyze the coding process by outlining specific procedures pertaining to the research design, data collection and analysis (Lincoln & Guba, 1985). Researchers regularly discussed and reviewed their individual coding decisions with one another, in addition to providing these findings to their auditor. The auditor then examined these results and identified any areas of potential bias reflected in the coding and discussed such concerns with coders to maintain reliability of the results. (See Step 2 for biases info). The steps below provide a review of the components of analysis recommended by Stiles et al. (1999) which are discussed in the Research Design portion of the current study.

This study examined clients' [target of measurement] verbal expressions of gratitude in single, separate [modality of treatment] psychotherapy sessions [scoring unit] by analyzing transcriptions [format of data collection] of video recordings and constructing nominal coding categories [format of measurement]. This study mainly examined the semantic meaning of the clients' verbal expressions [dimension of coding measures]. For the purpose of analyzing the qualitative data utilized in this study based on these coding categories, the researchers implemented the following steps in accordance with the protocol suggested by Hsieh and Shannon (2005) for directed content analysis.

Step 1: Highlighting. The coders reviewed each of the previously transcribed sessions (which included verbal content as well as nonverbal behaviors such as: pauses, laughter, sighs, and body movements). They individually highlighted all content that initially appeared to demonstrate client-participant verbal expressions of gratitude (e.g., use of a gratitude-related word such as fortunate, blessed, or grateful).

Step 2: Coding selected text. Each of the researchers examined the highlighted sections of the selected transcripts and assigned pertinent codes where applicable (for further information on code definitions, see the Instrumentation section). Each researcher entered these codes on individual *Microsoft Word* documents; other documents were used to record their rationale for coding, questions for the team, notes, and process commentary. Content that had been highlighted and appeared to capture the client's verbal expression of gratitude according to this study's definition, but did not meet the criteria of the predetermined coding categories, were assigned a not otherwise specified/other (G-NOS/Other) code. The coders regularly attempted to evaluate relevant patterns that emerged among the coding categories in order to determine if the coding categories or subcategories needed to be modified to capture these patterns (Hsieh & Shannon, 2005).

Following discussion among the researchers after practice coding, one new code emerged from this process. A prosocial behavior code (GN-3-PROSOC) was added to the *Gratitude as a Narrow State category* to capture expressions of gratitude for benefits received as a motivator for altruistic behavior that was not directed towards the benefactor. Several other changes to the codes were made throughout the coding process (based on coder agreement), including: 1) requiring that a gratitude related word in addition to a reciprocation word be used in a statement to code it as GN-3-RECIP (in order to be consistent with the other codes), 2) coding statements that included a gratitude related word but did not appear to convey sincere gratitude (e.g., "He told me I looked thin and I thought gee thanks, what did I look like before?") as G-NOS/Other, 3) coding statements related with seeking or receiving social support, which may be directed towards more than one person or social supports generally for benefits received, as G-NOS/Other and 4) removing "seeking social support as a means of coping" from the GN-3-POS definition.

120

Each coder reviewed the data individually prior to meeting as a group to discuss the rationale for each researcher's coding decisions and reach an agreement. Hill and colleagues (1997) asserted that utilizing several researchers in this manner can be valuable because it reduces individual biases, better captures the intricacy of the data, and allows for distinct viewpoints and impressions. During the meetings when the rationale for each researcher's coding choices was discussed, if codes were not in 100% agreement, at least one of the researchers modified her coding decision following information that she received from the other coders. Generally this is because one or more of the researchers coded a client's expression of gratitude as a personal gratitude statement, which may have been due to misinterpretation of the codes or individual bias. This finding was particularly relevant in the initial sessions that were coded since all three researchers were becoming familiar with one another's codes and were more likely to code differently than one another. Following a discussion of these codes with one another, the group typically reached an agreement, which contributed to increased inter-rater reliability. However, it is important to note that the objective of these discussions was not to reach a perfect consensus on all coding selections, but to aid each researcher in assigning a code that she perceived to be most applicable to the gratitude statement being discussed.

Following these discussions, some codes were still in disagreement. For example, in Session 2 the client-participant stated,

> 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 at me. So that was very very nice and um I-while I totally appreciated the help, I really felt the- um-I was- um- I fought against using that help. I would try to do things myself or try and get -I would try and go without help if I could. (C145, Session 2)

Coder 1 initially coded this statement as G-NOS/Other while Coder 2 coded it as GN-1 and GN-3-RECIP and Coder 3 coded it as GN-3-RECIP. Following a discussion regarding this code disagreement, the team decided to consult with the auditor prior to making a final decision about this code. After the team discussed this code with the auditor, all 3 coders agreed that expressions of gratitude related with social support that do not fit into the predetermined categories would be coded as G-NOS/Other.

During such times when inter-rater disagreement was present, the group recorded it as well as the rationale for each choice that was made so that the auditor could better understand the group's judgment process (Orwin, 1994). In order to diminish potential group bias or consensual observer drift that may arise during this process (i.e., when coders alter their coding decisions to be consistent with another researcher's codes; Harris & Lahey, 1982), every researcher saved a copy of her original codes (which were decided separately) in addition to the codes that were agreed upon as a group.

During the group meetings, the researchers sought to discuss any potential individual biases that may have impacted their coding decisions, for the purpose of being cognizant of these biases for subsequent coding sessions. For example, the primary researcher typically perceived gratitude as an emotion that did not usually overlap with negative feelings, which contributed to her primarily coding statements that appeared to convey sarcasm or mixed feelings related with gratitude as NOS, while Coders 2 and 3 initially perceived gratitude statements as personal gratitude based on their familiarity with benefit-triggered gratitude.

Inter-rater reliability among the coders was calculated using Fleiss' Kappa coefficient prior to meeting as a group to discuss initial coding decisions and following discussion of final codes (K; Fleiss, 1971). These findings are presented in Tables 2 and 3 below. The Fleiss' Kappa

coefficient was designed for the purpose of measuring whether the consensus attained by researchers surpassed an outcome that would be expected if researchers assigned codes randomly (Gwet, 2010). The Fleiss Kappa coefficient is useful for determining reliability for nominal-scale ratings and a set number of coders. In contrast to Cohen's Kappa, Fleiss Kappa can be used to determine reliability among more than two coders and is applicable to the current study since the team consisted of three coders (Fleiss, Cohen, & Everitt, 1969).

Table 2 and Table 3 present summaries of the K scores, observed agreement, and expected agreement for each particular code as well as means for the codes across researchers. Despite no universal agreement regarding the degree of significance for K values, Landis and Koch (1977) protocol indicates that $0.81 < K < 1.00$ suggests perfect agreement; $0.61 < K < 0.80$ suggests substantial agreement; $0.41 < K < 0.60$ suggests moderate agreement; $0.21 < K < 0.40$ suggests fair agreement; $0.01 < K < 0.20$ suggests slight agreement; and $K < 0$ suggests poor agreement. A negative K value suggests that the degree of agreement attained by coders was deemed to poorer than chance.

The average Fleiss' Kappa score for initial codes that were decided upon before the group discussion ranged from perfect agreement (1) to no better than chance (-0.001). According to Landis and Koch's (1977) protocol for understanding inter-rater reliability, the Kappa scores for this study suggest that the group was in agreement perfectly for GN-2, in substantial agreement for GN-1, in moderate agreement for GN-3-RECIP and G-NOS/Other, in fair agreement for GN-3-POS, and no better than chance agreement for GB-1, GB-2u, and GB-2p. Three codes (GB-2, GN-3, and GN-3-PROSOC) were not assigned Fleiss' Kappa scores since they were not coded in any of the five transcripts used in this study (i.e., clients did not express these types of

statements). Table 2 presents a summary of the average levels of agreement for codes before

meeting as a team to discuss the codes:

Table 2

Pre-Discussion Inter-Rater Reliability

Code	Session					
	1	2	3	4	5	Average
GB-1						
Fleiss' Kappa	N/A	N/A	N/A	N/A	-0.00	-0.00
Observed Agreement	1	1	1	1	1.00	1.00
Expected Agreement	1	1	1	1	1.00	1.00
GB-2						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
GB-2u						
Fleiss' Kappa	N/A	N/A	N/A	-0.00	N/A	-0.00
Observed Agreement	1	1	1	1.00	1	1.00
Expected Agreement	1	1	1	1.00	1	1.00
GB-2p						
Fleiss' Kappa	N/A	N/A	N/A	N/A	-0.00	-0.00
Observed Agreement	1	1	1	1	1.00	1.00
Expected Agreement	1	1	1	1	1.0o0	1.00
GN-1						
Fleiss' Kappa	N/A	0.75	1	0.94	0.66	0.78
Observed Agreement	1	1.00	1	1.00	1.00	1.00
Expected Agreement	1	0.99	0.99	0.94	0.99	0.98
GN-2						
Fleiss' Kappa	N/A	N/A	1	N/A	1	1
Observed Agreement	1	1	1	1	1	5
Expected Agreement	1	1	0.97	1	0.99	0.99
GN-3						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
GN-3-RECIP						
Fleiss' Kappa	N/A	0.50	N/A	N/A	N/A	0.50
Observed Agreement	1	1.00	1	1	1	1.00
Expected Agreement	1	0.99	1	1	1	1.00
GN-3-PROSOC						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1

(continued)

GN-3-POS						
Fleiss' Kappa	N/A	N/A	N/A	0.75	-0.00	0.37
Observed Agreement	1	1	1	1.00	1.00	1.00
Expected Agreement	1	1	1	0.99	1.00	1.00

Code	Session					
	1	2	3	4	5	Average
G-NOS/Other						
Fleiss' Kappa	1	-0.00	N/A	1	-0.00	0.50
Expected Agreement	0.98	1.00	1	0.98	1.00	0.99

Note. Table 2 depicts average inter-rater reliability scores for each of the applied codes across sessions using Fleiss' Kappa, Observed Agreement, and Expected Agreement. N/A is used for Fleiss' Kappa scores for sessions in which the identified code was not applied.

As previously discussed, independent coding was completed for each of the transcripts. The researchers met as a group to reach consensus regarding final codes and calculate inter-rater reliability before submitting their findings to the auditor of the study for final review.

Step 3: Submission of codes to auditor. After the team discussed their initial coding impressions and made the relevant modifications, the codes were turned in to the auditor for final review. An audit trail (a detailed review of the research and coding process that provided an in-depth review of the individual and team coding decisions that occurred throughout the process) was utilized in order to make communication between researchers and the auditor as comprehensive as possible. The audit trail allowed the auditor to effectively analyze the coding process by outlining specific procedures pertaining to methods of reporting, research design, data collection and analysis (Halpern, 1983; Lincoln & Guba, 1985).

Each coder also used a method called bracketing which is used to protect against potential research biases influencing the coding process (Ahern, 1999). In conjunction with individual coding decisions each coder documented information relevant to her own expectations in the electronic documents of selected psychotherapy sessions. This information included: (a)

125

potential biases in relation to demographic variables, such as ethnicity and gender and how these factors are relevant to the current study, (b) areas of bias and specific values that the researcher is personally aware of and that may impact the data collection process, (c) factors that may contribute to role conflict, (d) the impact that others involved in the study have and the degree to which they are invested in the study, and (e) feelings that indicate difficulty maintaining neutrality (Ahern, 1999). Each coder as well as the auditor used such a journal and discussed related findings during group meetings prior to and after the coding procedures.

Step 4: Reaching consensus on final codes. After the auditor reviewed the codes that were submitted by the team, she provided input on the group's decisions. The researchers and auditor then discussed the final coding decisions through consistent correspondence on the audit trail. If the auditor provided feedback that elicited further discussion of codes and contributed to a reconsideration of original coding decisions, the group would revisit these codes and deliberate about them until an agreement was reached on the final codes, which are discussed in the following sections.

For example, in session 5, the client stated, "Yeah I always notice the little things and I always appreciate them" (C30). Following the team meeting as a group, it was decided that this statement would be coded as GN-1. However, after the auditor reviewed the code, she suggested that the client's statement of "always" was more indicative of the client's general state rather than a narrow form of gratitude. After the team discussed and reflected upon this consideration, it was decided that this gratitude statement would better fit a GB-1 code. Thus, all three researchers agreed to modify this code to GB-1. This process continued until all 26 gratitude expression codes were discussed and reflected upon. Throughout the coding process, several codes were modified. These modifications are discussed in Step 3 above.

126

After the team submitted the codes to the auditor for review, post-discussion rates of code agreement were established. The following Fleiss' Kappa values are indicative of the team's attempt to reach a final coding decision on codes that were not agreed upon after the initial independent coding process. Table 3 presents the average Fleiss' Kappa score for the four codes (GB-1, GN-1, GN-2, G-NOS/Other) that were decided upon post-discussion which fell in the perfect agreement range (K=1). The post-discussion inter-rater reliability rates of agreement increased due to several factors (e.g., each researcher discussed her rationale for her coding choice, modifications were made to codes, and researchers agreed that for some codes the auditor needed to be conferred with). As previously noted, GB-2, GN-3, and GN-3-PROSOC were not assigned in any of the selected sessions prior to meeting as a team to discuss coding decisions. In addition to these codes, the following codes were not assigned post-discussion in any of the selected sessions used for this study (GB-2, GB-2u, GB-2p, GN-3, GN-3-RECIP, GN-3-PROSOC, and GN-3-POS), thus there are no results regarding those codes.

Table 3

Post-Discussion Inter-Rater Reliability

Code	Session					
	1	2	3	4	5	Average
GB-1						
Fleiss' Kappa	N/A	N/A	N/A	N/A	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	0.99	1.00
GB-2u						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
GB-2p						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1

Code	1	2	3	4	5	Average
GN-1						
Fleiss' Kappa	N/A	1	1	1	N/A	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	0.99	0.99	0.95	1	0.98

Code	Session					
	1	2	3	4	5	Average
GN-2						
Fleiss' Kappa	N/A	N/A	1	N/A	1	1
Expected Agreement	1	1	0.97	1	0.99	0.99
GN-3-RECIP						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
GN-3-POS						
Fleiss' Kappa	N/A	N/A	N/A	N/A	N/A	N/A
Observed Agreement	1	1	1	1	1	1
Expected Agreement	1	1	1	1	1	1
G-NOS/Other						
Fleiss' Kappa	1	1	N/A	1	1	1
Observed Agreement	1	1	1	1	1	1
Expected Agreement	0.99	0.95	1	0.99	0.98	0.98

Note. Table 3 depicts average inter-rater reliability scores for each of the applied codes across sessions using Fleiss' Kappa, Observed Agreement, and Expected Agreement. N/A is used for Fleiss' Kappa scores for sessions in which the identified code was not applied.

Step 5: Evaluation of the coded data. The coder examined the data and kept track of the different types of verbal expressions of gratitude client-participants made and how frequently they occurred. The coder used *Microsoft Excel* spreadsheets to calculate and record the prevalence of each code within each session. Following this step, the coder analyzed the data for any themes that were present (i.e., examination of G-NOS/other codes), calculated the frequency of types of gratitude expression that occurred in trauma discussions vs. non-trauma discussions within and across sessions, and examined whether certain variables may have influenced the results such as type of trauma and extent of gratitude expression.

Step 6: Presentation of findings. The results from this study are reviewed in the subsequent two chapters and provide a summary of the prevalence of each code and the category to which they were assigned. The prevalence of the particular types of gratitude expressed by client-participants demonstrates how frequently clients expressed different types of gratitude within the context of the selected psychotherapy sessions that also consisted of trauma discussions. Frequencies of the client coded verbal gratitude expressions are reviewed in the subsequent two chapters. Additionally, analysis of the different types of gratitude expressed by clients during trauma discussions versus non-trauma discussions as well as other themes (i.e., therapist expressions of gratitude, patterns of codes within the G-NOS/Other category,) are presented in order to contribute to a deeper understanding of these themes . The subsequent chapters include examples with quotations in order to illustrate the different ways in which client-participants who have experienced trauma express gratitude in the context of psychotherapy.

Chapter III: Results

This chapter reviews the results obtained from the qualitative content analysis of expressions of gratitude by clients who are trauma survivors in psychotherapy. The purpose of the analysis was to examine the different ways in which clients who are trauma survivors express gratitude during psychotherapy sessions. To allow for a more comprehensive understanding of how trauma survivors express and use gratitude in therapy, gratitude expressions were coded across whole psychotherapy sessions, and then codes identified within the trauma discussion sections of each transcript were compared with codes identified in the non-trauma discussion sections.

The coding system used for the analysis of verbal gratitude expressions across five transcribed sessions of psychotherapy with five distinct therapists-client pairs was based on an in-depth review of the existing literature on gratitude and trauma survivors (see Chapter 1 for literature review and Appendix C for further information on operational definitions). The coding system classified verbal expressions of gratitude into three main categories: (a) Gratitude as a Broad, General Tendency or Trait (GB), (b) Gratitude as a Narrow State (GN), and (c) Expressions of Gratitude That are Not Otherwise Specified (G-NOS/Other). Subcodes within each category were also created. In GB, there was: (a) generalized gratitude as an attitude (GB-1), and (b) transpersonal gratitude (GB-2; with its own 2 subcodes: undeserved kindness (GB-2u), and gratitude for the present moment (GB-2p). In the GN category, there were 3 subcodes: a) personal gratitude (GN-1), (b) gratitude for specific benefits received from a higher power (GN-2), and (c) Gratitude Outcomes (GN-3), which had its own 3 subcodes: reciprocation (secular) (GN-3-RECIP), prosocial behavior (GN-3-PROSOC), and changed perceptions of self and others (GN-3-POS). Although the coding system was based on existing literature, the following codes did not emerge from the coding process (as noted in the Methods section): transpersonal gratitude (GB-2) codes or subcodes, and gratitude outcomes (GN-3) codes or

subcodes.

The subsequent sections provide a review of the directed content analysis findings across and within sessions. Findings across sessions begin with a review of overall code frequencies, then findings within and across Trauma Discussions and Non-Trauma Discussions are discussed. Next, a content analysis of findings across sessions and participants is provided that includes coding frequencies in addition to examples of coded client expressions of gratitude presented with quotations obtained from the transcribed psychotherapy sessions utilized in this study. Then this chapter presents a review of coding frequencies within sessions and presents qualitative examples of client expressions of gratitude that occurred within each individual session. This chapter concludes with a review of three themes that emerged from the coding process.

Overall Code Frequency Across Sessions

The content analysis of expressions of gratitude by trauma survivors across all five transcribed sessions yielded 26 codes among the 1,369 talk turns (1.90% of all talk turns). Across the five psychotherapy sessions, the total number of gratitude codes per session ranged from two to seven, with an average of 5.2 (SD =1.92). The amount of client talk turns that occurred during each session ranged from 184 to 418, with a mean of 273.8 client talk turns per session (SD=95.86; See Table 4 for a summary of gratitude frequencies across sessions).

Of the 26 gratitude codes, the following categories were coded and are listed in order from most frequent occurrence to least frequent occurrence across sessions: 50% (n=13) of all codes fell in the Gratitude as a Narrow State category (GN-1, n= 8; GN-2, n= 5; GN-3, n= 0; GN-3-RECIP, $n = 0$; GN-3-PROSOC, $n = 0$; GN-3-POS, $n = 0$); 46.15% (n=12) of all codes fell in the Gratitude NOS category (G-NOS/OTHER, n=12); and 1 code (3.85%) fell in the Gratitude as a Broad, General Tendency or Trait category (GB-1, n=1). These categories are

discussed by order of frequency for the purpose of organizing the data; however this order does not suggest that the codes which occurred more frequently are more meaningful than others that occurred less frequently. Table 4 below provides a summary of the percentages of gratitude codes that occurred in each of the five psychotherapy sessions in this study, and Table 5 provides an overall summary of the percentages of codes that occurred from each category across all five sessions.

Table 4

Overall Coding, Talk Turn Frequencies and Percentages Across Sessions

	Session					
	1	2	3	4	5	Total
Total Codes	2	6	6	7	5	26
Total # Talk Turns	418	189	278	184	300	1,369
% of GE	0.48	3.17	2.16	3.80	1.67	1.90

Table 5

Overall Summary of Coded Frequencies and Percentages Across Fully Coded Sessions

	Coding Frequencies			
	GB 1-5	GN- 1-5	G-NOS 1-5	Total Codes
Total codes	1	13	12	26
% of coded responses	3.85	50	46.15	100

Table 6 provides a summary of individual coding frequencies within and across sessions. This table presents only those codes that emerged after the coding process; it does not include codes GB-2, GB-2u, GB-2p, GN-3, GN-3-RECIP, GN-3-PROSOC, and GN-3-POS. The non-identified codes will not be referenced further in the results section.

