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Pepperdine University
Graduate School of Education and Psychology

THE USE OF EXPERIENTIAL ACCEPTANCE IN PSYCHOTHERAPY WITH EMERGING
ADULTS

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

by

Lauren Ford, MMFT

October, 2015

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

This clinical dissertation, written by:

Lauren Ford, MMFT

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 on the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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

Judy Ho, Ph.D.

Joan Rosenberg, Ph.D.

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VITA

EDUCATION

Doctor of Psychology in Clinical Psychology **May 2015**
Pepperdine University (APA Accredited)
Graduate School of Education and Psychology, Los Angeles, CA

Master of Marriage and Family Therapy **May 2011**
University of Southern California, Los Angeles, CA
Summa Cum Laude

Bachelor of Arts in Psychology **May 2009**
Minor: Nutrition and Health Promotion
University of Southern California, Los Angeles, CA
Cum Laude

SUPERVISED CLINICAL EXPERIENCE

Pre-Doctoral Intern
The Guidance Center (APA Accredited)
Long Beach, CA **September 2014-present**

- Conduct individual and family treatment to children, adolescents, parents, and families in multiple settings, such as within agency, in the home, and at school
- Conduct structured diagnostic interview and case conceptualization; completed Los Angeles County Department of Mental Health intake evaluations
- Conduct brief and comprehensive cognitive and socioemotional testing for children and adolescents
- Collaborate and consult with interdisciplinary professionals who are members of clients' treatment team including social workers, psychiatrists, probation officers, teachers, and psychiatric hospitals
- Create and design quality improvement project assessing access to care utilizing plan, do, study, act (PDSA) methodology

Appointed as student representative to Southern California Association of Psychology Training Programs

- Engaged in leadership and psychology training professional growth activities as student representative to SCAPTP
- Evaluated trainee/psychology student perceptions and feedback about training application and experiences
- Implemented technological advances to organization including development of student-friendly website

Supplemental Track: Jonathan Jacques Children's Cancer Center, Miller Children's Hospital

- Conduct neuropsychological assessments for patients with hematology and oncology diagnoses
- Manage all aspects of the assessment process including battery selection, clinical interviewing, test administration, scoring, case conceptualization/diagnosis, report writing, feedback, and case management/consultation
- Provide brief, outpatient supportive therapy for youth and their families targeting school reintegration, adjustment to illness, and medical coping.

Pediatric Assessment Extern

**Harbor UCLA-Medical Center
Torrance, CA**

September 2013-August 2014

- Conducted psycho-diagnostic and neuropsychological assessments for children and adolescents with a variety of referral questions. Common diagnoses include ADHD, Oppositional Defiant Disorder, Traumatic Brain Injury, and Pervasive Developmental Disorders
- Managed all aspects of the assessment process including battery selection, clinical interviewing, test administration, scoring, case conceptualization/diagnosis, report writing, feedback, and case management/consultation
- Collaborated with school administrators, school district officials, regional center staff, psychiatrists, and medical teams to provide a continuum of care
- Collaborated with Psychiatrists and presented cases in Psychiatry grand rounds
- Co-facilitated Individualized Education Plan meetings and Section 504 Plan meetings
- Managed client files with Los Angeles County Department of Mental Health paperwork including client care plans and case notes

Psy.D. Extern

**School Transition & Re-Entry (STAR) and Teen Impact Programs
Children's Center for Cancer and Blood Diseases
Children's Hospital Los Angeles
Los Angeles, CA**

July 2012-July 2013

- Provided outpatient and inpatient individual and family therapy to children, adolescents, and young adults who have hematology and oncology diagnoses
- Facilitated an open, bi-monthly process group for young adults with hematology and oncology diagnoses at various stages of medical diagnosis and treatment
- Participated in multidisciplinary team meetings as a member of the Bone Marrow and Stem Cell Transplant Medical Team; advocated for and coordinated delivery of psychosocial services to inpatient BMT patients including psychotherapy, art therapy, child life services, music therapy, and psychiatry consultation
- Observed and participated in feedback sessions for neuropsychological assessments
- Collaborated with school administrators, school district officials, regional center staff, and medical teams to facilitate successful transition back to school after hospital stays
- Advocated for specific educational accommodations for patients transitioning back to a typical learning environment after prolonged hospital stays at the school and district levels

- Provided classroom and staff presentations about cancer and blood diseases at schools throughout Los Angeles Unified School District, Conejo Valley Unified School District, and Montebello Unified School District
- Co-facilitated Individualized Education Plan meetings and Section 504 Plan meetings

Psy.D. Extern

**Pepperdine Encino Community Counseling Center
Encino, CA**

September 2011-August 2014

- Provided child, adolescent, emerging adult, couple, and family therapy to culturally and socioeconomically diverse clients in a community mental health setting
- Provided individual adolescent and emerging adult treatment to clients of Children of the Night, a group home for youth who have been sexually exploited and abused
- Provided individual adolescent school-based therapy to diverse, at-risk, students with learning disabilities at Canoga High School
- Managed scheduling, intake evaluations, and client case files including administration and scoring of outcome measures to assess therapeutic progress (e.g. the Beck Depression Inventory and the Outcome Questionnaire)

MFT Intern in Private Practice

**Therapy Offices of Rachel Bar, LMFT
Encino, CA**

September 2011-December 2014

- Provided child, adolescent, adult, couple, family, and group psychotherapy services to a diverse client population
- Collaborated with members of client's treatment team including school administrators, family members, psychiatrists, and general practitioners/pediatricians
- Managed all aspects of running a practice including billing, scheduling, maintenance of client files, obtaining client referrals, and advertising

Clinical Counselor

**Partnerships to Uplift Communities (PUC)
Lakeview Charter High School
Sylmar, CA**

August 2010-June 2011

- Provided creative school-based individual, family, and crisis counseling to high school students and their families
- Collaborated with other members of student treatment teams, such as special education teachers, principals, probation officers, and social workers
- Developed and implemented group counseling curricula for parenting group and 9th grade girls group
- Managed client files with psychosocial assessments, client care plans, and case notes

Intern Therapist

**San Fernando Valley Counseling Center
Northridge, CA**

July 2009-November 2011

- Provided child, adolescent, and adult, couple and family therapy to culturally and socioeconomically diverse clients
- Managed phone screening and structured intakes for new clients

- Managed scheduling, structured intake evaluation, fee setting, and maintenance of client records

OTHER CLINICAL EXPERIENCE

Crisis Counselor and Advocate

Peace Over Violence

December 2007-August 2011

Los Angeles, CA

- Provided counseling, advocacy, education, and referrals to child and young adult survivors of sexual assault, domestic violence, stalking, and child abuse
- Answered crisis calls on the 24-hour Los Angeles Rape and Battering Hotline
- Responded in-person to hospitals and police stations to provide one-on-one crisis intervention counseling to survivors and significant others
- Co-lead training of new crisis intervention volunteers

Peer Health Educator

USC Health Center

December 2007-May 2009

Los Angeles, CA

- Provided pre- and post- HIV test counseling to university students at the anonymous testing site
- Offered resource referral to university students

SUPERVISORY EXPERIENCE

Clinical Peer Supervisor

Wisburn School District & Pepperdine Counseling Center

August 2013-August 2014

Los Angeles, CA

- Provided 1st and 2nd year doctoral students with one-to-one peer supervision for individual child, adult, couple, and family cases.
- Facilitated group peer supervision for 1st year doctoral students conducting individual and group child treatment at a school-based practicum site.
- Assisted supervisees in developing case conceptualization, diagnostic, treatment planning, and case presentation skills through reviewing audio and video recordings of trainees' sessions, providing specific feedback, role playing, and giving didactic information.
- Co-facilitated 1st year doctoral student case conferences in which supervisees present case conceptualizations and video recordings of their therapy sessions; utilized reflective supervision approach to increase trainee insight and self-reflection.
- Collaborated with supervisees' primary supervisors on competency-based evaluation of students' clinical progress over the course of the training year.

Supervisor – Emergency Response Team

Peace Over Violence

August 2008-August 2011

Los Angeles, CA

- Supervised on-call crisis intervention volunteers; aided in problem-solving, provided guidance, support, and debriefing when necessary

- Dispatched volunteer counselor/advocates to service area hospitals and/or law enforcement agencies and answered overflow Los Angeles Rape and Battering Hotline calls
- Provided personal, confidential, peer counseling to sexual assault and domestic violence survivors and their significant others
- Completed required forms, assessed clients' needs for additional services, and made appropriate referrals
- Completed volunteer evaluations and provided feedback to volunteers about their performance and skill development.

RESEARCH EXPERIENCE

Research Assistant

Teen Impact Program

Children's Center for Cancer and Blood Diseases

Children's Hospital Los Angeles

Principal Investigator: Betty Gonzalez-Morkos, Psy.D.

September 2013-March 2015

Los Angeles, CA

- Developed the mixed method data analysis procedures for a pilot study focusing on the acceptability and feasibility of video-conference facilitated process/support group meetings for adolescent patients with cancer or a blood disorder
- Supervised doctoral-level research assistants who served as the primary coding team for the qualitative portion of the study; provide training on coding procedures, feedback on coding process, and serve as research auditor
- Implemented intervention protocol including introducing the pilot study to patients and caregivers, providing instruction on the use of the video link software to hospitalized patients, conducting semi-structured interviews with participants, and administering paper-and-pencil measures to patients.
- Contributed to manuscript development by personally writing method and results sections

Research Assistant

Pepperdine Positive Psychology Lab; Pepperdine Applied Research Center

Principal Investigator: Susan Hall, J.D., Ph.D.

September 2011-September 2014

Los Angeles, CA

- Developed qualitative dissertation exploring how therapists utilize experiential acceptance to facilitate identity development with emerging adult clients
- Coordinated research database of client information, outcome measures, and videotaped psychotherapy sessions across three Pepperdine Community Counseling Centers
- Supervised Master's level research assistants by training them in data entry and video transcription procedures, answering questions, and co-leading monthly research assistant meetings
- Managed recruitment, interviewing, hiring, and training, of Masters-level research assistants

Research Assistant

USC Family Studies Project

Principal Investigator: Gayla Margolin, Ph.D.

May 2008-May 2010

Los Angeles, CA

- Developed and implemented a quantitative study assessing the prevalence and impact of emerging adult peer and dating aggression, especially as perpetrated through electronic media
- Presented findings at USC and National conferences
- Collected interview and assessment data from families participating in the USC Family Studies Project, a longitudinal study investigating risk and protective factors for youth and families.
- Managed participant compliance with saliva collection procedure designed to measure and record diurnal cortisol levels
- Participated in weekly lab meetings designed to socialize lab participants to presenting research findings, discussing data and data analysis, and collaboratively developing research projects
- Contributed to manuscript development by writing portions of introduction and method sections

Research Assistant

USC Department of Psychology – Social Psychology

Principal Investigator: Norman Miller, Ph.D.

September 2006-May 2007

Los Angeles, CA

- Acted as experimenter/confederate in studies concerning displaced aggression, team dynamics and complementary projection
- Managed coding of rumination tapes of depressed and anxious individuals
- Data entry of self-report measures

TEACHING EXPERIENCE & INVITED SPEAKING ENGAGEMENTS

Adjunct Professor

University of the West

Marriage and Family Therapy Master's Degree Program

September 2013-present

Rosemead, CA

Course: Research and Writing Practicum

- Developed specific learning objectives targeting Master's level research methods and scholarly writing skills
- Created a syllabus with class exercises, assignments, and evaluative methods that reflected class learning objectives
- Provided constructive feedback and support to students

Educational Speaker

National Charity League Inc.

August 2007-present

San Fernando Valley, CA

- Develop outreach programming focusing on variety of topics including: peer pressure-related concerns, the transition to high school, the transition to college, time management skills, coping with bullying, and healthy relationships
- Provide didactic presentations on various topics and lead group discussion for groups of 20-30 high school girls

Discovery Science Center, Teen Group

April 2013

Invited Lecturer

The Importance of Technology and Evidence-Based Practice in the Behavioral Sciences

University of Southern California, Department of Psychology

2009-2012

Guest Lecturer

Professional Development in Psychology, Upper Division Course

Exploring Careers in Psychology and the Transition to Graduate School

POSTER PRESENTATIONS

Ford, L., Cram, A., Kessler, R., & Pontón, M.O. (2014, November). *Lateralized cognitive deficits related to prenatal alcohol exposure in a pediatric patient*. Poster presented at the annual meeting of the National Academy of Neuropsychology, Fajardo, Puerto Rico.

Kessler, R., Ford, L., Cram, A., & Pontón, M. O. (2014, November). *Psychosis, epilepsy, and brain damage: A neuropsychological evaluation case study*. Poster presented at the annual meeting of the National Academy of Neuropsychology, Fajardo, Puerto Rico.

Cram, A., Kessler, R., Ford, L., & Pontón, M. (2014, November). *Cognitive impairments and circumscribed strength areas in a child with prolonged status epilepticus and developmental delays*. Poster presented at the annual meeting of the National Academy of Neuropsychology, Fajardo, Puerto Rico.

Ford, L. M., Leever, X., C., and Riel, K. (2013, August). *Familias Unidas: A Proposed Acculturative Learning Program for Mexican American Families*. Poster presented at the annual American Psychological Association Convention, Honolulu, HI.

Ford, L. M., Bellete, N., Edwards, N., and Bryant-Davis, T. S. (2012, March). *Gender and the Integration of HIV/AIDS Information in the African American Church: Implications for Intervention*. Poster presented at the 37th Annual Conference of The Association for Women in Psychology, Palm Springs, CA.

Bellete, N., Ford, L. M., Edwards, N., and Bryant-Davis, T. S. (2012, March). *The Impact of Trauma on Women's Sexuality*. Poster presented at the 37th Annual Conference of The Association for Women in Psychology, Palm Springs, CA.

Ford L. M., Bennett, D. C., Guran, E. L., Ramos, M. C., Baucom, B., and Margolin, G. (2010, March). *You defriended me? Associations between electronic aggression, other forms of aggression, and risky behavior in a college sample*. Poster presented at the biennial meeting of the Society for Research in Adolescence, Philadelphia, PA.

Bennett, D. C., Ford L. M., Guran, E. L., Ramos, M. C., Baucom, B., and Margolin, G. (2010, March). *Reports of victimization in peer and dating relationships: What is upsetting?* Poster presented at the biennial meeting of the Society for Research in Adolescence, Philadelphia, PA.

Guran, E. L., Bennett, D. C., Ford L. M., Ramos, M. C., Baucom, B., and Margolin, G. (2010, March). *Attitudes condoning dating aggression: When it's "no big deal."* Poster presented at the biennial meeting of the Society for Research in Adolescence, Philadelphia, PA.

Ford L., Bennett, D., Guran, E. (2009, November). *Frienemies: Interpersonal Victimization, Distress, and Risky Behaviors.* Poster presented at the biannual USC Graduate and Professional Student Senate Research Fair, Los Angeles, CA.

Ford L., Bennett, D., Guran, E., Rice, R., Ramos, M., and Margolin, G. (2009, April). *You defriended me?! The scope and prevalence of interpersonal aggression.* Poster presented at the annual USC Undergraduate Research Symposium for Scholarly and Creative Work, Los Angeles, CA.

HONORS & AWARDS

Glen and Gloria Holden Scholarship **2011**
Pepperdine University Graduate School of Education and Psychology, Merit-based scholarship

Ruth Russel Shelby Scholarship **2009-2011**
Rossier School of Education, Merit-based scholarship

Phi Kappa Phi **2009-2011**
University of Southern California, Honor society for students in the top five percent of their academic program

USC Undergraduate Research Grant **2009**

Order of Troy **2009**
USC Award for graduating seniors recognizing leadership, volunteerism, and commitment to the campus & community

Remarkable Woman Award **2009**
University of Southern California

Volunteer Award for Crisis Intervention **2009**
Peace Over Violence

TRAININGS & CERTIFICATIONS

- Managing and Adapting Practice (MAP) Training; certification April 2015
- Seeking Safety Training, Spring 2015
- Non-Violent Crisis Intervention (NCPI) Certification
- 65-hour California state certified domestic violence and sexual assault training
- 10-hour online Trauma-Focused Cognitive Behavioral Therapy training

PROFESSIONAL AFFILIATIONS

- American Psychological Association
Student Affiliate
- Association for Humanistic Psychology
Board Member (Executive Committee) - Secretary
Editor-in-Chief, Perspective Magazine
- Southern California Association of Psychology Training Programs (SCAPTP)
Student Representative

ABSTRACT

Emerging adulthood is recognized as a growing developmental stage that varies within and across cultures. Existing research generally characterizes this period as one of identity exploration, instability, self-reflection, and optimism. For many in this cohort, life events that were once organized into a stable sequence such as entering the workforce, marriage, and having children are increasingly a highly individualized and somewhat unstructured trajectory. This lack of structure provides opportunities and potential challenges to those transitioning from adolescence to adulthood. To this end, experiential acceptance may be an important target skill for intervention in guiding emerging adults through this tumultuous period.

Experiential acceptance is multiply defined in the literature, but is generally understood to be a present-focused approach that encourages a willingness to engage with one's moment-to-moment experience, nonjudgment of moment-to-moment experiencing, and nonattachment to thoughts or feelings. This focus may be useful for both therapists to use as an intervention tool in helping clients to form an integrated sense of self; a developmental task that is predictive of mental health in young adults. Despite the apparent fit between experiential acceptance and the emerging adult age range, no studies to date have explored experiential acceptance as an intervention with this population.

Accordingly, the purpose of the current study was to qualitatively explore how therapists facilitate experiential acceptance with emerging adult clients. A sample of 5 client-therapist pairs from community counseling centers was selected, and two videotaped therapy sessions for each participant pair were analyzed. Inductive content analysis was employed, using open coding and abstraction methodology to create a hierarchy of themes. Results indicated that experiential acceptance, overall, was rarely employed by trainee therapists in psychotherapy sessions with emerging adults. The one parent theme that emerged across participants was termed Increasing

Awareness. Comments aimed at increasing flexibility in thinking were also observed, but not across participants. It is hoped that this study will provide foundational information on experiential acceptance use in psychotherapy with emerging adults, which could be used to promote more attention to skill and theory integration in clinical training and spur future research on experiential acceptance use in therapy-as-usual.

Chapter I: Introduction

This chapter begins with an overview of the current literature on emerging adulthood as viewed from a positive psychology perspective that balances negative with positive aspects of this population. Next, the construct of acceptance is introduced through tracing its roots in various psychological theories, then operationally defined and described as it is applied in psychotherapy. Finally, the construct of experiential acceptance as it is defined in the current third wave cognitive-behavioral literature is explored and defined for the purpose of this study. This chapter concludes with the purpose of the study and its research questions.

Emerging Adulthood

Emerging Adulthood describes the period from age 18-29 when individuals move from identifying as children to identifying as adults. Coining the term Emerging Adulthood, Arnett's (1998, 2000) theory views Emerging Adulthood as a stage that bridges the developmental stages of adolescence and adulthood and is marked by a subjective feeling of being in flux as well as intensive identity exploration. Specifically, Arnett describes that the once well-defined role of "adult" has become increasingly amorphous and independently defined. For example, adulthood was once qualitatively defined by the occupation of roles such as spouse and parent. In essence, adulthood was defined by "settling down" (Arnett, 2004, p. 6). In contrast, many young people of today, both in the United States and other industrialized nations view settling down activities such as getting married or having children as an end to spontaneity, possibility, and independence (Arnett, 2004, 2011). Although most "settle down" by the time they reach age 30, the period from 18-29 is increasingly a time for self-exploration in which traditional markers of adulthood have been postponed (Arnett, 2004, 2011; Schwartz, 2001).

It is however important to note that the concept of emerging adulthood is inherently a culturally bound theory. Arnett (2011) has noted that emerging adulthood, in the way that it was originally conceptualized, is more likely to be seen among individuals from industrialized cultures where education is protracted and marriage is delayed. Arnett (2011) cites countries such as the United States, Canada, the United Kingdom, Australia, New Zealand, several other European countries, as well as Japan and South Korea, as examples of nations who have seen trends resembling emerging adulthood in the past half century. Arnett has also proposed that emerging adulthood can exist, in developing nations, albeit for a small group of individuals who are afforded the resources to delay entering adulthood responsibilities (Arnett, 2011). Several studies have been conducted abroad that asked individuals the same questions that were asked of emerging adults in the US, which has provided evidence that emerging adulthood indeed exists in other countries (e.g., see Facio, Resett, Micocci, & Mistrorigo, 2007; Fierro-Arias, & Moreno-Hernandez, 2007; Negru, 2012; Sirsch, Dreher, Mayr, & Willinger, 2009).

Arnett (1998) notes that during the emerging adult period, people develop the skills, values, and capacities necessary to be considered an adult within their sociocultural context. As such, five features or “pillars” of this period have been described: (a) the age of identity explorations, (b) the age of instability, (c) the age of self-focus, (d) the age of feeling in-between, and (e) the age of possibilities (Arnett, 2004). It is important to note that while these elements have been identified, their expression continues to be explored in the context of moderating factors, such as race, cultural beliefs, and socioeconomic status (e.g. Azmitia, Syed, & Radmacher, 2008; Hogan & Astone, 1986; Santos, Ortiz, Morales, & Rosales, 2007; Syed, 2010; Syed & Mitchell, 2013) After describing each of these features, this section discusses other theoretical perspectives on identity development during the emerging adult age range, then turns

to an exploration of cognitive and brain development, and ends with a discussion of mental health concerns prevalent in emerging adulthood.

Five features of emerging adulthood. Arnett (2004) argued that Emerging Adulthood offers an ideal opportunity for self-exploration. During this age range, young people are neither bound to their parents nor tied up in adult roles. They are therefore free to explore many different ways of being, especially as related to occupation and romantic relationships. For example, whereas adolescent love tends to be transient, exploration in romantic relationships during emerging adulthood yields more intimate relationships rooted in careful self-reflection and reflection on what qualities would be important in a potential life partner. Similarly, while employment during adolescence is typically transient and focused on immediate reward (e.g. part time summer job in retail to have money to buy concert tickets), job-searching during emerging adulthood is characterized by the pursuit of a career that is a good fit with personal values, goals, and character traits. That is, employment in emerging adulthood is viewed as a means to lay the groundwork for a rewarding and fulfilling career in adulthood (Arnett, 2004). The intensive identity exploration that manifests in these different life domains has been well-studied for Caucasian individuals, but research on other cultural subgroups both in the United States and in other countries has been largely limited specifically to ethnic identity development during emerging adulthood, rather than identity development across multiple domains. Within the research on ethnic identity development in the United States, it has been found that intensive exploration similar to what Arnett describes also occurs in this domain (Azmitia, Syed, & Radmacher, 2008; Santos et al., 2007; Syed, 2010).

Although the product of intensive exploration during emerging adulthood is a somewhat structured and goal-directed life plan, the plan is subject to many revisions, as exploration

persists through a person's twenties. As such, emerging adulthood is also marked by a subjective feeling of being in flux (Arnett, 2004; Smith, 2009). Perhaps the most well-discussed example of the instability described by Arnett is the statistic that university students often change their major several times before graduation (Allen & Robbins, 2008): A student may pick a course of study only to realize that it is not as interesting as imagined, and change his/her major. As such, the "plan" is revised (Arnett, 2004). Arnett also notes that instability notably manifests in emerging adults' living arrangements. Rates of moving sharply spike between the ages of 20-29. Emerging adults often move away from home, move to live with roommates, move for work, or move home again. Each of these moves represents exploration (school, self, career, etc.). As such, exploration and instability are related (Arnett, 1998, 2004).

While this second EA theme has been well-researched in the United States and among Caucasian emerging adults, the degree to which a sense of instability is experienced cross-culturally is somewhat unclear (Syed & Mitchell, 2013). Syed and Mitchell (2013) note that instability in work and living arrangements appears similar across different racial groups in the United States. However for some groups, the sense of instability may not be confined to emerging adulthood in the way it is for Caucasian emerging adults. For example, over the period of one year, 26% of Caucasian and Asian emerging adults moved at least once, while only 15% of their older counterparts (aged 30-39) moved (U.S. Bureau of the Census, 2012). In contrast, Black and Latino emerging adults moved at approximately the same frequency as their older counterparts (U.S. Bureau of the Census, 2012).

Arnett's third pillar, the *Age of Self Focus* describes how emerging adulthood is the only age range in which people are not directly responsible to others. In childhood and adolescence, caregivers and family members set rules and expectations. Similarly, in adulthood, decisions are

often jointly made with a significant other or are made in consideration of a child. In contrast, emerging adulthood is fraught with many important decisions about education, occupation, and romantic relationships that are made largely independently (Arnett, 2004).

Arnett's research has been questioned regarding the cultural generalizability of these emerging adulthood themes, largely because of the overarching emphasis on independence that is particularly evident in the *Age of Self Focus*. Tamis-LeMonda et al. (2008) noted that research often incorrectly categorizes individualism (or independence) and collectivism (or interdependence) as two end points of a binary construct. However, independence and interdependence have a dynamic, rather than mutually exclusive relationship (Fuligni, 2007; Tamis-LeMonda et al., 2008). In fact, interdependent-oriented behavior may be one of the causal factors associated with greater independence: Attending college or participating in higher education is often viewed as a family obligation among minority youth, while greater education and upward mobility are associated with lower levels of family obligation and higher levels of independence (Fuligni, 2007). For example, one study interviewed 14 indigenous Maya students (9 female, 5 male) who were first generation college attendees in Mexico (Manago, 2011). The traditional Maya culture is based on the cargo system, in which interdependence is emphasized within a community, and people with greater economic standing are expected to share their resources with families and neighbors. Using semi-structured interviews, the study demonstrated that the experience of moving from rural homes to urban colleges resulted in themes related to emerging adulthood and adopting nontraditional values, such as individual autonomy, gender equality, romantic love, having and several choices for adult fulfillment. While being in college opened the students to different roles and choices that were in contrast to the limited options they

had at home, they maintained some of their traditional values, such as interdependence with their family.

Similarly, being “self-focused” does not necessarily mean completely independent, nor is it used pejoratively. In fact, the self-focus during this time is temporary and is necessary to help emerging adults to begin to decide what they find important in life, to discover who they are, to develop the framework for self-sufficiency and to develop skills for daily living (Arnett, 2004).

Arnett (2004)’s fourth pillar, the *Age of in Between*, developed out of his finding that 60% of emerging adults report a *yes-and-no* feeling in response to a question about characterizing themselves as an adult. Specifically, Arnett (2003) found that emerging adults from White and Asian American backgrounds provided *yes-and-no* as their most common response, but Blacks and Latinos were more likely to just say *yes*. Further analyses revealed that these differences could be accounted for by the fact that the Black and Latino emerging adults came from lower social class backgrounds that demand more financial responsibility and were more likely to have become parents, two established role markers of adulthood. In fact, the Arnett and Tanner (2011) state “having a child is the point of no return for emerging adulthood” (p. 47). For those who did endorse a feeling of being in-between, the *yes-and-no* response may be a product of the gradual nature of assuming perceived adult characteristics such as taking responsibility for oneself, becoming financially independent, and making independent decisions (Arnett, 2004).