Table 6

Overall Individual Code Frequencies Across Sessions

Code	Code Frequencies					
	Session 1	Session 2	Session 3	Session 4	Session 5	Total
GN-1	0	1	2	5	0	8
GN-2	0	0	4	0	1	5
GB-1	0	0	0	0	1	1
G-NOS/Other	2	5	0	2	3	12
TOTAL	2	6	6	7	5	26

Trauma Discussion vs. Non-Trauma Discussion Code Frequencies Across Sessions

Next, client expressions of gratitude that took place during discussion of trauma were examined in comparison with those that took place during non-trauma discussions. The following section reviews separate findings for trauma discussions and non-trauma discussions, after which comparative findings will be discussed.

There were 695 talk turns that qualified for trauma discussion across the 1,369 total talk turns in the five psychotherapy sessions. The following codes were used to identify client expressions of gratitude that occurred during trauma discussions (TD): G-NOS, GN-1, and GN-2. Within each trauma discussion across the five psychotherapy sessions, the overall number of gratitude statements that were coded ranged from 0 (sessions 1 and 5) to 5 (sessions 2 and 3), with a mean average of 2.4 codes (*SD*=2.51) across all five sessions and a mean average of 4 codes (*SD*=1.73) across all sessions in which a code was assigned. A total of 12 gratitude codes occurred during TD in the following categories: (a) Gratitude as .a Narrow State (GN-1; *n*=2, 16.67%; GN-2; *n*=4, 33.33%); (b) Expressions of Gratitude That Are Not Otherwise Specified (G-NOS/Other; *n*= 6, 50%).

With numbers slightly less than trauma discussions, there were 674 talk turns across the

five psychotherapy sessions that qualified for non-trauma discussion. The following codes were

used to identify client expressions of gratitude that occurred during non-trauma discussions

(NTD): G-NOS, GN-1, GN-2, and GB-1. With the exception of GB-1, the gratitude codes

identified during NTD were the same as the ones that took place during TD. Within each NTD

across the five psychotherapy sessions, the overall number of gratitude statements that were

coded ranged from 2 (session 1) to 5 (sessions 4 and 5), with a mean average of 2.8 codes

(SD=2.05), which is similar to the average found in TD codes across sessions (TD 2.4 codes,

SD=2.51). A total of 14 gratitude codes occurred during NTD in the following categories: (a)

Gratitude as a Narrow State (GN-1; n=6, 42.86%; GN-2; n=1, 7.14%); (b) Expressions of

Gratitude That are Not Otherwise Specified (G-NOS/Other; n= 6, 42.86%); and (c) Gratitude as

a Broad, General Tendency or Trait (GB-1; n= 1, 7.14%).

Findings between TD and NTD results are discussed next. In Table 7, client expressions

of gratitude code frequencies and percentages within the trauma discussion and non-trauma

discussion are presented for comparison.

Table 7

Coding, Talk Turn Frequencies and Percentages Across Sessions During Trauma Discussions (TD), Non-Trauma Discussions (NTD), and Overall Session

Code	Session					
	1	2	3	4	5	Total
Total Codes						
TD	0	5	5	2	0	12
NTD	2	1	1	5	5	14
Talk Turns						
TD	108	159	177	110	141	695
NTD	310	30	101	74	159	674
Overall	418	189	278	184	300	1,369
% of GE						
TD/Overall	N/A	3.14/	2.82/	1.82/	N/A	1.73/
NTD/Overall	0.65/	2.65	1.80	1.09	3.14/	0.88
	0.48	3.33/	0.99/	6.76)/	1.67	2.08/
		0.53	0.36	2.72		1.02

Table 8 provides a summary of the individual codes (presented in order of frequency) within and across sessions for gratitude statements that occurred during TD and NTD. All of the codes that were assigned during this study are included for the purpose of comparing the findings to the overall results discussed earlier.

Table 8

Individual Code Frequencies Across Sessions During Trauma Discussions (TD) and Non-Trauma Discussions (NTD)

Code	Code Frequency					
	Session 1	Session 2	Session 3	Session 4	Session 5	Total
GN-1 (TD)	0	1	1	0	0	2
GN-1 (NTD)	0	0	1	5	0	6
GN-2 (TD)	0	0	4	0	0	4
GN-2 (NTD)	0	0	0	0	1	1
G-NOS/Other (TD)	0	4	0	2	0	6
G-NOS/Other (NTD)	2	1	0	0	3	6
GB-1 (TD)	0	0	0	0	0	0
GB-1 (NTD)	0	0	0	0	1	1
TOTAL (TD)	0	5	5	2	0	12
TOTAL (NTD)	2	1	1	5	5	14

Content Analysis: Synthesizing Coded Results Across Sessions/Participants

This section provides a synthesis of the frequency and percentages of gratitude codes identified across all 5 psychotherapy sessions as well as within trauma discussions (TD) versus non-trauma discussions (NTD). This section also provides qualitative descriptions of gratitude expressions made by client-participants.

Across sessions, client-participant expressions of gratitude were more often coded as *Narrow* (GN; 13 codes) rather than *Broad* (GB; 1 code), and represented 50% of all coded client-participant expressions of gratitude. In other words, client-participants tended to frequently express gratitude in a narrow manner for benefits received towards a specific person, and rarely as a broad, general tendency or trait. Across sessions, client expressions of gratitude which were coded as *NOS/Other* occurred slightly less frequently than Narrow gratitude codes (G-NOS/Other; 12 codes) and more frequently than Broad gratitude codes (GB; 1 code). These results are next presented in order of which parent category was most frequently coded to least frequently coded across sessions.

Expressions of gratitude as a narrow state. Across all five psychotherapy sessions, 13 of the 26 codes fell in the *Gratitude as a Narrow State* category, which was the most frequently coded category (captured 50% of all coded client expressions of gratitude). *Gratitude as a narrow state* category was used to identify expressions of gratitude that were either a state, emotion, and/or mood that arose temporarily as a response to receiving gifts or benefits (material or nonmaterial) from a specific person.

Further analysis reveals that slightly less than half of the 13 narrow gratitude codes identified across four of the five sessions (Sessions 2,3,4, and 5), 46.15% (*n=6*) occurred during a trauma discussion (TD). Of these 6 gratitude codes identified across TD, 2 (33.33%) were

coded as Personal Gratitude (GN-1) while 4 (66.67%) were coded as Gratitude for Specific Benefits Received from a Higher Power (GN-2). Of the 13 narrow gratitude codes identified across sessions 2, 3, 4, and 5, slightly more than half (53.85%, $n=7$) occurred during a non-trauma discussion (NTD). Of these 7 gratitude codes identified across NTD, 6 (85.71%) were categorized as Personal Gratitude (GN-1) while 1 (14.29%) was categorized as Gratitude for Specific Benefits Received from a Higher Power. In other words, results indicated that across sessions 2, 3, 4, and 5 clients were slightly more likely to express gratitude in a narrow manner during a non-trauma discussion than during a trauma discussion.

Personal gratitude. Personal gratitude (GN-1, $n= 8$) was assigned most frequently within this category and accounted for 30.77% of all gratitude codes. It is important to note that all expressions of personal gratitude made by the three client-participants who expressed such statements were directed towards the therapist across sessions 2, 3, and 4. Of these three client-participants, CPT4's expressions of personal gratitude accounted for 62.5% of all GN-1 codes and occurred during a NTD. Client-participant 4 was more likely to express personal gratitude during discussions not involving trauma ($n=5$, 35.71% of NTD codes) than during discussions of trauma ($n=2$, 16.67% of TD codes), In contrast, Client-participant 2 was slightly more likely to express personal gratitude during a trauma discussion ($n=1$, 8.33% of TD codes) than during a non-trauma discussion (NTD=0). Lastly, client-participant 3 expressed personal gratitude equally during the trauma discussion ($n=1$, 8.33%) and non-trauma discussion ($n=1$, 7.14%).

Expressions of personal gratitude included three main themes. These included: social pleasantries (e.g., thanking the therapist for a compliment. thanking the therapist for wishing the client a happy holiday; TD=2; NTD=3), thanking the therapist for providing a material object (a

137

pen; NTD=1), and gratitude related with the benefits associated with the session (e.g., therapist advocating for a lower therapy fee, session timing, etc.)(NTD=2).

Several of these personal gratitude expressions were prompted by the therapist. For example, during a TD discussion in CPT3's session, the therapist stated "…I just want to say I know it's really hard for you to talk about those things today and I'm really glad that you did and I'm really proud of you for saying them" (T263), to which the client responded "thank you" (C263). During a NTD in CPT4's session, the therapist provided the client with a compliment regarding her daughter and stated "...oh is she beautiful what's her name?" (T19), to which the client responded, "thank you her name is Sara [pseudonym was used to protect confidentiality]" (C20).

Gratitude for specific benefits received from a higher power. The second most common occurring Narrow Gratitude code was Gratitude for specific benefits received from a higher power (GN-2, *n*=5), which represented 19.23% of all gratitude codes. Client expressions of Gratitude for benefits received from a higher power (GN-2, *n*= 4) accounted for 33.33% of all TD codes and occurred 0.58% of the time across all trauma discussion talk turns. On the other hand, client expressions of Gratitude for benefits received from a higher power (GN-2, *n*=1) accounted for 7.14% of all NTD codes and occurred 0.15% of the time across all NTD discussion talk turns.) It is important to note that all expressions of gratitude for benefits received from a higher power occurred in sessions 3 and 5. When comparisons are made between these two clients, the results indicate that client-participant 3 was more likely to express gratitude for benefits received from a higher power during a TD (*n*= 4, 33.33% of TD codes; NTD=0) than during a NTD, while client-participant 5 was slightly more likely to express gratitude for benefits

received from a higher power during a NTD than during a TD (n=1, 7.14% of NTD codes; TD=0).

Expressions of gratitude that are not otherwise specified. There were four themes that emerged from the NOS category. Specifically, G-NOS/Other codes were placed in the following categories: gratitude that occurs as a result of seeking or receiving social support from multiple people (which may include benefits received) without the use of a gratitude related word, (n=4, 33.33%), statements that would have fit into specific codes, but did not include a gratitude related word (n=4, 33.33%), statements that used a gratitude related word but did not appear to convey sincere gratitude (n=3, 25%), and gratitude for benefits received from an object (n=1, 8.33%). Each category is further described below, and presented in order of frequency. In regards to gratitude statements that occurred during TD vs. NTD, results indicated that CPT1 and CPT5 expressed phrases coded as Gratitude Not Otherwise Specified exclusively during NTD (CPT1, TD=0, NTD=14.29%; CPT5, TD=0, NTD=21.43%). By contrast, CPT2 and CPT4 were more likely to express Gratitude Not Otherwise Specified statements during a TD than during a NTD (CPT2, TD=33.33%, NTD=7.14% ; CPT4, TD=16.67%, NTD=0).

Four G-NOS codes included statements which expressed gratitude that occurred as a result of seeking or receiving social support from multiple people (which may include benefits received) without the use of a gratitude-related word. For example, towards the end of CPT2's session, the therapist asked the client if she would be able to pay the therapy fee since she was applying for disability at the time, to which the client responded, "Now I am [writing check on lap], there for the good graces of friends [smiles and laughs], I got a nice check at Christmas so..." (C179). The team agreed that the client appeared to state that if it were not for her friends providing her with a check, she would not be able to afford therapy. Although the client did not

use a gratitude related word, the researchers coded this statement as G-NOS/Other since her statement "for the good graces of friends" appeared to indicate gratitude for the benefit received from her social support system.

Four statements were identified that would have fit into specific codes, but did not include a gratitude related word. For example, CPT5 discussed qualities about her husband that she appreciated, "Like he respects my space…Which, he never used to do…So that's really, really cool because I value it very highly" (C24-C26). This statement indicated that the client was grateful for the changes her husband was making, and the word "value" can be seen as having a gratitude component. If this statement had a gratitude related word, it would have been coded as GN-1 since the client was expressing gratitude towards a specific person (her husband), for benefits she received from him. During this same conversation the client stated, "Yeah I, I always notice the little things and I always appreciate them. And that makes him happy too" (C30-C31). These statements indicate that the client is expressing that her tendency to be grateful in most circumstances has contributed to an outcome. If the statement the client made in C31 included a gratitude related word, it would have been coded as GN-3 since the client expressed an outcome that occurred as a result of her general gratitude state.

Three G-NOS codes captured statements that used a gratitude related word but did not appear to convey sincere gratitude. For example, CPT1 stated "…And I'm like, I used to like you, but I ain't telling. And he's like dang, you look good and I'm like oh thanks, I didn't then?" (C197). One G-NOS code was identified as a statement that expressed gratitude for benefits received from an object, as opposed to a person. More specifically, CPT2 stated,

> I don't see things until they are [using right hand to show distance] this close to me and
>
> then it is too late for to me to stop my momentum. Cause um with my legs braces [client

extends right leg and is looking down, semi lifts right pant leg, touching leg brace..

These have been a lifesaver for me. (Transcript 2, C96).

This statement represented a unique finding, as all statements that included gratitude for benefits received were directed towards a specific individual, rather than an object.

Expressions of gratitude as a broad state. This category was only coded one time, and as such was the least coded across all five sessions (GB-1, *n*=1). It represented 3.85% of all gratitude codes, and occurred during a NTD (7.14% of all NTD codes). The Gratitude as a Broad, General Tendency or Trait category was designed to identify expressions of gratitude that demonstrate a general tendency and characteristic of an individual to approach and respond to most circumstances with appreciation or thankfulness. The only code that was identified in this category across all sessions was generalized gratitude as an attitude (GB-1), which refers to a component of trait or dispositional gratitude. The statement that was coded as GB-1 was: "Yeah I always notice the little things and I always appreciate them" (C30).This statement illustrates that the client is referring to being grateful in most circumstances, which qualifies as an attitude, rather than a temporary state.

Themes That Emerged from the Coding Process

Three themes were identified during the coding process. Although these statements were not coded for this study, they contained important data, were recorded throughout the coding process, and are discussed as themes here. The first theme related to the therapist expressions of gratitude. The second theme involved therapist prompts for client gratitude expressions. Finally, the third theme included client expressions of other peoples' gratitude.

Therapist prompts for client gratitude expressions. Since the study was primarily examining client expressions of gratitude, comments or questions expressed by the therapist that

prompted the client's gratitude expression were not coded, but were examined in order to shed light on factors that may have impacted client expressions of gratitude. A total of 9 statements that included therapist statements or questions which prompted client expressions of gratitude were identified in sessions 3, 4, and 5. Five such statements included social pleasantries and/or a compliment or praise towards the client (see Personal Gratitude in results section).

Further examination of the session that included the most gratitude statements revealed that 57.14% (*n*=4) of these gratitude statements were prompted by the therapist. As previously discussed, one reason for this finding might be that CPT4's session was an intake session. For example, several times during session 4 the therapist emphasized the client's strength of social support. One such instance occurred when the therapist stated, "so in there it seems to me on the one hand you have this incredible work this incredible pain this incredible anger but you have some wonderful support system" (T92) to which the client responded, "I'm blessed I'm blessed in that area" (C93).

Therapists also prompted clients' gratitude expression in non-intake sessions. For example, after CPT3's trauma discussion, the therapist stated, "… I just want to say I know it's really hard for you to talk about those things today [C wipes nose with tissue] and I'm really glad that you did and [C nods] I'm really proud of you for saying them (T263), which prompted the client's personal gratitude statement 'Thank you' " (C263). Another example occurred during Session 5, when the client discussed her relationship with her husband, and the therapist asked, "What surprised you this week?" (T23), to which the client responded that he respected her space which he never used to do (previously quoted, C23-C26).The therapist's question (T23) appeared to prompt the client's gratitude response. Then the therapist directly asked the client "You told

him you appreciated it?" (T30), to which the client confirmed that she did (previously quoted, C30).

Therapist expressions of gratitude. The second theme that emerged was therapist expressions of gratitude. A total of 4 statements that indicated therapist expressions of gratitude were identified in sessions 3 (*n*=3) and 5 (*n*=1). None of the therapist's gratitude statements expressed in sessions 3 and 5 prompted a gratitude response from the client.

The therapists in sessions 3 and 5 both expressed gratitude during session. When the client brought in an assignment the therapist had previously requested, the therapist expressed personal gratitude twice for the client completing the assignment in an organized manner, to which the client responded, "You're welcome" (C7). Towards the end of CPT5's session, following the client's trauma discussion, the therapist stated, "Well I wanted to thank you for sharing that with me" (T289), to which the client responded "yeah" (C289). During Session 3, the therapist asked the client, "Do you think that, so it sounds like you're saying, so you're different from your family?" (T171) to which the client responded, "You know, thanks God, I think I am" (C171), which appeared to prompted the therapist to echo the client's gratitude statement in the following talk turn:

> You're saying that from your side, you recognize that you're different than your family, they're crazy, [T make air quotes around 'crazy'] sounds like, I mean not even in quotes, they sound crazy and they do terrible things and they think it's okay to hit their own children and you're, you say you're just not like that, you don't believe that way and thank God you don't…(Transcript 3, T181).

In this case, it appeared that the client's own gratitude statement had prompted the therapist's gratitude statement.

Client expressions of other people's gratitude. The third theme that arose from the findings from Sessions 1 and 4 was the clients' expression of other peoples' gratitude, rather than their own. Since the coding manual was utilized to code client expressions of their own gratitude, rather than others', these statements were not coded. A total of two statements that indicated clients' expression of other peoples' gratitude were identified in sessions 1 and 4. For example, in Session 1, the client expressed a statement about her co-worker expressing gratitude towards her:

> …"He's really nice and saying thank you and stuff, but it's too damn late [therapist nods head]. You've been pissing me off all day" (C373).

The client's statement indicated that she had difficulty reciprocating her co-worker's gratitude.

Another example occurred in Session 4, when the client made a statement that conveyed another individual's gratitude expression when she stated, "you know I mean your dad's lucky he's alive it's because he's your father [client laughter] he's still alive kind of feeling is you know which is understandable" (C63). The client's statement indicated that her husband made a gratitude statement about the client's father since he was angry with him. Among the definitions in the coding manual for this study, this statement most closely resembles undeserved kindness (see Coding Manual). However, since the client did not express this statement in relation with herself, a gratitude code was not assigned.

Content Analysis: Synthesizing Coded Results within Participants

The following section provides a review of each transcribed session utilized in this study. The themes that emerged within each session as well as a summary of each client participant's background history are discussed in order of prevalence and include examples of relevant gratitude statements.

Client-participant 1. Client Participant 1 was an African American, Christian, female. When the transcribed session took place, she was 28 years old. She sought therapy to deal with adjustment issues related to relocating to a new city and difficulties with expressing and coping with her emotions. She reported that she was sexually abused by her uncle who raped her when she was in third grade.

This session was the 7th of 21 sessions. During this session, the therapist and client engaged in a therapeutic "feeling game," which consisted of each of them taking turns answering questions and discussion prompts from the game cards they selected. The client appeared to be open to answering the questions and discussed interpersonal struggles she had experienced with her co-workers, prior relationships, and financial difficulties. During the feelings game, when one of the cards the client selected asked her to "talk about something you will never forget," she discussed the sexual trauma she experienced as a child. This trauma discussion consisted of 108 talk turns (C46-T120, T155-T157, T210-T244). During the first trauma discussion, the client talked about the details of her sexual abuse, and how the experience shaped her beliefs and has impacted her current relationships. The second discussion of trauma began at T155, when the therapist was prompted by the game to "say something about child abuse." The therapist then discussed with the client how it is "never the victim's fault, and it's always the perpetrator's fault." The final discussion of trauma began at T210, during which the therapist discussed with the client how even if the victim of child abuse enjoyed it or "wants it," he/she is not old enough to consent to sexual behavior and that because of this lack of maturity and development, the abuse is always the perpetrator's fault.

During session 1, two G-NOS/ Other gratitude statements took place exclusively during non-trauma discussions and accounted for 0.65% of the non-trauma discussion. No gratitude

statements occurred during any of the trauma discussions in this session (TD; n=0). Thus, the 2

gratitude codes accounted for 0.48% of this client's total 418 talk turns.

Although the client used a gratitude-related word in both of her G-NOS statements, the

coders agreed that both client's expressions of gratitude appeared to be sarcastic and not sincere,

and were directed towards her male friend and her boyfriend. As previously discussed, while

talking about a man the client used to have romantic feelings for, she stated that he gave her a

compliment, "And he's like dang, you look good and I'm like oh thanks, I didn't then?"(C197)

Later in the session the client discussed how she was compared to a five year-old by her

boyfriend, stating "And I'm like ok thanks, you make me feel great [client chuckles] Like you

gonna tell the five year old now so she can laugh too?" (C302)

Client-participant 2. Client-Participant two was a single, Caucasian, female. She

reported that she was originally from England. When the transcribed session took place, she was

47 years old. CP2 was also unemployed at the time of her session due to her disability status. She

sought therapy to address problematic scratching that was triggered by stress.

CP2's session contained 189 talk turns. This session had a total of 6 gratitude codes,

which accounted for 3.17% of the 189 talk turns. The coded categories within CPT2's session

included G-NOS/Other (5 codes; 0.83% of all gratitude codes) and Gratitude as a Narrow State

(GN-1; n=1 codes; 16.67% of all gratitude codes). No codes from the Gratitude as a Broad,

General Tendency or Trait category were identified.

During this session [data not available about when in the context of therapy this session

occurred], the client discussed her apprehension regarding her upcoming eye surgery as well as

the multiple health issues that occurred as a result of her stroke that occurred one year prior to

this session. Within Session 2, a total of five gratitude expressions were identified within the TD

(C7-C166) and accounted for 3.14% of trauma discussion talk turns within this session, while 1 gratitude statement was identified within the NTD and accounted for 3.33% of non-trauma discussion talk turns within this session. Thus, it appears that within this session, expressions of gratitude occurred more frequently during trauma discussions (TD, $n=5$) than during non-trauma discussions (NTD, $n=1$). One reason for this finding could be that the majority of the session was considered a trauma discussion. During this trauma discussion, the client talked about the details of her stroke and the numerous hospital visits and surgeries she had endured. When compared with CPT 1, 4 and 5, CPT 2's session contained the most TD codes, and the same amount of TD codes as CPT3's session.

Expressions of gratitude that are not otherwise specified. During this session, 5 of the client's gratitude statements were coded as G-NOS/Other (83.33% of the gratitude codes identified in this session). G-NOS/Other codes occurred more frequently during trauma discussions (TD, $n=4$, 80%) than non-trauma discussions (NTD, $n=1$, 20%).

Within CPT2's session, two of her NOS statements were related to the theme of gratitude that occurs as a result of seeking or receiving social support from multiple people (which may include benefits received) without the use of a gratitude related word (40% of CPT2 codes), two of her NOS gratitude statements fell in the category of statements that would have fit into specific codes, but did not include a gratitude related word (40% of CPT2 codes), while one of the NOS codes was gratitude for benefits received from an object (20% of CPT2 codes). A theme that arose in 4 out of 6 of the gratitude codes that were assigned in this session was the considerable amount of social support from caretakers and friends that helped her cope with her health complications and improve her overall functioning. Regarding the G-NOS code during a non-trauma discussion, the therapist asked the client if she would be able to pay the $15 for the

session since she was in the process of applying for disability, to which the client responded, "Now I am [writing check on lap], there for the good graces of friends [smiles and laughs], I got a nice check at Christmas so..." (C179). In this statement, the client appeared to state that if it were not for her friends providing her with a check, she would not be able to afford therapy. Although the client did not use a gratitude related word, the researchers coded this statement as G-NOS/Other since her statement "for the good graces of friends" appeared to convey gratitude for the benefit received from her social support system.

At the same time, however, the client discussed the mixed feelings she had about receiving social support. For example, during the trauma discussion she stated,

> 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 at me. So that was very very nice and um I-while I totally appreciated the help, I really felt the- um-I was- um- I fought against using that help. I would try to do things myself or try and get -I would try and go without help if I could. (C145, Transcript 2)

In this statement, the client conveyed appreciation for the help she received from her social support system while coping with her health complications. However, since the client expressed gratitude for benefits received from a group of people, rather than one benefactor, the team decided that this statement would be assigned a G-NOS/Other code.

Two of CPT2's gratitude statements indicated personal gratitude towards a benefactor for benefits received, without a gratitude related word. First, earlier in the trauma discussion the client talked about her recent visit to the hospital and stated,

….Um [client raises lips and looks to the left] last week, at the hospital when I went for

my pre-opt. (Female friend) is very very good and she has driven me to all my

appointments and has been an incredible support. (Transcript 2, C92)

Later in the trauma discussion, the client again discussed her female friend who provided her

with social support during her health complications and stated,

Yes, it was broken. And took very good care of it. I mean, (Female friend) is very, I call

her 'Florence Nightingale' when she is doing my nurse/maid stuff [looks at therapist,

both smile]. She took very good care of my foot for me. (Transcript 2, C114)

The coders agreed that the client's statements appeared to convey gratitude for the benefits she

received from her friend such as her friend driving her to appointments and taking care of the

client's foot. However, no gratitude related word was included in these statements, so the team

agreed that they would both be coded as G-NOS/Other.

Also during the trauma discussion, the client discussed the leg braces that had helped her

improve her ability to walk, stating "These have been a lifesaver for me…" (C96). Although the

client did not use a gratitude related word in this statement, the coders agreed that it appeared

that she was grateful for the benefits the leg braces provided her. This statement was a unique

finding as the majority of gratitude statements coded across sessions were typically directed

towards a specific person or higher power or people, but never directed towards an object.

Gratitude as a narrow state. During this session, one of the client's gratitude statements

was coded within this category (GN-1, *n*=1, 16.67% of all gratitude codes in session 2), and

occurred during her discussion of trauma. Toward the end of this session the therapist wished

the client luck on her upcoming surgery, to which the client responded, "Thank you. Thank you.

Thank you" (C166); the coders agreed this was a statement of personal gratitude (GN-1).

Client-participant 3. Client-participant three was a married, Hispanic, Christian female, who emigrated from El Salvador when she was 19 years old. She was 21 years old when the transcribed session took place. The client sought therapy to address feelings hopelessness, guilt, anger and depression. Additionally, she reported experiencing suicidal ideation intermittently. The client reported a history of childhood abuse that occurred physically, sexually, and emotionally. She reported that her mother and grandmother physically abused her and that she experienced two sexual assaults in her past.

During this session, the client discussed her worries for the safety of her sisters who were residing with her parents and grandmother in El Salvador. The client's initial discussion of the childhood trauma she experienced occurred during the 91st talk turn and ended at T269. This session was 6th of 31 sessions. Most of the session focused on the client's memories of the childhood abuse she experienced as a child as well as her familial relationships. This session had a total of 6 gratitude codes, which accounted for 2.16% of the 278 total talk turns. All of the expressions of gratitude that occurred in CPT3's session were coded in the Gratitude as a Narrow State category (6 codes). No codes from the Gratitude as a Broad, General Tendency or Trait or NOS categories were identified. A total of five gratitude expressions were identified within the TD and accounted for 2.82% of trauma discussion talk turns within this session. One gratitude statement was coded within the NTD in this session and comprised (0.99%) of non-trauma discussion talk turns within this session. Thus, within this session expressions of gratitude occurred more frequently during trauma discussions (TD, $n=5$) than during non-trauma discussion s (NTD, $n=1$). When compared with CPT 1, 4 and 5, CPT3's session contained the most TD codes, and the same amount of TD codes as CPT2's session.

Gratitude as a narrow state. During this session, all six (100%) of the client's gratitude statements were coded within the Narrow Gratitude category; five of which occurred within TD (GN-2, *n*=4, 80% of TD codes; GN-1, *n*=1, 20% of TD codes). The most frequently occurring type of narrow gratitude that was coded was gratitude for specific benefits received from God (GN-2, *n*= 4) and accounted for 66.67% of all gratitude codes and 80% of all TD codes. This code did not occur during non-trauma discussions within this session. Results indicate that Gratitude for Specific Benefits Received from a Higher Power occurred more frequently during trauma discussions (TD, GN-2, *n*=4) than non trauma discussions (NTD, GN-2, *n*=0). For example the therapist asked, "Do you think that, so it sounds like you're saying, so you're different from your family?" (T171) to which the client responded, ("You know, thanks God, I think I am" (C171). In another example, the client expressed her gratitude towards God that she did not grow up with her family,

> I think they all crazy and thanks God I didn't grow up with them. Cause they're crazy, they think it's okay if you hit someone, they think it's okay, that's totally okay, if, just because, let's say you have a child, you can hit this child because this is your child, you can do whatever the heck you want. (Transcript 3, C168).

The next most frequent code that occurred in this category was personal gratitude (GN-1, *n*=2, 33.33%). Personal gratitude accounted for 20% of all TD codes (GN-1, *n*=1) that occurred in this session and 100% of NTD codes (GN-1, *n*=1). Results indicate that personal gratitude occurred with the same amount of frequency during trauma discussions and non-trauma discussions (TD, GN-1, *n*=1; NTD, GN-2, *n*=1). During both of these statements, CPT3 expressed personal gratitude towards the therapist. More specifically, during a TD, the therapist stated, "…I just want to say I know it's really hard for you to talk about those things today and

I'm really glad that you did and I'm really proud of you for saying them," (T263) to which the client responded "thank you" (C263). The other occurred at the end of the session when the therapist stated, "Well that'll be nice, well have a very happy Thanksgiving" (C27), to which the client responded, "Thanks you too" (C277). As noted before, this was the client's only non-trauma discussion coded statement (NTD, n=1, 16.67%).

Client-participant 4. Client participant four was a 39 year old married female of African American, American Indian, and Caucasian descent. The client reported that she had four daughters, two of whom moved away from home due to college. At the time when this session took place, she was residing with her husband and two of her daughters (one of whom she and her spouse had guardianship of, but were not related to biologically). She sought therapy to manage her emotions of depression, guilt and anger due to discovering that her father sexually abused her step-daughter. The client reported a history of being sexually abused by her paternal grandfather when she was about seven years of age.

The selected session was an intake session, during which the session focused on gathering information on the client's background history and presenting problem. In addition to these factors, the majority of the session was focused on the client disclosing the memories of the past sexual abuse that she experienced when she was 14 years old as well as the sexual abuse her step-daughter experienced. CPT4's session contained 184 talk turns.

This session had a total of seven gratitude codes, which accounted for 3.80% of the 184 talk turns. Of the seven gratitude expressions that were coded within CPT4's session, 5 were coded as personal gratitude (71.43%), while 2 were coded as G-NOS/Other (28.57%). No codes from the Gratitude as a Broad, General Tendency or Trait category were identified. When

compared to the other 4 client-participants, CPT4's session included the highest number of gratitude codes across all sessions (7 codes), and accounted for 26.92% of all gratitude codes.

The client's initial discussion of her previous trauma she experienced as well as her step-daughter's trauma started in the 25th talk turn. Of the 184 total talk turns, 110 met criteria for TD which took place in three different portions of the transcript (CT25-T95, C106-T143, and T150-T156). During these trauma discussions, the client discussed the details of her previous sexual abuse and her reactions to her step-daughter's sexual abuse. Results indicate that gratitude expressions which were identified within the NTD accounted for 6.76% (n=5) of non trauma discussion talk turns and occurred more frequently than gratitude expressions which were identified within the TD and accounted for 1.82% (n=2) of trauma discussion talk turns.

Gratitude as a narrow state. During this session, five of the client's gratitude statements were coded within this category; all were personal gratitude (GN-1, n =5; 71.43% of all gratitude codes in this session) that occurred during a NTD. Each of CPT4's expressed personal gratitude statements were directed towards her therapist (all of the following examples were shared previously). During one of these statements, the client expressed gratitude for the therapist for a material benefit that was received, stating "thanks" (C5) after the therapist handed her a pen. Another example of personal gratitude occurred when the therapist provided the client with a compliment regarding her daughter and stated "...oh is she beautiful. What's her name?" (T19), to which the client responded "thank you, her name is Sara" [pseudonym was used to protect confidentiality]" (C20). Towards the end of the session, the therapist let the client know that she would ask her supervisor if she could lower her therapy fee, to which the client responded, "Thank you very much" (C183).

Gratitude NOS. During this session, 2 of the client's gratitude statements were coded as G-NOS/Other and accounted for 28.57% of the gratitude codes identified in this session; all were identified within the TD. Both G-NOS statements pertained to client expressions of gratitude for being able to seek and/or receive social support. Following the client's discussion of how her step-mother helped her to start dealing with the anger she experienced due to her past abuse, the therapist responded that the client has a "wonderful support system", to which the client responded , "I'm blessed I'm blessed in that area" (C93) . Later in the session, the client reported that she was seeking social support following the session, and that she was grateful for her social support system, when she noted, "yeah, I am actually meeting a girlfriend after this, this afternoon to, just as support for what I am going through today...so I do, I am blessed, very blessed there…" (C155). The team decided to code these statements as G-NOS/Other since she was expressing gratitude for her social support system generally, and the gratitude was not directed towards a specific person for benefits received.

Client-participant 5. Client-participant five was a 28 year old, Caucasian female who identified as Protestant. The client-participant reported that she had two children and that she had recently reconciled with her husband from whom she had previously been separated. The client reported a history of physical and sexual abuse, including several years of sexual abuse by her neighbor from the time she was four years old to eight years old. The client also reported that when she was 14 years-old her father tried to persuade her to have intercourse with him, but that she was uncertain if she engaged in any sexual activity with him. She also reported that she was physically abused by her father when she was 16 years-old. She sought therapy to manage her emotions, and reported feeling fearful and overwhelmed.

The majority of this session [data not available about when in the context of therapy this session occurred], was focused on discussing the client's marital problems which had led to her separation from her husband. The client's discussion of the previous trauma she experienced as well as her step-daughter's trauma started in the 148th talk turn (T148-T290). During this trauma discussion, the client discussed her history of sexual, physical and emotional abuse and how these experiences impacted the way she related with others.

During session 5, gratitude statements took place exclusively during non-trauma discussions (NTD, *n*=5) and accounted for 3.14% of non-trauma discussions. This session's five total gratitude codes accounted for 1.67% of the 300 total talk turns. When compared with other client-participants, CPT5's session was the most varied, as at least one gratitude statement from all three parent categories was coded within this session. The coded categories within CPT5's session included G-NOS/OTHER (3 codes; 60% of all CPT 5 gratitude codes), Gratitude as a Narrow State (GN-2, *n*=1 code; 20% of all CPT5 gratitude codes) and Gratitude as a Broad, General Tendency or Trait (GB-1, *n*=1; 20% of all CPT5 gratitude codes).

Expressions of gratitude that are not otherwise specified. During this session, three of the client's gratitude statements were coded as G-NOS/OTHER during NTD, accounting for 60% of all NTD codes; no G-NOS/Other codes occurred during a TD (*n*=0).Two of CPT5's NOS statements fell in the category of statements that would have fit into specific codes, but did not include a gratitude related word. First, the client discussed the change she had noticed in her husband's behavior now that they had reconciled, and stated, "He's offered to do stuff." "He's not gotten in my way of things I'm doing." "Like he respects my space." "Which [Client laughs], he never used to do." "So that's really, really cool because I value it very highly" (C23-C26). Later during the session, the therapist asked the client "You told him you appreciated it?" (T30),

155

to which the client responded that she did. Although the client did not use a gratitude related word, the coders agreed that her statement "I value it very highly," appeared to be indicative of gratitude and was coded as G-NOS/OTHER. Additionally, the client stated, "Yeah I,I always notice the little things and I always appreciate them"(C30)…."And that makes him happy too" (C31). The client's statements in C30 and C31 indicated that her gratitude practice of appreciating the "little things" makes her husband "happy," which the coders agreed could be seen as a gratitude outcome without the use of a gratitude related word..

During this session, CPT5 also expressed gratitude that did not appear to be sincere, which was a theme that also emerged in CPT1's session. For example, during the session CPT5 described her way of gaining control with adults as a child, stating

It's really odd. Yeah, even in my past, people whose heart would race at the mention of my name, couldn't say that they didn't like me, but that was usually adults who had no idea what to do when they told me something and I said, "I really appreciate you caring enough to express your opinion and I really appreciate your input and I will definitely consider what you said." (Transcript 5, C139)

Then the client said, "And then I'd do whatever I want anyway" (C40). Although the client used a gratitude-related word, her statement in C140 indicated that she did not sincerely "appreciate" the opinions she was receiving, which is why the coders agreed to code this statement as G-NOS/Other.

Gratitude as a narrow state. During session 5, one of the client's gratitude statements was coded GN-2, gratitude for specific benefits received from a higher power, during a non-trauma discussion (accounted for 20% of all NTD codes). This coded statement occurred in the context of discussing the financial difficulties she and her husband have experienced and how it

contributed to a strain in their relationship. The client discussed how she had a conversation with her husband about paying the rent stating

> But yeah, he felt it very hard, and when I told him, I said, "This is what I mean when I need you to take care of the rent." He said, "I am going to take care of it." I said, "No, you're not. You're going to reimburse me for it. That's not taking care of it. (C107)

Then the client said, "And it was like light bulbs went off in his head and I said, thank you God" (C108. The client's statement demonstrates that her husband understood her perspective regarding their financial difficulties, which she thanked God for.

Gratitude as a broad, general tendency or trait. During this session, one of the client's gratitude statements was coded within this category as GB-1, generalized gratitude as an attitude and accounted for 20% of all NTD codes. When compared with the other client-participants, CPT-5 was the only client-participant who expressed gratitude in a broad manner. As previously discussed, during this session the client reported that she had noticed some behavioral changes her husband had been making. The therapist then asked the client, "You told him you appreciated it?" which appeared to prompt the client's gratitude statement: "Yeah I,I always notice the little things and I always appreciate them" (C30).The coders agreed that this statement would be coded as GB-1 since the client appeared to be expressing a component of trait gratitude that indicated an attitude of being grateful in most circumstances since she noted that she "always" notices the "little things" and "always" appreciates them.

Chapter IV: Discussion

Research examining the expression of gratitude by trauma survivors in the context of psychotherapy is limited, despite promising evidence in two studies that demonstrated gratitude can help survivors positively process difficult events and can also potentially lead to positive effects as a part of the post-trauma recovery experience (Kashdan et al., 2006; Vernon et al., 2009). Research has also demonstrated that using gratitude interventions can contribute to positive effects with individuals suffering from medical issues such as low-back pain and neuromuscular disease as well as individuals struggling with clinical issues such as depression (Carson et al., 2010; Emmons & McCullough, 2003; Seligman et al., 2006; Seligman et al., 2005). Yet, no research has examined different types of gratitude that can occur during psychotherapy sessions with clients who have experienced trauma. Additionally, despite the fact that gratitude is a widely known construct, researchers have consistently had difficultly agreeing on a unitary definition of gratitude; it has been variously defined as a positive psychological character strength and trait, coping response, attitude, moral virtue, emotion, and habit (Emmons et al., 2003). Although gratitude has been conceptualized as narrow and broad (e.g., benefit-triggered vs. generalized gratitude), significant overlap exists among these categories (Lambert et al., 2009).

Thus, this study sought to more clearly examine the different types of gratitude, and focus specifically on those expressed by trauma survivors in the context of psychotherapy. In order to achieve this goal, the researcher developed an observational coding system that was based on existing gratitude literature, used the deductive coding system, and then analyzed coded expressions of gratitude by clients who are trauma survivors in psychotherapy sessions through a qualitative content analysis. This study also compared gratitude expressions that took place

during trauma discussions and non-trauma discussions within sessions, which is an area of research that had not been examined.

The results from this study are reflective of the multifaceted nature of gratitude. In contrast to existing assessment and research that focuses exclusively on benefit-triggered or narrow gratitude versus generalized or broad gratitude, the findings revealed that clients tended to express gratitude in a *Narrow* manner or in a manner that was *Not Otherwise Specified*, rather than in a *Broad* manner. Only one code (GB-1) was identified within the *Gratitude as a Broad, General Tendency or Trait* category. While *Broad* gratitude occurred less frequently in the present study than it did in previous research, the results are consistent with previous studies reviewed by Lambert et al. (2009) that have found individuals are more likely to express gratitude in a *Narrow* manner rather than a *Broad* manner .Since transpersonal Gratitude is characterized as Broad, this may be a reason for the lack of Transpersonal codes identified in this study. Notwithstanding, it was surprising that no Transpersonal codes were given, as research has demonstrated that the widely used self-report measures of gratitude, the GQ-6, is positively correlated with measures of spirituality and religiosity, such as spiritual and self transcendence (McCullough et al., 2002).

Two other coding categories were not identified during the coding process: *Gratitude Outcomes* codes or subcodes. These results were similarly surprising given the numerous studies that suggest that gratitude can be prosocial in nature, such that it either prompts others to reciprocate benefits received or engage in helping behavior not necessarily directed towards their benefactor (Bartlett & Desteno, 2006; Emmons & McCullough, 2003; Frederickson, 2004; Tsang, 2006a). The current study found that for 2 of the 5 clients, receiving benefits was either

related with guilt and indebtedness (without gratitude), or gratitude mixed with guilt and indebtedness.