The age of possibilities pillar/feature refers to the spontaneity and optimism that is characteristic of this age group. Intensive exploration has the potential to leave many futures open. During emerging adulthood, few decide for certain on any specific path. In fact, nearly all

emerging adults surveyed by Arnett believe that one day, they will be able to achieve their goals in life, and that their lives will be better than those of their parents (Arnett, 2004). Arnett (2004) postulates that because emerging adults have typically not committed to a network of relationships, a life partner, or a specific career path, this developmental stage promises many possibilities. This is especially true for emerging adults who strive to break out of difficult childhood situations in their family of origin (Syed & Mitchell, 2013). In this context, the age of possibilities is primarily related to hope for meaningful change (Arnett, 2001, 2004). In fact, emerging adults from low socioeconomic status backgrounds are even more likely than their more advantaged counterparts to feel that they will be better off than their parents, suggesting that this sense of optimism is not only felt by the most privileged (Arnett, 2004). Similarly, emerging adults from minority backgrounds tend to hold high aspirations for the future, despite being faced with significantly more structural barriers (for example, underrepresentation in higher education, difficulty financing goals, etc.; Syed & Mitchell, 2013). Yet, while emerging adults from marginalized backgrounds may initially hold high aspirations for the future, barriers to achievement and advancement may engender feelings of doubt and dismay that make their experience of the “age of possibilities” different from their Caucasian counterparts (Syed & Mitchell, 2013). Research suggests that this paradox is often managed through a variety of behaviors and beliefs that serve to maintain a sense of optimism and continuity. Cooper (2011) has described how low-income immigrant youth with high aspirations for the future may alter their dreams to be both realistic and fulfilling. For example, a Mexican-heritage boy who aspired to become a lawyer may see law school as unlikely as he approaches college. However, his interest and commitment to law and his community may lead him to become a police officer.

In sum, the theory of emerging adulthood refers to an in-between stage that is marked by self-reflection and exploration. This exploration presents the perceived opportunity for many possible positive outcomes, but also comes with a feeling of instability. There are however differences among minority groups in the United States and among different countries in how emerging adulthood is experienced and expressed. Arnett (2011) therefore calls for the need to understand the micro-, meso-, and macro-level factors that influence the expression and experience of emerging adulthood.

Other theoretical perspectives on identity development. Prior to Arnett, the path to adulthood was well studied. However, as noted above, this path has lengthened and become increasingly complex as life events that once clearly delineated “adulthood” have become less structured. In fact, Arnett (2000) contended that the experiences of individuals aged 18-29 is now qualitatively different from what was described in developmental theories that previously described this age range, such that it now involves intensive identity exploration which was previously a hallmark of adolescence.

The development of an integrated sense of self is one of the primary developmental tasks of the emerging adult age range (Arnett, 2000; Josselson, 1987). At the most basic level, identity is how people make sense of their experience and how they communicate their meaning systems to others (Josselson, 1987). Further, identity development has been conceptualized as a continuous interaction between individuals and their sociocultural environment, with people moving from a segmented way of viewing the world to a more holistic worldview (Sevid, Highlen, & Adams, 2000). The principal questions of identity are: Who am I? What is my purpose in life? How do I want others to think of me? What beliefs and values do I espouse? (Schwartz, 2001). These questions play a central role in emerging adult identity development and

may usefully map onto acceptance-based psychotherapy interventions. Many scholars have described the pathway to adulthood as it pertains to identity development. This subsection will explore noteworthy pioneers in identity theory who describe the developmental tasks, characteristics, strengths, and struggles in late adolescence and young adulthood.

Erikson's psychosocial theory. In his article *Self Knowledge*, Erikson (1950) established the tradition of psychosocial identity theory in clinical psychology. Although trained in psychoanalysis and id psychology, Erikson's stages of development are primarily rooted in ego psychology which emphasizes the impact of the ego on a person's social environment (Monte & Sollod, 2003; Slater, 2003). Thus, Erikson's theory of identity development reflects the complex relationship between identity, self-reflection, history, and a person's larger sociocultural environment. Phinney (1993) similarly noted that the process of identity development gives credence to the context of development and involves an exploration of one's abilities, interests, and options; leading to a commitment to a personal identity that serves as a template for future behavior.

Like Freud, Erikson believed that personality develops in a structured trajectory, which he divided into eight stages: Trust vs. Mistrust, Autonomy vs. Shame and Doubt, Initiative vs. Guilt, Industry vs. Inferiority, Identity vs. Role Confusion, Intimacy vs. Isolation, Generativity vs. Stagnation, and Ego Integrity vs. Despair. The first five stages encompass ages 0-18 and the final three stages describe development in adulthood; however, Erikson noted that chronological age bounds did not rigidly define these stages. Each stage centers on acquiring competence in a specific domain of life. More specifically, each stage is represented by a crisis which must be resolved. If the stage is handled well, the person feels a sense of self-efficacy, which is often referred to as ego strength or ego quality. Conversely, if the stage is mismanaged, the person will

emerge with a sense of inadequacy. Erikson further hypothesized that people experience conflicts or crises as they go through life, which is a functional imperative for identity to be achieved (Arnett, 2001; Erikson, 1968). In this view, these conflicts or crises are based on either cultivating a, or failing to develop a, specific feature (for example, autonomy vs. shame and guilt). Failure to successfully navigate the crisis or conflict can result in a reduced ability to complete further developmental stages, which in turn leads to an unhealthy or stunted personality/sense of self. These unresolved crises, however, can be resolved successfully at a later time (Erikson, 1968). The two stages that are perhaps most relevant to the emerging adult age range are Identity vs. Role Confusion (13-18 years) and Intimacy vs. Isolation (18-40 years). Although beyond the scope of this literature review, the role of generativity (Generativity vs. Stagnation crisis; 40-65 years) also is being studied in Emerging Adults (e.g., Frensch, Pratt, & Norris, 2007; McAdams, 2001; McLean, 2005; Slater, 2003)

Identity vs. role confusion. Damon (1983) suggested that an adolescent's most challenging task in forging his/her own identity is to let go of or separate from others in a meaningful way. Similarly, Erikson (1968) noted that adolescents must focus on gaining a deeper understanding of their own strengths and weaknesses in the context of the many changes that occur physically, cognitively, and emotionally during this time period. As such, the primary task for adolescents is to explore the roles that they may occupy as adults. Self-understanding, or identity, consists of cognitive and affective components which are the product of the adolescent's exploration. Bee (1992) described the desired end result of the Identity vs. Role Confusion stage as an integrated sense of self in which the person knows who (s)he wants to be.

When considering this stage in relation to emerging adulthood, Arnett (2001) noted that individuals who successfully navigate the "crisis" of individuating are those who are given the

opportunity to explore different roles through making independent choices. However, the inability to resolve crises from earlier stages or difficulty integrating all of the opportunities presented for exploration/individuation may leave emerging adults confused about who they are, doubting their own strengths, and/or feeling incompetent to occupy an “adult” role. Thus, they may need more time to complete this stage.

Intimacy vs. isolation. This stage is primarily focused on the development of close personal relationships. Erikson believed that committed interpersonal relationships are important to healthy development. In fact, he noted that the successful development of intimate relationships is a watershed event in the transition to adulthood (Erikson, 1968). In this process, it is necessary to have navigated the identity vs. role confusion crisis and developed a personal identity. As such, individuals with a poor sense of self (for example, young adults who are in a prolonged state of identity moratorium or role confusion, as discussed more below) may have difficulty opening up to others or sharing themselves in relationships, and therefore may end up in a state of isolation (Erikson, 1968).

The central process in resolving psychosocial crises. The way in which emerging adults resolve the psychosocial crises of Identity vs. Role Confusion and Intimacy vs. Isolation is paramount to how emerging adults support change. Newman and Newman (2003) describe this process as the way individuals make sense of and integrate cultural expectations at different developmental stages. In this pursuit, a person’s coping and significant relationships play an important role in the dynamic evolution of personal boundaries, values, and images of oneself and others (Newman & Newman, 2003).

Marcia’s identity status model. Marcia’s (1966) identity status model expanded Erikson’s crisis/resolution approach to development by positing that the balance between identity

development and identity confusion lies in the exploration of and commitment to an identity. Like Erikson, Marcia describes “crises” in development. Whereas Erikson defined a crisis as a prompt to develop competence in a certain life domain, Marcia expanded this notion and describes a crisis as a time of upheaval where old values or choices are explored or reexamined. According to this theory, the adaptive outcome of *exploration* is a *commitment* to a certain role or value (Bosma & Kunnen, 2001). Exploration is defined as the ability to seek out novel information about oneself or one’s environment in order to decide between different alternatives. Commitment is faithfulness to a set of beliefs, values, goals, and assumptions (Marcia, 1993). Using this framework of exploration of and commitment to values/roles, Marcia conceptualized identity in terms of four independent statuses: identity diffusion, identity foreclosure, identity moratorium, and identity achievement (Schwartz, 2001).

Identity diffusion occurs when there is no sense of having choices about values or roles in life. This lack of exploration is coupled with a lack of commitment to an identity. Marcia (1980) described diffused individuals as disinterested in or apathetic about occupational roles or ideological choices. More generally, Schwartz (2001) noted that diffusion describes a lack of identity structure that would allow for exploration and commitment. The negative psychosocial consequences of diffuse identity are well documented and include maladaptive decisional and coping strategies, nonclinical depressive reactions, neuroticism, and low levels of personal agency, psychological hardiness, and subjective well-being (e.g., see Berzonsky, 1989, 2003; Berzonsky & Ferrari, 1996; Berzonsky & Neimeyer, 1994; Dollinger, 1995; Nurmi, Berzonsky, Tammi, & Kinney, 1997).

Identity foreclosure describes the process of commitment to a role, set of values, or a goal without any exploration. For example, a child who grows up in a family of lawyers, and who is

told from a young age that s/he should be a lawyer, and who ultimately becomes a lawyer, may be in identity foreclosure. That is, the person committed to a profession (role) without having had the opportunity or the impetus to explore alternatives. Identity foreclosure may look like the more mature status of identity achievement (described below) in that the person appears to have a solid sense of self. However, Marcia (1993) argues that in the absence of identity exploration resulting from a crisis, a person cannot develop a genuine sense of self. Similarly, Adams, Berzonsky, and Keating (2006) noted that identity foreclosure is correlated with poor psychosocial outcomes including excessive need for structure and low tolerance for ambiguity.

An individual in identity moratorium may be active in exploration, but has not committed to any set of values or roles (Marcia, 1994). For example, a college student may be taking a variety of different classes, participating in many social activities, but has not yet declared a major or developed occupational goals. In their survey of 351 ethnically diverse US college students between the ages of 18 and 21, Adams et al. (2006) noted that self-exploring individuals, even those who have not yet made a commitment, tend to have greater psychological resources, including self-regulatory techniques, than their less self-exploring counterparts. Although Moratorium has been found to be positively associated with openness and curiosity in college-aged individuals (Luyckx, Goossens, & Soenens 2006), it has also been found to be associated with anxiety, depression, and low self-worth (Schwartz, Zamboanga, Weisskirch, & Rodriguez, 2009). In fact, Schwartz et al. (2009) explored these associations for both personal and ethnic identity exploration in Caucasian, Hispanic, and Black university students. Factors that explain these mixed findings are discussed further in a later section.

Finally, identity achievement is described as the most adaptive and mature identity status (Marcia, 1993; Markstrom and Kalmanir, 2001; Markstrom, Sabino, Turner, & Berman, 1997).

Identity achievement occurs when a person has done intensive self-exploration and has committed to goals, values, or roles based on his/her exploration. Individuals who have reached identity achievement tend to have an *informational style* (Berzonsky, 1989, 1990, 2003) of dealing with identity issues and decisional situations characterized by actively seeking out, processing, and evaluating self-relevant information. Although the direct link between identity status and psychosocial outcomes is somewhat unclear, the informational style of coping with identity issues that is characteristic of identity achieved individuals has been correlated with cognitive and psychological markers of high psychosocial resources in multi-ethnic samples of university students including: need for cognition, problem-focused coping, experiential openness, cognitive complexity, a conscientious sense of purpose, personal agency, psychological hardiness, and a positive sense of subjective well-being (e.g., see Berzonsky, 1989, 1992, 2003).

Gender and cultural considerations in identity development. Critics of the Eriksonian perspective challenge the universal nature of identity development (For example, see Cote, 1996; Gergen, 1991; Gilligan, 1982; Josselson, 1988; Sorell and Montgomery, 2001). In particular, they argue that both the process and the outcome of identity development is androcentric, individualistic, and may be an over-simplification of a dynamic process that differs between genders and among different levels of acculturation (Schwartz & Montgomery, 2002). For example, Gilligan (1982) and others (Archer, 1985, 1992; Schiedel & Marcia, 1985) argue that the structure, primary processes, and outcome of identity development may differ among young men and young women as they mature in contexts differing in gender-related expectations about self-development.

Loevinger pioneered a model for identity development that may address this concern. She proposed that one's ego (i.e., conceptualization of the self, others, and the world), was a multifactorial construct consisting of impulse control, interpersonal style, conscious preoccupations, and cognitive style (Loevinger, 1976). Further, she postulated that ego development can be conceptualized as occurring along seven hierarchical developmental stages. However, she emphasized that these stages were not tied to particular age ranges nor is it necessary for an individual to progress through all of them over the course of his/her life (Hauser, 1976). Because of the flexibility inherent in Loevinger's model, it appears to be more applicable to a diverse emerging adult population.

Furthermore, in addressing concerns about gender and culture in Eriksonian developmental models, Schwartz and Montgomery (2002) surveyed 357, primarily female (77%), diverse university students in the United States. Participants were given several measures of identity development process and outcome, as well as measures that addressed gender orientation and level of acculturation. Results indicated that the fundamental structure of identity is quite stable across gender and culture. However, the process and outcome of identity development is largely context dependent (Schwartz & Montgomery, 2002). Similarly, in a review of identity process/developmental pathways and outcome across genders for Marcia's identity status model, Kroger (1997) noted that there were no significant gender differences in the developmental pathways taken. Kroger did however note that in studies that assessed for identity development within the domain of family/career priorities, women tended to display higher rates of moratorium and achievement than their male counterparts (Kroger, 1997).

Luyckx's expansion of the identity status model. The exploration and commitment process of identity formation described by Marcia and Phinney has also been addressed by

Luyckx and colleagues. Whereas Marcia viewed exploration as the process underlying identity development and viewed commitment as the outcome of that process, newer models such as that proposed by Luyckx view both exploration and commitment as multidimensional, dynamic processes. These newer models extend those proposed by Marcia (e.g., Crocetti, Rubini, Luyckx, & Meeus, 2008; Luyckx, Goossens, Soenens, Beyers, & Vansteenkiste, 2005; Luyckx, Schwartz, et al., 2008). The exploration and commitment process has also been expanded in the context of ethnic identity development (Lee & Yoo, 2004; Phinney & Alipuria, 1990). For example, exploration in ethnic identity development is conceptualized as a multidimensional construct, as the type of exploration varies tremendously by individual (for example, reading a book vs. attending an event; Syed et al., 2013).

Luyckx et al. (2006) noted that individual variation in identity development experiences may be the product of nuances in the exploration and commitment processes. Out of this idea emerged a four-factor model of identity formation. This model specifically addresses the somewhat mixed findings in the literature regarding psychological outcomes for different dimensions of identity development. In this model, individuals *form* commitments through exploring various options in breadth or by “borrowing” identity elements from parents or other significant people in one’s life and adhering to one or more of the options selected. Individuals then *evaluate* their commitments by exploring them in depth. Provided that individuals continue to view their commitments positively, they will identify with these commitments and will incorporate them into their overall sense of self. Luyckx et al. (2006) therefore subdivide exploration into exploration in *breadth* and exploration in *depth*, and they subdivide commitment into *commitment making* and *identification with commitment*.

Exploration in breadth describes the amount of exploration individuals do with respect to their goals, values, and beliefs before making commitments. *Exploration in depth* encompasses a deeper evaluation of one's existing commitments and determines the extent to which these commitments resemble an individual's internal standards. Recognizing that the exploration process can be both adaptive and distressing, Luyckx et al. (2008) differentiated this construct as reflective versus ruminative. Of note, Luyckx et al. (2008) proposed a fifth dimension, *ruminative exploration*, to characterize the chronic, repetitive, and passive pattern of exploration that induces feelings of hopelessness and uncontrollability. This novel approach to identity development offers an attempt at understanding the cognitive, emotional, and behavioral aspects of the identity formation process in a more active way.

Commitment making is consistent with Marcia's (1966) commitment construct, defined as the degree to which individuals have made decisions about identity-relevant issues.

Identification with commitment consists of how certain individuals feel with their decisions or choices about these issues. Luyckx's theory has been studied with both United States populations and with college students from Belgium (Luyckx et al., 2008).

Myer's optimal theory of adult development. Myers et al. (1991) similarly discussed the importance of introspection, openness, and self-reflection in their developmental theory. They noted that many individuals in the emerging adult age range adopt a "suboptimal worldview" in which they are externally focused and motivated; that is, their worth, identity, and esteem are based on external criteria such as education, clothing, or their looks to the exclusion of introspection. Optimal Theory of Adult Identity Development (Myers, 1984, 1988) posits that such characteristics as openness to change, self-discovery, and self-knowledge contribute to positive identity development. Similarly, Ryan and Deci (2000) note that assigning relative

importance to extrinsic motivational factors such as fame, image, or wealth is inversely related to wellbeing factors such as self-esteem and self-actualization. Conversely, placing relative importance on intrinsic aspirations such as personal growth, community, and affiliation, is positively correlated with wellbeing. Further, emphasizing intrinsic aspirations increases the likelihood that basic psychological needs such as relatedness, autonomy, and competence are met (Ryan & Deci, 2000). These motivational factors related to autonomy and wellbeing have been studied and applied across cultural subgroups, which has led to an increased understanding of how economic and cultural contexts impact the invariant aspects of human motivation and identity development (e.g. see Chirkov, Ryan, Kim, & Kaplan, 2003; Lynch, LeGuardia, & Ryan, 2009; Ryan, La Guardia, Solky-Butzel, Chirov, & Kim, 2005).

Narrative approaches to identity development. In addition to the stage and process models just discussed, narratives have also been used to understand identity development, specifically with regard to meaning making and extending the Eriksonian idea of generativity (McAdams, 2001, 2006; McAdams & McLean, 2013; McLean, 2005). *Narrative identity* (Singer, 2004) refers to the constantly evolving stories a person has about him/herself, which are internalized within the context of time and social environment. Narrative identity is thought to be a measure of personality, and while themes and events likely will have some continuity, it is conceptualized to not be as stable as dispositional traits (McAdams, 2006). In addition to being influenced by cultural and environmental forces (Syed & Azmitia, 2010), narrative identity may be influenced by developmental stage (McLean, 2005). For example, in comparing the identity status model of development to narrative identity development, McLean (2006) found that the sophistication of the emerging adult narrative (especially with regard to meaning-making) was

associated with an overall more mature identity status, while less sophisticated narratives were associated with diffusion and foreclosure.

Cognitive and brain development in the transition to adulthood. The intensive feeling of being in flux, and the processes of decision-making that accompany exploration and commitment may be related to significant cognitive gains during this age range. Adolescence and young adulthood are marked by several notable changes in the speed, efficiency, and capacity of cognition. Specifically, the human brain goes through a number of remarkable changes during adolescence such as increased growth, connectivity, and synaptic pruning (Spear, 2010). There is a growing body of research that posits that this important brain development occurs well into a person's 20s (Giedd, 2004; Giedd et al., 1999; Hudspeth & Pribram, 1990; Kelley, Schochet, & Landry, 2004; Toga, Thompson, & Sowell, 2006). These brain-based changes have been hypothesized to directly relate to specific changes in cognition and behavior observed during the adolescent and emerging adult period such as an increased capacity for learning, an expanding social life, and a taste for exploration and limit testing (NIMH, 2011; Spear, 2010). As such, exploring cognitive and neurobiological changes in adolescents and young adults may increase understanding of emerging adult mental health. Specifically, brain development may help to elucidate the apparent paradox of adolescence and emerging adulthood: adolescents, and to a certain extent young adults, are described to be at the peak of physical condition and are more likely to have good health than any other developmental age group. However, the injury-related mortality rates of late adolescents and young adults are six times those of younger adolescents (NIMH, 2011).

The most widely studied brain-related change in emerging adulthood has to do with the maturation of the prefrontal cortex. The prefrontal cortex is associated with judgment, planning,

problem-solving, modulation of intense emotions, and impulse-control; processes generally referred to as executive functioning (Casey, Jones, & Hare, 2008; Simpson, 2008). There are two specific developments within the prefrontal cortex that contribute to its maturation and efficiency: myelination and synaptic pruning. Myelin is an insulating substance that surrounds nerve fibers in the brain. During late adolescence and emerging adulthood, the myelin sheath surrounding nerve fibers in the frontal region of the brain significantly increases. This increase in myelination allows for signals within the brain to be transmitted more efficiently (Simpson, 2008). Synaptic pruning is a regulatory process in which unused neuronal pathways such as those that are the result of a surge in neuronal growth that takes place in early adolescence are “trimmed” back, leaving more efficient synaptic configurations intact. Both myelination and synaptic pruning, especially in the frontal regions of the brain, set the stage for increased efficiency and integration within the brain (Geidd, 2004; NIMH, 2011; Simpson, 2008).

As such, the prefrontal cortex, and its associated executive functions, is able to communicate with other areas of the brain, particularly those that are associated with emotion regulation and impulse control. The result is an increased ability for emerging adults to modulate the risk-taking behavior that is characteristic of adolescence, to reflect on their own internal process with respect to emotion and cognition, and to generally be more effective in problem-solving (Bechara, Damasio, & Damasio, 2000; Kelley et al., 2004; Passingham, 1993; Romer, 2010; Spear, 2010). This increased efficiency within the brain, especially as related to emotion regulation and risk-taking, presents a unique opportunity for mental health intervention and prevention. For example, psychotherapy focusing on internal experiences and modulation of intense emotions during this time may help to reinforce adaptive neuronal and synaptic networks that will persist through pruning.

Mental health concerns in emerging adulthood. Emerging Adulthood is both a time of tremendous wellbeing, and a unique opportunity for mental health prevention and intervention. In fact, subjective wellbeing increases from 18-26 and general risk-taking behavior and aggression decrease during this time (Schulenberg & Zarrett, 2006). However, despite an overall increase in wellbeing, rates of psychopathology increase (American Psychiatric Association, 2000). In fact, the rate of serious mental illness defined as a clinical diagnosis in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and substantial functional impairment interfering with or limiting one or more major life activities, and established utilizing a screening of psychological distress, is highest in the 18-25 age range (SAMHSA, 2003).

Most studies that explore the transition to adulthood in relation to psychopathology generally note that difficulty during this transition is a predictor of mental health concerns. For example, Reinherz, Paradis, Giaconia, Stashwick, and Fitzmaurice (2003) noted that childhood and adolescent familial and behavioral-emotional factors predicted depression in the transition to adulthood. More specifically, Reinherz and colleagues traced their participants from age five through young adulthood. Low family cohesion, high family conflict, and family composition were the most salient factors in childhood and adolescence that predicted major depression during the transition to adulthood (age range of 18-26).

Berry (2004) and Galambos, Barker, and Krahn (2006) linked certain characteristics of diverse groups of emerging adults in the United States and Canada with internalizing symptoms. As may be expected, social support and committed romantic relationships – variables most commonly associated with identity commitment or adaptive identity development - were related to increases in psychological wellbeing, while prolonged periods of unemployment – a variable often associated with moratorium or delayed identity development- were associated with

increased depressive symptoms and decreased self-esteem. These findings are consistent with more recent findings that link lack of exploration and lack of commitment to an identity with internalizing symptoms in samples of multi-ethnic university students (Adams, Berzonsky, & Keating, 2006; Schwartz, Zamboanga, Weisskirch, & Rodriguez, 2009).

Despite research describing the unique mental health needs of this transitional age, only one fifth of emerging adults received treatment and outpatient therapy attrition rates for emerging adults are remarkably high (Blanco, et al., 2008). As such, psychosocial interventions that encourage active self-exploration and build self-awareness, such as acceptance- and mindfulness-based therapies; as well as modalities of treatment that influence intrinsic motivation (e.g., motivational interviewing) and build support (e.g. multisystemic therapy) may be useful in preventing and treating mental health concerns in emerging adults (e.g. Chawla & Ostafin, 2007; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Schulenberg, Bryant, & O'Malley, 2004; Schulenberg & Zarrett, 2006);

Theoretical Foundations of Acceptance

Recognition of the value of acceptance of the self, others, and the flux of human experience has philosophical and religious roots that date back thousands of years. Acceptance is traditionally defined as agreement with or belief in an idea (Shorter Oxford English Dictionary, 2002). This definition implies a process of condoning or approving that is perhaps contradictory to recent conceptualizations of acceptance as it pertains to clinical psychology. However, the word accept is derived from the Latin *accipere*, which is further derived from the Latin *capere*, meaning to take toward or capture (Miriam-Webster Dictionary, 2008). At its root, accepting something means to take in or capture the experience. This definition describes an active process and does not imply approval.

The past two decades have witnessed a swell of interest in acceptance, as evidenced by an increase in acceptance-based therapeutic interventions and a growing appreciation of the relationship between acceptance and experiential avoidance in psychopathology and recovery. This section begins with an overview of the theoretical underpinnings of acceptance as it is used in clinical psychology then turns to a discussion of current trends in acceptance-based interventions. Differing definitions of acceptance are then discussed and this section concludes with an outline of current methods for measuring experiential acceptance and a proposed definition of experiential acceptance for the purpose of this dissertation.

Early uses of acceptance. The term acceptance has been used in a wide variety of psychological texts and permeates not only theoretical foundations in psychology, but also condition- or symptom-specific treatments. This subsection explores the theoretical development and uses of acceptance in clinical psychology.

Humanistic theory. Emphasizing the potential of all individuals to flourish, the Humanistic approach is arguably the first therapeutic perspective to stress nonjudgmental acceptance in psychotherapy (Dryden & Still, 2006). Its early exploration of acceptance led to a two-pronged approach that included acceptance of others and acceptance of oneself (Williams & Lynn, 2010).

Carl Rogers was perhaps one of the first individuals to introduce acceptance into the psychological nomenclature. He used the term first in the 1950s to refer to a particular way of being with clients. Rogers (1957) defined acceptance as “warm regard for the client as a person of unconditional self-worth” (p. 60). As such, Rogers’ definition refers to acceptance of others, specifically clients. Rogers also emphasized the creation of acceptance in the therapeutic alliance through his three primary core conditions for growth, especially unconditional positive regard.

This type of acceptance provides the client a space to explore thoughts/feelings without judgment or criticism.