Unique to this study was the identification of ways of coding outside of the traditional [broad vs narrow] categories. Patterns within the NOS category that emerged highlight areas of research related to gratitude that have not yet been explored in-depth. For example, the literature has traditionally focused on gratitude as a result of benefits received from one benefactor or general gratitude that does not occur as a result of benefits received. However, in the present study several statements were identified that included gratitude as a result of seeking or receiving social support from multiple people (some which included benefits received). Furthermore, the results found support for expanding researchers' focus on defining gratitude beyond the use of gratitude related words as some statements that conveyed gratitude but did not use a gratitude related word were identified. This study also found that some gratitude statements appeared to be insincere, which is an area of research that has not yet been examined. Lastly, one statement included gratitude for benefits received from an object, which has been typically discussed in broad context in the literature, rather than in a narrow context where benefits are received from the object. These results can potentially help therapists develop awareness of a character strength that may emerge as a result of a client's struggle with trauma and about the role of gratitude expression in therapy during trauma and non-trauma discussions.

This chapter begins with a discussion of findings related to coded client verbalizations of gratitude and reviews the specific codes that occurred both within and across participants, in order of frequency. These findings are discussed in relation with the current literature. Next, limitations of the current study are discussed. Then contributions of this study are presented.

Finally, this chapter concludes with a discussion of directions for future research on the topic of gratitude.

Findings Related to Verbalizations of Gratitude

Results from this study indicated that across the five psychotherapy sessions with clients who were trauma survivors, client expressions of gratitude accounted for 1.90% of total talk turns. Session 4 contained the most client expressions of gratitude (7 of 184 talk turns), which comprised 3.80% of the 184 talk turns. However, it is important to note that these results are fairly similar to the frequency findings across sessions 2 (6 codes, 3.17%), 3 (6 codes, 2.16%), and 5 (5 codes, 1.67%), with session 1 having the lowest frequency rate across all 5 sessions (2 codes, 0.48%). Since no other studies specifically examining gratitude expression in the context of psychotherapy have been conducted, it is difficult to discern whether these findings should be considered infrequent. For this reason, this researcher attempted to locate other ways that frequency data has been collected on gratitude to put her findings in context. Emmons et al., (2003) posited four factors that determine one's disposition toward gratitude: "intensity, frequency, span, and density" (p. 332), and attempted to measure those facets with the GQ-6 (see Gratitude Assessment section of the literature review chapter). Of note, the majority of gratitude self-report measures assess these facets of dispositional gratitude in an overlapping manner; as such, gratitude frequency and other facets are not easily separated out in the current literature.

Gratitude frequency, the second facet, can be defined as the number of times an individual feels grateful on a regular basis and has also been described as the effortless manner in which gratitude is provoked (McCullough et al., 2002). A sample item on the GQ-6 related to gratitude frequency is "Long amounts of time can go by before I feel grateful to something or someone." Individuals who have higher levels of dispositional gratitude as measured with the

GQ-6 typically reported experiencing gratitude multiple times per day for a variety of events (including small favors or acts of kindness), whereas individuals who had a lower level of dispositional gratitude experienced gratitude less frequently (McCullough et al., 2002).

Given the prominence of frequency in this model, we expected to find research documenting how often people, and psychotherapy clients in particular, expressed gratitude, and compare our results with such research findings. Yet, such findings proved difficult to locate as research that uses the GQ-6 and mood rating forms do not yield the type of data used in our study. Instead, this data reports the intensity of self-reported gratitude emotions experienced within an allocated time period.

One area of research examined general population self-report surveys of gratitude. Although not tracking actual expressions of gratitude, Sommers and Kosmitzki (1988) found that 10% of Americans responded that they "regularly and often" experience the emotion of gratitude, as compared to 30% of Germans More recently, a national survey conducted by The John Templeton Foundation (2012) found that 51% of participants reported that they think about the things they are grateful for on a daily basis; higher than the rates in the 1988 study. Yet, this study noted that respondents were not expressing gratitude consistent with those thoughts. For example, 90% of participants reported that they were grateful for their immediate family, but only 49% reported consistently expressing gratitude towards their parents. These findings could suggest that the client-participants in the present study may not have expressed gratitude as frequently as they thought about or experienced it.

Another factor that may have impacted the results of the present study is that implementing gratitude interventions in session is not standard practice. Such implementation may be affected by variables such as theoretical orientation, knowledge about such interventions,

and willingness to prompt discussions about gratitude. When gratitude practices are a part of research studies, diary methodology has been used to track frequency and intensity of gratitude through the use of mood rating forms, which assess the degree to which each individual has experienced a variety of affects including gratitude (through words such as grateful, thankful and appreciative), on a weekly (gratitude condition, 9 weeks period, mean=10.16) or daily basis (gratitude condition, 13 day period, mean=9.78; Emmons & McCullough, 2003). Such research finds that although gratitude interventions such as Count your blessings (see Gratitude Interventions section of the Literature Review chapter), can increase intensity and frequency of gratitude experienced, practicing a gratitude exercise on a daily basis as opposed to a weekly basis was more influential in facilitating gratitude as the effect size for the daily manipulation was larger than the weekly condition. This finding is potentially relevant in regards to the present study since the majority of clients typically attend therapy once per week. Thus, if the therapist facilitates gratitude in session on a weekly basis, the client may experience an increase in gratitude level, but potentially not as much as if the client were to practice gratitude on a daily basis outside of session.

Of note, clients' gratitude expressions occurred during trauma discussions within only three of the five sessions: Sessions 2, 3, and 4, at rates similar to the overall / across 5 session totals (TD total across 3 sessions =1.73%; Across 5 sessions total=1.90%). More specifically, in Session 2 gratitude expressions occurred roughly equally during trauma and non-trauma discussions TD =3.14%, NTD =3.33%; total=3.17%). Whereas in Session 3, gratitude expressions occurred more often during trauma discussions than non-trauma discussions, (TD=2.82%, NTD =0.99%, total =2.16%). By contrast, in Session 4 gratitude expressions occurred more frequently during non-trauma discussion than during trauma discussions

(TD=1.82%, NTD=6.76%, Total=3.80%). Thus, it is difficult to conclude that gratitude is more or less likely to occur during TD than NTD from the results of the current study.

Since no previous studies were identified that examined the frequency rates of client expressions of gratitude within trauma discussions, or within trauma treatment generally, the aforementioned percentages could not compared equally with other studies. With that said, some comparisons can be made. A study conducted by Kashdan and colleagues (2006) was identified which tracked the intensity of gratitude emotions based on a 5-point Likert scale that ranged from 1 (very slightly or not at all) to 5 (extremely), experienced by a sample of 55 male veterans felt on a daily basis (as measured by the Gratitude Adjectives Checklist; Emmons & McCullough, 2003; McCullough et al., 2002) for a period of 14 days. The group with participants who were diagnosed with PTSD ($n=27$) consisted of 13 veterans who were in outpatient treatment and 14 veterans who were in residential treatment and had a mean daily gratitude rating of 4.1, $SD=3.2$, while the Non-PTSD group who were not in treatment ($n=28$) had a mean daily gratitude rating of 5.1, $SD=3.14$. Although this study was examining self-reported intensity of gratitude experienced on a daily basis, and not specifically examining the frequency of gratitude expressions, the daily gratitude intensity level reported by both groups of participants who had experienced trauma in the aforementioned study is similar to the mean number of gratitude expressions made by participants in this study who had experienced trauma, as the total number of gratitude codes per session ranged from two to seven, with an average of 5.2 ($SD =1.92$) per session.

Another study conducted by Becker and Smenner (1986), observed how frequently a sample of children between the ages of 3 and a half and 4 and a half ($n=250$, 121 boys, 129 girls) expressed gratitude verbally (i.e., Thanks, thank you) after they were given a reward for

guessing a color correctly. The results indicated that less than half of the children responded with "thank you" after receiving the reward (37%). The current study however, demonstrated that gratitude for benefits (material and nonmaterial) received from the therapist was the second most frequently assigned code (n=8 codes across sessions 2, 3, and 4) and accounted for 30.77% of all gratitude statements. Future studies with more comparable methodology should test whether one hour of therapy can potentially facilitate a day's worth of gratitude experiences.

In regards to the other facets, gratitude span refers to the amount of blessings (including people, events and other circumstances) that an individual is grateful for during a given time period, whereas gratitude density refers to the amount of individuals that a person feels gratitude towards for a specific positive event or benefit disposition (Peterson & Seligman, 2004). The present study was not able to assess the client's level of gratitude density since this facet involves the number of people an individual is grateful towards for a single positive outcome. Furthermore, since gratitude span refers to the amount of blessings an individual is generally grateful for, this facet of gratitude was not assessed since the majority of participants expressed gratitude in a Narrow manner for benefits received. Of note, CPT5 was the only client who expressed generalized gratitude when she indicated that she "always" appreciates the little things; however, her other gratitude statements were either narrow or NOS.

The subsequent section reviews the specific codes that were identified in the current study and are discussed in relation with the existing literature on the different types of gratitude expression. First, the most frequently coded gratitude expressions are presented in order of frequency. Themes that emerged across sessions are discussed next.

Gratitude Expressions Across and Within Sessions

Expressions of gratitude that are not otherwise specified. Although the majority of previous studies have focused on benefit-triggered gratitude versus broad gratitude, the current study explored whether other types of gratitude would emerge. *Expressions of Gratitude Not Otherwise Specified* was the most frequently coded gratitude expression (12 codes, 46.15% of all gratitude codes). There were four patterns that occurred within the G-NOS/Other category: gratitude that occurs as a result of seeking or receiving social support from multiple people (which may include benefits received) without the use of a gratitude related word, (n=4, 33.33%); statements that would have fit into specific codes, but did not include a gratitude related word (n=4, 33.33%); statements that used a gratitude related word but did not appear to convey sincere gratitude (n=3, 25%); and gratitude for benefits received from an object (n=1, 8.33%). Expressions of gratitude not otherwise specified occurred in all sessions except session 3. NOS expressions of gratitude occurred most frequently in Session 2 (n=5) and accounted for 41.67% of all NOS codes. Results indicate that CPT1 and CPT5 expressed gratitude not otherwise specified exclusively during NTD (CPT1, TD=0, NTD=14.29%; CPT5, TD=0, NTD=21.43%). By contrast, CPT2 and CPT4 were more likely to express gratitude not otherwise specified during a TD than during a NTD (CPT2, TD=33.33%, NTD=7.14%; CPT4, TD=16.67%, NTD=0). This subsection discusses these themes as well.

Gratitude that occurs as a result of seeking or receiving social support from multiple people. The majority of literature defines benefit-triggered gratitude as occurring in response to a benefit received from a benefactor, not multiple benefactors (Lambert et al., 2009; Peterson & Seligman, 2004). In the present study, however, examples of gratitude occurred as a result of seeking or receiving social support from multiple people (which may include benefits received)

166

without the use of a gratitude related word ($n=4$, 33.33%), which provides support for expanding the literature's definition of personal gratitude to include multiple benefactors or to create a separate definition that adequately captures seeking and/or receiving social support from one or more persons (which may include benefits received).

In this first G-NOS theme, findings were consistent with literature that demonstrates received social support can diminish and/or protect against psychological distress following trauma (Cohen & Wills, 1985; Lyons, 1991). For example, CPT4 discussed the client's social support system and said, "…okay, we'll we have established that you have a phenomenal social support system" (T155), to which the client responded "yeah, I am actually meeting a girlfriend after this, this afternoon to, just as support for what I am going through today...so I do, I am blessed, very blessed there…" (C155). The client's statements indicate that the social support she has received has helped her cope with previous trauma and is an ongoing source of support and gratitude. Such gratitude for benefits were also tangible in nature, such as at the end of CPT2's session during a non-trauma discussion when the therapist inquired if the client was capable of paying the therapy fee since she was applying for disability at the time, to which the client responded, "Now I am [writing check on lap], there for the good graces of friends [smiles and laughs], I got a nice check at Christmas so..." (C179).

Moreover, coded statements within this theme were consistent with research that demonstrates gratitude can be prosocial in nature, and prompts others to reciprocate benefits received (Bartlett & Desteno, 2006; Frederickson, 2004; Tsang, 2006a). Session 2's previously discussed karma quotation (C145) indicated that the help she has given others has been reciprocated, which suggests that others likely engaged in reciprocity behavior as a result of the benefits they received from her. Furthermore, in (C145), the client discussed how she was

surprised to find that even though she expected people would not "stick around" to help her cope during her medical complications, that there were a lot of people who desired to help her. This finding also provides support for the broaden-and-build theory, which asserts that when individuals experience gratitude they become aware of the kindness directed towards them from others, which motivates them to think and act in ways that will help strengthen their psychological resources (Frederickson, 2001). This awareness can potentially shape the perspective that others can be relied on for support.

While the client noted that she experienced changed perceptions of others such as Frederickson suggested, she also discussed how she "fought against" receiving the help, stating that she felt grateful for the support, but at the same time had mixed feelings about receiving the help since she has nothing to return to others. CPT2 stated,

> It's not a good feeling. Um, I know that 6-months ago (female friend) went in for a breast biopsy……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. (C150-C151)

While CPT2 felt gratitude for the social support she received, it appears she may also have felt guilt or obligation to repay the favors she received. Bono, a prominent gratitude researcher, asserts that guilt can overlap or even inhibit gratitude in the case of an individual who survives a tragedy when others do not, and also in a situation that involves "inequity" in a relationship that builds up over time (Kennelly, 2014) Thus, receiving benefits from others may trigger gratitude, but it also may trigger feeling indebted or obligated to return the favor.

Although some researchers have considered gratitude and indebtedness as overlapping categories (Greenburg, 1980, Komter, 2004), others have argued that these are two distinct emotions (Watkins et al., 2006). Research by Watkins and colleagues (2006) has demonstrated that when a benefit is received, if the beneficiary perceives an expectation of return from the benefactor, the benefactor is more likely to feel a higher level of indebtedness than gratitude. Other research has demonstrated that the perception of helper intention can potentially inhibit or reduce gratitude if the beneficiary perceives that the favor was given for selfish reasons (Tsang, 2006b). Contrary to the aforementioned literature, CPT2's mixed feelings did not appear to be wholly the result of a perceived expectation that the favor needed to be returned. When the therapist asked the client if she was afraid she would lose her friendships because she was not able to give back to her benefactors, the client responded that at first she was, then stated, "The people are still around that they are still in my life, that they still want to help me and its a year and a half down the road…"(C156). This finding suggests that future research should expand its focus beyond perceived expectations or intentions of the benefactor, and examine the mixed feelings including guilt or obligation that may arise as a result of benefits received, regardless of perceived expectation of the benefactor. Moreover, while previous research has demonstrated the positive and negative effects of gratitude, this study shed light on the need for researchers to focus on expanding studies examining gratitude related with mixed emotions, particularly guilt.

Statements that would have fit into specific codes. Another theme that emerged in the NOS category was statements that would have fit into specific codes, specifically GN-1 or GN-3, but did not include a gratitude related word (*n*=4, 33.33%). One finding in this theme related to the identification of certain words and/or metaphors outside of typical gratitude words (e.g., grateful, thankful, blessed etc.) that may indicate gratitude. Two such statements were expressed

by CPT2 and were indicative of personal gratitude without the use of a gratitude related word. For example, during a trauma discussion in Session 2, the client discussed the benefits she obtained from receiving social support from her good friend,

> …Um [client raises lips and looks to the left] last week, at the hospital when I went for my pre-opt. (Female friend) is very very good and she has driven me to all my appointments and has been an incredible support. (Transcript 2, C92)

Later during the trauma discussion the client discussed the same female friend and stated, Yes, it was broken. And took very good care of it. I mean, (Female friend) is very, I call her 'Florence Nightingale' when she is doing my nurse/maid stuff [looks at therapist, both smile]. She took very good care of my foot for me (Transcript 2, C114).

The client's statements indicated gratitude through the use of words such as "incredible support" and a metaphor comparing her friend to Florence Nightingale for taking care of her during her recovery. These two statements also related with the theme of social support previously discussed (See Expressions of Gratitude That Are Not Otherwise Specified); however, in this case the gratitude occurred as a result of benefits obtained from receiving social support from one person, instead of multiple social supports. This finding provides support for creating a new category that captures gratitude that results from seeking or receiving social support, which may or may not include benefits.

Another statement that indicated gratitude included the word "value", rather than a gratitude related word. During a non-trauma discussion in CPT5's session she discussed qualities about her husband that she appreciated, "Like he respects my space…Which, he never used to do…So that's really, really cool because I value it very highly" (C24-C26). During this same conversation the client stated, "Yeah I, I always notice the little things and I always appreciate them (C30; coded GB-1)", which gave context to the NOS coded phrase.

Another finding in this theme related to a positive outcome for the recipient of the gratitude expression. For example, after CPT5 expressed her tendency to notice and appreciate "the little things" (C30), she stated, "And that makes him happy too" (C31, coded NOS). The client's statement indicated that the gratitude outcome occurred for a different individual than the one who engaged in the gratitude practice, thus the statement was coded as NOS. This finding suggests that gratitude expression can contribute to positive outcomes, not only for the person expressing the gratitude, but also for the recipient of the gratitude expression, which is consistent with literature demonstrating the positive impact of gratitude expression on relationship satisfaction (Algoe, Fredrickson, & Gable, 2013).

Additionally, a pattern was noted in this subtheme that 1 in 4 participants (CPT5) who had a significant other in the current study expressed gratitude towards that person (CPT2 was single at the time of treatment). This finding was inconsistent with a nation-wide gratitude survey (Kaplan, 2012) that was conducted with 2,000 individuals (ages 18-65+), which found that 49% of participants expressed gratitude daily to their spouse or partner. Although the size of the survey group differs significantly from the number of participants in the current study, it appears that the frequency of gratitude expression towards significant others was relatively infrequent since it accounted for only 3.86% of all 26 gratitude statements (n=1). Also, since other aspects of the methodology differed, and none of the -participants were observed with their significant others, definitive conclusions about whether they directly expressed gratitude and how frequently they did so towards their significant others outside of session cannot be made. With that said, however, one reason for this finding may be that gratitude can be related with negative or mixed feelings, as previously discussed. Emmons and McCullough (2003) argued that for some people being grateful means "to allow oneself to be placed in the position of a recipient—to feel

171

indebted and aware of one's dependence on others" (p. 379). This assertion may be particularly

relevant for trauma survivors, especially those who have experienced sexual abuse, as the

literature suggests this population frequently feels powerless in interpersonal relationships,

which contributes to reluctance to depend on others (Alexander 1992; Beth,1999; Cloitre et al.,

1997; Ray & Jackson, 1997, as cited in Kallstrom-Fuqua, Marshall, & Westin, 2004). Thus, this

reluctance to depend on others may have inhibited or even prevented the client-participants from

expressing gratitude towards their significant others.

Statements that convey insincere gratitude. Another finding from this study emphasized

the need for research to examine statements that do not appear to convey sincere gratitude. Three

such statements (25% of all NOS codes) occurred in Sessions 1 and 5. All three of these

statements occurred exclusively during a non-trauma discussion. Of note, CPT1 and CPT5's

sessions also contained the least amount of gratitude codes across all five sessions (CPT1=2,

CPT5=5). Both included themes of not trusting others, difficulty accepting help for fear of being

vulnerable and "owing" others, and desire to control. These findings demonstrate support for

literature that suggests sexual assault survivors are often hesitant to be intimate with or depend

on others due to feeling powerless in relationships (Alexander 1992; Beth, 1999; Cloitre et al.,

1997; Ray & Jackson, 1997, as cited in Kallstrom-Fuqua, Marshall, & Westin, 2004). As

previously mentioned, research has also demonstrated that feeling "indebted" or "obligated" to

repay a favor can reduce or inhibit gratitude (Tsang, 2006b; Watkins et al., 2006). Emmons also

asserted that the inability to acknowledge dependency on others can be a barrier to experiencing

gratitude (Emmons, 2008).

Given CPT5's trauma history and that the adults in her life violated her trust, her

statements suggest that expressing insincere gratitude was her way of gaining control as a child,

in order not to depend on others' support or opinions. During her session, CPT5 discussed her difficulty depending on others in the following statement: by saying, "Like, I would never want to depend fully on someone else…because apparently I don't trust people but….(C67-68). Later in the session, she described her way of gaining control with adults as a child,

> It's really odd. Yeah, even in my past, people whose heart would race at the
>
> mention of my name, couldn't say that they didn't like me, but that was usually
>
> adults who had no idea what to do when they told me something and I said, "I
>
> really appreciate you caring enough to express your opinion and I really
>
> appreciate your input and I will definitely consider what you said." (Transcript 5,
>
> C139)

Then the client stated, "And then I'd do whatever I want anyway" (C140). And I stuck with it pretty much, I would still say it if somebody that I didn't trust tried to tell me something.…but nobody could make me do anything (C140-C146).