Abraham Maslow also discussed acceptance as a mechanism of growth. In developing his theory of motivation, Maslow (1962, 1971) studied individuals who he believed had *self-actualized* or realized their full potential in life. Among the characteristics he found to be common in these individuals were self-acceptance and acceptance of others. He also identified tolerance of uncertain situations as an admirable quality. This quality appears conceptually similar to acceptance of one's experience. Self-acceptance and acceptance of others are integrated into Maslow's (1943, 1971) hierarchy of needs under level three, *Belonging Needs* and level four, *Esteem Needs*. Similar to Rogers' idea of unconditional positive regard, Maslow posited that individuals need to feel an affiliation to and acceptance by others in order to grow (belonging needs). Further in his hierarchy is *Esteem*, or the need for an individual to gain self-value and an acceptance of him or herself internally. Maslow's theory of motivation implies that in order to grow, one must feel accepted by others and then be able to employ a degree of self-acceptance.

Existential theory. Yalom (1980) outlined a similar approach to therapy that many humanists do, emphasizing personal growth or transformation over simple symptom reduction. He posited that personal transformation, an important outcome of therapy, occurs through acceptance of one's experience and also through acceptance by others (Yalom, 2005, 2008). The domain of acceptance from Yalom's perspective is seemingly more expansive than that of humanism, and he is one of the first to mention the notion of experiential acceptance.

Frankl (1967) similarly emphasized experiential acceptance as it related to personal transformation, which he called "existential reorientation" (p. 148). He often utilized paradoxical

intention as an intervention to reduce symptoms and to trigger reorientation. For example, a client who may be prone to rumination would be asked to intentionally worry all day long. Frankl noted that this intervention is useful because it can sever the client's attachment to his/her symptoms, allowing him/her the opportunity to accept his/her experience rather than avoid it (Frankl, 1967).

Further, Frankl (1959) and later, Wong (2009) incorporated acceptance of one's experience into the notion of *Tragic Optimism*. Tragic Optimism refers to the worldview that acknowledges adversity and suffering as part of the human condition. Frankl first discussed this concept in relation to his experience in a concentration camp during World War II and posited that humans have the capacity to create meaning and therefore retain optimism, in even the most tragic of circumstances. He noted that optimism, as he defines it, is more closely related to the Latin *optimum* and refers to making the best out of the situation at hand through (a) turning suffering into a human achievement and accomplishment; (b) deriving from guilt the opportunity to change oneself for the better; and (c) deriving from life's transitory nature an incentive to take responsible action (Frankl, 1959).

Wong (2009) more explicitly outlined acceptance as a component of Tragic Optimism, and noted it as a defining characteristic. He posited that Tragic Optimism depends on being able to confront, acknowledge, and endure one's circumstances, no matter how painful (Wong, 2009). Wong also included acceptance in his proposed five characteristics common to resilient worldviews, including Tragic Optimism: Affirmation of the meaning and value of life, acceptance of what cannot be changed, self-transcendence in serving a higher purpose, faith or trust in God and others, and courage to face adversity.

Gestalt theory. Similar to existential and humanistic theories, the Paradoxical Theory of Change (Beisser, 1970) in Gestalt therapy posits that change occurs when an individual maintains a stance of self-acceptance, acknowledging all parts of him or herself, including dysfunctional or distressing behaviors. As such, from this theory's perspective, pathology is maintained when individuals deny or disown aspects of themselves. Therefore, the paradox is that the more people try to be who they are not, the more they stay the same (Yontef, 2007). For example, if an individual presents with self-dissatisfaction and highlights her chronic disorganization, she may try and change herself (e.g., starting a filing system, creating a contingency plan) without really exploring why she is so dissatisfied with herself or what the function of her disorganization is. Thus the attempt to change often fails.

Gestalt theory is grounded in phenomenology, the study of individuals' subjective experience of being in the world (Yontef, 2007). As such, one primary goal of Gestalt therapy is to help clients increase their awareness of what they are doing, how they are doing it, and how they can both learn to change parts of themselves that are causing distress and learn to accept themselves as whole beings (Dryden & Still, 2006).

Gestalt therapists Fritz Perls, Ralph Hefferline, and Paul Goodman (1972) emphasized, in particular, a stance of awareness and acceptance of experience; especially as it relates to one's moment to moment bodily sensations. In fact, the first part of their book is dedicated to exercises that help clients to bring their awareness to thoughts and their physicality through experimentation with different perspectives. Dryden and Still (2006) note that these exercises are similar to Kabat-Zinn's (1994) definition of mindfulness (paying attention on purpose in the current moment), and require the client to accept the current moment by suspending judgment about oneself as they experience in the here and now. For example, in processing childhood

trauma, a client may be asked to become the hurt child, rather than talk about the trauma itself. In becoming the hurt child, the client is able to increase his/her awareness of his/her moment-to-moment thoughts, feelings, and sensations.

Acceptance within the therapeutic alliance also plays a critical role in Gestalt therapy. The therapist's acceptance of the client's here-and-now experiencing, including the client's struggles and conflicts, serves as a model and supports the client's self-recognition and self-acceptance (Brownell, 2010; Yontef, 2007). Acceptance of client and client self-acceptance appear to be conceptually similar to acceptance as it is defined in ACT (described further below): "the conscious abandonment of a mental and emotional change agenda (when change efforts do not work) and an openness to one's own emotions and the experience of others" (Callaghan, Gregg, Marx, Kohlenberg, & Gifford, 2004, p. 196). Both therapist and client strive to dissolve the struggle associated with painful emotions or dysfunctional behavior, and instead adopt a stance of tolerance of one's own experiences and the experiences of others.

Grief and grieving. Elisabeth Kübler-Ross (1969) derived her widely-known five stages of grief from her work and personal interviews with terminally ill patients. The five emotional stages (viz., denial; anger; bargaining; depression; acceptance) grew out of Bowlby (1961, 1980) and Parkes' (1972) four stages of adjustment to bereavement (shock-numbness, yearning-searching, disorganization-despair, and reorganization) and attempt to describe how terminally ill patients adjust to the knowledge of their own mortality. Acceptance in particular is characterized by a return to a state of stability in which patients are able to move on to the next phase of their lives through taking ownership of their mortality. Because Kübler-Ross' model appeared to center on adjustment to change and focused on how individuals perceive change, her definition of acceptance relates to altering one's perception of an event originally perceived to be

destabilizing or negative. Although originally developed as a model for death and dying, the stages of grief have been generalized and applied to other sources of loss such as one's career, loss of ideals and values, loss of a relationship, and loss of one's health, as in chronic illness or other medical condition (Brewington, Nassar-McMillan, Flowers, & Furr, 2004; Dennis, 2009; Holland, 2011; Kastenbaum, 2004).

As bereavement research has expanded, criticisms of Kübler-Ross' stages have also emerged. Most notably, Kastenbaum (2004) and Maciejewski, Zhang, Block and Prigerson (2007) questioned the validity of the stage theory of grief as well as the rigidity that may come from identifying a single trajectory for grief. Maciejewski et al. (2007) noted that self-report of grief in a community sample of 233 predominantly Caucasian, bereaved individuals did not map on to the stage theory of grief proposed by Bowlby, Parkes, Kubler-Ross, and others. They did however find that acceptance was the most commonly reported grief indicator both at the time of the loss and thereafter (Maciejewski et al., 2007). Similarly, Bisconti, Bergeman and Boker (2004) had recently bereaved widows track their emotional wellbeing using a daily diary model over a three month period. They demonstrated that grief more closely followed a linear oscillator model rather than a stage model. They further noted, similar to Maciejewski et al. (2007) that opportunities for growth and development coexisted with the losses associated with the death of a loved one.

In sum, the construct of acceptance has evolved over time. First validated as primarily a two-pronged concept including self- and other-acceptance (for example, in humanistic theory), the notion of accepting life circumstances and one's experiences has also been incorporated into Existential, Gestalt, and Grief theories. Contemporary applications of acceptance in psychotherapy continue to expand upon experiential acceptance.

Contemporary applications of acceptance in psychotherapy. Acceptance, as it is most commonly used in specific interventions, can best be understood through cognitive and behavioral theoretical frameworks. This section describes the development of acceptance within Cognitive and Behavioral therapies and ends with an outline of current acceptance-based therapies in what Hayes (2004a) called the “Third Wave” (p. 658) of the behavioral tradition.

The first wave: Behaviorism. Although behavioral theory is traditionally not concerned with measuring or adjusting thoughts and perceptions, Pavlovian and Operant principles of behaviorism set the foundation for the mechanism of change in current acceptance-based therapies. In fact, Mowrer’s (1947) two factor theory of avoidance learning and D’Amato’s (1970) theory of avoidance learning are particularly useful in understanding how acceptance may work. The first main premise of both Mowrer’s and D’Amato’s theories is that when a neutral stimulus is paired with an aversive event (such as a shock in Pavlovian behaviorism), the two become associated. Consequently, the now conditioned stimulus (CS) is perceived as aversive and causes an escape response. The second premise of the avoidance learning theories is that an association between the CS and the escape response develops when attempts to escape or avoid discomfort in the presence of the CS are followed by reduction in the discomfort generated by the CS (negative reinforcement in Operant conditioning). For example, if an individual is bitten by a dog, the presence of a dog may become associated with a fearful response in the individual. Whenever a dog is present, even if there is no actual danger, the individual may feel fearful. Additionally, trying to escape or avoid dogs keeps the fear associated with dogs at a tolerable level.

In the equation between CS, fear response, avoidance, and relief or reduction in fear, acceptance is particularly relevant when examining the link between avoidance/escape behaviors

and relief. The relief provided by avoidance is highly negatively reinforcing. That is, a reduction in fear or anxiety reinforces the behavior(s) that provided the relief. Acceptance, or tolerance of one's experience, may be incorporated in order to extinguish the fear response. Instead of engaging in escape behaviors, the individual can be taught to tolerate the distressing experience until relief is experienced. This process is similar to the concept of exposure.

Exposure therapy is based on the principle that exposing client to feared stimuli in a safe environment will diminish the fear response (Massad & Hulsey, 2006). In exposure therapy, the client is asked to tolerate their fear response, instead of engaging in behaviors to escape or avoid it, until the fear has substantially subsided. In fact, exposure therapy is the predominant intervention for anxiety-based disorders. Hayes (2004) later incorporated these elements of traditional behaviorism into Relational Frame Theory, the theoretical framework for Acceptance and Commitment Therapy. Relational Frame Theory posits that thoughts can serve as conditioned stimuli (CS) that lead to action. As such, a thought can be paired with other thoughts to produce new associations leading to new actions.

The second wave: Cognitive-behavior therapy. As therapists and behavioral scientists began to study and treat more complex problems, simple stimulus-response explanations for observed behaviors appeared inadequate. Beck (1976) and Ellis (1958, 1962) expanded on traditional behaviorism and posited that mental disorders and psychological distress are maintained by cognitive factors. As such, cognitive theories represent a distinct shift away from how pure behaviorists viewed the mind. Whereas behavioral theory posits that internal experiences are a "black box," unable to be quantified or studied, cognitive theorists believe thoughts and feelings act as mediators in stimulus-response model (Ledley, Marx, & Heimberg, 2011).

Rational-emotive behavior therapy. Ellis (1958, 1994) developed the first distinct model of cognitive-behavioral therapy. Rational Therapy, now termed Rational-Emotive Behavior Therapy (REBT), is based on the philosophy articulated by Epictetus (trans. 1950) over 2,000 years ago that “men are not disturbed by things, but by the views that they take of them.” In other words, Ellis posited that beliefs about or perceptions of events are what cause distress. The ABC Model, created by Ellis (1958), illustrates the link between events, perceptions or beliefs, and reactions, and is used to explain psychological problems: When an activating event (a) occurs, it is our beliefs (b) about the situation that cause emotional consequences (c). For example, if a friend has not called back for a couple of days (a), an individual may believe that the friend has not called back because (s)he does not want to be friends anymore (b), which may trigger a feeling of sadness or anxiety (c). However, if the individual had a different belief about the same activating event, the emotional consequence would change. In the same example as above, if the individual believed instead that the friend had not called back because she was just busy, the emotional consequence may have been different. In this example, the perception of or the belief about the situation changed the feeling associated with the event. As such, thoughts or perceptions are thought to mediate the link between events and reactions (Ellis, 1999).

Ellis further posited that individual irrational beliefs or perceptions about situations are all variations of three common irrational beliefs, also called the Three Basic Musts: (a) I must do well and win the approval of others for my performances or else I am no good; (b) Other people must treat me considerately, fairly and kindly, and in exactly the way I want them to treat me. If they don't, they are no good and they deserve to be condemned and punished; and (c) I must get what I want, when I want it; It's terrible if I don't get what I want, and I can't stand it. When these

beliefs are present, individuals tend to be more emotionally or behaviorally distressed (Ellis 1994, 1999).

Therefore, one primary goal of REBT is to help clients to alter their thinking from irrational to rational. Acceptance is a primary method through which this goal is accomplished. In fact, Jacobson (1992) wrote that Ellis was the first to introduce acceptance, as it is currently used in acceptance-based treatments, to the field of clinical psychology in his book *Reason and Emotion in Psychotherapy* (1962). Similarly, Ellis (1999) noted that acceptance and commitment are fundamental principles of REBT.

Acceptance is encouraged to combat the stance of non-acceptance and low frustration tolerance that rigid or demanding beliefs such as The Three Musts create. REBT actively promotes a “thinking-feeling-acting philosophy of acceptance” (Ellis, 1999, p.158) that includes three forms of acceptance: Unconditional self-acceptance, unconditional other-acceptance, and unconditional life-acceptance (experiential acceptance). Unconditional self-acceptance refers to one’s ability to accept himself regardless of success and regardless of other people’s approval. Unconditional other acceptance refers to being able to accept (which Ellis noted does not necessarily mean like) other humans, regardless of how they act. Finally, unconditional life-acceptance refers to accepting life regardless of positive or negative circumstances. Further, people do their best to pursue opportunities for discovery and enjoyment (Ellis, 2001a, 2001b, 2002, 2003, 2004; Ellis & Harper, 1997). Ellis noted that while REBT is often characterized by its disputation of irrational beliefs, the mechanism of change in REBT is more closely related to acceptance of oneself *with* dysfunctional or irrational perceptions that are *sometimes* disputed (Ellis, 1999; Hayes 2005).

Cognitive therapy. Similar to REBT, Beck's (1976) cognitive theory emphasizes the role of dysfunctional or irrational patterns of thought in psychopathology. Like Ellis, Beck believed that the way in which we perceive events directly influences our emotional, physiological, cognitive and behavioral reactions to those events. Cognitive therapy developed as a treatment for depression and was originally founded in the premise that one could reduce suffering caused by unresolved past events by changing one's thinking about the present and future (Beck, Rush, Shaw, & Emery, 1979). Seligman (2002) similarly noted that overemphasis of, or what Beck would term a cognitive bias toward, negative events undermines contentment and life satisfaction.

Beck's cognitive model emphasizes three types or levels of thought. At the deepest level are core beliefs. Core beliefs are generalized, fundamental beliefs about self, others, and the world. Judith Beck (1995) characterized these beliefs as so deep, that the person regards them as "just the way things are" (p. 15). For example, a person may hold a core belief that she is unlovable or incompetent. This is a generalized belief held about the nature of the self. The second level of thought consists of Intermediate Beliefs which are characterized by a person's attitudes, rules, and assumptions. These are often phrased in "if...then" terms. For example, an intermediate belief may be "if I am not perfect, then I will not be loved." The third and final level of thought is Automatic Thought, the exact words and/or images that go through a person's mind in a situation. For example, if a person does not receive a phone call from a friend over the weekend, s(he) may immediately think "my friend forgot about me" or "my friend doesn't care about me." While the three levels of thought are not necessarily related, the cognitive model posits that certain situations can trigger automatic thoughts that are extensions of deeper intermediate and core beliefs. Cognitive theory posits that distress arises when perception of a

given situation (the automatic thoughts that are triggered in reaction to the situation, which may or may not be extensions of deeper beliefs) is distorted or irrational. Beck articulated several types of cognitive distortions such as all-or-nothing thinking, personalization, and catastrophizing.

Beck's theory perhaps best illustrates the integration of cognitive and behavioral approaches. The cognitive model outlined by Beck adheres to a stimulus-response approach to behavior, much like traditional behaviorism, but expands the idea of what constitutes stimuli and responses. A stimulus consists of an event plus the interpretation of the event or a thought by itself (Beck, 1995; Ledley et al., 2011). Responses or reactions fall into three categories: emotional, behavioral, and physiological. For example, if a person's friend is late to a dinner date (situation), the person may think that something bad must have happened to his/her friend (automatic thought). In response, he/she may feel worried (emotion), call his or her friend repeatedly (behavior), and experience physical symptoms such as rapid heartbeat or sweating (physiological). In this example, the person's appraisal of the situation triggered the response. A different appraisal (e.g., (s)he is just running a few minutes behind) would likely trigger a different response. Thus, a fundamental premise of Cognitive-Behavioral Therapy is that restructuring distorted methods of thinking into more flexible, balanced ways of thinking will alleviate distress (Ledley et al., 2011).

Acceptance is not as overtly incorporated into Cognitive-Behavioral Therapy as it is into Rational-Emotive Behavior Therapy. However, a degree of experiential acceptance or distancing is implied in a number of cognitive and behavioral exercises used commonly in CBT. In fact, Beck noted that achieving a certain distance from or nonattachment to one's thoughts is the first step in cognitive restructuring (Herbert & Froman, 2011). Further, behavioral activation for

depression requires a degree of acceptance of depressed feelings while committing to engage in social and occupational activities. Similarly, exposure in the treatment of anxiety requires the individual to tolerate or accept a negative affective state. Although acceptance may not be an overt intervention in second-wave CBT, there is evidence to support that interventions that incorporate acceptance are more efficacious than cognitive therapy alone. In fact, recent large scale studies of behavioral activation in severely depressed individuals found that behavioral activation was superior to cognitive therapy and equal to pharmacological therapy in alleviating symptoms of depression (Dimidjian et al., 2006) and in preventing relapse/recurrence of depressive symptoms (Dobson et al., 2008).

Despite evidence of acceptance in cognitive and behavior therapies, Cognitive-Behavioral Therapy is often considered a change-based therapy. As such, it has been contrasted with or deemed fundamentally incompatible with more recent acceptance-based therapies (e.g., Flaxman, Blackledge, & Bond, 2011; Lau & McMain, 2005).

The third wave: Acceptance-based therapies. Cognitive-Behavioral therapy has continued to evolve since its conception in the 1960s, and has given rise to new methods of conceptualization and treatment. Research on the benefits of experiential acceptance in psychotherapy surged in the 1990s, driven in part by a convergence of mindfulness-based meditation, cognitive-behavioral interventions, and the notion that acceptance and change could be complementary therapeutic strategies (Herbert & Forman, 2011). Hayes (2004a) referred to this new direction in Cognitive and Behavioral approaches as the Third Wave or Third Generation in the behavioral tradition. He noted that newer therapies such as Acceptance and Commitment Therapy and Dialectical Behavior Therapy, do not fit into traditional notions of Cognitive or Behavioral therapies. Although third wave interventions do not have a unifying

theme, Hayes described each intervention as more experiential than didactic, and more contextual than mechanistic. They also “emphasize such issues as acceptance, mindfulness, cognitive defusion, dialectics, values, spirituality, and relationship” (Hayes, 2004b, p. 640).

Due to the increased interest in third wave interventions in the past decade, there is currently a considerable body of literature that focuses on these interventions with a variety of populations and clinical concerns. Acceptance-based interventions are increasingly used to treat a wide array of presenting concerns (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Ost, 2008; Pull, 2009). Although this body of literature includes many researchers, noteworthy pioneers include Hayes (Hayes & Wilson, 1994), Kabat-Zinn (e.g., Kabat-Zinn, Massion, Kristeller, & Peterson, 1992), and Linehan (e.g., Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). This subsection first describes ways of defining acceptance within psychology and then reviews the integration of acceptance and change in third wave cognitive-behavioral approaches, specifically Acceptance and Commitment Therapy, Dialectical Behavior Therapy, Mindfulness-Based Cognitive Therapy, and Integrative Behavioral Couples Therapy.

Defining acceptance in psychology. Although acceptance has been popularized in the self-help literature to refer to an ability to tolerate negative emotions, the construct as it relates to clinical psychology is much broader and more nuanced than this definition (Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009; Sauer & Baer, 2010). At the same time, despite the current interest in the incorporation of acceptance into psychotherapy, most current literature focuses on the efficacy of acceptance-based treatments, rather than on defining or exploring the construct itself. In fact, Wulfert (1994) noted that the meaning of the term when used in intervention or conceptualization in clinical psychology remains somewhat unclear.

A variety of definitions can add to the richness of meaning or nuance of a construct. However, broad, multiply defined, or overlapping definitions can lead to poor specificity in both measurement and intervention. A number of researchers have attempted to define, operationalize, and measure acceptance since Wulfert (1994)'s comment. The following subsections will describe recent interpretations of acceptance in the context of third generation CBT theoretical models as well as the clinical utility of the related concept of mindfulness.

ACT and DBT. Acceptance and Commitment Therapy (ACT) is arguably the most well-known acceptance-based intervention. Developed from Relational Frame Theory (Hayes, Barnes-Holmes, & Roche, 2001; Luoma, Hayes, & Walser, 2007), ACT is focused on promoting acceptance of one's experience and commitment to action in accordance with personal values.

Several studies have shown that ACT is efficacious when applied to depressive disorders (e.g. Zettle & Hayes, 1987; Zettle & Rains, 1989); anxiety disorders, including obsessive-compulsive disorder and agoraphobia (Hayes, 1987); combined anxiety and depression (Bond & Bunce, 2000; Forman, Herbert, Moitra, Yeomans, & Geller, 2007; Lappaliainen et al., 2007; Zettle, 2003); the emotional distress of families with severely physically handicapped children (Biglan, Glasgow, & Singer, 1990); physical health problems (Dahl, Wilson, & Nilsson, 2004; Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007; Lundgren, Dahl, Melin, Kies, 2006; Vowles, et al., 2007); and substance abuse (Hayes & Levin, 2012). Additionally, while there is a paucity of outcome research with ACT and psychosis, Bach and Hayes (2002) conducted a randomized-controlled trial (RCT) and found that psychotic patients receiving ACT had significantly lower rates of re-hospitalization over a 4-month period. Recent meta-analytic studies have been conducted for ACT with effect sizes ranging from mild ($g=.42$; Powers et al., 2009) to moderate ($g=.68$; Öst, 2008). These studies have found that ACT is a superior treatment to control groups

(e.g. treatment as usual, waitlist, and placebo). However, when compared to established treatments such as cognitive and cognitive-behavioral therapy, there is no significant effect size for ACT (Öst, 2008; Powers, et al., 2009).

One of the primary tenets of Acceptance and Commitment Therapy concerns experiential acceptance. Hayes defines acceptance as the moment by moment process of actively embracing the private events evoked in the moment without attempts to change their frequency or form (Hayes & Strosahl, 2005; Hayes, Strosahl, & Wilson, 1999). Hayes' definition also describes an active process rather than a passive one and focuses on attending to the current moment nonjudgmentally. More specifically, Hayes notes the process of acceptance allows the individual to “practice experiencing a difficult emotion such as anxiety without having to struggle with it” (Hayes, 1987, p. 365). This process is sometimes described as a means of psychological flexibility, one of the main goals of Acceptance and Commitment Therapy (ACT). Hayes and Strosahl (2004) defined psychological flexibility as the ability to maintain contact with present moment experiencing (positive or negative), to accept present moment experiences for what they are, and to behave in a way that is congruent with one's values. For example, if an individual has a large amount of anxiety about living on her own for the first time, she might first seek to avoid the sensation of anxiety in order to cope. This effort to avoid unpleasant emotions often leads to rigid, inflexible, patterns of thought and behavior that are at the root of many psychological disorders (Kashdan, Morina, & Priebe, 2009). Additionally, the sensation of anxiety might initially be evaluated or judged negatively: “I won't be able to move out. I am not competent enough to be on my own.” In contrast, acceptance urges the individual to suspend initial judgment and regard all emotional experiences from a stance of curiosity. The investigative process that stems from such curiosity dissolves the struggle often associated with unpleasant

emotions by broadening the individual's view and allowing him or her to see the experience for what it is, which may or not have involved the negative event that it may have first appeared to be. As illustrated in this example, ACT does not seek to change or restructure cognitions. Instead, ACT promotes the abandonment of any change agenda (experiential control) related to one's experience. In abandoning a change agenda, Hayes believed that suffering would be alleviated. Conversely, struggling to escape or avoid painful internal experiences only perpetuates them. Acceptance itself can also trigger transformation. In fact, Hayes (1994) noted "when one gives up on trying to be different, one becomes... immediately different in a very profound way" (p. 20).

This paradox between acceptance and change or experiential control is articulated in the common ACT metaphor "Tug of War with a Monster" (Hayes, 1987; Hayes et al., 1999). In this metaphor, the client is asked to imagine he is in a game of tug-of-war with a monster that represents his symptoms (e.g. anxiety or depression); the client holds one end of the rope and the monster has the other end. The client is pulling on the rope as hard as (s)he can, but the monster is equally strong, if not stronger. Although in this scenario, pulling harder comes naturally, the harder one pulls, the harder the monster pulls back. Hayes notes that the solution to this conundrum lies in dropping the rope. Dropping the rope means that the monster is still there, but that the struggle associated with the monster has been dissolved. No longer having to pull tightly on the rope allows the client to explore more enjoyable or valued behaviors. That is, experiential acceptance allows clients to have contact with their symptoms without having to struggle with them (Hayes, 1987).

Marsha Linehan's Dialectical Behavior Therapy (DBT) similarly integrates acceptance and change through the use of dialectics. Linehan (1993a, 1993b, 2000) developed DBT in

response to perceived shortcomings of Cognitive-Behavioral approaches when applied to individual with Borderline Personality Disorder. Specifically, she observed that individuals with features characteristic of Borderline Personality Disorder exhibited extreme sensitivity to rejection and invalidation, which made the change-based agenda of CBT models appear inappropriate. However, the extreme suffering and high-risk behaviors (specifically, parasuicidal behaviors) that these individuals exhibited made purely acceptance-based approaches inappropriate as well. Linehan's solution was to develop a dialectical approach that focused on the tension between two seemingly disparate positions: change and acceptance (Linehan, 1993a, 1993b). Linehan (1993b, 1994) notes that high-risk or destructive behaviors must be changed, while the client learns simultaneously to accept him or herself.

Specifically, Linehan promotes Radical Acceptance (Linehan, 1994). Radical Acceptance is defined as a thorough willingness to experience whatever is taking place in the moment (Brach, 2003; Linehan, 1994). Linehan described this process specifically as a "constant accepting in each successive moment" (p. 80). Williams and Lynn (2010) noted that Radical Acceptance, as described by Linehan (1994) and later Brach (2003) and others (e.g. Fruzzetti and Iverson, 2004; Robbins, Schmidt, & Linehan, 2004), is a "positive extreme" (p. 26) of experiential acceptance. In fact, Fruzzetti and Iverson (2004) noted that such acceptance creates an extreme nonattachment to a stimulus that may have been previously experienced as negative. In turn, this nonattachment can sometimes reverse the valence of the stimulus so that it not only is less aversive, but actually acquires pleasant properties. For example, it is possible for a person who is phobic of dogs to actually come to enjoy them.

Radical Acceptance in DBT is observed in both therapist treatment strategies and in client target behaviors (Linehan, 1994; Robbins & Rosenthal, 2011). First developed in response

to the perceived shortcomings of Cognitive-Behavioral approaches in the treatment of individuals with Borderline Personality Disorder, DBT specifically focuses on the therapist's acceptance of the client as a means of validation. Linehan's (1993a) biosocial model of Borderline Personality Disorder posits that an invalidating environment early in life is at the root of the emotional dysregulation that is the cornerstone of BPD. Regular expressions of negative emotion may have been ignored, denied, or punished, while extreme expression of negative emotion was taken seriously. For example, a parent may tell an upset child, "I don't know why you are upset about this. You shouldn't be upset. You are being ridiculous. Stop crying." Over time, the individual may have learned to self-invalidate their emotional experiences in this same way. As such, Linehan notes that in treatment with individuals who experience emotional dysregulation (such as in BPD), therapists must use validation tools. The therapist's acceptance of the client's moment-by-moment experiencing by noting that the client's responses make sense, are understood, and are in a sense reasonable, is one of these tools. Similarly, while change-based strategies such as problem-solving are employed in DBT to reduce risk-taking behavior, a sole focus on change is likely to be interpreted as invalidating or punishing (Linehan 1994; Robins & Rosenthal, 2011). As such, therapist acceptance of the client serves two main purposes. First, the client's painful experiences are validated instead of ignored or punished. Secondly, therapist acceptance serves as a model for acceptance of self, others, and life experiences.

While DBT therapists model acceptance, clients are also specifically taught Radical Acceptance as a skill for fostering mindfulness and, in turn, distress tolerance (Linehan, 1994; McKay, Wood, & Brantley, 2007). Radical acceptance for the client is defined in five parts. First, the client is taught to acknowledge what is. Secondly, clients are taught a nonjudgmental

approach to their experiences. For example, therapists may use experiential exercises to help clients notice their own thoughts and feelings in the moment, and accept them as simply thoughts or feelings rather than things that have to be literally true. Specifically, parts one and two of radical acceptance help the client to learn that they don't have to buy into thoughts as absolute truths (Robbins & Rosentall, 2011). The third and fourth parts of Radical Acceptance concern experiential acceptance. Clients are taught that freedom from suffering requires (a) acceptance rather than resistance of reality and (b) acceptance rather than avoidance of painful emotions. Finally, Linehan denotes radical acceptance as choosing to tolerate pain or distress in the moment that it is occurring (Linehan, 1994). For example, clients are taught to utilize coping statements that emphasize self and experiential acceptance such as "this too shall pass," "I may not like what's happening right now, but I can tolerate it," and "I may have some faults, but I am still a good person" (McKay et al., 2007, p. 11). In sum, acceptance in Linehan's model encompasses acceptance of others (acceptance of client by the therapist), tolerance of negative emotions, nonattachment to stimuli (e.g. distressing thoughts, feelings; not "buying into thoughts") and a willingness to experience whatever is happening in the moment.

The efficacy and effectiveness of DBT has been summarized in multiple reviews (e.g. Bohus et al., 2004; Oldham, 2006). Across RCT's for DBT with Borderline Personality Disorder and other disorders, effect sizes range from .39-.58 (Kröger & Kosfelder, 2010; Öst, 2008). Non RCT's show similar effect sizes. More specifically, individual studies that investigate the efficacy of DBT illustrate that DBT is a superior treatment to treatment as usual, comprehensive validation plus 12- step therapy, and community therapy by experts (Bohus et al., 2004; Koons et al., 2001; Linehan et al., 1991, 1999; van den Bosch, Koeter, Stijnen, Verjeul, & van den Brink, 2005).

Other third generation CBT models. Although it does not overtly stress acceptance in the way that ACT and DBT do, Mindfulness-Based Cognitive Therapy (MBCT; Teasdale et al., 2000) similarly notes the importance of nonattachment to one's thoughts. Teasdale et al. (2000) refer to this nonattachment as metacognitive awareness. It is also sometimes referred to as metacognitive experiencing (e.g. Wells, 2000) or decentering (e.g. Segal, Williams, & Teasdale, 2002). Like DBT and ACT, MBCT aims to help clients to distinguish thought from reality by severing attachment to thoughts (Herbert & Forman, 2011). For example, a client may be asked to detach from the thought "I am bad" and instead think, "I am having a thought that I am bad."

Finally, Integrative Behavioral Couple's Therapy (IBCT; Jacobson & Christensen, 1996; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000) also incorporates elements of acceptance, specifically in regard to helping partners acknowledge aspects of each other that were previously considered unacceptable. While acceptance in IBCT most closely aligns with acceptance of others (namely, one's partner), Jacobson et al. (2000) also note the importance of acknowledging, rather than acting on, one's emotional reactions to a partner's behavior.

In sum, contemporary uses of acceptance in psychotherapy focus primarily on acceptance as a tool for emotion regulation. Acceptance as described by Hayes and Linehan will serve as the theoretical underpinning for acceptance as it is used in this dissertation. Both authors describe the importance of a willingness to experience uncomfortable feelings without attempting to escape, avoid, or change them. Their approaches are similar to early uses of acceptance in that they promote acceptance of the self, but they differ in that they focus largely on acceptance of moment-to-moment experiences.

Acceptance and mindfulness. Didonna and Kabat-Zinn (2008) assert that clinicians often use the terms mindfulness and acceptance interchangeably in their assessment and treatment with

clients, which further complicates the issue of independently defining acceptance. In order to understand the relationship between acceptance and mindfulness, an exploration of the construct of mindfulness is also warranted.

Similar to acceptance, the construct of mindfulness has been discussed throughout history; however, it did not become a dominant force in psychological literature until Langer (1982) coined the term in their research with older adults. Langer defined mindfulness as the active engagement of one's mind in reconstructing the environment through creating new categories or distinctions, thus directing attention to new contextual cues that may be consciously controlled. According to Langer (1982, 1989a, 1989b), these new categories can be somewhat inconsequential or they can be larger, more major shifts in thinking, as long as they are effortful. Brown and Langer (1990) expanded upon Langer's original definition and re-defined mindfulness as, "a state in which one is (a) open to see information as new, (b) sensitive to context, (c) creating new categories, or (d) aware of more than one perspective" (Brown & Langer, 1990, p. 307). This construct emphasizes openness, cognitive flexibility, and curiosity, which is similar to the more recent conceptualization of mindfulness by Jon Kabat-Zinn (1994).

Kabat-Zinn derived his definition of mindfulness from the concept of *sati* (consciousness, wakefulness or intentness of mind), the central component of Buddhist meditation (Davids & Stede, 1997). Although mindfulness is not a direct translation of the word *sati*, as *sati* makes no distinction between the heart and the mind, Kabat-Zinn outlined the term to mean "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p. 4). Kabat-Zinn's conceptualization of mindfulness in this way emphasizes intentional awareness of sensory perceptions, including internal sensations such as thoughts and emotional reactions.

There are two pragmatic considerations that arose from Kabat-Zinn's (1994) popularized definition. First, although derived from Buddhist philosophy, the phrasing of the definition isolates mindfulness as a construct that can be conceptualized and cultivated separately from Buddhist practice, religion, or culture. As such, its components can be incorporated into mental health intervention with diverse individuals. Secondly, Kabat-Zinn's more recent writings conceptualize mindfulness, with special attention to the nonjudgmental acceptance aspect, as both a teachable technique and a discipline that can be cultivated through practice (Baer, 2003; Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008; Dryden & Still, 2006; Kabat-Zinn, 2005). As such, the moment-by-moment noticing and nonjudgmental acceptance of internal experiences have become target skills for clients and treatment strategies for therapists in many mindfulness and acceptance-based treatments such as Acceptance and Commitment Therapy (Hayes & Strosahl, 2005; Hayes et al., 1999), Dialectical Behavior Therapy (Linehan, 1993a, 1993b), Integrative Behavioral Couple Therapy (Jacobson & Christensen, 1996; Jacobson et al., 2000), Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002; Teasdale et al., 2000), and Mindfulness-Based Stress Reduction (Kabat-Zinn, 1990; Kabat-Zinn et al., 1992).

Kabat-Zinn's conceptualization grew alongside those of Marsha Linehan and Steven Hayes. During the same time period, Hayes was writing about techniques (also derived from Buddhism) for developing awareness and acceptance of experience, but did not originally stress the word mindfulness (Hayes, 1984; Hayes, Strosahl & Wilson, 1999). Similarly, Linehan incorporated mindfulness-derived techniques as an avenue to achieve decentering or Wise Mind, central components of Dialectical Behavior Therapy (Linehan, 1993a).

In response to the rapid development of mindfulness as an intervention, many of its early pioneers (e.g., Dimidjian & Linehan, 2003; Roemer & Orsillo, 2003) called for a way to measure it. As such, Cardaciotto et al. (2008) have most recently defined mindfulness for the purpose of measurement as a two-part construct that includes awareness of the present moment and acceptance: “The tendency to be highly aware of one's internal and external experiences in the context of an accepting, nonjudgmental stance toward those experiences” (p. 2). Awareness incorporates the purposeful attention to current experience that was originally a component of Kabat-Zinn's definition. Acceptance refers to the way that behaviors or events are perceived, experienced or integrated.

In sum, acceptance may be thought of as a quality of mindfulness. Dimidjian and Linehan (2003) note that acceptance has to do with how an observation or perception is received (non-judgmentally). This non-judgmental perception is then a preparatory stage for a mindful response.

Defining acceptance in the current study. It is clear that within the psychological literature acceptance has been conceptualized broadly, even within the smaller field of clinical psychology. Acceptance can describe many processes such as non-judgment, nonattachment, acknowledgment, and tolerance; and refer to many domains such as self, others, internal experiences, reality, and life circumstances. The current study plans to focus broadly on experiential acceptance. In particular, it aims to explore how experiential acceptance is incorporated by therapists into treatment-as-usual. For this reason, it defines experiential acceptance in psychotherapy as an active process involving (a) a willingness to engage with one's moment-to-moment experience (b) nonjudgment of moment-to-moment experiencing, and (c) nonattachment to thoughts or feelings.

The assessment of acceptance. In defining, understanding and using the construct of acceptance, it is also important to consider how the construct is measured. Scales designed to measure acceptance have developed alongside emerging conceptualizations of the construct. Although there are many scales to measure self-acceptance (e.g. *Unconditional Self-Acceptance Scale*, Chamberlain & Haaga, 2001; *Scales of Psychological Wellbeing*, Ryff & Keyes, 1995), and mindfulness (e.g. *Kentucky Inventory of Mindfulness Skills*, Baer, Smith, & Allen, 2004; *Mindful Awareness and Attention Scale*, Brown & Ryan, 2003; *Cognitive and Affective Mindfulness Scale*, Feldman, Hayes, Kumar, Greeson & Laurenceau, 2007; *Freiburg Mindfulness Scale*, Walach, Buchheld, Buttenmüller, Kleinknecht, & Schmidt, 2006), there are very few measures to date that directly measure experiential acceptance as it is conceptualized in third wave interventions (e.g., ACT, DBT, MBCT); these include, most notably, the Acceptance and Action Questionnaire (Hayes et al., 2004a) and the Distress Tolerance Scale (Simons & Gaher, 2005). Further, there are very few studies that have proposed a structure for the qualitative analysis of experiential acceptance. In fact, most qualitative analysis of acceptance is related to measuring acceptance as a facet of emotion-focused coping using content analysis in case studies (Lazarus & Folkman, 1984) or as a quality of mindfulness (e.g., see Chadwick, Kaur, Swelam, Ross, & Ellett, 2011; Mason & Hargreaves, 2001). Therefore, this section explores the quantitative measurement of experiential acceptance; namely the use of the Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004a), the Distress Tolerance Scale (Simons & Gaher, 2005), subscales in multidimensional measures, as well as current methods for the qualitative analysis of acceptance as a facet of mindfulness. The present study proposes a method for the qualitative measurement of experiential acceptance.

Acceptance and Action Questionnaire (AAQ). The AAQ (Hayes et al., 2004a) was originally developed to measure experiential avoidance in a therapeutic context, and initially consisted of a 32-item scale based on the theory of experiential avoidance employed in ACT. In this context, experiential avoidance was defined as:

The phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences . . . and takes steps to alter the form or frequency of these experiences and the contexts that occasion them, even when these forms of avoidance cause behavioral harm. (p. 554)

The measure was originally validated using ten samples collected during discrete investigations of experiential avoidance during therapy (Hayes, 2004a). In addition to the 32-item scale, Hayes also proposed a nine item, single-factor scale with adequate reliability ($\alpha=.70$).

Since its conception, the AAQ has been studied and revised several times due to concern specifically over its factor structure. Bond and Bunce (2003) developed a hybrid 16-item measure that included items from the original AAQ in addition to newly generated items that loaded on the two factors originally conceptualized by Hayes: willingness and action. Later, Bond et al. (2011) developed the AAQ-II, a ten-item measure with higher internal consistency ($\alpha=.81-.85$) that measures psychological flexibility and acceptance.

In addition to the general measures of experiential avoidance (e.g., “I try to suppress thoughts and feelings that I don’t like by just not thinking about them”), psychological flexibility (e.g. “when I evaluate something negatively, I usually recognize that this is just a reaction, not an objective fact”), and acceptance (e.g. “It’s okay if I remember something unpleasant”), the AAQ has been adapted to measure these factors in a number of specific clinical populations. In fact, the AAQ has been used in at least 70 studies investigating the role of avoidance in adults with

such disorders as anxiety (e.g., Tull & Roemer, 2007), depression, (e.g., Cribb, Moulds, & Carter, 2006), body image (e.g., Ferreira, Pinto-Gouveia, & Duarte, 2011), diabetes (e.g., Gregg et al., 2007), auditory and command hallucinations (e.g., Shawyer et al., 2007), cigarette smoking (e.g., Gifford, Antonuccio, Kohlenberg, Hayes, & Piasecki, 2002), chronic pain (e.g., Feldner et al., 2006; McCracken, Vowles, & Eccleston, 2004), trauma (e.g., Braekkan, 2007) and personality (e.g., Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006). The AAQ has also been used to study experiential avoidance as it relates to general psychological vulnerability (e.g., Kashdan, Barrios, Forsyth, & Steger, 2006), well-being (e.g., Kashdan & Breen, 2007), and job performance (e.g., Bond & Flaxman, 2006). In fact, Williams and Lynn (2010) noted that the AAQ can be considered the gold standard for the measurement of experiential acceptance when reverse scored.

Distress Tolerance Scale. Distress tolerance has been conceptualized by Linehan (1994) and others as related to experiential acceptance. The Distress Tolerance Scale (DTS; Simons & Gaher, 2005) assesses “the capacity to experience and withstand negative psychological states” (p. 83). The DTS fit a single factor model in the initial validation study, with four sub-domains: tolerance of emotional distress (e.g. “Feeling upset or distressed is unbearable to me”), subjective appraisal of distress (e.g. “My feelings of distress or being upset are not acceptable”), absorption in negative emotion (e.g. “My feelings of distress are so intense that they completely take over”), and attempts at regulation (e.g. “When I feel upset or distressed, I must do something immediately”). The 14-item scale has reasonable internal consistency ($\alpha=.89$). Outside of its initial validation, the DTS has not been validated or adapted for specific concerns.

Subscales in multidimensional measures. The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) includes an Emotional Nonacceptance (EN) subscale reflecting

“a nonaccepting reaction to one’s distress” (p. 47). The DERS operationalizes emotion regulation as involving awareness, understanding, and acceptance of emotions. The EN subscale is based on the theory that a lack of emotional acceptance is maladaptive and associated with greater difficulties in emotion regulation (Linehan, 1993; Hayes, 2004a). The DERS measures EN in six items using a likert-type scale in which participants rate items such as “When I am upset, I feel guilty for feeling that way” and “When I am upset, I feel weak.” All subscales on the DERS have a reasonable internal consistency ($\alpha=.80$) when studied in a sample of 479 predominantly Caucasian undergraduate university students.

Similarly, the COPE scales (COPE; Carver, 1997; Carver, Scheier, & Weintraub, 1989), which are a general measure of coping, include an Acceptance subscale composed of four items assessing the degree to which a person can accept the existence of stressors and accept the limits of his or her own coping strategies (e.g. “I accept that it happened and can’t be changed,” “I learn to live with it,” “I accept the reality of the fact that it happened” and “I get used to the idea that it happened”). The COPE operationalizes acceptance as the opposite of denial and assesses coping in part as the ability to attempt to deal directly with stressors even when one’s coping skills are inadequate. The internal consistency of the Acceptance subscale is moderate ($\alpha=.65$). The COPE has been utilized to measure generalized coping in a variety of different populations (e.g., see Fortune, Smith, & Garvey, 2005; Kirkland, 1998; Ward & Kennedy, 2001).

Qualitative analysis of acceptance as a facet of mindfulness. Several studies to date have explored mindfulness and its components (e.g., acceptance) from a qualitative perspective. Most recently, Chadwick et al. (2011) utilized thematic analysis (Joffe & Yardley, 2004) and inductive coding to explore the practice of using mindfulness with 12 (seven men, five women, aged 24-58, predominantly self-identified as White British) individuals diagnosed with Bipolar

Disorder. All participants had participated in some form of CBT-based mindfulness training during their treatment. Through their exploration of raw interview data that was obtained outside the context of therapy, the researchers developed several themes, one of which was Acceptance. The acceptance category included client statements about non-judgment of fluctuating mood (e.g., between mania and depression), recognition of their condition, and distress tolerance. These facets are similar to definitions of experiential acceptance as outlined by Linehan, Hayes, and others.

Similarly, Mason and Hargreaves (2001) utilized grounded theory to explore MBCT for depression in a sample of seven adults aged 24-59 of unknown cultural background recruited from a Mindfulness-Based Cognitive Therapy group. All participants were interviewed outside the context of therapy about their practice of mindfulness. In this study, acceptance was delineated as a subcategory of the primary theme, “coming to terms [with depression],” and encompassed recognition or acknowledgment of one’s affective experience with mental illness.

While these studies may be useful in illuminating how clients with depression and BPD may express acceptance as it is related to specific types of psychotherapy, a study by Huffziger et al. (2013) is helpful in illustrating how therapists may induce or prompt acceptance using a specific technique. Researchers used mindfulness induction to explore the effects of this focus of attention on current mood in a sample of 50 German undergraduate students, outside the context of therapy. The mindful induction included such statements as “as best you can, accept all your feelings, also unpleasant ones,” “take note of your thoughts and feelings without judging them,” and “consciously attend to your breath for some seconds” (p. 324). These statements may be similar to what therapists may use to help clients attend to the current moment, tolerate their

current affective experience, and willingly experience both positive and negative emotions; facets of experiential acceptance.

Finally, McCollum and Gehart (2010) illustrated how the therapist's own practice of mindfulness and acceptance may influence the therapeutic context. In particular, these authors utilized thematic analysis to code the journal entries of thirteen adult (aged 22-60), predominantly Caucasian, Marriage and Family Therapy Master's degree students in the context of a graduate-level class. Results indicated that these student therapists felt as though their own practice of mindfulness increased their self and client acceptance, increased their presence in therapeutic sessions, and aided them in balancing being and doing modes of intervention (McCollum & Gehart, 2010). Similarly, in a study of 488 graduate students in psychology in the United States, Myers et al. (2012) found that the cultivation of experiential acceptance was inversely related to stress.

Purpose of the Current Study

Emerging adulthood presents a unique opportunity for clinical intervention and prevention. Specifically, the intensive exploration, the subjective feelings of both instability and hope for the future, and the self-focus that are characteristic of this age range fit well with third generation CBT models. Experiential acceptance in particular may help emerging adults to increase their willingness to experience life as it occurs, to embrace the process of exploration and commitment, and to tolerate unpleasant emotions that may arise from instability and uncertainty. Despite the apparent fit between acceptance-based interventions and the emerging adult age range, no studies to date have directly measured experiential acceptance as an intervention in psychotherapy with this population to facilitate the transition to adulthood. As such, the purpose of the current study was to provide a foundation for such research through the

qualitative exploration of how experiential acceptance was expressed and fostered in psychotherapy sessions with a sample of emerging adults.

Chapter II: Method

This chapter provides an overview of the methods used for the proposed study. It begins with a description and rationale for the study's design, and then turns to information about the participants, instrumentation, sampling procedure, data collection, and data analysis procedure used in the study.

Research Design

An inductive qualitative content analysis was used for the current study, as the research question was exploratory in nature. Rather than deductively testing a hypothesis and asking a “Why” question, qualitative research, is in itself inductive, in that its goal is to understand a situation without imposing preexisting theory or themes on the phenomena being studied (Mertens, 2009; Morrow, 2007). This type of research aims to understand the occurrence of an event or series of interrelated events within the context of its/their natural environment, and to elucidate the process by which this occurrence emerges (Creswell, 2009; Mertens, 2009). More specifically for this study, inductive content analysis was used to generate and examine themes within the data concerning the use of experiential acceptance in psychotherapy in order to scientifically classify patterns that naturally emerge (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Mertens, 2009; Zhang & Wildemuth, 2009). This approach can be especially helpful in situations where the current theories do not sufficiently explain phenomena in their context, and where more accurate theoretical development might occur through researcher interaction with the data (Mertens, 2009).

The present study investigated expressions of experiential acceptance in psychotherapy with emerging adults. As explored in the review of the literature, there appear to be a variety of ways in which experiential acceptance can be defined, a number of theories that explain

experiential acceptance within the context of psychotherapy, and a multitude of techniques that aim to foster experiential acceptance. Therefore, the design of this study allowed researchers to better understand experiential acceptance as it naturally occurred and was used by therapists. By design, the type of analysis conducted is pan theoretical; it attempted to look at the language and behavior of an individual or unit of individuals without being limited by preexisting theoretical constructs. Then, themes that cut across a variety of diverse clinical situations involving acceptance were explored (Mertens, 2009).

Participants¹

Therapist-Client Participant Pairs. In accordance with the recommended guidelines for this type of qualitative and observational research study (Creswell, 2009; Denzin & Lincoln, 1998; Mertens, 2009), purposeful sampling was used to choose and examine five psychotherapy cases, which contained sufficient data, from the archival research database of a Southern California university's community counseling centers. The procedures and materials used in the procurement of research data were approved through the university's Institutional Review Board (IRB) prior to the collection and accessing of client archival data.

Prior to their first intake session for psychotherapy, clients provided informed written consent to have written records (e.g., treatment summaries, assessment measures) as well as audio/videotaped sessions included in the research database. In turn, therapists also gave consent to have their written/audio/video session and treatment data included in the research database. These therapists were comprised of doctoral and master's level psychology students who were in

¹ Participants were shared across the two dissertations for the PARC ASC research team. Therefore, descriptions of client-participants and researcher-participants are the same in both dissertations in order to avoid confusion during review.

training practicum rotations at the time of the psychotherapy sessions. The names on all used research data were removed and replaced with research codes.

In order to be included in the study, the client-participants had to meet certain inclusion and exclusion criteria. Due to the specific developmental period described in the current study, each client-participant was within the emerging adult age range, as defined by Arnett (2004) at the time of intake. Also, the client must have had a presenting problem that appeared to be related to emerging adulthood. Whether or not a presenting problem related to developmental challenges during the transition to adulthood was determined by unanimous consensus between the study coders and auditor. Several developmental theories were used as a guide for identifying these issues (for example, Erikson, Arnett, and Marcia), but were not used as rigid or exclusive criteria. Additionally, participants were fluent in English and provided written consent for his or her written and audio/video records to be included in research database (Appendix A). Further, the therapists on the selected cases provided written consent for the written and audio/video records to be reviewed (Appendix B). Finally, for inclusion in this study, sufficient data was needed for each participant, including: videotapes of therapy sessions, the Client Information Adult Form, Telephone Intake Summary, the Intake Evaluation Summary form, and the Treatment Summary form. Individuals who came to the clinic seeking family, couples, or child/adolescent therapy were excluded from this study. In order to protect confidentiality and to avoid biases in the coding process, therapist-participant dyads did not contain someone the researchers know personally.

Table 1 provides a brief overview of the five client-participants chosen for inclusion in the current study. The following paragraphs describe background information, presenting

problem, diagnosis, and psychotherapy disposition information in more depth for each of the five client-participants.

Table 1

Client-Participant (CP) Demographic Information

CP	Age	Gender	Ethnicity	Diagnoses at Intake	Diagnoses at Termination
1	23	Female	Latina	Anxiety D/O NOS, Academic Problem, Borderline Personality Traits, Educational Problems	Cannabis dependence, alcohol abuse, depressive D/O NOS, 300.00 Anxiety D/O NOS, Borderline PD, Education problems
2	29	Female	Caucasian	Anxiety D/O NOS, kidney stone, migraines problems with primary support	Not available
3	23	Male	Latino	Adjustment D/O with depressed mood, acute problems with primary support group, occupational problems, problems related to interaction with the legal system, relational difficulties	Relational problem NOS, Occupational problem, problems with primary support group, occupational problems, financial stress, discord with ex-wife, shared custody of children, relational difficulties
4	20	Male	Caucasian	Partner relational problem, alcohol abuse, frequent arguments with girlfriend, family history of substance abuse and divorce, death of parent, financial strain	Phase of life problem, problems related to social environment
5	28	Female	African-American	Partner-Relational problem social support problem, tense relationship with current boyfriend	Not available

Client-Participant 1. Client-Participant 1 (CP1) identified as a 21-year-old, Latina, female, who did not have a religious-affiliations, and was a full-time student in a graduate program. CP1 reported that she was working at three jobs, as a student-teacher, on-call assistant at a medical center, and a graduate assistant. She stated that she lived at home with two younger

siblings and her mother, and that she shared a room with the latter. CP1 referred herself for therapy because she felt overwhelmed with graduate school and that her longstanding history of procrastination was impairing her ability to complete her program. She reported that thinking about homework resulted in symptoms of panic, including shaking and hyperventilation. CP1 stated that she was using alcohol and marijuana and that their use had caused her to miss classes and avoid schoolwork. She reported a history of self-injurious behaviors (e.g., self-cutting with scissors) and that she had serious thoughts of cutting herself two to three times a week at the time of intake. CP1 also reported a history of visual hallucinations (e.g., black humanoid forms with red eyes and fangs) since childhood that she still occasionally experienced. At the time of intake, she had been single for six months, after ending a relationship with her fiancé, who she met in high school.

The therapist's initial impressions resulted in a diagnosis of Anxiety Disorder NOS and academic problems, with Borderline Personality features. According to the Treatment Summary, the client's treatment shifted to focus on depressive symptoms and problematic substance use, as well as a Borderline Personality disorder, which CP1 met full criteria for over the course of treatment. The client recorded that a cognitive-behavioral therapy approach was utilized, to which the client was generally resistant. Treatment lasted for 28 sessions and the fifth and approximately 25th sessions (based on DVD dates and appointment log) were used for transcription and analysis.