Analysis also revealed that CPT1's session contained a theme of difficulty trusting others. For example, while the client was discussing difficulty accepting help from her boyfriend she stated,

> And then it's kinda like with him, it would always be like, I'm gonna take care of it,
>
> cause I don't want y'all saying nothing, you know I don't owe you nothing, [client
>
> motions hand back and forth] I don't even want to get into a position where you're
>
> doing stuff for me, and I gotta owe you something [therapist nods head] Nope, I got
>
> it[client motions hand back and forth and shakes head] if I ain't got it, I don't need it.
>
> You know, it's just that, like I feel [client motions towards self] more comfortable taking
>
> care of them [client motions hand away from her body] because that way, it's, to me

173

it's equal, like I don't have to worry about you owing nothing, because I'm doing

everything, you know what I'm saying? (Transcript 1, C85)

Later in the session, the client stated,

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, [therapist nods

head] therefore don't anything for me when I ask you [client makes sweeping motion

with one hand across the other palm]. (Transcript 1, C102)

CPT1 reported that her uncle would buy her lunch and tell her she "owed" him before he

molested her. Consequently, she described that this experience shaped her beliefs about

accepting help from others since it was associated with having to "owe" someone something.

The client's statements suggest that while she was growing up, she protected herself by trying to

be independent in order to avoid relying on others. When taken in this context, acknowledging

the receipt of a benefit and expressing gratitude may cause the client to feel as if there is a shift

in power, which would likely contribute to her feeling indebted to the benefactor. The client's

avoidance of relying on others is demonstrated by the following statement,

Yeah, cause even after it took, [client makes circle motion with hand] like I was with him

for seven years, it took a long time for me to accept help or to accept something, even

kind of with him, he'll be like why didn't you tell me you wanted to eat? [therapist nods

head] why didn't you tell me? And I'd be like, I'll let it be like the last straw [client

makes motion with hands emphasizing "last straw"] [therapist nods head] You know, and

not to mention that I'm hurt, whereas kind of like anybody whose offering help wants

something. (Transcript 1, C99)

Additionally, CPT1 also discussed feelings of jealousy towards her significant others' child. Her statements also included themes of feeling put down (e.g., "And I'm like ok thanks, you make me feel great [client chuckles] Like you gonna tell the five year old now so she can laugh too?" (Session 1, C302), and expressions of the converse of gratitude (*n*=3) by using words such as "unfortunately" or "unlucky." According to McCullough et al. (2002), gratitude is contradictory with negative emotions. Furthermore, gratitude may decrease or inhibit emotions of greed, jealousy, anger and bitterness (McCullough et al., 2002), which could be a potential reason why the client is experiencing a negative state, along with previous abuse and its impact on the client's interpersonal relationships.

Benefits received from an object. The final G-NOS theme highlights a need for the literature to expand its focus beyond gratitude that occurs toward an object generally, and examine gratitude for benefits received from an object. Some theorists have noted that gratitude can occur broadly towards an object. For example, Adler and Fagley (2005) referred to gratitude as "acknowledging the value and meaning of something—an event, a person, a behavior, an object—and feeling a positive emotional connection to it" (p. 81). However, research in this area has not yet examined narrow gratitude that can occur towards an object for benefits received, as the benefactor is typically referred to as a person in the literature. Thus, during session 2, when the client stated,

> I don't see things until they are [using right hand to show distance] this close to me and then it is too late for to me to stop my momentum. Cause um with my legs braces [client extends right leg and is looking down, semi lifts right pant leg, touching leg brace. These have been a lifesaver for me. (Transcript 2, C96)

This statement represented a unique finding, as all statements that included gratitude for benefits received were directed towards a specific individual, rather than an object.

Statements That Were Close to Gratitude

Throughout the coding process, three statements were identified in sessions 1 and 2 that were close to and/or related with gratitude but were not coded. This finding illustrated the need for the literature to expand its focus beyond typical gratitude words (e.g., grateful, thankful, fortunate). For example, during session 1, when the therapist and client were playing a feeling game, the game prompted the client through the following statement, "If you feel peaceful now, relax". (C316). The client then discusses how she recently got paid, which alleviated some of her financial concerns, "I mean like we've been like barely, barely, barely making it." "So yes, I feel peaceful today, I got paid, I got money" (C318-319).The client's statements indicate that she felt relived since she got paid that day. Although research on different words that may indicate gratitude is limited, Lambert and colleagues (2009) conducted two studies which asked participants to list the attributes that they think of when they consider the word gratitude. Results indicated that emotions such as, "warm feeling, peacefulness, or happy feeling", were frequently listed (p. 1196). Furthermore, 4.40% of participants rated peacefulness as a central attribute of gratitude (mean centrality rating = 6.19).

Another example occurred in Session 2 when the client was discussing her leg braces and stated,

> …I was thrilled. Because, they made such a difference, as soon as I put them on. To me, they [client looks up and to the side] gave me a real sense of security. A real sense of balance. Of safety. I was standing taller. I wasn't, before I had them, if I was standing talking to somebody, I always had a hand on the wall [extends right arm to the right side]

or a chair or something to make sure I was steady. And these I didn't. I still have my

wobbly days, as I call them. But most days I [client shaking head] don't. And um, I didn't

care [client shaking head and raises eyebrows] what people thought. What it, you know,

was like. So what- but I always wear pants. (Transcript 2, C100)

As previously discussed, CPT2 made a statement about her leg braces being a "lifesaver," which

was coded as a gratitude statement in NOS. Examining what emerged prior to the statement

listed above can also shed light on the client's discussion of the benefits she received from her

leg braces, and indicated that her use of the word "thrilled" may be related to gratitude. In the

aforementioned study by Lambert and colleagues (2009), 4.40% of participants rated enthusiasm

as being a central feature of gratitude (mean=6.19).

In sum, these findings illustrate the importance of expanding research to explore how

different populations may express and perceive gratitude. These findings also suggest that

individuals perceive gratitude as having central attributes that may not necessarily be a gratitude

related word. Taken in this context, it can be reasonably assumed that the words individuals use

to express gratitude depends on which attributes they perceive to be central to gratitude.

Expressions of personal gratitude. Expressions of personal gratitude were the 2nd most

frequently coded type of gratitude and occurred in response to material and nonmaterial benefits

received. For example, five personal gratitude statements occurred as a result of social

pleasantries that were prompted by the therapist (e.g., thanking the therapist for a compliment,

wishing the client a happy holiday; TD=2; NTD=3). One personal gratitude statement occurred

in response to the therapist providing the student with a material object (a pen; NTD=1).

Gratitude for benefits related with the session were also identified (i.e., thanking the

therapist for ending the session early for another appointment and thanking the therapist for

attempting to lower the therapy fee) (NTD=2). All personal gratitude expressions were directed towards the therapist across sessions 2, 3, and 4. Of these three client-participants, CPT4's expressions of personal gratitude accounted for 62.5% of all GN-1 codes (See Expressions of Personal Gratitude in results section for comparisons of this code during TD vs. NTD discussions).

Several personal gratitude expressions were prompted by the therapist and included social pleasantries. For example, at the end of Session 4 during a NTD, the therapist let the client know that she will try her best to lower her therapy fee, to which the client responded "okay, awesome. Okay, next Thursday at noon. Thank you very much" (C183). During a NTD in CPT4's session, the therapist provided the client with a compliment regarding her daughter and stated "...oh is she beautiful what's her name?" (T19), to which the client responded, "thank you her name is Sara [pseudonym was used to protect confidentiality]" (C20). It is difficult to compare these findings to the literature as there is a lack of research on how personal gratitude is expressed in therapy towards therapists. However, some studies have examined clients' behavioral expressions of personal gratitude, such as giving therapists gifts in session. While gift giving may be perceived as gratitude reciprocity, it is also related to personal gratitude since a gift can be a way of saying thanks to the benefactor for benefits received. Research has demonstrated that while there may be a variety of reasons for giving gifts in therapy, many clients give therapists gifts as a sign of their gratitude and appreciation (Knox et al., 2003; Knox et al., 2009). It is possible that CPT4 had the most personal gratitude statements because of the therapist providing her both material and nonmaterial benefits throughout the session which triggered her gratitude (e.g., giving a compliment, giving her a pen, advocating for a lower fee etc.).

Across sessions, client-participant expressions of gratitude were more often coded as *Narrow* (GN; 13 codes) rather than *Broad* (GB; 1 code), and represented 50% of all coded client-participant expressions of gratitude. More specifically, GN-1 accounted for 31% (*n*=8) of all gratitude codes, while GB1 accounted for 3.85% (n=1) of all codes. As previously mentioned, no studies examining gratitude expression in the context of therapy have been conducted, and cannot serve as a means for comparison to this study. However, some research has been conducted which examined the types of gratitude a sample of undergraduate students typically expressed. Lambert and colleagues (2009) conducted two experiments during which participants were instructed to write a narrative about a recent gratitude experience. Results for both studies indicated that participants tended to express benefit-triggered gratitude more than generalized gratitude. Findings from the first study indicated that 58% of responses were benefit-triggered gratitude, 22% of responses were generalized gratitude, and 20% included both. Results from the second study indicated 53% were benefit triggered gratitude, 22% were generalized gratitude, and 25% included both. These results are similar to the current study since the client-participants tended to express gratitude in a narrow manner, rather than a broad manner, with 50% (n=13) of gratitude statements being categorized as narrow or benefit-triggered gratitude. Additionally, 3 of the NOS statements would have been coded as personal gratitude, if they had included a gratitude related word. However, the percentage of generalized gratitude expressions were significantly lower in the current study, with 3.85% (*n*=1) of the gratitude statements being categorized as generalized or broad gratitude.

As previously mentioned sessions 1 and 5 contained the least amount of gratitude codes and neither contained a GN-1 code. Since both sessions contained themes of having difficulty trusting and depending on others (See Expressions of Gratitude That Are Not Otherwise

Specified), it is possible that this was a barrier to feeling gratitude, particularly personal gratitude for benefits received from the therapist as that might contribute to feelings of owing the therapist or a misbalance in power. CP2's session contained 1 GN-1 code, however it is important to note that several of her NOS codes would have fit into the GN-1 category had they included a gratitude related word (C92 and C114). On the other hand, CPT4 contained the most GN-1 codes of all 5 sessions. One reason for this contrast may be that while CPT1 and CPT5 discussed difficulty trusting others, CPT4 noted that she does trust and rely on others for social support (as does CPT2), which could contribute to her ability to thank the therapist more readily. It is also important to take into consideration that CPT4's session was an intake session. Although this session occurred early in treatment, it contained the most gratitude expressions across all 5 sessions. This finding illustrates the importance of examining during which phase of treatment gratitude is most frequently expressed, and of expanding research to focus not only on gratitude interventions in therapy but how to facilitate gratitude for strengths the individual has during the intake session.

Gratitude for specific benefits received from a higher power. The final narrow gratitude theme was related to Gratitude for Specific Benefits Received from a Higher Power. Expressions of Gratitude for Specific Benefits Received from a Higher Power represented 19.23% (*n*=5) of all gratitude codes. Two of the three clients who identified as religious made at least one GN-2 expression during their sessions. Furthermore, GN-2 codes accounted for 33.33% of all TD codes (*n*=4) and 7.14% of all NTD codes (*n*=1) (See Expressions of Gratitude for Specific Benefits Received from a Higher Power in results section for comparisons of this code during TD vs. NTD discussions).

All expressions of gratitude for benefits received from a higher power occurred in sessions 3 and 5, with the majority of the GN-2 codes occurring in session 3 (4 of 5 codes). All of CPT3's GN-2 statements were coded exclusively during a trauma discussion. During this trauma discussion, the client discussed the previous abuse she experienced by her mother and grandmother and says "thank God" several times for benefits received such as not growing up with her family and not being like her family. CPT3 identified as being Christian and her expressions of gratitude for benefits received from God support the literature that asserts religion can be a significant factor of the meaning making process. Although these global beliefs and goals can be violated by stressful events, the majority of religions emphasize different ways of interpreting distress (Pargament, 1997; Park, 2005, as cited in Shaver & Mikulincer, 2012).

Furthermore, the client's religion may explain why all of her GN-2 statements occurred during a TD discussion as gratitude is a virtue emphasized repeatedly throughout religious texts and teachings, which assert that regardless of circumstance, individuals are supposed to maintain an awareness of benefits received from God and provide thanks to God for those gifts. This finding connects with Emmons' (2008) research that demonstrates individuals who report that they are religious or spiritual have an increased likelihood to experience more gratitude than individuals who report being neither religious nor spiritual.

A common theme emphasized in Christian teachings is the necessity to cultivate gratitude towards God despite adverse circumstances (Emmons, 2008). An example of a statement that was included in this category occurred during Session 3, when the client stated, "I think they all crazy and thanks God I didn't grow up with them"….. (Transcript 3, C168). Later in the session the client stated expressed GN-2 for being able to find the strength not to punch her mother during one of the times when she physically abused her, and stated,

I got so angry at [inaudible], I should punch her and then she punch me without a reason but then I'm like, no, thanks God I didn't, [T nods] I don't have that in my heart that I did it, you know... (Transcript 3, C233)

A nation-wide gratitude survey (Kaplan, 2012) that was conducted with 2,000 individuals (ages 18-65+), found that 63% of respondents who identified as "most religious" expressed gratitude on a regular basis, compared with 48% of respondents who did not identify as religious. This finding could explain a potential reason why CPT3 was the 2nd most frequently coded gratitude session (besides CPT2), and why the majority of the CPT3's gratitude expressions were directed towards God (66.67%).

During Session 5, the client's GN-2 statement occurred during a NTD. This coded statement occurred in the context of discussing the financial difficulties she and her husband have experienced and how it has contributed to a strain in their relationship. The client discussed how she had a conversation with her husband about paying the rent and that he understood her perspective about helping her with it. She stated, "And it was like light bulbs went off in his head and I said, 'thank you God' " (C108). The client's statement demonstrated that her husband understood her perspective regarding their financial difficulties, which she thanked God for. Although CPT5 identified as Protestant, it appears that she did not use GN-2 as frequently as CPT3. Additionally, CPT5'S GN-2 statement occurred during an NTD, while CPT3's GN-2 statements all occurred during a TD. One reason for the discrepancies may be that CPT5's religion was not a significant part of her meaning making, post-trauma recovery process or even the ways she typically expresses her beliefs, as it might have been for CPT3.

Finally, CPT1 identified as Christian; however, there were no GN-2 codes that occurred during her session. However as noted previously, CPT1's session also contained the least amount of

gratitude codes; hypothesis for this finding are discussed in the statements that convey insincere gratitude section.

Generalized gratitude as an attitude. This category was only coded one time, and as such was the least coded across all five sessions (GB-1, *n*=1). GB-1 represented 3.85% of all gratitude codes, and occurred during a NTD (7.14% of all NTD codes). The only code that was identified in this category across all sessions was generalized gratitude as an attitude (GB-1) . The statement that was coded as GB-1 was: "Yeah I always notice the little things and I always appreciate them" (C30).This statement illustrated that the client is referring to being grateful in most circumstances, which qualifies as an attitude, rather than a temporary state.

Upon intake, CPT5 was diagnosed with: PTSD, Depersonalization Disorder, and Dysthymic Disorder. Going by diagnosis alone, this finding that CPT5 expressed evidenced gratitude was inconsistent with the literature as previous research has suggested that individuals with dispositional gratitude are less likely to develop PTSD or disorders related with Depression (Frederickson et al., 2003; Kendler et al., 2003; Linley & Joseph, 2004; Kashdan et al., 2004). However, it is difficult to conclude that one phrase is indicative of a gratitude disposition, particularly given the fact that the researcher was not able to use typical measures that assess dispositional gratitude in addition to the coding manual (e.g., GQ-6, GAC, etc.) Although these self-report measures were not used, the client's expression of trait gratitude appeared to indicate one specific facet of dispositional gratitude, gratitude frequency (see Gratitude Broadly defined in literature review section).The client stated that her trait gratitude contributed to an outcome of her husband being "happy," suggesting that her tendency to "appreciate the little things" has improved her relationship. This finding is consistent with literature that indicates expressing

gratitude towards one's partner for benefits received can improve relationship satisfaction (Algoe et al., 2013).

Furthermore, the literature suggests that grateful people are more likely to seek social support from others as a way of coping (Wood et al., 2007). However, as previously noted, CPT5 discussed how her trauma history has impacted her ability to trust and depend on others (see Expressions of Gratitude Not Otherwise Specified in the discussion section), which is consistent with the previously cited literature demonstrates trauma survivors, particularly those who have suffered from previous sexual abuse have difficulty trusting others. With that said, the client is working on her relationship with her husband.

Themes that emerged from the coding process. Although this study's aim was to examine client expressions of gratitude, three themes falling outside of this category were identified during the coding process. They are discussed next.

Therapist prompts for client gratitude expressions. The first theme that emerged from the findings was comments or questions expressed by the therapist that prompted the client's gratitude expression (occurring in sessions 3, 4, and 5). A total of 9 statements were identified that included therapist statements or questions which prompted client expressions of gratitude. Five such statements were identified in sessions included social pleasantries and/or a compliment or praise towards the client (see Personal Gratitude in results section).

As previously discussed, CPT4's session was an intake session and contained the highest number of gratitude statements. Further examination of this session revealed that 57.14% ($n=4$) of these gratitude statements were prompted by the therapist. Research has demonstrated the importance of therapists obtaining information regarding their clients' social support system initially, in order to determine the availability of current social supports (Lukas, 1993). Consistent with these recommendations, Session 4 was an intake session, and the only session

184

during which the therapist asked specific questions about the client's current social support system and reflected about it with the client. As previously noted, CPT4's session contained the highest number of gratitude statements. The therapist's emphasis on the client's strong social support system appeared to prompt her to discuss and reflect about her gratitude for her social support, which suggests that the intake session may provide valuable opportunities for therapists to discuss and emphasize a client's current strengths (including social support) and how this may play a role in coping. Several times throughout Session 4 the therapist emphasized the client's strength of social support. For example, during the session the therapist stated, "so in there it seems to me on the one hand you have this incredible work this incredible pain this incredible anger but you have some wonderful support system" (T92) to which the client responded, "I'm blessed I'm blessed in that area" (C93). Later in the session, the therapist emphasized the client's support system again when she stated, "…well we have established that you have a phenomenal social support system (T155), to which the client responded, "yeah, I am actually meeting a girlfriend after this, this afternoon to, just as support for what I am going through today...so I do, I am blessed, very blessed there…" (C155).

Therapists also prompted clients' gratitude expression in non-intake sessions. For example, after CPT3's trauma discussion, the therapist stated, "… I just want to say I know it's really hard for you to talk about those things today [C wipes nose with tissue] and I'm really glad that you did and [C nods] I'm really proud of you for saying them (T263), which prompted the client's personal gratitude statement 'Thank you' " (C263).

The findings in this study indicated that two out of five therapists facilitated the client's gratitude in ways similar to gratitude interventions that are discussed in the literature.

While the therapist noted the significant difficulties and trauma CPT4 experienced, she also emphasized the strength of the client's social support system, which provided the foundation for her to discuss it in the context of a blessing. Similarly, a gratitude intervention that has been tested in the context of psychotherapy is "count your blessings" (Emmons, 2008; Seligman et al., 2005; Seligman, 2002). This exercise involves an individual reflecting about and writing blessings on a daily basis. Another example occurred during Session 5, when the client discussed her relationship with her husband, and the therapist asked, "What surprised you this week?" (T23), to which the client responded that he respected her space which he never used to do (previously quoted, C23-C26).The therapist's question (T23) caused the client to reflect about the changes her husband is making and the contrast with his previous behavior. Then the therapist directly asked the client "You told him you appreciated it?" (T30), to which the client confirmed that she did (previously quoted, C30). This is similar to the "Remember the Bad" exercise (Emmons, 2008) which involves the practice of recalling negative events and contrasting the past with how the individual is doing now in an effort to highlight his/her strengths. While Emmons (2008) discusses this exercise as a way for the individual to reflect about his/her own progress and ability to cope, the results from this study indicate that it can be a useful exercise for reflecting about a significant others' progress as well. Emmons (2008) further emphasizes this point by explaining that "when we remember how difficult life used to be and how far we have come, we set up an explicit contrast in our mind, and this contrast is fertile ground for gratefulness" (p. 191). Although no studies thus far have tested this intervention in the context of psychotherapy, this finding demonstrates potential benefits to therapists utilizing it in session.