Client-Participant 2. Client-Participant 2 (CP2) self-identified as a 29-year-old Caucasian female with no children. She reported being enrolled in graduate school while working as a preschool teacher. At the time of intake, she was living with her sister and a roommate at an apartment. CP2 referred herself for therapy with the goal of becoming more aware of her

behavior and to learn how to approach herself with acceptance, rather than judgment. She also reported that she desired to develop a stronger relationship with her partner, a 49-year-old man with two children (seven and 14 years of age), as he went through a divorce. CP2 reported that she was raised in a Mormon household but had not been practicing since she was 17-years-old. She described having a history of panic attacks and substance abuse when she was 18-years-old.

The therapist's initial impressions included a diagnosis of Anxiety Disorder NOS, medical issues of kidney stones and occasional migraines, and problems with primary support group. The course of treatment (e.g., treatment orientation, changes in diagnosis) was unclear, as there was no Termination Summary for CP2. However, based on other documentation sources (i.e., appointment log, dates and numbers of DVD-recorded sessions) it was estimated that treatment lasted approximately 24 sessions. Therapy sessions five and 22 were used for transcription and analysis.

Client-Participant 3. Client-Participant 3 (CP3) self-identified as a 24-year-old single, Christian, Latino male with two children and no previous marriages. At the time of intake, he was employed a repairman, airport employee, and massage therapist as he attended a criminal justice program in college. CP3 reported that he lived with his children, mother, step-father, step-brother, and his step-brother's girlfriend in an apartment. He referred himself for therapy for feelings of depression, as well as difficulties related to trust and assertiveness with others, legal difficulties with the mother of his children, and concerns about being able to provide for his children. CP3 reported experiencing feelings of sadness for the past two months, which followed the ending of a romantic relationship with a female friend. He reported that five years prior to this relationship, the mother of his children had an extra-relational affair with his best-friend, which led him to becoming the primary caregiver to his children. CP3 reported that he

considered committing suicide with a handgun on one occasion, but threw away the gun after considering the impact it would have on his daughters. CP3 reported that his parents were born in Guatemala while he and his siblings were born in California. His parents divorced when he was a child as a result of his father having an extramarital affair.

The therapist's initial impressions resulted in a diagnosis of an acute Adjustment disorder with depressed mood and problems with primary support group, occupational problems, relational problems and problems related to interacting with the legal system. According to the Treatment Summary, a humanistic approach was utilized with CP1, and a strong therapeutic alliance was established. The client reportedly improved throughout the course of treatment, and his diagnosis before being transferred consisted of a relational problem NOS, occupational problem, problems with primary support group, occupational problems, financial stress, and discord with ex-wife. Treatment lasted for 41 sessions before transferring to another therapist. The fifth and 25th sessions were used for transcription and analysis. The 25th session recorded was the last working DVD for this participant before the participant transferred to the new therapist.

Client-Participant 4. Client-Participant 4 (CP4) self-identified as a 20-year-old Caucasian male who was enrolled in an undergraduate program as he work as a manager at a supermarket. CP4 stated that he resided in a house with four to five peers. He was referred to therapy by his girlfriend of two months because she disliked his alcohol use, which reminded her of her own father's alcohol abuse. According to CP4, he typically had two to three drinks per occasion, about two to three times a month. CP4 also reported he had difficulty experiencing and coping with emotions. CP4 reported that his parents divorced when he was 12 and his father, a Vietnam veteran with PTSD, died of a heroin overdose when he was 17. CP4 reported that he did not

believe in marriage and did not intend to have children, which was a source of conflict with his current partner.

The therapist's initial impressions resulted in a diagnosis of partner relational problem, with a rule out for alcohol abuse, as well as v-code diagnoses for frequent arguments with girlfriend, family history of substance abuse, death of a parent, and financial strain. Four months into treatment, his diagnosis was changed to Attention-Deficit/Hyperactivity disorder, inattentive type, and v-codes for not succeeding in school, financial strain, and history of family problems with a note that he had ended the relationship with his partner. After two and half years in treatment, his diagnosis was changed to a phase of life problem, and problems related to the social environment. According to the Treatment Summary, insight-oriented psychodynamic therapy was used to increase CP4's emotional awareness. According to the clinician notes, he made progress slowly but steadily and was not receptive to cognitive-behavioral interventions when they were introduced at various points during the course of treatment. His diagnosis remained unchanged at the end of treatment, which lasted for 100 sessions (three years). The fifth and 97th sessions were used for transcription and analysis.

Client-Participant 5. Client-Participant 5 (CP5) self-identified as a 28-year-old, African-American, Christian, female who moved to Los Angeles from Kentucky four years ago. At intake, CP5 worked as an accountant and lived in a one-bedroom apartment, where her boyfriend would stay with her for months at a time when he visited Los Angeles. She referred herself for therapy because she reportedly had difficulty opening up to her friends, who she considered to be shallow. She stated she also wanted advice with regards to her boyfriend of four years, who she did not trust. A year prior to the intake, CP5 found that her boyfriend was caring for a child that he may have fathered before their relationship. The boyfriend reportedly did not know whether

or not he was the father, but continued to care for the child because he felt attached. CP5 lived with her mother and brother (two years senior) and never knew her biological father. CP5 reported that she was raped by her uncle when she was in third grade, but did not report the incident, nor received any treatment related to the event. She grew up in a neighborhood that exposed to her frequently to violent crimes, and many people she knew were shot or incarcerated.

The therapist diagnosed CP5 as having a partner relational problem, social support problem, and tense relationship with current boyfriend. According to the Treatment Summary, the clinician utilized a psychodynamic approach to help CP5 explore childhood trauma and later utilized a cognitive-behavioral approach to help her communicate her emotions to others, which was well-received. Treatment lasted for 21 sessions and the fifth and 18th sessions were used for transcription and analysis.

Researcher-Participants. The Researcher-Participants for this study consisted of a team of two clinical psychology doctoral students who were responsible for coding the collected data (Coders 1, and 2). A clinical psychologist served as the auditor for the study and supervised the research team throughout the data collection, coding, and analysis process. The inclusion of multiple researchers and an auditor assisted in providing different perspectives, minimizing individual biases, and helping to sufficiently capture the complex nature of the data (Hill, Thompson, & Williams, 1997). The following is a personal description (e.g., background, professional views) provided by each of the coders and auditor in an effort to identify potential areas of bias.

Coder 1, the primary researcher and dissertation author, is a 27-year-old, Caucasian, female clinical psychology doctoral student. She was born and raised in a middle-class family in

the southwestern part of the United States. Coder 1 was raised in a Catholic family, however she considers herself to be agnostic. Coder 1 generally conceptualizes and treats clients, from an integrative perspective; including positive psychology, humanistic, and cognitive-behavioral techniques. More specifically, she believes that unhelpful or distorted ways of thinking, in combination with a tendency to buy into or “fuse” with those systems of thought can strongly influence affect, behavior, and general functioning. Accordingly, she believes that the identification and modification of various levels of thought, rapport and empathy in the relationship, emotion regulation skill-building, and a strong therapeutic alliance in therapy will contribute to improvements in mood and behavior. Consistent with this perspective, Coder 1 also views the therapeutic relationship and a sense of authenticity as necessary elements upon which such change can occur.

Moreover, Coder 1 believes that acceptance-based interventions such as learning to tolerate difficult emotions, building nonattachment to unhelpful thoughts, and willingness to experience affect on a moment-to-moment basis may be particularly useful in helping emerging adults to cope with the subjective feeling of being in flux that is a primary characteristic of this age group. Moreover, in her training and experience working with emerging adults, Coder 1 has recognized that many aspects of individuation, exploration, and commitment to an identity involve coming to terms with elements of the person’s upbringing that have contributed to distorted thinking, realizing and tolerating the imperfection of the person’s family of origin, and setting achievable goals for the future. For these reasons, Coder 1 feels it is important to explore how acceptance is actually cultivated and expressed in psychotherapy sessions.

The second researcher, Coder 2, identifies as a 32 year-old, heterosexual, Chinese-American male doctoral student in clinical psychology. His family is originally from China, and

he is the second generation that has been born in the United States. He has been brought up in the upper middle class, been married for three years, and considers himself to be agnostic. He generally conceptualizes clients and conducts psychotherapy from a cognitive-behavioral perspective. He believes that many clients present to treatment for many reasons, chief among them being that developmental/biological predispositions lead to maladaptive responses to psychological and environmental stressors. He believes that, broadly, learning is the primary mechanism for positive change in therapy, be it psychoeducation, self-knowledge, or developing abilities to cope with psychological and environmental stressors. In regards to developmental status, although Coder 2 does not believe that milestones such as marriage or having a child are necessarily sufficient to being an adult, he views himself as an adult because of the interdependence he shares with his partner.

The auditor of the study, who is also the dissertation chair, is a European-American, Christian female who is married. She has a doctoral degree in psychology as well as a terminal law degree and is a tenured, associate professor of clinical psychology. She teaches courses and conceptualizes cases first through third wave cognitive-behavioral theories, informed by systems, developmental and strength-based approaches. Her research lab focuses on psychotherapy process research and she enjoys mentoring the emerging adults in her work. Accordingly, she supports the use of and research on mindfulness and acceptance techniques in personal and professional settings, and believes that such approaches are helpful with therapists and clients across the developmental spectrum.

Procedure. Because of the particular research question being investigated, this study used purposeful sampling to target the specific participants in the study (Creswell, 2009). An advantage of using a purposeful random sample of participants is that an examination of multiple

cases for this study increases the likelihood of generalizability in spite of the fact that the clients to be included may or may not have been representative of all clients who go to therapy as a whole (Mertens, 2009). However, Creswell (1998) suggests that generalizability is not a critical issue when conducting qualitative research. In addition, because Creswell (1998) recommends an extensive investigation of four or five individual cases in qualitative research, five individual adult psychotherapy clients that met the inclusion and exclusion criteria were selected from the confidential research database of the university community counseling center. Particular client characteristics, length in treatment, and a broad range of demographic variables (i.e., age, gender, ethnicity, religious affiliations, socioeconomic status) were considered during the sampling to help ensure that the sample obtained is diverse and representative of the clinic population from which they were drawn (Kazdin, 2003; Mertens, 2009).

In order to purposefully sample, a complete list of research records was first obtained (clients who have terminated their therapy and whose clinical data has been de-identified and entered into the research database). Second, adult English-speaking clients between the age of 18 and 29 who participated in individual therapy were selected. Client self-report on two data instruments was used to determine whether potential client-participants meet the inclusion criteria related to age at intake. In the Caller Information section of the Telephone Intake Interview (Appendix C) and in the Personal Data section of the Client Information Adult Form (Appendix D), a client must have indicated that his or her age was between 18 and 29 at the time of intake. This information was corroborated by the noted age on the Client Intake Evaluation Summary (Appendix E).

Third, the sample was narrowed to include only clients who have presenting concerns related to Emerging Adulthood. Multiple data instruments were examined to determine whether

the potential client-participants met the inclusion criteria related to expression of Emerging Adulthood concerns. During this phase of sample selection, Emerging Adulthood concerns were broadly construed, and derived from several developmental theories that outline characteristics that may be indicative of this age group. Emerging Adult concern identification was not strictly related to the five pillars of Arnett's theory. For example, in the Current Difficulties section of the Client Information Adult Form, the client-participant may have selected at least one of the following: Afraid of being on your own, wondering "Who am I," difficulty with school or work, concerns about finances, family difficulties, breakup of a relationship, difficulty making or keeping friends, difficulty making decisions, or feeling conflicted about attraction to members of the same sex.

Similarly, information from the Telephone Intake Form (Appendix C), from multiple sections of the Intake Evaluation Summary (Appendix E), and from the Treatment Summary (Appendix F) were utilized to corroborate information boxes the client checked on the Client Information Adult Form and/or to gather more information. The Reason for Referral section of the Telephone Intake Summary provided information about the nature of why the client sought services at one of the counseling clinics. On the Intake Evaluation Summary, the Presenting Problem/Current Condition (Section II), History of The Presenting Problem and Other Psychological Conditions (Section III), Psychosocial History (Section IV), DSM-IV TR Multiaxial Diagnosis (Section XIII), and Treatment Recommendations (Section X) were also examined. On the Treatment Summary form, researchers looked for diagnostic information and notations about emerging adult concerns that were discussed during the course of psychotherapy.

Fourth, from the remaining clients, the researchers selected one session from the beginning phase of treatment and from the end phase of treatment for each client. The

“beginning phase” of treatment was defined for the purpose of this study as a session occurring directly after the formal intake period (first 3 sessions). The “end phase” of treatment was defined as the third to last recorded session available. Table 2 presents the client-therapist participant pair numbers with the session numbers selected for transcription and coding.

Table 2.

Client-Therapist Participant Pairs and Session Numbers Included for Analysis

Client-Therapist Participant Pair	Initial Session Number	Later Session Number	Total Sessions
1	5	25	28
2	5	22	24
3	5	25 ^a	41 ^b
4	5	97	100 ^c
5	5	18	21

^aThe 25th session was the last functional DVD before therapist transfer. ^bClient transferred to another therapist after session 41.

^cThe researchers purposefully sampled for a client with a significant amount of time in treatment.

Given the exploratory nature of this study, there were no inclusion criteria regarding the content of these sessions. Once these sessions were selected, they were transcribed and subsequently coded. Therefore, a total of ten sessions were transcribed and coded for the purpose of this study.

Fifth, of these participants, specific client characteristics and demographics were analyzed in order to obtain a diverse sample that varied across age (based on year of birth or reported age at intake), gender, race/ethnicity, and religion/spirituality. Length in treatment was also considered (range of total sessions: 21-100). The specific demographic information of the client-participants can be found in Table 1. The demographic information was obtained through clinic forms included in the archival database. The Telephone Intake (Appendix C) was examined for age and gender whereas the client’s religion/spirituality, ethnicity/race, and disability status, if provided/discussed, were found in the optional Social Cultural section of the

Client Information Adult Form (Appendix D) or within Cultural Factors & Role of Religion in Client's Life (Section F) of the Intake Evaluation Summary (Appendix E).

Transcription. Transcription of the sessions was completed by six bachelor- and master-level psychology graduate students, who were recruited on a volunteer basis. Prior to working with the data for the study, they were taught to transcribe sessions verbatim using a system adapted from Baylor University's Institute for Oral History. Specific instructions for how these volunteers were instructed to transcribe the sessions can be found in the Coding Manual (Appendix G).

Coding. The coders for this study consisted of two doctoral level psychology graduate students (the primary researchers for the study). Their research supervisor served as an auditor. Prior to coding the participants' therapy sessions, the coders and auditor practiced coding until they were 100% in agreement on practice cases (2 out of 2 coders in agreement, with auditor review). The coders were trained to understand the essential concepts, terms, and issues that were relevant to the study (Ryan & Bernard, 2003; Yin, 2003), including how to accurately identify and code potential occurrences of expressions of experiential acceptance. The coders were each trained on the techniques of the coding method to be used in this study. Specific instructions for how the coders were trained can be found in the Coding Manual (Appendix G).

Human subjects/ethical considerations. Confidentiality and maintenance of ethical standards for the treatment of research participants was maintained in several ways. First, limits of confidentiality for therapy and for research database inclusion were reviewed as part of the intake procedure for the counseling center. All participants provided informed written consent to have their clinical records (i.e., written and video) included on the research database prior to the initial intake interview to become counseling center clients (Appendix A). In turn, therapists

included in the study provided written consent to allow their client records and session videos to be included in the research database (Appendix B). When a clinical case was terminated, all client/therapist clinical information was prepared for entry in the research database. All identifying information was redacted from therapist and client written documents in order to preserve confidentiality for therapists/clients whose records were transferred to the research database. Both participating therapists and clients were assigned a research number to de-identify them for research purposes (Mertens, 2009). All individuals who handled the transfer of clinical data to the research database completed an Institution Review Board (IRB) certification course (See Appendix H).

In addition to the research data preparation, provisions were made so that those handling the de-identified data did so in a confidential and ethical manner. Prior to accessing research database content, researchers/coders, and transcribers completed an IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to ensure adherence to ethical standards of participant research and handling confidential health information. Further, steps were taken to maintain confidentiality by making sure that research coders did not know the client-participants or therapist-participants on research videos personally. Finally, one of the benefits of a content analysis methodology is that it is by nature non-invasive and did not require direct engagement of the participants by the researchers (Denzin & Lincoln, 1998). In this study, previously recorded psychotherapy sessions and corresponding written clinical documents were accessed from the archival database.

Data Analysis Approach

First, the data was prepared for an inductive content analysis. To do this, research assistants transcribed the videotaped therapy sessions of the five participants whom the researchers selected for inclusion in the study. Session numbers were noted on each transcript.

After the data preparation, the coders examined the data for specific themes connected to experiential acceptance that emerged from the therapist-participants, in accordance with recommendations for inductive content analysis (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). This three-part process involved open coding, creating categories, and abstraction (Elo & Kyngäs, 2007).

More specifically, open coding began with the researchers reading through each transcription as many times as necessary, making notes and writing down thoughts and ideas, until each felt he or she captured the essential headings to describe aspects that answered the research question (Elo & Kyngäs, 2007). Next, the primary researcher independently grouped similar codes, generating category/concept labels for each grouping. Once the concept groups were formed, the researcher organized these groups hierarchically and identified Parent Themes, or theme titles that described one or several concept groupings (Elo & Kyngäs, 2007). In this process, known as abstraction, the researcher moved back and forth between hierarchical concept levels (codes, concept categories, and parent themes), making sure all tied back to the research question (Elo & Kyngäs, 2007).

The researcher then submitted the theme hierarchy to the other researcher and auditor for review and feedback in order to identify idiosyncratic analyses or data that was mislabeled (Hsieh & Shannon, 2005). To help ensure reliability of the researchers' process and findings, the auditor reviewed the themes and abstracted codes as well as examined the steps and session

dynamics notes that the researchers took during the coding process. The purpose of this step was to make certain that the findings of the researchers have dependability and confirmability (Zhang & Wildemuth, 2009). This process involved reviewing data and notes of each researcher. The auditor separately coded the transcribed data and noted her own thought processes in the session dynamics/missed opportunities section of the coding document. The auditor then went back through the data and noted areas of agreement with the researchers' codes as well as areas for further thought. With regard to the theme hierarchy review, the auditor reviewed the abstracted codes, concept sub-categories, and Parent themes, and offered feedback based on her own experience of coding transcripts, reviewing codes, and thinking about the data hierarchically. Following this review, the primary researcher adjusted codes and themes within the hierarchy to incorporate feedback. Final codes were determined after a second review of the hierarchy by the auditor.

Researchers could not assume that an agreed upon coding system would definitely ensure that the entire body of data was coded consistently (Zhang & Wildemuth, 2009). Therefore the checking process during open coding and abstraction was important for a number of reasons, which included minimizing the impact of coder fatigue on coding, accounting for how pre-existing biases of each of the researchers can influence how they chose coding themes, and establishing inter-coder verification (Zhang & Wildemuth, 2009). Potential researcher biases and the checking process are discussed further in the Discussion section.

Chapter III: Results

This study investigated the ways in which trainee therapists elicited experiential acceptance from emerging adult clients in psychotherapy sessions. The purpose of this chapter is to present the results of this study's inductive qualitative content analysis of transcribed therapy sessions. This chapter begins with an overall description of the emergence of themes related to experiential acceptance, then turns to a description of the one Parent Theme that was used to represent across-participant themes. Finally, a section describing the themes that emerged within each client-participant's sessions is presented. The review of within-participant themes captures the nature and nuances of each therapist-participant's use of experiential acceptance-eliciting interventions.

Of the ten psychotherapy sessions (representing five participants) that were reviewed and coded, only eight of the sessions had experiential acceptance codes. The two sessions that did not have experiential acceptance codes were from the same client/therapist pairing. In other words, only four out of the five participants had session content that was coded as experiential acceptance. Moreover, ordinarily, highest level Parent Themes are generated inductively from the open coding, abstraction, and categorization process, and represent themes that emerged across all participants. However, the open coding, abstraction, and categorization process in the current study did not generate themes that were emergent across all participant sessions. Therefore, for the purpose of this dissertation, the Parent Theme represents a theme that was emergent across at least two out of five participants. Specific examples from the therapy transcripts are provided to illustrate the concepts at each of the aforementioned levels. Additionally, as part of the abstraction/categorization process, the number of occurrences of each code/initial theme within each session was calculated and recorded. As qualitative content

analysis typically does not produce counts and statistical significance, these frequency calculations were not used to justify themes. Rather, they were used to track and organize codes within the context of sessions. Finally, missed opportunities and notable session dynamics were noted by the researchers during the coding process and are presented within the corresponding participant's results. For all of the following results, ellipses (i.e., ...) are used to indicate that some session material was omitted when providing the examples, as it was deemed non-essential for illustration of the concept.

Parent Theme Across Participants

Inductive content analysis of ten psychotherapy sessions yielded one Parent Theme, consisting of two categories, which reflected therapist-participants' experiential acceptance-based interventions across three out of five client-participants. The Parent Theme identified was *Increasing Awareness*.

The *Increasing Awareness* theme can be defined as therapist interventions or comments that were aimed to deepen a client's ability to perceive, feel, or to be conscious of thoughts, emotions, or sensory experiences and/or patterns in the present. Although increasing awareness can include focus or attention on the past and/or future, only the present experiences of the client were coded for the purpose of this study. The Increasing Awareness theme is comprised of two categories: a) Bringing awareness to the current moment and b) Shifting from content to experience.

Bringing Awareness to the Current Moment. Three out of the five therapist-participants made comments that prompted the client-participant to be present in the here-and-now process of the psychotherapy session. Bringing Awareness to the Current Moment was classified under the *Increasing Awareness* parent theme because intentionally bringing a client's

awareness to the current moment in order for the client to observe his/her experience may be looked at as the first step in acceptance from a third wave CBT perspective (e.g., ACT, DBT). Out of 2001 therapist statements across five sessions, the bringing awareness to the current moment category was coded in six therapist statements (these therapist statements were found in four of the 10 coded sessions). Although the specific domain of the awareness in the current moment differed based on session context (e.g., thoughts, feelings, sensory experience), therapist-participants who used this skill always cued a transition in session process by including the words “right now.” The following exchange between client-participant and therapist-participant three illustrates this concept:

T167-1: What would it mean if they did? (5) We all have weaknesses. (18) It is really interesting that, you know, cuz we don't have the time usually to sit down and really think about things like this but when we do just to see these different connections and how things that we've experienced have affected us in some ways. Some ways good, some ways bad.

C167-1: Mm-hmm.

T168-1: But it's very interesting [Looks down]. (8) What are you thinking right now? [Makes direct eye contact; Orients face toward client].

C168-1: Actually, my mind is really, it's clear right now.

In a similar manner, therapist-participant four asked:

T57-1: ...What's going on in you right now? You look like...something's going on inside...

Whereas the therapist in the first example inquired specifically about here-and-now thinking, the therapist-participant in the second example inquired about general sensory experience in the moment. Both therapist-participants also asked here-and-now process questions about emotions (e.g. “What are you feeling right now?” or “How do you feel right now?”).

Shifting from Content to Experience. In addition to process comments that encouraged the client to focus on the here-and-now of the session, three out of the five therapist-participants also made more general comments that prompted their clients to shift from content-based descriptions (e.g., what happened) to a reflection on their experience of the situation (e.g., how they presently felt about/experienced the situation or similar situations). Out of the 2001 total therapist statements across five participants, shifting from content to experience was coded in nine therapist statements.

These statements were classified under the *Increasing Awareness* parent theme because helping clients to focus their attention on the experience of a situation, in the here-and-now of the session, is conceptualized as an important component of deepening the client’s ability to reflect on how behavioral and interpersonal patterns may be contributing to distress or emotional dysregulation. Information about the way in which this concept fits into the overall third wave theoretical perspective is further elaborated upon in the Discussion section. Moreover, because third wave interventions are present-focused, only therapist statements that encouraged the client to reflect on their experience in the present were given this code; statements about past or future experiences were not coded, but may have been described as a notable session dynamic or missed opportunity.

The following exchange illustrates an example of this concept. In the discussion leading up to this exchange, client-participant three had been speaking about his ex-partner’s behavior

for the majority of the session. While nonverbal notes and his language clearly indicated he was angry, it was not until this specific question that the client was able to shift from describing the content of his ex-partner's behavior to discussing his experience of being on the receiving end of the behavior:

T154-2: How does it make you feel, when she does stuff like that?

C154-2: It pisses me off! Cuz I'm telling you, it's not for me, it's for the girls!

In this example, therapist-participant three asked a feeling question which prompted the client to think more about how he was reacting to the situation, rather than continuing to describe what actually happened.

Whereas therapist-participant four asked a very open-ended feeling question, therapist-participant 4 employed closed-ended feeling questions to shift the client from content to experience:

C71-2: Well, she knew him 'til she was in her 40s, so probably a lot better than mine and my dad. So...she probably knew him more than [unintelligible]...I don't know...maybe she was in her 30s, still he got to live 'til he was 80 something - 'er 70 something.

T72-2: Mm hmm

C72-2: Er...actually he was 60 something...69?

T73-2: Mm hmm. Well, you know she probably had a chance to grow up with him and have him watch her grow up.

C73-2: Kinda.

T74-2: Things that your dad didn't do. Do you think that you might be...angry or sad or...

C74-2: Yeah (6) [looks at window]

Finally, one therapist-participant employed more general questions that appeared designed to encourage the client-participant to reflect on his experience of the situation he were describing:

C27-2: And, um, now neither one of them has any motivation to, like - get a job back - or something started up again...I mean, he could go to like, literally, he should be at least able to get a bar job...or a serving job right off the bat. But he...doesn't care, and he's kinda going through like this really hard slump that no one can really pull him out of. And every time he drinks he turns into, like, this totally different person - he's just an asshole. And...I don't know...

T28-2: What's it like to live with someone like that?

C28-2: [sighs] I hardly ever talk to him, he's kind of in...every time he does something stupid he ostracizes himself even more. He'll like drunk and...like, for a while he stopped drinking...cuz he started to realize that it was a problem. But he's back to doing...back to drinking, and back to doing whatever, and just isn't [shakes head and shrugs shoulders] doesn't really care.

T29-2: And what is it like for you?

C29-2: Oh. It's um (2)...I don't know? It's more - like kinda awkward - cuz he used to be a really good friend, ya know? He used to be someone I could depend on...someone I could even talk to. Now it's...feels like every conversation we have is forced - it's kinda just like - Oh. Hey...[strained voice/expression]

How's - it - going...Ya know? Kinda awkward...

In this particular example, the therapist-participant used two experience-oriented questions back-to-back in order to help the client deepen his awareness and understanding about his experience of his roommate. These questions not only helped the client shift from content to experience, but also prompted the client to consider the relationship rather than just his peer's behavior.

Emergent Themes Within Participants

For each of the client-therapist participant pairs in which experiential acceptance was coded (4 out of 5 pairs), the emergent themes and accompanying session process are presented for each session that was included for coding. General comments about the two sessions coded per client-therapist pair as well as a brief mention of missed opportunities are also provided. Please see the Discussion Section for a complete discussion of missed opportunities and session dynamics that may have inhibited experiential acceptance. As indicated in the Method Section, an emergent concept or topic was determined to be a pattern only when it was coded twice or more across both sessions for each client-participant/therapist-participant pair.

Client-Therapist Pair 1, initial coded session. The first coded session for client-therapist pair 1, was the fifth individual psychotherapy session. Client 1 was a 23 year-old Latina initially diagnosed with Anxiety Disorder NOS and Borderline Personality Traits. In this session, there were no codes for experiential acceptance that occurred frequently enough to be classified as an emergent pattern or theme. In fact, there was only one instance of experiential acceptance coded in the session out of 125 talk turns: Shifting from Content to Experience. This instance occurred at the beginning of the session, when the therapist was reviewing the results of the Outcome Questionnaire administration. Specifically, the client and therapist discussed the client's response to others criticizing her alcohol and/or illicit substance use. The client then

reported that she has cut back her alcohol use to just on the weekends:

C12: Um, I haven't really actually heard anything from anyone in the last couple weeks. Um, cuz I think that I wasn't doing it every night, like I kinda cut back on it and just went back to the weekends and stuff. So, I haven't really heard anything. But still, if it comes up, I still get annoyed.

T13: [Therapist chuckles] How does that feel for you, cutting back to just the weekends?

C13: Um, it feels better.

In this exchange, the therapist used a feeling-based question to transition the client from discussing content to reflecting on her experience of making a positive change (reducing alcohol consumption).

Client-Therapist Pair 1, later coded session. The second session coded for this client-participant/therapist-participant pair was approximately the 25th session. In this session, the therapist utilized four comments and questions (out of 121 talk turns) aimed at shifting the client's thinking away from unhelpful thoughts toward a stance of detachment or questioning. This recurrent code, within the current session, was termed Reducing Struggle Through Cognition. Although this code occurred multiple times for this participant, it was not present in other sessions, and therefore was not included as one of the across participant sub-themes. For example, when the client talked about frustration in her relationship with her partner, the therapist responded:

C115: Cuz like, he'll come back and complain. I can't believe he did this...[throws her hands up] what do you want me to do?

T116: And it's another one of those, you know, you can't change what other people do, you can only change your own interactions with those people, your own responses to them, your own choices...

In this example, the therapist encouraged the client not to fuse with her perception of the situation; rather, the therapist encouraged the client to employ flexibility in thinking and responding.

The therapist also utilized one comment that shifted the client to focusing on her moment-to-moment experience. The instance of this code occurred at the beginning of the session, during what appeared to be an initial-check in:

T15: Okay, um, how, where are you right now on your scale of 1 to 10?

C15: [while yawning] my mood or my [unintelligible, guessing "anxiety"]?

T16: Let's do mood first.

C16: I'm tired. [Client laughs]. I'm tired and kinda lazy, like one being like horrible and ten being the greatest, I'd probably say like, 5 or 6.

T17: Okay. And what about for your anxiety?

C17: [while yawning] [unintelligible mumble/yawn]. 3 or 4. Yeah I have homework and I have a lesson I have to write but I'm not, ch- worried about it. Like I was like, I should be chickened out about it, but I'm not because it's in a different format and she asked for different things and it's not like, I'm not chickened out.

This particular example of encouraging the client to shift her awareness to the current moment appears to be different than previous examples in other client-participant sessions. Although the therapist still signaled the shift to the here-and-now by using the words "right now," this shift occurred within the context of a specific intervention (emotional scaling) rather than as a part of

the larger session process. The specific scaling question allowed the client to reflect on her mood and anxiety in the moment, consider the contextual contributions to her mood/anxiety, and assess the intensity of her current experience. In fact, following this initial intervention, the session continued to involve a review of patterns in the client's mood and anxiety over time.

Client-Therapist Pair 1, session comparison and missed opportunities. The dynamic in both sessions for this client/therapist-participant pairing appeared somewhat friend-like. A number of opportunities for acceptance-based interventions were therefore missed because the therapist often got caught up in her own curiosity and/or non-relevant self-disclosure. For example:

C15 Well that and money, man. [Therapist laughs] It's expensive!

T16 It, those are expensive habits.

C16 [Unintelligible] expensive...

T17 I had a cocktail the other night and it was eleven dollars for one drink, so...

C17 That's crazy. See that's what, if I'm going to buy something from a bar I gotta make sure it's like a heavy, hard drink cuz thats when it's worth it. You know, thirteen dollars for an AMF or something, [shrugs] it's worth it.

T18 Yes.

C18 It's good, so, you know.

This discussion occurred in the context of discussing the client-participant's recent decrease in alcohol consumption. The therapist first briefly asked a process-oriented question about what it was like for the client to cut back (see Client 1, Session 1 for the exchange). Instead of staying with the process, or encouraging the client to further reflect on this experience, the therapist

appeared to get distracted by the client's comment about the price of alcohol and utilized self-disclosure.

Similarly, when the session 1 discussion content turned to the client's identified presenting problem, procrastination, the therapist again appeared to favor his/her own personal knowledge and problem-solving over connecting with the client's feelings and experience of this concern. For example, when discussing the client's difficulty keeping track of assignment dates, the following exchange occurred:

C27 Um, in terms of assignments when they're due, I do write them out, and so I can see it, and then I just, do work off to- do lists. Like, of all the things that help me, to-do lists are the one thing that gets the closest to actually having me do something, you know.

T28 Mm-hmm. Have you ever tried working with, um, Outlook? Outlook has a calendar in it, that has, you can put in, you know, when your assignments are, and put in a to-do list, and put in, Here are reminders to myself about these things that are to do.

C28 No, I haven't looked at Outlook. I'll check it out. It seems so, it seems so confusing to me.

T29 And, and I think it is that at first, and then you have to remember to always have it open, and stuff like that. It's just, you know, trying to find something that works for you is a good...

C29 Yeah.

T30 ...reminder. So tossing out, you know, there's the google calendars and you can even have that, that will text message your phone with reminders.

- C30 Are you serious?
- T31 Yeah.
- C31 That's cool.
- T32 Yeah, and you can set up the google calendars with reminders to your phone, and... that's neat.
- C32 That's cool.
- T33 ...that's neat. And you can have it email you each morning with, This is what you're supposed to be doing today, this is what's on your calendar for today.
- C33 That's cool.

In this example, the therapist turned to problem-solving through technology rather than helping the client express her struggles and/or current feelings. The client's repeated "That's cool" response to the therapist's repeated suggestions to use Outlook or Google Calendar, especially after the client indicated confusion, may signal that she is not engaged with or following the therapist during this discussion.

Of note, the type of experiential acceptance codes in this client-therapist pair was different than all other client-therapist pairs' sessions. This therapist appeared to favor flexibility in thinking as an intervention strategy, especially in the later session. Therefore a separate concept category, Reducing struggle through cognition, was created in order to capture the specific session process of this client-therapist pair, but was not elevated to a between session sub-theme given its uniqueness.

Client-Therapist Pair 2, initial coded session. The first session coded for this client-participant/therapist-participant pair was the fifth psychotherapy session. Client-participant 2 is a 29 year-old Caucasian female initially diagnosed with Anxiety Disorder NOS. During this

session the therapist used process comments to challenge the client's assumptions about her thoughts, emotions, and sensory perceptions:

C210: I'm not giving myself so many reasons to cry anymore?

T211: You're not giving yourself reasons? Or there aren't reasons

The therapist also encouraged the client to engage in an awareness-raising or self-monitoring exercise, which could be related to mindfulness:

T50: So if you want to, ya know, just think about [clears throat] what you're feeling about the situation before hand and then what actually happens. Um...

However, these comments did not occur frequently enough to rise to the level of an emergent experiential acceptance concept or topic. More specifically, there was only 1 of each of these codes (i.e., self-monitoring, challenging assumptions) out of 282 total therapist comments.

Client-Therapist Pair 2, later coded session. The second session coded for this client-participant/therapist-participant pairing was session number 22. During this session, the therapist utilized a comment that shifted the client's awareness from content to experience (occurred once within the session, out of 280 total therapist statements). The instance of Shifting from Content to Experience occurred during a discussion about the client's family of origin. Interestingly, despite this session occurring at the end of treatment, the therapist used this discussion as a way to gather information about the client's family composition and childhood psychosocial history. After a brief period of information-gathering, in which the client explained that her mother was emotionally and often physically absent for the majority of her childhood, the therapist shifted the client's awareness from content to experience through a process question:

C174: [Shakes head] They don't, well, my sister just, she just shut herself off and created her separate, life. Ya know, she worked after school, not to contribute to the household or anything. She was worthless in that regard, but

T175: And you, gave everything to, try to get the household to run because your mother...what was your mother doing?

C175: She actually gave up on it, like there were phases, my mom was working, she had several jobs. Um

T176: Are you? Do you have any sort of, like, feelings (3) against your mother for putting you in that position?

C176: Uh?

T177: Or, your father for that matter?

C177: I mean, I know I used to. I had A LOT of resentment towards them, shit tons. I was horrible to them.

In this example, the therapist-participant's question about the client's feelings toward her mother encouraged the client to reflect on how she felt about the situation, rather than the details of what happened. The comment appeared somewhat abrupt, and the client may have had difficulty understanding this transition as evidenced by her comment of confusion (i.e., uh?). The client nonetheless was able to shift to discussing her reaction to the situation she described, although she described past reactions rather than present-moment feelings. Once again, these interventions did not occur frequently enough to rise to the level of an emergent theme or topic.

Client-Therapist Pair 2, session comparison and missed opportunities. Although the Client 2/Therapist 2 pairing had three total instances of experiential acceptance coded, no individual codes occurred more than once across the two sessions. A review of the transcript and

accompanying Missed Opportunities notations revealed a pattern in which the therapist appeared to have difficulty balancing content and process. Notably, there were several instances in which the client was discussing emotional material, and the therapist followed up on content, rather than focusing on the feeling or emotion behind the client's statements. The following excerpt from the later session, which began with the client discussing her frustration with her current student teaching position, illustrated an example of this dynamic:

C21: Yeah. I feel like I have to like hold the light [holds hand in the air as if carrying a light] in the classroom. That's the only way I can really describe it cuz she's negative and she's not real. The kids can never get any kind of human connection with her. Um...

T22: Wait, she's the teacher in a...

C22: She's my master teacher

T23: OK...

C23: At [identifying information redacted]

T24: Oh, OK, so she's the...

C24: I'm like observing under her...

T25: Oh! That must really affect the kids too, then.

C25: I mean, they're great. The kids are good. It's...it's not horrible. I've seen worse, but it could be so much better if she would just give a little [brings hands together in a gathering motion]. She doesn't have the...she doesn't think that learning is fun. I mean one of my first days student teaching she like drilled them that you know, "We are not here to have fun."

T26: How old are they?

This example not only represents a missed opportunity for the therapist to have implemented an experiential acceptance-based intervention, but also is a missed opportunity for the therapist to have validated or reflected the emotional content that was implicitly communicated by the client in C21.

Moreover, the therapist then moved the discussion away from focusing on the client in favor of a focus on the children in the classroom and gathering factual information. This dynamic was observed by the coders to continue throughout the session. The following excerpt represents another example in which the therapist missed an opportunity to shift the client from content to experience and/or to facilitate moment-to-moment processing:

C42: But um...Yeah, I guess I'm just trying to allow myself to really [clears throat]...Also it's part of me allowing myself to be loved by Tim and realizing that I'm more important...He knows I'm more important than these other women. It's can I realize that he sees that and that's not going to shift [snaps her fingers] suddenly, abruptly

T43: Right

C43: Um, so...

T44: That's good [smiles]

C44: Yeah [smiles], so that's good.

T45: So did you have any other encounters with the other women?

C45: No... I mean they just are like around.

Again, the therapist appeared to favor content over process, and moved the discussion forward using a fact-based question (T45). Another general pattern across the two sessions was the therapist's notable reliance on questions (again, that were primarily content-based). Although

questions related to gathering information are expected in early sessions, this pattern continued in the second session that was coded. In fact, the therapist spent the end portion of the later coded session gathering familial information (i.e., how many siblings the client had).

Client-Therapist Pair 3, initial coded session. The first session coded for Client 3, a 23 year-old Latino diagnosed with Adjustment Disorder upon intake, was the fifth psychotherapy session. During this session, the therapist-participant asked questions that brought awareness to the current moment (coded twice in this session out of 246 talk turns) and shifted the client from content to experience (coded once in this session).

Toward the middle of the session, the therapist-participant shifted the session discussion to focus on client's previous report of symptoms of depression, including sadness. The therapist-participant mentioned the ebb and flow of the client's reported sadness, and then brought the client to the current moment:

T104: Um, okay. So I wanted to ask you a little bit more about when you were feeling more sad. Do you feel like, I remember a few, a couple weeks ago you said that you feel like you did before, you don't feel sad at all— You know, you don't feel sad at all...

C104: Exactly.

T105: Do you still feel that way right now?

C105: Um. Like I said, everything is less, you know, well since I've [been?] to you guys, the last two weeks— Everything been okay. I have been talking to people and I'm just back to myself and I'm, I can see myself walking with my head up and everything. Just today [Gestures], started to bring [Unintelligible] stuff, you know, from 6 months ago, getting in a fight and everything, so...

In this context, the therapist-participant's question, "Do you still feel that way right now?" represented a transition in the process of the session and prompted the client to reflect on the experience of his feelings over time. The content of the session that follows was notably more emotion- and self-focused. For example, whereas up until this transition the client was talking mostly about his mother's behavior, after this exchange, the client and therapist focused primarily on the client's feelings and role in his interpersonal relationships.

Specifically, the client and therapist talked more in depth about the client's reported interpersonal difficulties and how they might be related to lack of trust and vulnerability. When the client-participant appeared to move back into the content of what was happening in his relationships, the therapist responded with a question aimed at shifting the client from content to experience:

C157: (11) My, the— It was the last time my dad kept telling me that I was stupid for having the girls and not dating (?) her mom. So yeah, it just...

T158: Yeah.

C158: That's where I see, you know, the connection that everybody's out just to to backstab me and that's about it.

T159: Like they're all trying to hurt you? [Clinician appears extremely calm; hand on neck for great majority of session].

C159: [Nods head].

T160: (9) How does it feel talking about it like this?

C160: It feels good that I am actually releasing it but at the same time you know it makes me think, and you know...

T161 Like there is a lot of connections? [Gesturing].

C161 Mm hmm.

The therapist-participant's question, "How does it feel talking about it like this?" followed a brief period of silence and helped to focus on the client on his internal experience as he explained interpersonal conflict. Although the client responded in a cognitive way to a feeling question, the question still served the purpose of encouraging the client to express his experience to the therapist, in order to further process this experience in the room.

After this exchange, the therapist-participant and client-participant continued to discuss trust. The therapist-participant drew a connection between the client's lack of trust in relationships and the client's tendency to present a false social self. The therapist and client then turned their attention to exploring how the client was reacting to reflecting on his current and past interpersonal relationships. Following a period of brief silence, the therapist again prompted the client to focus on his experience in the here-and-now:

T167: What would it mean if they did? (5) We all have weaknesses. (18) It is really interesting that, you know, cuz we don't have the time usually to sit down and really think about things like this but when we do just to see these different connections and how things that we've experienced have affected us in some ways. Some ways good, some ways bad.

C167: Mm-hmm.

T168: But it's very interesting [Looks down]. (8) What are you thinking right now? [Makes direct eye contact; Orients face toward client].

C168: Actually, my mind is really, it's clear right now.

T169: And seeing all this, I mean it's not— To some degree I think it gives us more power because it helps you to learn more about why things are the way they are, you know, every little piece of— Every time you go, "Hey, really that makes sense." Every time you kinda have those moments...

C169: [Nods; Chuckles]. Exactly.

T170: Its, it might feel a little, sometimes a little scary or a little weird but nothings changing [Gestures]. The only thing that's changing is that you have more control and more knowledge about it. And through that, I like to say, you know, being aware of something is the first step to doing anything else. You have to actually know that there is something there to change it or to think about it or to do something, you know?

In this exchange between the client and the therapist, the therapist noticed that the client was already reflecting on his current experience, and invited the client to share his moment-to-moment experience. This session concluded with the therapist and client continuing to reflect upon the client's interpersonal relationships.

Client-Therapist Pair 3, later coded session. The second included session for this client/therapist pair was the 25th individual psychotherapy session. The client spent a considerable portion of the session detailing the difficulties he has had navigating a co-parenting relationship with his ex-partner. About halfway through the session, the therapist asked a question that shifted the client's focus from content to experience (occurred once during the session out of 289 total therapist statements).

The instance of Shifting from Content to Experience occurred in the context of a discussion about the client's ex-partner and his children. Up until the following exchange, the

client primarily related content to the therapist (e.g., what the ex-partner does, examples of arguments):

T153: Sounds like she, that she hasn't put her share, ya know

C153: Exactly. Um, Disneyland. First time I took them to Disneyland. I called her, you know?

Give me some money for I could go? She gave me ten dollars each [waves off with hand and laughs] - same thing, shove where, wherever the sun doesn't, ya know? Take your twenty dollars!

T154: How does it make you feel, when she does stuff like that?

C154: It pisses me off! Cuz I'm telling you, it's not for me, it's for the girls!

T155: What do you think pisses you off about it?

C155: What am I gonna do with, OK fifty dollars? What am I gonna do with fifty dollars when the entire tab was six hundred and something dollars? Or the Disneyland thing? Ten dollars what you gonna buy in Disneyland [unintelligible]

Although the client's language and description in the second line of the exchange (C153) communicated that he was angry (e.g. "shove where, wherever the sun doesn't..."), it wasn't until the therapist asked a specific process question that the client was able to focus on the emotion that informed the way he described the situation. The therapist-participant then continued to deepen the client's experience by asking him to reflect upon the connection between the nuance of the situation and his anger. The session concludes with the therapist commenting on the dynamic between the client and his ex-partner as well as a discussion of the client's current coping skills.

Client-Therapist Pair 3, session comparison and missed opportunities. The sessions coded for this client contained four total examples of the Increasing Awareness theme; namely,

Shifting from Content to Experience (two examples across the sessions) and Bringing Awareness to the Current Moment (two examples across the sessions). Notably, the majority of experiential acceptance that was coded occurred in the first of the coded sessions. These codes were primarily within the context of a discussion of material that was activating for the client.

A review of both transcripts seemingly illustrated a change in the therapist's approach over time from a reflective, process-focused approach to a more cognitive, interpretive style; although it should be noted that other approaches were not explicitly coded for. For example, in the following discussion, the therapist appears to attempt to build insight/awareness through cognitive means rather than through focusing on the client's willingness to engage with his internal experience:

C158: The whole party thing...she knows when I do it. I do it every year in November, eighth, ninth, somewhere around there...

T159: [nods] What message do you think she's sending when she gives only ten dollars? And she gave, ya know, only fifty dollars for, ya know, like the party, or only keeps the kids for three hours and then calls you back to pick them up. What, what do you feel is like the message she's sending with that?

C159: [shakes head] Never really thought about it

T160: Cuz, it sounds like that's pissing you off. Like you're getting a message from her when she's doing these things, it means something to you, and you're, you're getting mad. And I'm, I'm...totally, ya know...of course, you should get mad.

This discussion occurred in the context of the client expressing his frustration about his ex-partner's lack of responsibility in their co-parenting relationship. Rather than asking the client to engage with his feelings of anger, frustration, and hurt in order to build insight and reduce

emotional dysregulation, the therapist appeared to try to build awareness through directive cognitive means. The therapist asked the client cognitive reframing questions in order to deepen the client's understanding of the situation.

Similarly, in an effort to reduce depressive symptoms, the therapist again turned to a cognitive intervention:

T278: But, even if it's just a little bit, if it makes you feel good for just a little bit - a little while - it's something that can help. And so, it's just always important to remember that. So, um, if it's OK with you I'd like you, every once in a while, you know, think about, try to think about things that you have or that you've seen that you're doing, that are good, that make you feel good. Even your daughters. You could think about your daughters too, like what good thing did my daughter do today? Or what did she do? Oh, she got a B on this little paper...oh she did show and tell, and she was happy about showing this, ya know, special shiny rock that she found in the yard...whatever it is

C278: Exactly

T279: All those things count. Um, so use them to your advantage. Um, I'm gonna ask you again [laughs] So have some more for me next time

C279: [laughs] It's all I came up with right now, but I did think about it, I was thinking about it when you told me, and then I just thought...ok, well I'm not gonna say it now - and then I stopped thinking about it. So just now you got me, and I'm like, uh???

T280: No, you can't stop when you're not here, you gotta keep going.

C280: Exactly [laughing]

T281: If you can try to get yourself to think about it once a day, I mean you don't have to like sit there for hours and like meditate on what's, ya know, good in your life...

Although the instruction seemingly encouraged the client to be more present in his day-to-day life by reflecting on positive experiences, the therapist did not encourage this kind of engagement with the current moment during the latter session process.

Moreover, the therapist's tendency to resort to cognitive interventions resulted in the therapist having to explain reasoning behind an intervention, and give examples to illustrate a concept. Therefore, many therapist comments in the latter session were lengthy and may have confused the client. The following discussion is an example of this dynamic:

T283 Yeah, that's totally true. You know, this one person told me about one thing that they experienced, that they didn't think of it, it was like after a while that they started like thinking about these things. And they told me that they saw this one older lady that was waiting for a bus, at a bus stop, I think she had a really nice hat on? So the person just went up to her and said....Oh, your hat looks really nice on you, it looks really good! And, she smiled. And you know, the person walked away and when she turned to look at her, she was still smiling. You know, and that...that didn't seem like - oh so what, and so dumb, but...you don't know what

C283 Maybe she's

T284 Exactly! You don't know what that other person's life is like

C284 You know what, I've been thinking about that...when I've been driving I've been people like, just sad. I try to tell them get over it - you'll be ok!

T285 And, saying that to that person - ya know, maybe that person never gets compliments about how they look. You know? Maybe they don't have family or

anything and they live alone? And for this one stranger to say - to notice that and say something to them probably made them feel good! Even if it wasn't their biggest deal of their whole life. Maybe just for that little while...

C285 Exactly

In this example, in addition to the previous example, the therapist did most of the talking and appeared to get caught up in explaining a gratitude-based cognitive intervention.

Client-Therapist Pair 4, initial coded session. The first session coded for this client-participant/therapist-participant pairing was the fifth psychotherapy session. Client 4 was a 20 year-old Caucasian male initially diagnosed with Alcohol Abuse and Partner Relational Problem. In this initial coded session, no experiential acceptance concepts or patterns were identified because no acceptance code occurred two or more times. However, the therapist was coded as utilizing the Increasing Awareness interventions of Shifting from Content to Experience (occurred once out of 180 therapist comments) and Bringing Awareness to the Current Moment (also occurred once out of 180 therapist comments).

The instance of Shifting from Content to Experience occurred toward the beginning of the session during a discussion in which the client reported that his partner looked up all of his ex-girlfriends on MySpace.

T24 [Clinician, hands elevated in front of her, moves them back and forth in front of her.] How do you feel about that?

C24 Well - You know of course it's a little intrusive when my - past - but I can't really - Um - I guess it is for everyone to see and - I don't know, it's weird. Because she like, "Well I'm was just curious about the people you used to date."

This instance of shifting the client from content to experience represented a transition in process from the client discussing what his partner had been doing, to how he was currently reacting to the situation.

Later in the session, the client expressed doubt over his relationship with his partner. The instance of bringing the client's awareness to the current moment occurred within this context:

C56 Or, ya know, she says all the time she's looking for reassurance, or she's looking for me to say something - and when I try to...I just can't come up with what she's looking for, or (3), I don't know? And, that's where it gets to the point where - I don't know if we're compatible with each other...

T57 [Nodding] What's going on in you right now? You look like...something's going on inside...

C57 I don't know...um...I don't know, I'm sad? That I'm talking about - prospectively breaking up with her.

The therapist signaled the transition in process to the current moment by using the words “right now.” This transition in process was somewhat unique because the therapist paired the question with an observation/reflection of the client's current body language, which further encouraged the client to reflect on his current feeling state. The client was then able to take a moment to identify his emotional reaction to the content of the session.

Client-Therapist 4, later coded session. The second session coded for this client/therapist-participant pair was the 97th session. The client remained in therapy for over 100 sessions, which is the longest course of therapy of the five study participants. This second session included eight experiential acceptance coded comments out of 148 total therapist statements.

Bringing Awareness to the Current Moment occurred two times in the session. Both instances of Bringing Awareness to the Current Moment occurred about halfway through the session, within the context of a discussion about the client's grief. The client talked about some of the things that he missed out on because his father had substance abuse concerns and later passed away:

T74: Things that your dad didn't do. Do you think that you might be...angry or sad or...

C74: Yeah (6) [looks at window]

T75: What are you thinking about right now?

C75: I don't know...I was just staring (4)...[rests hand on chin]...I don't know. Just sad, I just wish he was older when he had passed away...I think that's the one...the one thing. Or that he'd gone through all this when I was older. Ya know, I always think back, and I wonder what I could've done, now that I have the faculties to actually do something. (2) So, I don't know...

In this example, the therapist noticed the client pause to reflect. The therapist gave the client space to do so (short pause in C74) and then invited the client to share his thoughts in the moment. The therapist signaled the transition in process to the current moment by using the words "right now." This question deepened the process of the session, and moves it to a powerful place by allowing the client to verbalize his grief over his father's substance abuse and death.

This exchange also included a shifting from content to experience code (T74; discussed further below). The client and therapist continued to process client's grief. It is in this context that the second instance of Bringing Awareness to the Current Moment occurred:

C88 [nods] Mm hmm (10) [shifts gaze to window] um...[looks down...sighs] (5) ...um,
I don't know what to say? Just...

T89 Well, how are you feeling right now?

C89 Sad...it's kinda - not really sad, but kinda...I just miss my dad. It's just so...[throws
hands up]...what I was going to say - it's just so...so, [smiles] why is it...uh...(5)

T90 Why is it, what?

Shortly before this exchange, the client talked about struggling with thoughts about being angry at himself for not helping or saving his father, and also knowing that there is nothing that he could have done. When the client appeared to have difficulty expressing and creating a narrative out of these competing thoughts, the therapist used a process question to help the client focus on the current moment:

C88 [nods] Mm hmm (10) [shifts gaze to window] um...[looks down...sighs] (5) ...um,
I don't know what to say? Just...

T89 Well, how are you feeling right now?

C89 Sad...it's kinda - not really sad, but kinda...I just miss my dad. It's just so...[throws
hands up]...what I was going to say - it's just so...so, [smiles] why is it...uh...(5)

T90 Why is it, what?

In this example, the bringing awareness to the current moment question (T89) could be seen to serve two purposes. Not only did it appear to help the client focus on his current internal experience rather than try to explain his thoughts over time, it also shifted the client from

thoughts to the affect that might be underlying some of his distorted thought processes (e.g., believing he could have saved his dad as a teenager). Once again, the therapist signaled the transition in process to the current moment by using the words “right now.”