Therapist expressions of gratitude. The second theme that emerged from the findings was the therapist's own expression of gratitude (*n*=4) which occurred in sessions 3 and 5. In contrast with the aforementioned theme, none of the therapist's gratitude statements that occurred in sessions 3 and 5 prompted a gratitude response. For example, when the client brought in an assignment the therapist had previously requested, the therapist expressed personal gratitude twice for the client completing the assignment in an organized manner, to which the client responded, "You're welcome" (C7). Towards the end of CPT5's session, following the client's trauma discussion, the therapist stated, "Well I wanted to thank you for sharing that with me" (T289), to which the client responded "yeah" (C289). One possible reason for none of the therapist's gratitude statements prompting the client's gratitude response might be that since CPT5 has difficulty trusting and depending on others (as previously discussed gratitude expressions not otherwise specified), that she may be less likely to express personal gratitude towards the therapist. Another example occurred during Session 3, when the therapist asked the client, "Do you think that, so it sounds like you're saying, so you're different from your family?" (T171) to which the client responded, "You know, thanks God, I think I am" (C171), which appeared to prompt the therapist to echo the client's gratitude statement in the following talk turn:

> You're saying that from your side, you recognize that you're different than your family, they're crazy, [T make air quotes around 'crazy'] sounds like, I mean not even in quotes, they sound crazy and they do terrible things and they think it's okay to hit their own children and you're, you say you're just not like that, you don't believe that way and thank God you don't… (Transcript 3, T181)

187

In this case, it appears that the client's own gratitude statement had prompted the therapist's gratitude statement rather than the converse being true.

Client expressions of other people's gratitude. A third theme that arose was the clients' expression of other peoples' gratitude, rather than their own, which occurred in sessions 1 and 4. For example, in Session 1, the client expressed a statement about her co-worker expressing gratitude towards her:

…"He's really nice and saying thank you and stuff, but it's too damn late [therapist nods head]. You've been pissing me off all day." (C373)

As previously discussed, CPT1's session contained the lowest amount of gratitude statements (n=2). The client's previous trauma history and difficulty trusting others (See Expressions of Gratitude That are Not Otherwise Specified) may have possibly impacted her ability to express sincere gratitude towards others and to experience the positive effects of receiving gratitude from others. The client's difficulty reciprocating her co-worker's gratitude is consistent with a study (Penn, Schoen, & Berland, 2012) that found individuals are less likely to express gratitude at work than other places. Furthermore, only 10% of participants from the study expressed gratitude towards their coworkers on a daily basis, while 60% reported that they either express gratitude at work once a year or never express gratitude at work.

Similarly, in Session 4, the client made a statement that conveyed another individual's gratitude expression when she stated, "you know I mean your dad's lucky he's alive it's because he's your father [client laughter] he's still alive kind of feeling is you know which is understandable" (C63). The client's statement indicated that her husband made a gratitude statement about the client's father since he was angry with him. Among the definitions in the coding manual for this study, this statement most closely resembles undeserved kindness (See

188

Coding Manual). However, since the client did not express this statement in relation with herself, a gratitude code was not assigned. This finding illustrates the need for the literature to expand its focus on individual expressions of gratitude to include expressions of other peoples' gratitude and assess individuals' reaction to these expressions.

Limitations

There were several limitations involved in the present study. First, the present study's use of a convenience sample of a small size reduced the generalizability of the results. Despite the researchers' attempts to use a culturally diverse sample, the small sample size only marginally represented populations that are culturally diverse, as the current study consisted solely of females. Also, the majority of the cases (4 out of 5) chosen for this study had a history of childhood sexual abuse, which restricted the range of traumatic events contained in the sample. Also, it is possible that clients who provided consent for their materials to be included in the research database might have varied from clients who did not provide consent since this study utilized a convenience sample. Similarly, clients who had a history of trauma may have been omitted from the sample because they did not report previous trauma on any of their written documents. However, the advantage of using qualitative methods for this study was that researchers were able to examine a vivid picture of each individual participant's experience through a detailed analysis, which can contribute to a deeper understanding of the multifaceted nature of gratitude expression in the context of psychotherapy by clients who are trauma survivors (Creswell, 1998; Merriam, 2002; Mertens, 2009).

The second set of limitations relates to the present study's topic. Since there is a lack of research that specifically examines expressions of gratitude in the context of psychotherapy, findings from the current study are difficult to compare with other studies. Information relating with the client's level of dispositional (trait) gratitude was unavailable since the data was

189

obtained from an archival database and there was no access to client-participants in order to administer gratitude measures that assess dispositional gratitude such as the GQ-6 and the GRAT. and/or interview participants . However, the qualitative methods used to analyze data for this study provided knowledge regarding the different types of gratitude expression communicated by trauma survivors without the typical limitations that are involved in the use of self-report questionnaires.

Third, researcher bias can occur as a result of a variety of factors such as personal beliefs and demographic variables (e.g., ethnicity; gender) that contribute to the manner in which the data is perceived and coded and as such may impact neutrality (Ahern, 1999; Hill et al., 1997). In order to reduce the likelihood that researcher biases would impact the coding process in the current study, the coding manual consisted of a thorough protocol and definitions which reduced the influence of these biases. The coders also regularly discussed any possible coding biases that could impact the coding procedure prior to submitting the codes to the auditor. Following this process, inter-rater reliability was in perfect agreement for the 26 gratitude codes identified in this study.

Fourth, the current study's use of a restrictive definition of gratitude presented some limitations. In order for statements to be assigned a gratitude code, a gratitude-related word was required. Accordingly, another limitation of the current study is that client expressions of gratitude may be underrepresented as a result of using a more restrictive definition for gratitude. In order to account for verbal statements that appeared to convey gratitude without the use of a gratitude related word, the G-NOS/Other category was developed so that these statements were not excluded from the current study for examination.

Additionally, given the variety of different definitions of gratitude and the subjective process of coding, the items deemed relevant for coding sometimes overlapped in different categories. In order to prevent this overlap from affecting consistent and reliable coding, potential coding obstacles were tracked and discussed through the use of audit trail, until a code that was deemed to best fit the statement was assigned (Hsieh & Shannon, 2005).

The coding process highlighted a limitation of the coding manual in regards to the definition for GB-1. For example, there were two statements that indicated gratitude for multiple supports, generally. However, the definition for this code indicated "being grateful generally for something or someone" as described by Adler and Fagley (2005). Other researchers have expanded the definition of generalized gratitude to being grateful generally for multiple relationships rather than just one (Lambert et al., 2009; McCullough et al., 2002). Thus the coding manual could benefit from expanding this definition to be consistent with current literature.

A final identified limitation is that the exact timing of the chosen therapy sessions (e.g., whether it was the 5th of 8 sessions) were not known for client-participants 2 and 5. Since the level of gratitude may change during the course of therapy, having access to this information could have shed some light on the frequency rates of client gratitude expressions that occurred across all five therapy sessions. Furthermore, one out of the five psychotherapy sessions (Session 4) was an intake session, which might have impacted the manner in which the therapist facilitated the session and the higher rate of gratitude expression that occurred in this session, when compared with others. If all five sessions had been initial intake sessions, a deeper understanding about client expressions of gratitude that occur during intake sessions could have been obtained.

Contributions and Clinical Implications

Despite the numerous studies that have been conducted on trauma, there is limited research examining how gratitude is expressed in psychotherapy with those who have experienced trauma. Previous research on gratitude has been impacted by the significant overlap among the different definitions of gratitude. The current study examined gratitude expression by trauma survivors, particularly within the context of actual psychotherapy sessions, which has yet to be studied in the literature.

By developing an observational coding system for gratitude, this study contributed to the current gratitude assessment methods beyond the typical use of self-report measures, which often assess the four facets of one type of gratitude. Taking into account current and past literature that defines gratitude in many overlapping categories, the coding system attempted to not only synthesize areas of overlap, but also separate different aspects of gratitude to allow for a comprehensive understanding of the different types of gratitude, which is an area of research that is limited. As previously discussed the current study employed a coding system that required that all client expressions of gratitude required a gratitude related word in order to be coded (see Appendix C). The themes that emerged from the NOS category that could be used to create new codes include gratitude that occurs as a result of seeking or receiving social support from multiple people (which may include benefits received) without the use of a gratitude-related word, insincere gratitude, and gratitude for benefits received from an object. The coding system used in this study, or modified to include new specific codes, could potentially be utilized in future studies analyzing client expressions of gratitude as the coding system evidenced preliminary interrater reliability (K>.81 for all codes).

192

As discussed, a theme that emerged from the NOS category was gratitude occurred as a result of seeking or receiving social support from multiple people (which may include benefits received) without the use of a gratitude-related word. This finding provides support for expanding the literature's definition of personal gratitude to include multiple benefactors or to create a separate definition that adequately captures seeking and/or receiving social support from one or more persons (which may include benefits received). Additionally, as previously discussed two statements that indicated gratitude for multiple supports generally were identified during the coding process; however, they were not coded because the definition for the GB-1 code indicated "being grateful generally for something or someone" as described by Adler and Fagley (2005). Other researchers have expanded the definition of generalized gratitude to being grateful generally for multiple relationships rather than just one (Lambert et al., 2009; McCullough et al., 2002); thus, the coding manual could benefit from expanding this definition to be consistent with current literature.

This study also found that gratitude for benefits received was related with mixed feelings such as guilt or obligation for 2 out of 5 clients. This finding has clinical implications as it can help therapists develop awareness about the negative or mixed feelings that may be related with gratitude, so that they can better process such emotions with clients in session. .

The current study also found that of the three clients who identified as religious, two of them expressed gratitude for specific benefits received from a higher power. This finding is consistent with literature that demonstrated how religiosity and gratitude are correlated with one another (McCullough et al., 2002). Yet, not all clients who identify as religious will spontaneously express gratitude, as occurred in the present study. These results suggest that

therapists who wish to facilitate gratitude in session should take a client's level of religiosity or spirituality into account.

Although this study primarily examined client expressions gratitude, other themes were noted throughout the coding process. The findings indicated that three statements included client expressions of other peoples' gratitude rather than their own. Further analysis revealed 2 of the 5 therapists expressed gratitude in session with clients. Additionally, results indicated that 2 of the 5 therapists facilitated the client's gratitude in ways similar to gratitude interventions that are discussed in the literature. These findings suggest that although gratitude interventions are not considered standard practice in therapy, some therapists are not only facilitating gratitude in session, but also expressing gratitude.

This study also has clinical implications as many student therapists or licensed professionals may not be aware of biases they may have about gratitude and/or how to facilitate gratitude, or even that they are doing facilitating gratitude in session unintentionally. By demonstrating to what degree gratitude is incorporated into psychotherapy as usual with clients who have experienced trauma, the results of this study can be used as a baseline from which to compare results of future studies that might test the effects of training therapists about gratitude interventions. This study may also help therapists develop awareness about and a deeper understanding of a character strength that may emerge as a result of clients' struggle with trauma. Informed by this knowledge, therapists might be encouraged to consider how they could potentially use gratitude in future assessment and treatment.

Directions for Future Research

For the purpose of obtaining a comprehensive understanding of the multidimensional nature of gratitude and how it may be expressed in therapy, directions for future research in

several domains are discussed. First, literature should continue to expand its focus on defining the different types of gratitude. Thus far, research conducted on gratitude expressions has typically required the use of a gratitude related word such as "thank you" or "blessed." Because this study demonstrated that there are certain words or metaphors outside of typical gratitude words that may also indicate gratitude, future research should examine words or affect terms that are similar or related to gratitude by a using a coding system that captures and tracks such terms and also utilizes self-report measures to assess the individual's level of trait gratitude.

This study also highlights a need for research to be conducted with trauma survivors as well as different populations in the context of actual psychotherapy sessions using a coding system similar to the one used in this study in order to gain further clarification on the different types of gratitude that were found in the current study, as well as codes that were not identified (e.g., transpersonal codes or subcodes and gratitude outcomes codes or subcodes), in addition to further analysis of the patterns that were identified within the NOS category.

Furthermore, it would be beneficial to utilize typical gratitude measures such as the GQ and the GRAT during such research, as researchers would be able to examine whether frequency and type of gratitude expressions occurring in sessions are correlated with these self-report measures.

Since the results from the current study were derived from five participants, future research may benefit from using a larger range of culturally diverse participants with varied trauma histories. A larger sample would allow for a more comprehensive understanding of the differences in gratitude expression according to the type of trauma clients have experienced as well as the cultural differences related with the type and frequency of gratitude expressed (e.g., ethnicity, gender, religion). Furthermore, a larger sample would provide the opportunity for

195

researchers to examine a range of therapist demographic variables such as willingness to facilitate gratitude, theoretical orientation, age, and gender. Additionally, a more in-depth analysis of frequency of gratitude expressions that occur during specific treatment duration (e.g., intake, mid-treatment, termination) would be possible with a larger sample. Thus, future research could compare the different types and frequencies of gratitude expression during different time periods in therapy.

Given the patterns of social support as well as benefits received from multiple benefactors that emerged from this study, findings suggest that expanding the definition of personal or benefit-triggered gratitude to include gratitude towards multiple benefactors rather than just one would be beneficial. However, while this modified definition would capture benefits received from multiple social supports, it would not capture gratitude occurring as a result of receiving or seeking social support without benefits. Given this pattern, it appears that a code that specifically addresses gratitude related with seeking and/or receiving social support from 1 or more individuals would be beneficial; however, the relationship between the role of social support and gratitude constructs needs further clarification.

Furthermore, the results indicated receiving benefits does not necessarily prompt gratitude, and that if it does, the gratitude an individual experiences may be related with mixed or negative feelings. While research has suggested that receiving benefits can be related with feelings of indebtedness or obligation due to perceived expectation of the benefactor, this study found that these feelings can occur even if the beneficiary perceives that others do not expect reciprocation. This finding suggests that future research should examine the mixed feelings including guilt or obligation that may arise as a result of benefits received, regardless of perceived expectation of the benefactor.

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APPENDIX A

Participant Selection Tracking Sheet (SAMPLE)

APPENDIX A

Participant Selection Tracking Sheet (SAMPLE)

Research ID	Total # of Sessions	Experience of Trauma (Ct Info-Adult Form; Intake; Tx Summary; Phone Intake)	Death/Loss; SA; PA; Rape/Sexual Assault; Illness/Injury/Disability; Culturally-based trauma	Trauma Discussion Session #	Other Demographic Factors

APPENDIX B

Therapist Consent Form

Therapist Consent Form

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

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.

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.

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 <u>do not</u> wish to have <u>any/all</u> of the above information included in the Research Database. _____

<u>Please choose from the following options by placing your initials on the lines.</u>

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

     OR

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

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

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.

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.

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

236

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).

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.

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.

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.

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

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

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.

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

_____   _____

Participant's signature   Date

_____

Participant's name (printed)

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

_____   _____

 Researcher/Assistant signature   Date

_____

 Researcher/Assistant name (printed)

APPENDIX C

Coding Manual

APPENDIX C

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). Krista Kircanski, Courtney Bancroft, and Roxanna Zarrabi will be using this data for their respective dissertations to gain a more in-depth understanding of how therapists who provide trauma treatment use self-disclosure, elicit gratitude and provide validation/invalidation with their clients. 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:
Review the list of pre-screened cases with transcribed sessions (those that have been used in former PARC research teams) for the following inclusion criteria: individual therapy clients who are over 18 and English-speaking; clients who reported experiencing a traumatic event(s) or experience(s); those who had at least one videotaped session in which a trauma discussion occurred. Discussions of trauma will be defined as a first-time or repeated verbal expression expressions by the client that is comprised of any of the following: (1) explanation of a traumatic event, the decision to discuss trauma, and the consequences (positive or negative) of disclosing the trauma (2) thoughts or perceptions regarding the traumatic event, the decision to discuss trauma, and the results of discussing the trauma (e.g., positive and/or negative thoughts, beliefs or attitudes); and (3) emotions related with the traumatic event, the decision to discuss the trauma and the results of discussing the trauma (e.g., positive and/or negative emotions about the trauma experience) (Chaudoir & Fisher, 2010; Chelune 1979; Jourard, 1971; Pennebacker, Zech, & Rime, 2001). As described in the literature review, the definition of a traumatic event was based on current DSM-5 (APA, 2013) criteria, as well as cultural recommendations and complex trauma:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) directly witnessing the traumatic event(s); 2) witnessing, in person, the event(s) as it occurred to others; 3) learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; and 4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to

details of child abuse; note: this criterion does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related; p. 271).

The individual who experienced the trauma must have done so in a direct manner, either by witnessing or experiencing it. 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 included forms of trauma related to cultural or race-based factors (e.g., hate crimes involving threatened or actual assault) as well as complex trauma resulting from repeated traumatic events such as childhood physical or sexual abuse, domestic violence, and multiple traumatic events that have accumulated over a person's lifetime.

Step 2:
In the case that at least five sessions from the pre-screened cases are not appropriate for the present study, researchers will obtain a complete list of research record numbers of all de-identified clients and screen the existing database for cases that identify trauma within the written intake materials.
Researchers will use several data instruments located in the de-identified research files to assess for the occurrence of a traumatic event. The researchers will first look at the information presented on the Client Information Adult Form (Appendix F). In this section, the client is asked to mark off "Which of the following family members, including yourself, struggled with," and is provided with a comprehensive list of distressing and potentially traumatic situations. These include, but are not limited to, death and loss, sexual abuse, physical abuse, and debilitating illness or disability. The researchers will look to see if the client marked "Yes - This Happened" in the "Self" column for the aforementioned stressors. Additional information from the Telephone Intake Form (Appendix G), the Intake Evaluation Summary (Appendix H), and the Treatment Summary (Appendix I) will also be used to determine whether clients have experienced trauma.

Step 3: .
 Further narrow the sample to include only those who have at least one videotaped session in which a trauma discussion occurred. Discussions of trauma will be defined as a first-time or repeated verbal expression expressions by the client that is comprised of any of the following: (1) explanation of a traumatic event, the decision to discuss trauma, and the consequences (positive or negative) of disclosing the trauma (2) thoughts or perceptions regarding the traumatic event, the decision to discuss trauma, and the results of discussing the trauma (e.g., positive and/or negative thoughts, beliefs or attitudes); and (3) emotions related with the traumatic event, the decision to discuss the trauma and the results of discussing the trauma (e.g., positive and/or negative emotions about the trauma experience) (Chaudoir & Fisher, 2010; Chelune 1979; Jourard, 1971; Pennebacker, Zech, & Rime, 2001).

There may be several sessions where trauma disclosures occur, but for the purposes of this dissertation, only one will be selected for examination and transcription. The session that is ultimately selected will be the one that includes a trauma discussion that occurs for the longest

amount of time, when compared with the others. This session will be transcribed and then coded and analyzed. The purpose of this proposed method is to increase the likelihood of coding statements involving different types of gratitude. For example, gratitude for specific benefits received from a higher power (GN-2) and gratitude outcomes (GN-3) may be disclosed when discussing religion and social support as forms of coping during intake sessions. Codes that may be more likely to occur in later sessions include personal gratitude statements (GN-1) as the therapeutic alliance is strengthened and may result in a gratitude outcome (GN-3) such as the client giving the therapist a gift as termination nears. Additionally, as therapy progresses it is likely that the therapist will highlight the client's strengths by comparing the client's current progress with his/her earlier functioning; an intervention similar to the "remember the bad" gratitude exercise Emmons (2008) indicates the "remember the bad" exercise can contribute to an individual experiencing gratitude for being able to cope with a difficult situation. Lastly, if the client is able to perceive benefits posttrauma, it is a process that will take time and is more likely to occur in later sessions.

Step 4.
Of these participants, specific client characteristics and demographics will be analyzed in order to obtain a diverse sample (see Appendix A). 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 selected sessions will be transcribed and the entire session will be coded.

II. CODING OVERVIEW

The second step of the process involves the researcher-participants engaging in the coding processes, specifically for A. gratitude, B. expressions of self-disclosure, and C. validation/invalidation. Operational definitions and relevant codes are discussed in this section.

A. Gratitude
For the purposes of this study, gratitude is defined as a broad trait (i.e., gratitude experienced generally for something or someone , God or higher power, life or nature, not directed towards a specific individual) or as a narrow cognitive-emotional state experienced specifically (i.e., directed toward particular individuals, God, or a higher power for benefits received, which may manifest in a desire to engage in reciprocity behavior or in altruistic behavior that is motivated by benefits received but is not directed towards the benefactor. Two general categories were created: 1. *Gratitude as a broad, general tendency or trait* (**Code GB**) is operationally defined as a general tendency and characteristic of an individual to approach and respond to most circumstances with appreciation and thankfulness, and 2. *Gratitude as a narrow state* (**GN**) refers to gratitude as a state, emotion, and mood that arises temporarily as a response to receiving gifts or benefits (material or nonmaterial) from a specific person.