The second experiential acceptance concept coded was Shifting from Content to Experience, which occurred four times in the session. One instance of this code occurred during the previously mentioned exchange in which the client and therapist discussed the client’s grief:

C71 Well, she knew him 'til she was in her 40s, so probably a lot better than mine and my dad. So...she probably knew him more than [unintelligible]...I don't know...maybe she was in her 30s, still he got to live 'til he was 80 something - 'er 70 something.

T72 Mm hmm

C72 Er...actually he was 60 something...69?

T73 Mm hmm. Well, you know she probably had a chance to grow up with him and have him watch her grow up.

C73 Kinda.

T74 Things that your dad didn't do. Do you think that you might be...angry or sad or...

C74 Yeah (6) [looks at window]

In this exchange, the client was comparing his mother’s relationship with her dad to his relationship with his dad. The client appeared to get caught up in specific content-oriented details (i.e., age differences), which was when the therapist first reflected content to help the client focus on the main idea of what they were talking about, and then asked a closed-ended question that helped to shift the client from the content of the comparison to his experience. This question

signaled a transition in process within the session, as it was after this exchange that the client and therapist were able to more deeply explore the client's grief.

In another example of Shifting from Content to Experience that occurred shortly after the above discussion, the therapist again utilized a closed-ended feeling question:

T81 One of you wanting to individuate, and move away from your parents. And you know, kind of the...the desperation and the kinda, cry for help...and, the - ya know - the things that your dad was going through and you couldn't do much about anything. Even if you hadn't been pulling away...

C81 Yeah...guess so...that's the hard part.

T82 I wonder if you're angry at yourself?

C82 Ya know, I'm not really angry at myself...but when I think back about it, I kinda try to push that on myself - but I know it's...it's full of S - so I don't like...I don't let it get to me - or even to me, or let it get that far, or where it's like a...any consistent thought in my head...

In this example, the therapist's question seemingly followed up on client's statement that alluded to a feeling (C81). Prior to this exchange, the client spoke about his wish that his father had died when he was at an age when he could have done something to help him, or wasn't so concentrated on being an independent teenager. This question helped the client to further explore his conflicted thoughts and feelings.

The third concept coded was classified as Shifting Thinking, which occurred twice in the session. This concept was unique to this client-participant/therapist-participant pairing, and only occurred during this specific session. Shifting Thinking is defined as a therapist intervention that helps the client to recognize that a thought is just a thought. Both examples of this code occurred

in the same context as the above exchange in which the client was reflecting on his thoughts about his role in the course of his father's substance abuse:

C82 Ya know, I'm not really angry at myself...but when I think back about it, I kinda try to push that on myself - but I know it's...it's full of shit - so I don't like...I don't let it get to me - or even to me, or let it get that far, or where it's like a...any consistent thought in my head. But,

T83 So the thought come up...

C83 The thought comes up - like what...what? Ya know...

T84 But you're able to realize...

C84 Yeah, that's it's kinda...

T85 ...that it's just a thought....

C85 ...yeah, that it's me thinking about it now versus who I was at 16 or 17, so it's not so...

A few talk turns later, they continued this discussion:

T88 Even if the thought isn't true, or it's not a helpful thought - at the same time - it means that you cared and you miss your dad.

C88 [nods] Mm hmm (10) [shifts gaze to window] um...[looks down...sighs] (5) ...um, I don't know what to say? Just...

In this therapist/client exchange, the therapist helped the client to defuse from his thoughts that there was something that he could have done to help his father. The therapist, in particular, attempted to help the client to focus on the concept of the thought as just being a thought, not a concept that he has to buy into or believe.

Client-Therapist Pair 4, session comparison and missed opportunities. The sessions

for this client/therapist pairing had the most coded instances of experiential acceptance interventions across the five participants. Interestingly, the later coded session, in which most experiential acceptance codes occurred, was the only session in which the therapist and client discussed feelings of sadness overtly. The powerful discussion about the client's grief provided the context for all instances of coded experiential acceptance. Nonetheless, there were a few missed opportunities for the therapist to use an acceptance-based intervention, particularly in the first session. In the initial coded session, the client spoke at length about his relationship with his girlfriend. The therapist and client appeared to have difficulty getting on the same page with how the client was experiencing the situation:

T39 Are you mad?

C39 No, I wasn't...

T40 Are you...sad?

C40 What made me mad is, that she left...and then I got upset...and, I wasn't sad, I'm not mad - I could care less about the letter, I mean, I forgot half of what it said.

This example occurred in the context of a somewhat confusing discussion about a recent incident that the client had with his girlfriend. The therapist could have asked an open ended questions to bring the client's awareness to the current moment, in order to help him understand his experience better. For example, instead of asking back-to-back closed ended feeling questions (e.g. T39-T40), the therapist might have had more success asking a question such as "as we talk about this incident, how are you feeling right now?" Other instances of missed opportunities in this session were similar and seemed to follow a pattern of the client and therapist getting out of

sync, and struggling to return to the process of the session (please see Discussion section for a more in depth review of this pattern).

Chapter IV: Discussion

Although existing literature suggests that experiential acceptance is a useful tool in reducing emotional dysregulation associated with many presenting problems in the psychotherapeutic context, there is minimal research that explores how therapists actually help their clients to engage in or use experiential acceptance. Even less is known about how and if therapists who are not using a specific acceptance-based model (e.g., DBT, ACT) utilize experiential acceptance in the course of therapy-as-usual. Accordingly, the current study sought to explore how therapists elicited experiential acceptance in the context of psychotherapy with emerging adult clients. In order to address this issue, the researcher utilized inductive content analysis to examine how therapists at two university-based community counseling centers utilized experiential acceptance.

The findings from this study illustrated that, despite a growing body of research citing the efficacy of acceptance-based interventions such as radical acceptance, mindfulness training, and abandoning a change agenda (Öst, 2008), trainee therapists did not frequently implement these interventions with emerging adult clients in therapy-as-usual. Instead, experiential acceptance was utilized quite infrequently (23 times across 2001 talk turns). More specifically, inductive content analysis across ten psychotherapy sessions, representing five client-therapist participant pairs, revealed no overall parent themes that were present in all five participants. In fact, one client-therapist participant pair did not have experiential acceptance coded in either transcribed session. For additional information on frequency across client-therapist pair sessions, along with known client and therapist variables, please see Appendix I.

However, there was one higher-order theme that was present in the majority of the participants (3 out of 5 participant pairs): Increasing Awareness. In other words, when

experiential awareness was used, it was observed to occur in the form of discrete process-oriented comments that appeared to be aimed at increasing clients' awareness of their internal experience (namely, bringing the client's awareness to his/her moment-to-moment experience and shifting from content to experience). More complex acceptance-based skills such as explicit distress tolerance training (e.g., helping the client to realize the flux of emotional states over time and/or helping the client not to buy into thoughts as truths) were not observed. Noted missed opportunities for therapists to implement experiential acceptance included discussions in which the therapists had difficulty balancing content and process and discussions in which clients expressed anger (typically related to interpersonal relationships). Thus, it is hoped that this study will shed light on opportunities for psychotherapists to implement acceptance-based interventions in helping emerging adults to increase their willingness to experience life as it occurs, to embrace the process of exploration, and to tolerate unpleasant emotions that may arise as they confront the ambiguity that is often characteristic of the emerging adult period.

This chapter begins with a discussion of specific patterns found in the data. First, the parent theme, Increasing Awareness is described in the context of the literature and is accompanied by its two sub-themes, Bringing Awareness to the Current Moment and Shifting from Content to Experience. Next, themes that were observed within participants are discussed in the context of current literature. Limitations of the study are then presented, followed by a discussion of the contributions from this study and implications for future research in the area of experiential acceptance use with emerging adult clients.

General Findings

Parent theme: Increasing Awareness. The Increasing Awareness theme was defined as therapist interventions or comments that were aimed to deepen a client's ability to perceive, feel, or to be conscious of thoughts, emotions, and/or sensory patterns. This parent theme fits with literature describing the acceptance process within the context of third wave cognitive-behavioral therapies. In particular, increasing the client's awareness of his/her internal experience can be conceptualized as the most basic acceptance-based skill to master. For example, Linehan et al. (1991) noted that the first step in helping a client develop radical acceptance is increasing the client's awareness of what is (i.e., his/her experience). Similarly, Kabat-Zinn's (1994) definition of mindfulness (a practice discussed in the literature review as conceptually related to acceptance) emphasized intentional awareness of sensory perceptions, including emotions and thoughts.

As such, therapist comments or questions that focus on helping the client to intentionally increase awareness of experience, as found in this study, can be conceptualized as a basic acceptance-based intervention that can then set the stage for more advanced skill-building (McKay, Wood, & Brantley, 2007). More advanced acceptance-based skills include, but are not limited to, abandoning a change agenda, explicit mindfulness training/skill-building, and building distress tolerance skills. No examples of these skills were observed in the present study, which could be explained by such factors as the therapists' level of training and the therapists' amount of exposure to third wave interventions (discussed further below).

Moreover, interventions that increase the client's awareness of his/her experience may be particularly useful for emerging adult clients. One of the most salient developmental changes that occurs during emerging adulthood is the maturation of the prefrontal cortex, which allows for

self-evaluation, emotion regulation, and the ability to modulate risk-taking behaviors (Siegel, 2007; Simpson, 2008). As such, therapy that focuses on helping them to solidify and hone the capacity to self-reflect, engage in metacognition, and increase awareness of their internal experiences may help to reinforce adaptive neuronal and synaptic networks that will persist through synaptic pruning (Spear, 2010; Stuss & Knight, 2002). To further explore the *increasing awareness* parent theme, its two lower level categories are next discussed: Bringing Awareness to the Current Moment (0.29% of talk turns) and Shifting from Content to Experience (0.45% of talk turns). Bringing Awareness to the Current Moment and Shifting from Content to Experience are two separate, yet related concepts that promote the opportunity for clients to respond mindfully to a situation. Shifting from Content to Experience statements were interventions that helped the client focus on what Linehan et al. (1991) referred to as what is. Similarly, Bringing Awareness to the Current Moment were interventions that focused the client on the “what is” in the here-and-now.

Sub-theme: Bringing Awareness to the Current Moment. Bringing Awareness to the Current Moment was defined in the current study as therapists’ comments that prompted client-participants to be present in the here-and-now process of the psychotherapy session. Awareness, as noted above, is a particular target for acceptance-based interventions, and is often noted as the precursor for an acceptance-based or mindful response (Dimidjian & Linehan 2003). In ACT, for example, intentionally bringing a client’s awareness to the current moment in order for the client to observe his/her experience may be looked at as the first step in acceptance. Later steps may include perceiving that moment in a nonjudgmental way, abandoning a change agenda and/or choosing to act in accordance with one’s values (Hayes & Strosahl, 2005).

Moreover, therapist comments that were categorized as *bringing awareness to the current moment* are reflected in the multiple definitions of experiential acceptance that have been posited thus far. For example, the act of bringing awareness to the current moment is closely related to how Hayes defined acceptance: A moment-by-moment process of actively engaging with one's private events (experience) without attempts to change their frequency or form (Hayes & Strosahl, 2005; Hayes, Strosahl, & Wilson, 1999). In particular, this definition of acceptance describes an active process that focuses on attending to the current moment. Similarly, Hayes and Strosahl (2006) defined one aspect of psychological flexibility, a key component of ACT, as the ability to maintain contact with present moment experiencing (positive or negative). Attending to the current moment is also emphasized in DBT core mindfulness skills (Linehan, et al., 1991) and mindfulness practice, a broader concept that some say encompasses experiential acceptance (Cardaciotto et al., 2008).

Although Bringing Awareness to the Current Moment appears to map onto elements of third-wave experiential acceptance, therapist comments can also be considered within the context of a pan-theoretical approach. For example, Perls, Hefferline, and Goodman (1972) emphasized the importance of bringing the client's awareness to the current moment, especially current bodily sensations (including affect and thoughts), in the pursuit of helping clients to acknowledge all parts of themselves – a primary goal in Gestalt therapy. Similarly, Carl Rogers (1957) emphasized the importance of moment-to-moment awareness in his description of Existential Living, one characteristic of what he considered to be a fully functioning person from a Humanistic perspective. More specifically, and perhaps conceptually similar to experiential acceptance as it is defined in third wave theory, Rogers (1957) noted the importance of being in touch with different experiences as they occur in life, avoiding prejudging and preconceptions.

Moreover, bringing awareness to the current moment comments can be conceptualized as basic process-oriented microskills (for example, see Ivey, 1971) that beginning therapists are exposed to more often than theory-specific (e.g., third wave CBT) approaches. Moreover, most therapist comments that were considered to be Bringing Awareness to the Current Moment occurred as discrete process-oriented statements rather than within the context of a larger acceptance-based intervention. In other words, therapist comments did not appear to occur as a product of the therapist attempting to utilize a specific acceptance-based intervention protocol or theory such as ACT or DBT. In fact, many therapists, after making these statements went on to attempt to change the frequency or form of clients' thoughts or feelings. For example:

T89 Well, how are you feeling right now?

C89 Sad...it's kinda - not really sad, but kinda...I just miss my dad. It's just so...[throws hands up]...what I was going to say - it's just so...so, [smiles] why is it...uh...(5)

T90 Why is it, what?

C90 I don't know. I don't have like, a (8)...um...I'm sorry.

T91 What are you sorry about?

C91 [throws hands up] Just sitting here.

T92 That's nothing to be sorry about. Can I tell you what I was thinking about?

In this example, the therapist brings the client's awareness to the current moment, orient's the client to focusing on his feelings of sadness, but then challenges the client's thoughts as he tries to explain his experience.

Sub-theme: Shifting from Content to Experience. In the present study, therapist-participants also made general comments that prompted their clients to shift from content-based descriptions (e.g., what happened) to a reflection on their experience of the situation (e.g., how

they felt about/experienced the situation). These comments were coded as Shifting from Content to Experience. In the current study, shifting from content to experience was thought of as an even more basic facet of acceptance than Bringing Awareness to the Current Moment because much of the body of literature on acceptance-based intervention focuses on the importance of attending to one's experience. For example, in describing third wave interventions, Hayes (2004a) noted that these interventions are experiential and contextual. Although he did not describe the type of comments that were found in the present study specifically, one could argue that shifting away from talking about what happened (e.g., the content of an argument with a significant other) toward the client's experience of the argument (e.g., how the client felt, what thoughts the client has about the argument) may be a particularly important, albeit nuanced, first step in working with a client from a third wave approach.

Because the experience in Shifting from Content to Experience can be the client's thought patterns, it can be argued that The Shifting from Content to Experience sub-theme, represents a more metacognitive process rather than describing an experiential intervention meant to increase awareness. It is true that the definition of the code may have captured interventions in which the therapist explicitly focused on the client's thoughts about his/her thoughts in particular situation. At the same time, however, this infrequently coded process still served the function of helping the client to increase awareness by priming him/her to focus on the experiential and contextual factors that may contribute to his/her distress. This particular focus on experience (whether through thoughts, or feelings and sensory perceptions), as noted above, is well-documented in the broad psychological literature as a first step in acceptance (of self, other, experience, etc.).

Yet, research on third wave approaches has traditionally not focused on how trainees or those working from a more general or integrated approach may utilize specific acceptance-based skills. Therefore, simply shifting the client from content to experience may not be explicitly discussed in the third wave literature because it is an implied first step in conducting process-oriented, contextual work; which is likely understood by more advanced clinicians or clinicians specifically practicing an acceptance-based model.

The importance of shifting from context to experience is, however, explicitly detailed as a process of acceptance in other theories within the psychotherapy literature. For example, from a Humanistic perspective, encouraging the client's focus on and expression of affect or conditions of worth (thoughts) is one way for therapists to express unconditional positive regard or nonjudgmental acceptance of the client (Rogers, 1957). Although the domain of acceptance is different in Humanistic theory than in some third wave theories (client vs. experience), the process of acceptance is similar (namely, awareness of and a nonjudgmental stance toward the specified domain). Similarly, from an Existential perspective, shifting the client's awareness toward his/her experience, especially as the internal experience pertains to inner conflicts around primary existential themes, is considered a paramount goal of therapy. Gestalt therapy, with its foundation in phenomenology, also emphasizes shifting the client's awareness toward experience (Dryden & Still, 2006).

Furthermore, similar to the bringing awareness to the current moment comments, shifting from content to experience comments can also be conceptualized as the implementation of micro-skills that beginning therapists learn. Helping skills training models (for example, see Ivey, 1971) specifically focus on helping developing clinicians to decrease the amount of time

they spend talking, focusing on content, asking closed-ended questions, etc. through increasing their use of process comments (similar to shifting from content to experience).

Synthesis. Taken together, Bringing Awareness to the Current Moment and Shifting from Content to Experience highlight ways in which trainee psychotherapists could be seen to incorporate preliminary elements of acceptance-based skills/approaches into psychotherapy sessions, albeit infrequently. At the same time, however, both of the subthemes/interventions that were most common among client-participant pairs were somewhat pan-theoretical (for example, comments that would be encouraged across Humanistic, Gestalt, Existential theories) and represented simple process comments. That is, therapist-participants most often used Increasing Awareness statements to orient the client to experiential, contextual, and/or process-oriented work (for example, “What are you thinking right now? You look like something is going on inside...”). More complex and thorough experiential acceptance-based interventions as they are conceptualized in the third wave literature (e.g., observing the moment-to-moment experience in a nonjudgmental manner or abandoning a change agenda) were not observed.

Moreover, while Increasing Awareness comments can be thought of as orienting, these interventions can also be thought of as basic intentional interviewing and counseling skills that trainee therapists are encouraged to use with clients (Daniels & Ivey, 2007; Ivey, 1971; Poorman, 2003). Therefore, it was somewhat surprising that only three of the five total client-therapist participant pairs had either sub-theme coded in one or more of the sessions that were examined, and that the frequency of their occurrence was so low.

It was also noted that experiential acceptance was most frequently coded during discussions that were client-focused (e.g., discussing a client’s grief, discussing client feeling vulnerable or like an imposter, discussing client’s symptoms) rather than in discussions that were

other-focused (e.g., client angry at partner for partner's behavior, client explaining partner's behavior that was upsetting). More specifically, the later session for client-therapist participant pair 4 in which the client discussed his experience of his father's substance abuse and subsequent death had experiential acceptance coded most frequently (8 therapist comments). The later session for client-therapist participant pair 1 had the second highest frequency of experiential acceptance codes (4 therapist comments). This was a session in which the client and therapist discussed the client's symptoms of anxiety and depression over time in the context of the client's procrastination behavior. This pattern may be related to how novice clinicians manage session flow and content. Whereas more advanced clinicians may focus on comments about the therapeutic process, or make observations about the client (Heppner, Rosenberg, & Hedgespeth, 1992), therapists that have just begun formal training often get caught up in the content of client narratives (Cozolino, 2004). Therefore, the trainee therapists in this study may have been more comfortable with or inclined to use process-oriented skills during discussions in which clients were already oriented to focusing on themselves.

Finally, the results of the current study are interesting to consider within the context of therapy-as-usual with emerging adult clients. Results of the study suggest that although it has been documented that emerging adults describe this developmental period as somewhat unstable (Arnett, 2011) and are undergoing tremendous neuropsychological development that primes them to be able to engage in emotion-regulation, self-reflection, and awareness-building (Giedd, 2004), clinicians who work with this age group may not be specifically focusing on helping their clients to tolerate the flux of human experience through increasing clients' awareness.

Within-participants coded concepts. In addition to the increasing awareness parent theme that was observed across sessions, there were two themes relevant to experiential

acceptance that infrequently emerged within particular client-therapist participant pairs: Shifting Thinking and Reducing Struggle Through Cognition Notably, these interventions were specifically focused on the client's thought-based experience, which is consistent with therapists' indications that they were working from either a CBT or psychodynamic perspective.

Shifting Thinking. Shifting Thinking was observed in the later session for client-therapist participant pair 4. These coded statements, which occurred twice in the session, could perhaps be seen through a third wave lens as most closely aligned with the ACT concept of defusion (Hayes, 2004b) and perhaps even Didonna and Kabat-Zinn's (2008) concept of nonjudgmental awareness. Within the context of a discussion about the client's grief, the therapist made the following statement(s):

T84 But you're able to realize...

C84 Yeah, that's it's kinda...

T85 ...that it's just a thought....

Just before this exchange, the client spoke about his occasional thought that he could have done something to save his father. The therapist's comments in this exchange may have been used to help the client to view the thought nonjudgmentally, and to recognize that a thought does not necessarily accurately represent reality. This particular code is, as previously mentioned, directly related to experiential acceptance as it is currently conceptualized in the third wave cognitive-behavioral literature.

It is also recognized that the therapist may have used this comment for other reasons, as informed by other theoretical approaches to psychotherapy. For example, CP4's therapist noted that an insight-oriented psychodynamic approach was used in therapy. This therapist may have been attempting to build insight into the client's tendency to assume blame for his father's death

by highlighting the client's specific thought pattern. This therapist may also have been using an approach in this session informed by the grief literature. For example, Kübler-Ross' (1969) stages of grief are primarily focused on helping a person to alter his or her perception of an event that was originally judged as destabilizing.

After the above exchange, the therapist noted the potential meaning of the thought (i.e., that the client misses his father) and connected it to the client's sadness about the loss of his father. This specific intervention is consistent with the therapist's noted insight-oriented approach and may be aimed at helping the client understand the connection between his feelings, behaviors, and relationship with his father. This intervention could also be conceptualized from a CBT perspective (e.g., connecting thoughts to feelings, understanding the meaning of automatic thoughts) and is different than how a therapist working from a third wave perspective may intervene. For example, instead of helping the client to understand where the thought is coming from or how it is related to the client's experience of sadness/grief, a therapist using a third wave approach might continue to encourage the client to let go of this and other unhelpful thoughts. Moreover, the therapist may encourage the client to simply notice the thought or to pay attention to how the thought comes and goes, rather than explore its origin (Hayes, 2004a; Linehan, 1991).

Reducing Struggle through Cognition. Reducing Struggle through Cognition is conceptually related to the Shifting Thinking code. This code occurred four times in the later session for client-therapist participant pair 1 and was used to describe therapist comments that encouraged the client to challenge her assumptions/thoughts, or look at a situation differently, but did not explicitly encourage the client to view her thought or belief in a nonjudgmental manner as in third wave approaches. In fact, the therapist who was observed as using these

comments usually challenged the client's belief by proffering an alternative thought. For example:

C115: Cuz like, he'll come back and complain. I can't believe he did this...[throws her hands up] what do you want me to do?

T116: And it's another one of those, you know, you can't change what other people do, you can only change your own interactions with those people, your own responses to them, your own choices...

In this example, the therapist encouraged the client to think about the situation differently. In particular, the therapist highlighted that in an interpersonal situation that was upsetting or frustrating, the only change that can be made was a personal one (i.e., changing how the client acts).

This code may illustrate one way in which the paradox between acceptance and change in many third wave behavioral therapies (Hayes, 1987; Hayes et al. 1999) is verbalized in psychotherapy-as-usual sessions with trainee therapists. Viewed from an ACT perspective, the therapist could be seen as encouraging the client to abandon an interpersonal change agenda (i.e., trying to change the situation; struggling with asking questions about why her partner is acting in a certain way) and instead noting that the client may be able to dissolve the struggle by changing her own response to the distressing situation. Viewed from a DBT perspective, the therapist could be seen as encouraging distress tolerance by helping the client to replace unhelpful thoughts or perceptions about the situation with more helpful and balanced thoughts (e.g., "I may not be able to change what is happening or how this person is acting, but I am in control of how I respond to this situation;" McKay, Wood, & Brantley, 2007, p. 11).

Missed opportunities. Reflection on the researchers' comments about session dynamics

and missed opportunities revealed patterns both across and within sessions that may account for the infrequency with which experiential acceptance was observed. One such noted pattern was that four out of the five participants had notations from all three researchers about each of these therapist's difficulty balancing content and process. For example, the therapist in client-therapist participant pair 1 focused on problem-solving or asking content-based questions over emphasizing experiential components of the client's presenting problems. More specifically, client-participant 1 struggled with procrastination and the therapist-participant's interventions focused on behavioral changes/problem-solving (e.g., using Outlook/Google calendar), rather than trying to understand or help the client cope with internal experiences that may have been contributing to these symptoms. Moreover, this therapist participant appeared to make assumptions about the client's internal experience. For example, when reviewing the Outcome Questionnaire during the initial coded session the therapist stated:

T12 Um, and the other stuff that you marked was obviously that you feel annoyed by people who criticize your drinking or drug use, and we've talked about that, too. Still having people do that? Is this Dawn still, or?

All three researchers noted that this therapist, perhaps in an attempt to demonstrate understanding of the client, labeled the client's feelings and followed up with a content question. In this way, an opportunity was seemingly missed to explore the client's response to criticism, and in turn employ elements of experiential acceptance (e.g., increasing awareness).

Similarly, in the coded sessions for client-therapist participant pair 5, the participant in which no experiential acceptance was observed in either session, researchers noted that the therapist exhibited difficulty containing the client and balancing content. In the following

example, which occurred midway through the initial session, the client had been talking for the first half of the session about her interpersonal relationship difficulties:

C70 Yeah and then she can just catch the bus on her own, but for right now it's from newborn to like, you know what I'm sayin'?

T71 Yeah, right.

C71 It's a package, you know. This five year old can't tell you what she needs. You can barely understand her. So it's kind of like, you have a package. She was harassing him from jump. I know how this person is.

T72 Does she want him back? Is that what's going on?

Instead of focusing on the client, such as asking a question about how the client responds to the situation or experiences it, the therapist instead asked a content-based question that served to encourage the client to continue to detail content. Instances similar to this example are noted 23 times across the two sessions for this client-therapist participant pair.

It is, however, important to consider the therapists' focus on content and content-based questions in the context of phase of therapy in which the coded session occurred and the therapists' skill level. For example, one might expect to see a heavier emphasis on content-based questions in the beginning phase of therapy because the therapist is still attempting to gather or clarify information (notably in the current study, this pattern did not emerge). Moreover, while trainee therapists are still learning how to use their therapy skills intentionally, it is common to get caught up in the details or content of a client's story (Ivey, 1971). In fact, it has been documented that novice therapists often utilize more self-disclosure, advice-giving, closed-ended questions, and problem-solving than their more advanced counterparts (Hill et al., 2008; McHenry & McHenry 2007). Self-disclosure in particular was noted as a component of

therapists' difficulty balancing content and process. In addition to the likelihood that training level of the therapist was related to this observed pattern, potential similarity in demographic variables (specifically, age and/or student status) between therapists and clients may have further contributed to this observed pattern (Bottrill, Pistrang, Barker, & Worrell 2010).