To assess gratitude in the context of recorded and transcribed psychotherapy sessions, only verbal expressions of gratitude will be examined. Words that are typically used to signify gratitude include grateful, fortunate, thankful, lucky, blessed and appreciative, and will be required to code for the categories described below (with the exception of G-NOS/OTHER). A G-NOS/Other code will be assigned for statements in which the client uses a gratitude word that does not convey sincere gratitude (e.g., "I should be feeling appreciative, but I'm not") or its opposite/converse (e.g., "unlucky", "unfortunate").In addition, words that describe a desire to reciprocate include but are not limited to: repay, reciprocate, and owe and will be coded accordingly. Coders should carefully consider whether a word that indicates reciprocation should be given a reciprocation code, given the context in which it is discussed (e.g., "My gratitude for the favor you did for me does not mean that I owe you.")

Client Expressions of *Gratitude as a Broad, General Tendency or Trait* (Code GB)

Codes *Gratitude as a broad, general tendency or trait* (Code GB)	Description	Examples
Generalized gratitude as an attitude (GB-1)	Generalized gratitude is referred to as a component of trait or dispositional gratitude and is an attitude towards life that indicates being grateful in most circumstances and/or displaying a tendency to be grateful generally for something or someone.	C: "I am so grateful for my mother, she is amazing," C: "I always appreciate the little things."
Transpersonal gratitude (GB-2)	Transpersonal or universal gratitude typically results from peak experiences that can include nature or spirituality and are typically characterized by a sense of undeserved kindness	C: "It took a long time for me to acknowledge my higher power in AA, but I'm so glad/thankful I got there;"
Subcode: Undeserved kindness (GB-2u)	Subcode GB-2u: This subcode will be given when client expressions of gratitude include a sense of undeserved kindness.	C:"During the trip I felt overwhelmed by thankfulness that I had the opportunity to enjoy all these wonderful things without even deserving too."
Subcode: Gratitude for the	The subcode GB-2p will be	C: "I am grateful for this

243

present moment (GB-2p)	used when the client expresses gratitude for the present moment.	present moment right now."

Client Expressions of *Gratitude as a Narrow State (GN)*

Codes *Gratitude as a narrow state (GN).*	Description	Examples
Personal gratitude (GN-1)	Personal gratitude is defined as thankfulness towards another person for the benefit (material or nonmaterial) he/she has given to this person.	Example: "I feel blessed that Martha wrote that letter of recommendation for me." Example: "Thank you."
Gratitude for specific benefits received from a higher power (GN-2).	Personal gratitude towards God or another higher power.	Example: "God has provided me with a wonderful social support system, for which I am so grateful."
Gratitude outcomes (GN-3)	Gratitude outcomes include results that occur after gratitude experiences or practices. These results may include: 1)an individual's desire to engage in reciprocity or helping behavior as a result of benefits received, and/or 2) an individual's desire to engage in altruistic behavior (not directed towards the benefactor), as a result of benefits received, as well as 3) changed perceptions of self and others in regards to skills developed as a result of adversity and/or as a result of enduring adversity.	Example of GN-3: "When I end my day by counting my blessings, I fall asleep so quickly and feel thankful and peaceful." Example involving subcodes: "I've realized after the loss I experienced that people can be relied on for support, which has made me grateful and has motivated me to return the favor by supporting others when they need somebody to talk to."
Reciprocation (Secular) (GN-3-RECIP).	GN-3-RECIP: This code will be given when the client expresses gratitude towards the benefactor for a benefit	Example: "I'm so grateful that Emily spent hours helping me with my homework, so I'm going to

	received as well as a desire to engage in reciprocity behavior.	repay her by bringing her favorite dessert to school."
Prosocial Behavior GN-3-PROSOC	GN-3-PROSOC: This code will be given when the client expresses gratitude for benefits received as a motivator for altruistic behavior (e.g., offering emotional support to others, helping others with personal problems), that is not directed towards the benefactor.	Example: "I am so thankful for the support my therapist has given me that it motivated me to volunteer at a crisis hotline so I can help others in need."
Changed perceptions of self and others (GN-3-POS).	GN-3-POS: This code will be given when the client expresses gratitude that is a result of changed perceptions of self and others in regards to skills developed as a result of adversity and/or as a result of enduring adversity.	Example: "The divorce was very difficult but without it I would have never realized how strong I am on my own, so I'm thankful for that."

Client Expressions of Gratitude That Are Not Otherwise Specified

Codes	Description	Examples
Gratitude expressions that are not otherwise specified (Code G-NOS/OTHER)	Expressions of gratitude that do not include a gratitude related word and/or are not included in any of the aforementioned categories.	Example: "Steve was able to talk with his employer and get me an interview at ABC. I really want him to know how much that meant to me, so I'm going to take him out to dinner this week." Example: "He told me I looked thin and I thought gee thanks, what did I look like before?"

A. Self-disclosure

For the purposes of this study, self-disclosure is defined as verbal statements (non-verbal cues are not coded) through which therapists intentionally communicate information about themselves to their clients (Hill & Knox, 2002) in two main categories: 1) self-disclosing statements, factual statements, and personal disclosures (SDIS) that can further be divided into consistent and inconsistent subcategories, and 2) self-involving or immediacy statements (SINV), resulting in the following classification categories: SDIS-CON: Self-disclosing consistent statements (reciprocal statements made by the therapist that are neither demographic nor personal in nature but are consistent with or is linked to the client's verbalization), SDIS-INC: Self-disclosing inconsistent statements (reciprocal statements made by the therapist that are neither demographic nor personal in nature and are inconsistent with the client's verbalization), SINV-PERS: Personal feelings, thoughts and reactions that arise in and about the therapy, and SINV-MIST: Therapist disclosures that involve any admission of a mistake by the therapist. In addition, a category of NOS/Other was created to capture statements that occur when the therapist makes a verbal statement that does not include demographic or personal information about the therapist and does not involve personal feelings/reactions to therapy nor admission of mistakes. The following coding system will be used to record trainee therapists' use of self-disclosure during the discussion of trauma in psychotherapy:

Demographic and Personal Therapist Expressions of Self-Disclosing Statements

Codes	*Demographic Disclosure* *(Code DEMO)*	*Personal Disclosure* *(Code PERS)*
	The therapist makes a verbal statement that includes demographic information (e.g., age, ethnicity, religious/spiritual affiliation, sexual orientation, marital status, professional credentials). Can be coded SDIS-DEMO alone if it is unclear whether the disclosure is consistent or inconsistent with the client's experience. Examples: "I'm in my third year in a doctoral program in clinical psychology." "I'm African American" [client's ethnicity in unknown]	The therapist makes a verbal statement that includes personal information (e.g., hobbies, leisure activities, trauma history, medical illness, death in family, personal discrimination, political beliefs, relationship history, experiences in the mental health field). Can be coded SDIS-PERS alone if it is unclear whether the disclosure is consistent or inconsistent with the client's experience." Examples: "I had to cancel our last session because my son was sick and I couldn't find a babysitter."

		"I saw that on the news."
Consistent Self-Disclosure (Code SDIS-CON)	*(Code SDIS-CON-DEMO)* The therapist makes a verbal statement of a demographic nature that is consistent with or is linked to the client's experience following the client's disclosure. CON would not be coded if the therapist disclosed first. Examples: "I'm also working on my doctorate." "I liken your experience in the army to mine with my children."	*(Code SDIS-CON-PERS)* The therapist makes a verbal statement of a personal nature that is consistent with or is linked to the client's experience following the client's disclosure. CON would not be disclosed if the therapist disclosed first. Example: "I felt some of the same things when I was going through a death in my family." "Your experience of camaraderie is deeply reminiscent of my bond with my siblings growing up."
Inconsistent Self-Disclosure (Code SDIS-INC)	*(Code SDIS-INC-DEMO)* The therapist makes a verbal statement of a demographic nature that is incongruous with the client's experience following the client's disclosure. INC would not be coded if the therapist disclosed first. Example: "No, I don't have kids [client has kids]."	*(Code SDIS-INC-PERS)* The therapist makes a verbal statement of a personal nature that is incongruous with the client's experience following the client's disclosure. INC would not be coded if the therapist disclosed first. Example: "I haven't struggled with drug addiction myself and can only imagine what you're going through."

Therapist Expressions of Personal Reactions and Mistakes

Codes	*Personal Reactions Disclosure* *(Code SINV-PERS)*	*Mistake Disclosure* *(Code SINV-MIST)*
	Personal feelings, thoughts and reactions that arise in and about the therapy that are complete and/or specific. Structural comments about the therapy process are coded here. "I," "we," and "me" are coded for in this category, but not "you" or therapy facilitatives.	Therapist disclosures that involve any admission of a mistake by the therapist.
		Example: "I made a mistake."
	Examples: "I'm struck about something you said."	
	"And, my gosh."	"I'm sorry for being late."
	"I'm feeling very hopeful about the plan we collaborated on."	"You're right, maybe I misunderstood what you were trying to tell me."
	"We've come a long way together."	
		"I was seriously only two minutes late."
	"I'm feeling sad as you tell me this."	
	"I'd like to hear more about that."	"Sorry about that."
	"I'm thinking about it this way, which maybe might make sense to you also."	
	"I love that idea."	

	"I wanted to give you the option of coming in two times a week."	
	"I know you like to help others"	
	"I see you brought something in today."	
	"I'm concerned about your lack of consistency in attending appointments."	
	"One thought I had was, going back to the strength thing… [thought is complete/specific]"	
	"I'm worried that you're not being honest with me."	
	"I'm very struck by the fact that you saw people get killed yet you feel very little emotion about it."	
	"I'm disappointed you didn't attend our last session."	
	"You're the most beautiful client."	

Therapist Expressions that are Not Otherwise Specified

Code	Description	Examples
Other Disclosure **(Code NOS/Other)**	The therapist makes a verbal statement that does not include demographic or personal information about the therapist and does not involve personal feelings/reactions to therapy nor admission of mistakes. "I," "we," and "me" are coded for in this category, but not "you" or general niceties (e.g., "Thank you."). Psychoeducation related to what has been gained through experiences in the mental health field could be coded here. For example, "You may experience flashbacks with PTSD." Additionally, self-involving statements that refer to the session structure can be coded here. For example, "I think we're out of time" and "We have two minutes left." Non-specific and/or incomplete verbal statements are coded here as well as therapy facilitatives (e.g., "I see," "I understand," and "Tell me about that")	T: "I'm just really hungry/thirsty." C: "Did you cut your hair recently? It looks different to me." T: "I cut it three weeks ago, actually." T: "I'm not saying let it all out at once…" T: "In that way, we can better help people around us." T: "That is so typical of what we see in clients who have experienced trauma." T: "Coz typically it's hard for people to overcome the PTSD without sharing their emotions and feeling them." T: "Could you turn your phone off? It's very distracting to me." T: "I see that you got a haircut." T: "I'm wondering if the journalist could trigger this is you because you

		don't have the camaraderie with that journalist?"
		T: "One thought I had was…. [thought is incomplete/non-specific]"
		T: "It's kind of like that I guess…"
		T: "I see."
		T: "I understand."
		T: "Tell me about that."

C. Positive/Negative/Neutral Responses to Trauma

The researcher-participants coded therapist-participant responses and reactions to a traumatic disclosure or discussion by the client-participant. For the purposes of this current dissertation, any verbalizations in reaction or response to a discussion of trauma (positive, negative or neutral) were coded and analyzed in the context of psychotherapy sessions, and were later separated by trauma discussion sections (TDS) or non trauma discussion sections (NTDS).

Responses and their definitions and examples are presented in the table below for the researcher-participant to use in coding the transcribed sessions. Given the complex nature of how an individual may respond to hearing about a traumatic event, codes were created based on extant research and include those responses that can be objectively measured via videotape/transcript. Therefore, the responses were coded as either (a) Positive Responses, (b) Negative Responses, or (c) Neutral Responses. More specifically, they were then coded into subcategories, as either (a) validating responses, (b), supportive responses, (c), empathic responses; (d) invalidating responses, (e) unsupportive responses, (f) unempathetic responses; (g) clarifying questions, or (h) summary/reflection statements. As responses were recorded, data was gathered by identifying the subcategories as certain types of examples, listed below in the tables. Furthermore, two types of adjunctive codes were added; (i) missed opportunities, (j) clinical responses.

Across all categories, + signs will be added as an addendum to each code represented below when there is a clear missed opportunity for a positive response (e.g., therapist changes the subject after client attempts to talk about or process trauma; or therapist focuses strictly on content after client expresses affect; etc.) Additionally, an * will be used for instances in which the therapist-participant uses clinical terminology or psychoeducation when speaking to the client about the traumatic event or presentation (e.g., recovery, symptom presentation, or treatment).

Positive Responses (Codes POS1, POS2, POS3)

Codes	Description	Example
Validating Responses *(POS1)*	Instances of the therapist-participant expressing a statement (not question) relating understanding and/or acceptance of a client's thoughts, feelings and behaviors related to the traumatic event. This includes the therapist expressing understanding/acceptance in the form of a reflective statement as well, as long as that reflection is deemed a "complex" reflection; as defined by either paraphrasing, which is when the clinician reflects the inferred meaning of a statement (meaning is added on to what was actually said by the client); or by reflection of feeling, which is when the clinician using paraphrasing to focus on the emotional aspect of the statement; both of which add new meaning to the client's statement, showing understanding and acceptance of the deeper meaning of what the client has said. [If both a "simple" reflection and validating response, only validating response would be coded, not NEU2- see NEU2	Understanding: C: [verbalizes feeling upset about traumatic event] T: "I understand how someone would be upset by that" Acceptance: T: "what you went through was difficult," Validation via Complex Reflection: C: Sometimes when I'm going about my day, it feels like I'm right back in that war zone. T: Even throughout a normal day, you might feel as unsafe as when you were at war and this can be very frightening for you.

	criterion]	
Supportive Responses *(POS2)*	Includes encouraging responses of the therapist-participant and/or those that advocate for and empower the client.	Encouraging: T: "I'm glad you're talking about this," "Go on," or "Tell me more" Advocacy/Empowerment: T: "You deserve to be at peace with this," or "You are very strong for having gotten through this"
Empathic Responses *(POS3)*	Those in which the therapist-participant verbalizes **using "I statements"** how s/he is able to imagine that s/he is the other person who has experienced the situation. Including; expressions related to personal disclosures by the therapist-participant regarding his ability to engage in the experience as if he actually had the feelings, thoughts, and behaviors of the survivor; and expressions related to the therapist inferring or imagining what it would be like to have had those thoughts, feelings, and behaviors of the survivor.	Feelings: T: "I would have been very afraid" Thoughts: T: "I would have been thinking the worst in that situation" "I could imagine that experience would have been difficult" Behaviors: T: "I would have wanted to run away" "I'd imagine that if I were in that situation, I would want to escape."

Negative Responses (Codes NEG1, NEG2, NEG3)

Codes	Description	Example
Invalidating Responses *(NEG1)*	Instances of the therapist-participant meeting the disclosure with an inappropriate, punishing, trivializing, or judgmental response, and/or meeting the disclosure with a dismissive response.	Inappropriate: C: [disclosure of trauma] T: "Oh wow, I've never worked with someone who has had such trauma!" Punishing/Trivializing/Judgmental: T: "Ugh! Why would you tell me that? You know I'm a mandated reporter!," "Well I mean that's bad but it's not the *worst* I've ever heard," or "I've never heard about anything like this happening to anyone but *you*, I wonder what that means" Dismissive: T: "That's not what we're talking about today, we are supposed to talk about your marriage" or changing the topic without being engaged or exploring/commenting further in that session
Unsupportive Responses *(NEG2)*	Includes responses in which the person exhibits disbelief over the traumatic event, belittles the client, or reacts with outrage or horror at the survivor, offender, or non-protective social supports of the survivor	Disbelief: T: "Did that really happen to you?" "That seems impossible" or " are you sure it happened the way you're remembering it?"

		Belittling the client:
		"You could have been such a better person if this didn't happen to you" or "You may never get over this"
		Outrage/horror at survivor:
		T: Therapist gasps aloud in reaction to traumatic disclosure
		Outrage/horror at offender: T: "I am so angry with the person who did that to you!"
		Outrage/horror at non-protective social supports:
		"How could your parents let this happen!? Clearly they are unfit parents!"
Umempathetic Responses (NEG3)	Instances in which the listener is either distracted while the client is speaking; or may be demanding of, or push expectations on, the survivor	Distracted: T: "What were you saying? I'm having a hard time paying attention"
		Demanding of survivor: T: "I know you said you're not ready to talk about it yet, but we're going to focus today's session on [material related to the traumatic event]," "It's about time you notify your family about this event," "You should really do X,Y, or Z to

255

		move on,"or "You really need to face the perpetrator of this right away"

Neutral Responses (Codes NEU1, NEU2)

Codes	Description	Example
Clarifying Questions *(NEU1)*	Instances of the therapist-participant asking questions (not statements as in POS1 Validation) to gather information or facts regarding the content of the traumatic event or about the client's affective experience.	T: "So what happened after the bomb went off?" "Were you injured badly?" "Who was the one who heard the gun shot?" "What were you feeling when that happened?"
Reflection/Summaries *(NEU2)*	Includes the therapist participant using "simple" reflective or summary statements that directly and concretely repeat back the content or affective experiences of the events that occurred in the client's recollection of the traumatic event or experience by either simply repeating one or more aspects of what is said, or changing one or more of the words used in a statement, but without adding any new meaning. The client's language is [often/always] used by the therapist when making these types of statements; not questions. Therapist stops at the reflection and	Simple Reflection: C: And I now become startled whenever I hear a loud noise. T: Hearing loud noises is startling/frightening for you. Summary: T: "So when you were in Afghanistan, you experienced XYZ within two months of arrival" "It seems like what you are saying is that first you saw the bomb go off, and after that you ran for cover, trying to survive…"

	does not delve further into suggested meanings of the statements to convey understanding/acceptance of the client's thoughts/feelings/behaviors as in POS1.	

APPENDIX D

Client Consent Form

APPENDIX D

Client Consent Form

Pepperdine University

Counseling and Educational Clinics

Consent for Services

INITIALS

Welcome to Pepperdine University's Counseling and Educational clinics. Please read this document carefully because it will help you make an informed decision about whether to seek services here. This form explains the kinds of services our clinic provides and the terms and conditions under which services are offered. Because our clinic complies with the Health Insurance Portability and Accountability Act (HIPAA; Appendix I), be sure to review the Privacy Rights pamphlet that was also given to you today. It is important that you understand the information presented in this form. If you have any questions, our staff will be happy to discuss them with you.

<u>Who We Are</u>: 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. _____

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

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

Psychological Assessment: The clinic provides psychological and psychoeducational assessments. These assessments may be initiated by you, your therapist or a third party. Assessment sessions are longer than therapy sessions and can take several hours to complete. The number of sessions required for conducting the assessment will be determined based on the nature and number of tests administered. You have the right to request a copy of your assessment report and test data. You also have the right to receive feedback regarding your assessment results. However, there are some situations in which we may not be able to release test results, including test data, to you: a) When such a disclosure may cause substantial harm or misuse of the test results and test data, and/or b) When you were notified and agreed in advance and in writing that the assessment was ordered and/or paid for by a third party and that we would release your results only to

that third party. The benefits of psychological assessment include a clearer understanding of your cognitive and emotional functioning. Although the risks of participating in a psychological assessment are generally no greater than the risks of counseling, test results may reveal information that may be painful and/or difficult to accept. If that is the case, we recommend that you review with the examiner options for addressing your concerns.

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

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

_____ Video/audiotaping

_____ Direct Observation

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

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

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

      _____   Written Data

      _____   Videotaped Data

      _____   Audiotaped Data

OR

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

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

programs.   _____

OR

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

programs.   _____

Fees: The fee for the initial intake is nonrefundable.

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

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

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

_____

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

_____

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

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

If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

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

_____

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

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

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

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

Treatment & Evaluation of Minors:

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

Over the age of 12, you can consent to services if you are mature enough to participate in services and you present a serious danger to yourself and/or others or you are the alleged victim of child physical and/or sexual abuse. In some circumstances, you may consent to alcohol and drug treatment.
Your parents or guardians may, by law, have access to your records, unless it is determined by the child's therapist that such access would have a detrimental effect on the therapist's professional relationship with the minor or if it jeopardizes the minor's physical and/or psychological well-being.

Parents or guardians will be provided with general information about treatment progress (e.g., attendance) and they will be notified if there is any concern that the minor is dangerous to himself and/or others. For minors over the age of 12, other communication will require the minor's authorization.

All disclosures to parents or guardians will be discussed with minors, and efforts will be made to discuss such information in advance.

_____

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

_____   and/or   _____

Signature of client, 18 or older   Signature of parent or guardian

(Or name of client, if a minor)

_____

Relationship to client

_____

Signature of parent or guardian

_____

Relationship to client

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

_____   _____

Clinic/Counseling Center   Translator

Representative/Witness

_____

Date of signing

APPENDIX E

HIPAA Certification

APPENDIX E

HIPAA Certification

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Certificate of Completion

This is to certify that

Roxana Zarrabi

_____

has completed the
HIPAA Training
on

Thursday, October 11, 2012
_____

Reference No: 118142

APPENDIX F

Client Information Adult Form

APPENDIX F

Client Information Adult Form

ID # _____

CLIENT INFORMATION **ADULT FORM

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

TODAY'S DATE_____

FULL

NAME_____

_____

HOW WOULD YOU PREFER TO BE

ADDRESSED?_____

___

REFERRED

BY:_____

_____

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

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

_____

_____

_____

Personal Data

ADDRESS:_____

_____

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

AGE: _____   DATE OF BIRTH ____/___/____ __

MARITAL STATUS:

☐ MARRIED   ☐ SINGLE   HOW LONG? _____

☐ DIVORCED   ☐ COHABITATING   PREVIOUS MARRIAGES? _____

☐ SEPARATED ☐ WIDOWED   HOW LONG SINCE DIVORCE? _____

LIST BELOW THE PEOPLE LIVING WITH YOU:

| NAME | RELATIONSHIP | AGE | OCCUPATION |

_____

_____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO _____

YOU:

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

_____

MEDICATIONS BEING TAKEN: _____

_____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE	HOSPITAL NAME	REASON	LENGTH OF STAY

_____

_____

_____

OTHER SERIOUS ILLNESSES

DATE	NATURE OF CONDITION	DURATION

_____

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHOLOGIST, PSYCHIATRIST, MARRIAGE COUNSELING, GROUP THERAPY, ETC.)

TYPE OF SERVICES	DESCRIBE PROBLEM	DURATION

DATE

_____

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

☐ ELEMENTARY/MIDDLE SCHOOL: LIST GRADE_____

☐ HIGH SCHOOL: LIST GRADE_____

☐ GED

☐ HS DIPLOMA

CURRENTLY IN SCHOOL?

☐ SCHOOL/LOCATION:

_____

☐ VOCATIONAL TRAINING: LIST TRADE

_____

☐ COLLEGE: LIST YEARS

_____

GRADUATE EDUCATION:

☐ LIST YEARS OR DEGREE

EARNED_____

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATES/DURATION

_____

_____

HOUSEHOLD

INCOME:

☐ UNDER
$10,000

$11,000-   OCCUPATION:_____
☐ 30,000   ___

$31,000-
☐ 50,000

$51,000-
☐ 75,000

OVER
☐ $75,000

Family Data

IS FATHER

LIVING?

YES ☐   IF YES, CURRENT AGE:

_____

RESIDENCE   _____   OCCUPATION: _____
(CITY):

HOW OFTEN DO YOU HAVE   _____

CONTACT?

NO ☐

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

AT DEATH: DEATH:

CAUSE OF   _____

DEATH:

IS MOTHER

LIVING?

YES ☐   IF YES, CURRENT AGE:

    _____

RESIDENCE   _____   OCCUPATION: _____

(CITY):

HOW OFTEN DO YOU HAVE   _____

CONTACT?

NO ☐

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

AT DEATH: 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 ANOITHER POINT. IF THE EXPERIENCE NEVER HAPPENED TO YOU OR SOMEONE IN YOUR FAMILY, PLEASE CHECK THE "NO" BOX. IF YOU ARE UNSURE WHETHER OR NOT THE EXPERIENCE OCCURRED FOR YOU OR IN YOUR FAMILY AT SOME TIME, PLEASE CHECK THE "UNSURE" BOX. IF THE EXPERIENCE HAPPENED TO YOU OR IN YOUR FAMILY AT ANY POINT, PLEASE CHECK THE "YES" BOX.

SELF   FAMILY

WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, *INCLUDING YOURSELF*, STRUGGLED WITH:

	SELF			FAMILY			PLEASE INDICATE WHICH FAMILY MEMBER(S)
	No- Never happened	Unsure	Yes- this happened	No- never happened	Unsure	Yes- this happened	
SEPARATION/DIVORCE	☐	☐	☐	☐	☐	☐	
FREQUENT RE-LOCATION	☐	☐	☐	☐	☐	☐	_____
EXTENDED UNEMPLOYMENT	☐	☐	☐	☐	☐	☐	_____
ADOPTION	☐	☐	☐	☐	☐	☐	_____
							_____

FOSTER CARE	☐	☐ ☐	☐ ☐ ☐	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	☐	☐ ☐	☐ ☐ ☐	_____
FINANCIAL STRAIN OR INSTABILITY	☐	☐ ☐	☐ ☐ ☐	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	☐	☐ ☐	☐ ☐ ☐	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	☐	☐ ☐	☐ ☐ ☐	_____
DEATH AND LOSS	☐	☐ ☐	☐ ☐ ☐	_____
ALCOHOL USE OR ABUSE	☐	☐ ☐	☐ ☐ ☐	_____
DRUG USE OR ABUSE	☐	☐ ☐	☐ ☐ ☐	_____
ADDICTIONS	☐	☐ ☐	☐ ☐ ☐	_____
SEXUAL ABUSE	☐	☐ ☐	☐ ☐ ☐	_____
PHYSICAL ABUSE	☐	☐ ☐	☐ ☐ ☐	_____
EMOTIONAL ABUSE	☐	☐ ☐	☐ ☐ ☐	_____
RAPE/SEXUAL ASSAULT	☐	☐ ☐	☐ ☐ ☐	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	☐	☐ ☐	☐ ☐ ☐	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	☐	☐ ☐	☐ ☐ ☐	_____

DIAGNOSED OR SUSPECTED MENTAL ILLNESS	☐	☐ ☐	☐ ☐ ☐			
SUICIDAL THOUGHTS OR ATTEMPTS	☐	☐ ☐	☐ ☐ ☐	_____		
SELF HARM (CUTTING, BURNING)	☐	☐ ☐	☐ ☐ ☐	_____		
DEBILITATING ILLNESS, INJURY, OR DISABILITY	☐	☐ ☐	☐ ☐ ☐	_____		
PROBLEMS WITH LEARNING	☐	☐ ☐	☐ ☐ ☐	_____		
ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	☐	☐ ☐	☐ ☐ ☐	_____		
FREQUENT FIGHTS AND ARGUMENTS	☐	☐ ☐	☐ ☐ ☐	_____		
INVOLVEMENT IN LEGAL SYSTEM	☐	☐ ☐	☐ ☐ ☐	_____		
CRIMINAL ACTIVITY	☐	☐ ☐	☐ ☐ ☐	_____		
INCARCERATION	☐	☐ ☐	☐ ☐ ☐	_____		
				_____		

Current Difficulties

PLEASE CHECK THE BOXES TO INDICATE WHICH OF THE FOLLOWING AREAS ARE CURRENT PROBLEMS FOR YOU AND REASONS FOR COUNSELING. PLACE <u>TWO</u> CHECK MARKS TO INDICATE THE MOST IMPORTANT REASON(S).

☐ FEELING NERVOUS OR ANXIOUS   ☐ DIFFICULTY WITH SCHOOL OR WORK

☐ UNDER PRESSURE & FEELING   ☐ CONCERNS ABOUT FINANCES

278

STRESSED

☐	NEEDING TO LEARN TO RELAX	☐	TROUBLE COMMUNICATING SOMETIMES
☐	AFRAID OF BEING ON YOUR OWN	☐	CONCERNS WITH WEIGHT OR BODY IMAGE
☐	FEELING ANGRY MUCH OF THE TIME	☐	FEELING PRESSURED BY OTHERS
☐	DIFFICULTY EXPRESSING EMOTIONS	☐	FEELING CONTROLLED/MANIPULATED
☐	FEELING INFERIOR TO OTHERS	☐	PRE-MARITAL COUNSELING
☐	LACKING SELF CONFIDENCE	☐	MARITAL PROBLEMS
☐	FEELING DOWN OR UNHAPPY	☐	FAMILY DIFFICULTIES
☐	FEELING LONELY	☐	DIFFICULTIES WITH CHILDREN
☐	EXPERIENCING GUILTY FEELINGS	☐	DIFFICULTY MAKING OR KEEPING FRIENDS
☐	FEELING DOWN ON YOURSELF	☐	BREAK-UP OF RELATIONSHIP
☐	THOUGHTS OF TAKING OWN LIFE	☐	DIFFICULTIES IN SEXUAL RELATIONSHIPS
☐	CONCERNS ABOUT EMOTIONAL STABILITY	☐	FEELING GUILTY ABOUT SEXUAL ACTIVITY
☐	FEELING CUT-OFF FROM YOUR EMOTIONS	☐	FEELING CONFLICTED ABOUT ATTRACTION TO MEMBERS OF SAME SEX
☐	WONDERING "WHO AM I?"	☐	FEELINGS RELATED TO HAVING BEEN ABUSED OR ASSAULTED

☐ HAVING DIFFICULTY BEING HONEST/OPEN

☐ CONCERNS ABOUT PHYSICAL HEALTH

☐ DIFFICULTY MAKING DECISIONS

☐ DIFFICULTIES WITH WEIGHT CONTROL

☐ FEELING CONFUSED MUCH OF THE TIME

☐ USE/ABUSE OF ALCOHOL OR DRUGS

☐ DIFFICULTY CONTROLLING YOUR THOUGHTS

☐ PROBLEMS ASSOCIATED WITH SEXUAL ORIENTATION

☐ BEING SUSPICIOUS OF OTHERS

☐ CONCERNS ABOUT HEARING VOICES OR SEEING THINGS

☐ GETTING INTO TROUBLE

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

_____

_____

Social/Cultural (Optional)

1. _____

RELIGION/SPIRITUALITY: _____

2. ETHNICITY OR RACE: _____
_____

3. DISABILITY STATUS? _____
_____

APPENDIX G

Telephone Intake Form

APPENDIX G

Telephone Intake Form

ID#_____

Pepperdine Community Counseling Center
Telephone Intake Interview

Caller Information

INTERVIEWER: _____ DATE OF TELEPHONE INTAKE: _____ TIME:_____

WHAT IS YOUR NAME?:_____

WHO IS THIS APPOINTMENT FOR?_____ ❑ M ❑ F DOB: _____ AGE: ____

_____ ❑ M ❑ F DOB: _____ AGE: ____

IF THE POTENTIAL CLIENT IS NOT THE CALLER, ASK, "WHAT IS YOUR RELATIONSHIP TO (CLIENT'S NAME)"?:_____

WHAT IS (CLIENT'S) ADDRESS?: _____

WHAT IS (CLIENT'S) PHONE NUMBER(S): _____(H)_____(W)_____(CELL OR PAGER)

IS IT OK THAT WE LEAVE A MESSAGE AT ANY OR ALL OF THE NUMBERS, IDENTIFYING OURSELVES AS BEING FROM THIS COUNSELING CENTER? ❑ Y ❑ N

HOW DID YOU HEAR ABOUT US? (LIST NAME AND NUMBER):_____

MAY WE CONTACT THEM TO THANK THEM FOR REFERRING YOU? ❑ Y ❑ N

WHO DOES (CLIENT) LIVE WITH? ❑ SELF ❑ OTHERS -

LIST:_____

DOES (CLIENT) HAVE CHILDREN?: _____

WHO IS INCLUDED IN (CLIENT'S) SUPPORT SYSTEM? _____

ADDRESS CONFIDENTIALITY AND LIMITS TO CONFIDENTIALITY BEFORE PROCEEDING WITH THE PHONE INTAKE:

"I'd like to find out about your situation and for what reason you're seeking help. This will help me figure out how our counseling center might be of assistance/service. But before we begin I need to explain about confidentiality and its limits. Here at the Pepperdine Counseling Center we pride ourselves on guarding our clients' privacy, and on creating an environment where people can feel comfortable about discussing very personal matters. With that said, we want you to know that everything you describe to me is confidential, however, if I begin to understand that your's or someone else's life is in danger, or when there are significant concerns about a child or elder person's safety, I may need to break that confidentiality and take steps to assure that everyone is safe. Do you have any questions about this?....if not, let's proceed"

Type of Service

What type of appointment is being requested? *Check all that apply*

❑ Therapy   ❑ Child   ❑ Individual

❑ Assessment   ❑ Adolescent   ❑ Couple (Ask if there has been any domestic violence)

❑ Don't know or unsure   ❑ Adult   ❑ Family

                   ❑ Don't know or unsure   ❑ Group

                                        ❑ Don't know or unsure

8/7/08   1

282

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

Reason for Referral

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ARE THERE ANY PAST OR CURRENT LEGAL PROBLEMS?: ☐ Y ☐ N _____

IS THERE A COURT ORDER THAT REQUIRES TREATMENT? ☐ Y ☐ N
FOR WHAT REASON?_____

    CLIENT TOLD LIMITS REGARDING COURT ORDERS? ☐ Y ☐ N

ARE THERE ANY PAST OR CURRENT DRUG AND/OR ALCOHOL PROBLEMS?: ☐ Y ☐ N

_____

ANY CURRENT THOUGHTS OF HURTING YOURSELF?: ☐ Y ☐ N _____

ANY PREVIOUS THOUGHTS OR ATTEMPTS AT HURTING YOURSELF?: ☐ Y ☐ N _____

  IF SO, WHEN WAS THE LAST TIME YOU *THOUGHT* ABOUT HURTING YOURSELF?: _____

    WHEN WAS THE LAST TIME YOU *ATTEMPTED* TO HURT YOURSELF?: _____

DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOU HAVE A "BAD TEMBER" OR THAT YOU GET MAD EASILY?: ☐ Y ☐ N

  IF SO, PLEASE PROVIDE EXAMPLES:_____

ANY PAST VIOLENCE TOWARDS OTHERS?: ☐ Y ☐ N _____

8/7/08 1

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

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

_____

_____

_____

_____

_____

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

    IF SO, LIST:_____

DO YOU HAVE ANY SCHEDULE CONSTRAINTS OR TIME/DAY

    REQUESTS?_____

_____

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

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

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

    IS THERE DOCUMENTATION AVAILABLE (IN CUSTODY PAPERS ABOUT WHO IS RESPONSIBLE FOR HEALTH CARE) THAT YOU CAN

    BRING TO THE INTAKE SESSION? ☐ Y ☐ N

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

WHO WILL BE BRINGING THE CHILD TO THE CLINIC?: _____

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

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY? ☐ Y ☐ N

Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL? ☐ Y ☐ N

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

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

        WHAT IS (CLIENT'S) OCCUPATION?:_____

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

Intake Interviewer Checklist

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

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

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

8/7/08   2

☐ I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT VIDEO AND SOMETIMES AUDIOTAPED SAMPLES OF THEIR SESSIONS DURING SUPERVISION.

☐ (PER CLINIC POLICY) I ASKED THE POTENTIAL CLIENT FOR PERMISSION TO HAVE THE INTAKE THERAPIST GIVE THEM A CALL PRIOR TO THE INTAKE SESSION

☐ I INFORMED THE POTENTIAL CLIENT THAT THE INTAKE SESSION IS 2.5 HOURS IN LENGTH AND THAT THIS SESSION HELPS THE THERAPIST AND HIS/HER SUPERVISOR GAIN A BETTER UNDERSTANDING OF THE POTENTIAL CLIENT'S PRESENTING PROBLEMS. GATHERING THE INFORMATION DURING THIS FIRST SESSION IS CRUCIAL FOR TREATMENT PLANNING. I ALSO INFORMED THE POTENTIAL CLIENT OF THE IMPORTANCE OF ARRIVING PROMPTLY FOR THE SESSION.

☐ I INFORMED THE POTENTIAL CLIENT THAT FOLLOWING THE INTAKE SESSION, THE THERAPIST WILL PROVIDE HIM/HER WITH FEEDBACK AND MAKE TREATMENT RECOMMENDATIONS WHICH MAY BE FOR CONTINUED TREATMENT IN OUR CLINIC OR MAY BE A REFERRAL TO ANOTHER CLINIC.

☐ I INFORMED THE CLIENT THAT THEIR PLACEMENT WITH A THERAPIST IS SOMEWHAT DEPENDENT ON THE POTENTIAL CLIENT'S TIME FLEXIBILITY.

☐ (PER CLINIC POLICY) I CREATED A CLIENT FILE AND PLACED THE TELEPHONE INTAKE INTERVIEW IN IT.

☐ (PER CLINIC POLICY) I PROVIDED THE CLINIC DIRECTOR WITH THE TELEPHONE INTAKE INTERVIEW.

☐ (PER CLINIC POLICY) I ASSIGNED THE POTENTIAL CLIENT TO A THERAPIST.
THERAPIST:_____

☐ I INFORMED THE POTENTIAL CLIENT ABOUT THE CLINIC LOCATION AND PARKING ARRANGEMENTS.

☐ I CONTACTED THE REFERRAL SOURCE AND THANKED THEM.

☐ (PER CLINIC POLICY) I SCHEDULED THE INTAKE SESSION.
DATE:_____
TIME:_____
THERAPIST:_____

sample

8/7/08   3

APPENDIX H

Intake Evaluation Summary

APPENDIX H

Intake Evaluation Summary

Pepperdine Psychological and Educational Clinic

Client: _____ Intake Therapist: _____

Intake Date(s): _____ Date of Report: _____

I   Identifying Information

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

II   Presenting Problem/Current Condition

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

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

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

IV   Psychosocial History

A   <u>Family History</u>

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

B   <u>Developmental History</u>

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

C   <u>Educational/Vocational History</u>

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

D   <u>Social Support/Relationships</u>

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

E   <u>Medical History</u>

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

F   <u>Cultural Factors and Role of Religion in the Client's Life</u>

(Cultural group identification/identity, acculturation issues relevant to presenting problems/therapy) (Religious affiliations, strength of commitment to and/or involvement in religion, view of spirituality and its role in emotional problems/suffering and intervention)

        G   <u>Legal History</u>

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

V   <u>Mental Status Evaluation</u>

<u>Hygiene & grooming</u>:

      <u>Interpersonal presentation/behavioral observations</u>:

<u>Orientation (person, place, time, situation)</u>:

      <u>Speech (pitch, pace, tone)</u>:

      <u>Motor Activity (calm, restless, agitated, retarded)</u>:

      <u>Mood (euthymic, dysphoric, elevated, irritable, anxious)</u>:

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

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

tangential):

Thought Content (appropriate; delusions; odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

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

VI   Client Strengths

(Intelligence, personality, internal resources, coping skills, support system, talents and abilities, motivation, education/vocational skills, health)

VII   Summary and Conceptualization

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

VIII   DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

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

Current GAF:

Highest GAF during the past year:

IX   Client Goals

X   Treatment Recommendations

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

_____   _____

Intake Therapist   Supervisor

_____

Date

APPENDIX I

Treatment Summary

Treatment Summary

TREATMENT SUMMARY

Identifying Information:

_____

_____

_____

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

_____

_____

_____

_____

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

_____

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_____

Revised 4-15-2009

Diagnosis at Termination:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

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

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
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_____
_____
_____
_____

_____   _____
Student Therapist   **Supervisor**

_____   _____
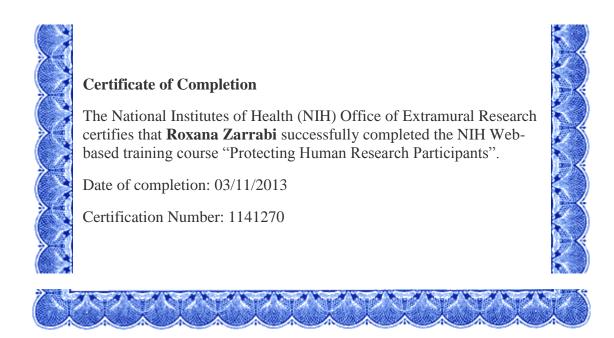**Date**   **Date**

Revised 4-15-2009

APPENDIX J

Protecting Human Research Participants Certificate

APPENDIX J

Protecting Human Research Participants Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Roxana Zarrabi** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 03/11/2013

Certification Number: 1141270

APPENDIX K

GPS IRB Approval Notice

APPENDIX K

GPS IRB Approval Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

July 1, 2013

Roxana Zarrabi

Protocol #: P0513D08
Project Title: Qualitative Analysis of Expressions of Gratitude in Clients Who Have Experienced Trauma

Dear Ms. Zarrabi,

Thank you for submitting your application, *Qualitative Analysis of Expressions of Gratitude in Clients Who Have Experienced Trauma*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Susan Hall, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 5 and 6) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Approval.** The IRB approval begins today, **July 1, 2013,** and terminates on **June 30, 2014**. In addition, your application to waive documentation of informed consent, as indicated in your **Application for Waiver or Alteration of Informed Consent Procedures** form has been **approved.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For *any* proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **June 30, 2014**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the

GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

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

Sincerely,

Doug Leigh, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Ms. Alexandra Roosa, Director Research and Sponsored Programs Dr.
Susan Hall, Graduate School of Education & Psychology