A second pattern in missed opportunities concerned the context in which acceptance codes were observed or not observed. Each of the client-participants in the current study spent at least one of their coded sessions expressing anger or frustration in the context of an interpersonal relationship, which is consistent with the literature on emerging adulthood that posits that while interpersonal relationships are paramount in providing emotional support and comfort, they also serve as a primary source of stress and conflict (Halpern-Meekin, Manning, Giordano, & Longmore, 2013; Meeus, Branje, van der Valk, & de Wied, 2007).

Notably, acceptance codes were not observed during client expressions of interpersonal frustration or anger (e.g., client was upset with his/her partner). This pattern is congruent with the literature on how trainee therapists respond to client expressions of frustration or anger in session. When therapists observe the client as angry (even if the anger is not directed at the therapist), trainee therapists tend to avoid the anger and/or stick to content-based comments in order to reduce client anger (Hess, Knox, & Hill, 2006). In contrast, as noted above, experiential acceptance was most frequently coded during discussions that were focused directly on the client (although as noted above, this rarely occurred in comparison to the total number of talk turns).

Both patterns of missed opportunities may be related to the therapists' own pattern of avoidance of affect. Resorting to content-based discussions may be one way in which therapists avoid clients' or their own emotional experiences. While common in beginning therapists (as discussed above), this pattern becomes problematic in the context of acceptance-based therapies,

which have a primary goal of helping clients to tolerate affect. Therefore, the therapists' capacity to respond to their own and their clients' affective states with empathy and poise, rather than with content-based statements or questions, may be a crucial in working from an acceptance-based perspective (Markowitz & Milrod, 2011). Implications related to clinical training for this point are discussed further in the Future Directions section.

Limitations. There were several limitations to the current study. First, one of the main challenges of an inductive content analysis is that the process of conducting it is highly flexible depending on the data set (Elo & Kyngäs, 2007). There is not a correct way of running the analysis, as the process is dependent on a dynamic interaction between the data and the researchers. As this process is not linear in nature, there is increased opportunity for researcher biases to impact the content derived from the data. Despite efforts to maintain neutrality toward the data, the researchers inevitably approached the inductive coding process with biases that may have influenced decisions during open coding and abstraction. For example, having conducted a thorough literature review on many concepts related to acceptance and having sought out training in acceptance-based interventions, the primary researcher was at first narrower and more rigid than the other coder and the auditor in identifying acceptance-based comments. In contrast, the auditor of the study and the other researcher often coded other forms or domains of acceptance (e.g., therapist's acceptance of the client, client self-acceptance). Similarly, the coding team initially differed in how acceptance-based interventions aimed at past experiences vs. present experiences were coded. Illustrated in the audit trail, the ultimate decision was to focus on present (here-and-now) experiences of the client. Moreover, in creating the coding manual, the researchers were aware of the constant tension between maintaining a stance of openness to the data, and defining some parameters for the coding of experiential acceptance.

For example, the audit trail reveals back and forth discussion about how detailed and well-defined the instructions for coding experiential acceptance should be. Further, the apparent paucity of experiential acceptance in some of the coded sessions sometimes resulted in one or more researchers attempting to justify coding statements that were the nearest approximation of experiential acceptance within the given session, to the initial detriment of maintaining fidelity to the coding parameters delineated in the coding manual. When such patterns were identified, all researchers reviewed the coding manual, discussed questions and points of clarification, and returned to the open coding process until agreement was reached. Therefore, the practice coding and the auditing/checking procedure were especially important in maintaining confirmability and reliability of codes (determined to be 100% after review) both within and across sessions.

Second, the nonrandom purposeful sampling procedure and small sample size of the current study limited the generalizability of the results from a quantitative perspective. However, the detailed data collection and analysis process used is typical of qualitative research and can provide a comprehensive understanding of how trainee therapists utilized experiential acceptance in these sessions (Thomson, 2011). The intensive and detailed analysis of five participants also assumed that each participant has a uniquely valuable experience or perspective that can add to the understanding of the concepts studied (Creswell, 2009; Merriam, 2002; Mertens, 2005). It is important to note, however, that when determining sample size for the current study, saturation (Glaser & Strauss, 1967) was not used as a guide. Rather, the specific aims of the study, practicality, and Creswell's (1998) recommendations for sample size in a qualitative phenomenological study informed sampling procedures. Another result of the small sample size is that the participants used in this study only marginally represent culturally diverse populations, even with researchers attempting to seek cases that appeared culturally and ethnically diverse

during sampling. Despite variation in gender (3 females, 2 males) and client-reported ethnicity (2 Caucasian, 2 Latino/a, 1 African-American), length of time in treatment (3 clients with approximately 20 sessions; 2 clients with 40-100 sessions) and age within the EA range (3 clients aged 18-25; 2 clients aged 26-33; range 20-29), the sample is of course not representative of all demographic variables that may contribute meaningfully to how experiential acceptance can be fostered with emerging adult clients. In an attempt to account for how experiential acceptance may have been fostered in client-therapist participant pairs who remained in treatment for more than 20 sessions, the researcher-participants purposefully sampled one participant who remained in treatment for approximately three years (CP4). Although this participant can be viewed as an outlier, CP4's data was viewed as contributing a uniquely valuable perspective that had potential to add to the understanding of how experiential acceptance is fostered over the course of therapy. For more complete information about client variables, known therapist variables and acceptance frequencies, please see Appendix I. Moreover, the current study only sampled two sessions from each participant's course of psychotherapy. The two sessions sampled cannot be assumed to be fully representative of how therapy was conducted or the frequency with which experiential acceptance was used across the full course of therapy.

A third limitation of this study had to do with the unknown nature of the demographic, sociocultural, and professional development information for the therapists included in this study. Given that this information was not recorded in the research database used for this study, it was not possible to fully explore therapist personal variables that may have contributed to their use of experiential acceptance in psychotherapy with emerging adults. For example, as previously mentioned, many client-participants expressed anger during the sessions selected for coding, and

the developmental level of the therapist (e.g., first semester master's level clinician vs. third year doctoral level clinician) may have impacted how the therapist processed those feelings in the room and/or helped the client to understand and cope with these emotions. Similarly, the therapists' exposure to third wave approaches, specific training in experiential acceptance (if any), intention of techniques employed, and outcome of techniques (i.e., if experiential acceptance increased) were also unknown.

Finally, because experiential acceptance was coded with such low frequency both within and across participants, it is difficult to make inferences about how therapists in general use experiential acceptance, or what experiential acceptance may look like over the course of therapy-as-usual. For example, in the current study, increasing awareness was conceptualized as a present-focused intervention. However, it is possible that in a sample in which experiential acceptance was coded with more frequency, the temporal nature of experiential acceptance would be expanded and further described. It was also not possible to determine whether the definition of the themes abstracted from the coding process would be consistent with or reliable across a sample in which experiential acceptance appeared more frequently. Rather, the current study predominantly provided descriptive results which are useful in providing foundational information.

Contributions and implications. The efficacy of third wave interventions, particularly those that focus on experiential acceptance, has been well-documented in the literature. The use of experiential acceptance has been tied to improvement in symptoms of a variety of different mental health disorders, while its absence has been tied to increased symptoms of depression and anxiety and general emotional dysregulation. Despite substantial quantitative data about its importance, very little is known about how and if therapists actually use experiential acceptance

over the course of therapy-as-usual. In fact, the current study is the first to describe how elements of experiential acceptance are used in therapy-as-usual. As such, it provided much needed foundational, descriptive information on this topic.

There are two key implications based on the literature review and findings for this study. The first implication relates to clinical training. The literature review for the current study noted that most of psychotherapy theory, not just third wave theory, emphasizes the importance of a process-oriented approach in achieving over-arching goals of therapy (e.g., acknowledging all parts of the self, existential reorientation). The results of the current study found that despite this pan-theoretical emphasis on process and to a degree, acceptance, trainee therapists are very infrequently implementing these skills. In fact, a primary pattern in missed opportunities across therapist-participant pairs was related to the therapists' difficulty balancing content and process. This pattern highlights a need for clinical training programs to focus more heavily on process-oriented skills training for therapists and counselors. Process oriented-skills training can be broken down into two distinct, yet related components: therapist self-reflection and psychotherapy skills.

It is important to note that consistent exploration of therapists' own process when conducting psychotherapy should occur alongside skills training. The pattern of results in the study paired with literature on trainee therapists suggest that beginning therapists must first learn to distinguish their different feelings, be aware of their beliefs, values, moral principles and their reactions to various stressful situations before they can successfully help a client to do the same (Dryden & Thorne, 2008). Because experiential acceptance interventions heavily emphasize affect regulation and tolerance, training programs should pay special attention to the personal aspect of clinical training. There has been debate in the psychotherapy training literature for

some time about how to address therapists' personal development (Bike, Norcross, & Schatz, 2009). While some are skeptical of requiring personal therapy for beginning therapists (Wiseman & Shefler, 2001), most agree that personal therapy is an integral part of professional and personal development as a psychotherapist (Atkinson, 2006). Short of requiring or strongly suggesting personal therapy for student therapists, an emphasis on experiential training may be one important way in which training programs can address this component of process-oriented training. For example, many group psychotherapy classes are experiential in nature; students participate in a process group during class in order to learn about group dynamics and group facilitation. Individual psychotherapy skills training can be done in a similar manner through frequent role play and reflective practice.

With regard to how training programs can address the second component of process-oriented training, psychotherapy skills training, one proposed idea, is to increasingly emphasize training in specific process-oriented microskills (e.g., reflection of feeling, reflection of meaning; Daniels & Ivey, 2007; Egan, 2007; Ivey & Ivey 2007). Such training would include both didactic and experiential opportunities, coupled with supervision from this perspective. The microskills approach is a widely accepted training framework (Ridley, Kelly, & Mollen, 2011). Particularly in the early phases of training, this framework is impactful primarily because it breaks down what may be experienced by trainees as an ambiguous, even overwhelming, therapy process into a set of discrete and learnable skills and behaviors. However, the major strength of the microskills framework (discrete skills training), may also reflect a significant weakness that training programs must recognize and address specifically in order to increase the frequency with which the effective components of psychotherapy are utilized by trainee therapists: discrete sets of skills that are taught separately from each other, as well as from any significant theoretical

framework, may impede the novice clinician's ability to keep the bigger picture in mind. More specifically, beginning therapists may not be able to put the parts they have learned back together again as reflected in either an integrated/general personal theory of change in psychotherapy or as a part of a specific treatment program/protocol (for example, ACT). Training programs should address this issue by continuously providing opportunities for students to learn microskills in the context of how and when different theories would utilize these skills. These opportunities should exist both in theory-driven classes and in foundational interviewing/skills-based classes.

The paradox with regard to skills training leads into the second key implication for the current study, which is also related to clinical training: The components of the multifaceted concept of experiential acceptance, specifically as it is related to third wave approaches, as well as its research base, may need to be broadened when introduced or applied to trainee therapists. More specifically, the most basic aspects of experiential acceptance found in this study should be included as necessary first steps in helping a client to engage in experiential acceptance. Instead, the current literature on the efficacy and use of third wave approaches is generally disorder specific and utilizes expert clinicians who are trained using a manual through funded research programs. Wilson (1995) and others (e.g., see Lappalainen et al., 2007; Strosahl, Hayes, Bergan, & Romano, 1998) noted that these studies do not take into account that the field of clinical practice is diverse in training and expertise. As such, it is the more complex and higher level skills that are most often talked about, researched, or written about in the literature.

Inclusion of more foundational skills in experiential acceptance training could assist clinicians to approach complex third wave approaches with less worry or concern. Perhaps in part because of the lack of basic acceptance skills research in the third wave literature, and in part due to the lack of theory integration into microskills training, advanced experiential

acceptance practices may appear inaccessible and even anxiety-provoking to novice therapists (Lappalainen et al., 2007). Beginning therapists may not necessarily understand that the process skills observed in this study (namely, bringing awareness to the current moment and shifting from content to experience) are the foundational skills for helping a client to engage in experiential acceptance of third wave therapies as well as acceptance processes relevant to other theoretical approaches. For this potential reason, as well as others, therefore, a gap exists between some evidence-supported methods of treatment and the implementation of these interventions in general psychotherapy practice.

Therefore, when training novice therapists and/or therapists practicing therapy-as-usual, supervisors and professors should expand the definition of an experiential acceptance-based intervention to include these preliminary steps in order to help clinicians to understand and connect basic process skills to theory. Practically, this may take the form of professors and supervisors explicitly connecting basic process skills to more complex third wave interventions when teaching these theories.

In sum, because acceptance-based therapies have some intervention skills that are conceptually similar to basic general microskills training, and have a number of studies supporting their efficacy in treating a range of psychological disorders, acceptance-based models may be an exceptionally useful framework when paired with an emphasis on therapists' personal reflection and introspection, in which beginning therapists may anchor their professional training.

Finally, as previously noted, emerging adulthood presents a unique opportunity for experiential acceptance intervention because of specific factors that are related to this developmental period; namely, intense self-reflection and exploration, a subjective feeling of

being in flux, and documented increases in psychopathology (especially severe mental illness). Very little is known about the actual psychotherapy process for emerging adults, especially those who are not currently attending a four-year college (which most participants in this study were not). The few previous studies that exist have examined post-hoc emerging adult client dissatisfaction with the treatment process (Kuwabara, Van Voorhees, Gollan, & Alexander 2007; Polvere, 2011). This study contributes meaningfully to the emerging adult literature in that it is the first study to date to explore the skills that trainee therapists may utilize in actual psychotherapy sessions when working with clients who are coping with themes related to emerging adulthood (e.g., self-development, interpersonal relationships).

Data from the current study suggests that with emerging adult clients, trainee therapists appeared to prefer content-based discussions over process-oriented interventions that are likely more useful in helping emerging adult clients solidify the newfound efficiency with they can engage in emotion-regulation, self-reflection, and awareness-building. Therefore, developmental courses for therapists and counselors should emphasize the unique developmental tasks, challenges, and themes of the emerging adult population, and tie these developmental needs specifically to therapeutic interventions. More specifically, lesson plans in developmental theory classes for therapists should include a practical component in which students have the opportunity to consider and/or rehearse how specific interventions may be most helpful with this population. Moreover, therapists interested in working with emerging adult clients should receive even further training in how use their skills intentionally within the context of emerging adult development, while mindful of individual differences, to promote adaptive skills that will persist through synaptic pruning.

Future directions. Future research looking at the use of experiential acceptance

strategies in therapy-as-usual could redress some of the limitations of the current study. First, due to the low frequency observed in this study, it may be beneficial in the future to utilize different sampling methodology, such as saturation (Glaser & Strauss, 1967) as a guiding principle. Although qualitative research is typically not concerned with frequencies, because even one occurrence of the data is useful, very low base rates of the phenomenon that is being studied may suggest that not all of the important perceptions of that phenomenon are accounted for. In other words, samples in qualitative research must be large enough to ensure that multiple opinions are perspectives on a given topic are accounted for, without being so large that data becomes repetitive. Saturation may therefore allow for a more representative analysis of experiential acceptance frequency in therapy sessions.

Second, future qualitative research should explore therapist variables that may be related to how and when therapists use experiential acceptance or other experiential/contextual approaches. Specific variables to consider may be the therapists' treatment plan, therapists' own conceptualization of how therapeutic change takes place, therapists' level of training, and/or educational variables (e.g., exposure to third wave approaches).

The current study was qualitative in nature because not enough information was known about the phenomenon of study to be able to generate meaningful hypotheses or select meaningful independent and dependent variables necessary for quantitative study. The current study therefore provided foundational information that can be used as a spring board for generating meaningful hypotheses for future research. One specific hypothesis generated by the current study is that therapist level of training influences the frequency with which therapists use process-oriented comments (e.g., commenting on session process, inquiring about the client's moment-to-moment experiencing). One proposed way to test this hypothesis would be as a

mixed methods expansion to the current study. Gathering information on therapist training (e.g., specific courses taken in theory and/or microskills) would allow for researchers to ascertain the nature of the relationship (if any) between observed frequencies of experiential acceptance and level of training.

A second hypothesis generated from considering patterns of missed opportunities to implement experiential acceptance in the current study is that developmental variables or themes that emerging adults bring into psychotherapy may moderate the relationship between therapist variables (e.g., level of training) and how therapists may use experiential acceptance. For example, emerging adult clients may have difficulty with emotional and behavioral regulation, which may present in session in a variety of ways. The emerging adult clients in the current study frequently expressed anger and frustration. Because experiential acceptance was notably absent from discussions in which anger was explicitly expressed, a future study that attempted to test this hypothesis could ascertain how therapists respond to specific emerging adult themes that clients express in psychotherapy through content analysis of psychotherapy sessions or through specific responses to themed vignettes. Quantitative analysis of this data would look for significant differences in how the therapists responded to different emerging adult themes (e.g., differences in frequency of acceptance or differences in process vs. content comments between emerging adult themes). Results from this study would provide additional guidance for clinical training pertaining to working specifically with the emerging adult population.

An example of a specific developmental client variable to explore would be client age. In the current study, there appeared to be a pattern in frequency of experiential acceptance observed based on the client's age. However, the nature of this relationship is unclear as the oldest clients were also women, and the therapist variables for these clients were unknown. A quantitative

study designed to test the age variable would control for confounding variables such as client gender and therapist variables through matching or utilizing covariates; creating two or more similar groups in which the only variable altered is age. Of course, if direct matching is used to generate these groups, the paired nature of the data has to be considered in order to obtain appropriate confidence intervals for the estimated effect of client age.

Finally, while not a specific hypothesis, a third area for future research that could build upon the additional foundational research mentioned above is in the area of therapeutic outcome. As previously mentioned, most efficacy for experiential acceptance-based therapy studies use expert therapists as their participants, despite the diversity in training and expertise that is represented in the field of clinical practice. Thus, one meaningful way to understand the outcome of experiential acceptance strategies in the absence of, for example, a 30-hour ACT training, is to control and/or account for the amount of training in experiential acceptance that therapists have and profess to use. Options for creating therapist experience groups could include therapists reporting any previous training, therapists reporting their attempted use of acceptance during sessions, and/or researchers providing specific basic training in acceptance-based skills combined with explicit instruction to utilize these skills in session. The change in clients' experiential acceptance over the course of treatment, as measured by qualitative ratings or one or more of the measures of acceptance discussed in the literature review of this study (e.g., the Acceptance and Action Questionnaire), along with other symptoms, would be measured as the dependent variables. The beginner therapist group's outcomes could be compared to those of more advanced therapists or to a waitlist control group.

In conclusion, it is hoped that therapists, supervisors, and future researchers can use the findings from this study in order to further explore and perhaps integrate experiential acceptance

into their work with emerging adult clients. It is further hoped that experiential acceptance will be increasingly explored as a useful intervention with emerging adult clients in order to help them to flourish and cope with the developmental themes these clients present with during psychotherapy sessions.

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APPENDIX A

Client Consent Form

Pepperdine University
Counseling and Educational Clinics
Consent for Services

INITIALS

Welcome to Pepperdine University's Counseling and Educational clinics. Please read this document carefully because it will help you make an informed decision about whether to seek services here. This form explains the kinds of services our clinic provides and the terms and conditions under which services are offered. Because our clinic complies with the Health Insurance Portability and Accountability Act (HIPAA), be sure to review the Privacy Rights pamphlet that was also given to you today. It is important that you understand the information presented in this form. If you have any questions, our staff will be happy to discuss them with you.

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

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

I understand and agree with the above three statements.

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

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

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

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

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

_____ Video/audiotaping

_____ Direct Observation

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

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

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

_____ Written Data

_____ Videotaped Data

_____ Audiotaped Data

OR

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

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

programs. _____

OR

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

programs. _____

Fees: The fee for the initial intake is nonrefundable.

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

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

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

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

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

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

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

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

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

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

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

Treatment & Evaluation of Minors:

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

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

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

_____ and/or _____

Signature of client, 18 or older

Signature of parent or guardian

(Or name of client, if a minor)

Relationship to client

Signature of parent or guardian

Relationship to client

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

Clinic/Counseling Center

Translator

Representative/Witness

Date of signing

APPENDIX B

Therapist Consent Form

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

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

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

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

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

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

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

• _____ I understand and agree that the following information will be included in the Research Database (check all that apply).

_____ Written questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures

_____ Written Data about My Clients (e.g., Therapist Working Alliance Form)

Video Data of sessions with my clients (i.e., DVD of sessions) _____

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

OR

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

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

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

OR

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

4. My participation in the study will last until I leave my position at the GSEP Clinic or Counseling Center.

5. I understand that there is no direct benefit from participation in this project, however, the benefits to the profession of psychology and marriage and family therapy may include improving knowledge about effective ways of training therapists and implementing policies and procedures as well as informing the field about how therapy and assessments are conducted in university training clinics.

6. I understand that there are certain risks and discomforts that might be associated with this research. These risks include potential embarrassment or discomfort at having faculty review materials about my clinic practices, which may be similar to feelings about supervisors reviewing my work ; however this risk is unlikely to occur since the written materials will be coded to protect your identity. Sensitive video data will be also coded to protect confidentiality, tightly secured (as explained below), and reviewed only by those researchers who sign strict confidentiality agreements.

7. I understand that I may choose not to participate in the research database project.

8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also understand that there might be times that

the investigators may find it necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).

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

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

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

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

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

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

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

Participant's signature

Date

Participant's name (printed)

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

Researcher/Assistant signature

Date

Researcher/Assistant name (printed)

APPENDIX C

Telephone Intake Form

ID# _____

A copy of this form should be included in the client's chart

Pepperdine Community Counseling Center Telephone Intake Interview

Caller Information

INTERVIEWER: _____ DATE OF TELEPHONE INTAKE: _____ TIME: _____

WHAT IS YOUR NAME?: _____

WHO IS THIS APPOINTMENT FOR? _____ M F DOB: _____ AGE: _____

_____ M F DOB: _____ AGE: _____

IF THE POTENTIAL CLIENT IS NOT THE CALLER, ASK, "WHAT IS YOUR RELATIONSHIP TO (CLIENT'S NAME)?: _____

WHAT IS (CLIENT'S) ADDRESS?: _____

WHAT IS (CLIENT'S) PHONE NUMBER(S): _____ (H) _____ (W) _____ (CELL OR PAGER)

IS IT OK THAT WE LEAVE A MESSAGE AT ANY OR ALL OF THE NUMBERS, IDENTIFYING OURSELVES AS BEING FROM THIS COUNSELING CENTER? Y N

HOW DID YOU HEAR ABOUT US? (LIST NAME AND NUMBER): _____

MAY WE CONTACT THEM TO THANK THEM FOR REFERRING YOU? Y N

WHO DOES (CLIENT) LIVE WITH? SELF OTHERS -

LIST: _____

DOES (CLIENT) HAVE CHILDREN?: _____

WHO IS INCLUDED IN (CLIENT'S) SUPPORT SYSTEM? _____

sample

ADDRESS CONFIDENTIALITY AND LIMITS TO CONFIDENTIALITY BEFORE PROCEEDING WITH THE PHONE INTAKE:

"I'd like to find out about your situation and for what reason you're seeking help. This will help me figure out how our counseling center might be of assistance/service. But before we begin I need to explain about confidentiality and its limits. Here at the Pepperdine Counseling Center we pride ourselves on guarding our clients' privacy, and on creating an environment where people can feel comfortable about discussing very personal matters. With that said, we want you to know that everything you describe to me is confidential, however, if I begin to understand that your's or someone else's life is in danger, or when there are significant concerns about a child or elder person's safety, I may need to break that confidentiality and take steps to assure that everyone is safe. Do you have any questions about this?...if not, let's proceed"

Type of Service

What type of appointment is being requested? Check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Therapy | <input type="checkbox"/> Child | <input type="checkbox"/> Individual |
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Adolescent | <input type="checkbox"/> Couple (Ask if there has been any domestic violence) |
| <input type="checkbox"/> Don't know or unsure | <input type="checkbox"/> Adult | <input type="checkbox"/> Family |
| | <input type="checkbox"/> Don't know or unsure | <input type="checkbox"/> Group |
| | | <input type="checkbox"/> Don't know or unsure |

ID# _____

Is there a preference for a particular type of therapist (i.e. gender, sexual orientation)?

Why? _____

Reason for Referral

PLEASE TELL ME A BIT ABOUT YOUR REASON FOR CALLING TODAY?: _____

sample

ARE THERE ANY PAST OR CURRENT LEGAL PROBLEMS?: Y N _____

IS THERE A COURT ORDER THAT REQUIRES TREATMENT? Y N _____

FOR WHAT REASON? _____

CLIENT TOLD LIMITS REGARDING COURT ORDERS? Y N _____

ARE THERE ANY PAST OR CURRENT DRUG AND/OR ALCOHOL PROBLEMS?: Y N _____

ANY CURRENT THOUGHTS OF HURTING YOURSELF?: Y N _____

ANY PREVIOUS THOUGHTS OR ATTEMPTS AT HURTING YOURSELF?: Y N _____

IF SO, WHEN WAS THE LAST TIME YOU *THOUGHT* ABOUT HURTING YOURSELF?: _____

WHEN WAS THE LAST TIME YOU *ATTEMPTED* TO HURT YOURSELF?: _____

DO YOU FEEL OR HAVE OTHERS SUGGESTED THAT YOU HAVE A "BAD TEMBER" OR THAT YOU GET MAD EASILY?: Y N _____

IF SO, PLEASE PROVIDE EXAMPLES: _____

ANY PAST VIOLENCE TOWARDS OTHERS?: Y N _____

ID# _____

ARE YOU CURRENTLY OR HAVE YOU EVER SEEN A PSYCHIATRIST, PSYCHOLOGIST, OR COUNSELOR?:
IF SO, ASSESS WHEN, WHERE, HOW LONG, TYPE (INPATIENT/HOSPITALIZATION OR OUTPATIENT)

ARE YOU CURRENTLY OR HAVE YOU EVER TAKEN PSYCHIATRIC MEDICATION?:
IF SO, LIST: _____

DO YOU HAVE ANY SCHEDULE CONSTRAINTS OR TIME/DAY
REQUESTS? _____

If Treatment is for a Minor (Under 18 Years Old)

WHO IS THE CHILD'S PRIMARY CAREGIVER?: _____

WHO HAS LEGAL CUSTODY OF THE CHILD?: _____

IF CALLER/PARENT INDICATES EITHER JOINT OR SOLE CUSTODY OF CHILD, ASK:

IS THERE DOCUMENTATION AVAILABLE (IN CUSTODY PAPERS ABOUT WHO IS RESPONSIBLE FOR HEALTH CARE) THAT YOU CAN
BRING TO THE INTAKE SESSION? Y N

IS THERE AGREEMENT AMONG CAREGIVERS REGARDING SEEKING TREATMENT FOR THE CHILD? Y N

WHO WILL BE BRINGING THE CHILD TO THE CLINIC?: _____

DOES YOUR CHILD KNOW THAT HE/SHE WILL BE COMING FOR THERAPY/ASSESSMENT SERVICES? Y N

IS YOUR CHILD COMING VOLUNTARILY/WILLINGLY? Y N

Occupation and Fees

ARE YOU CURRENTLY WORKING OR GOING TO SCHOOL? Y N

WOULD YOU LIKE TO KNOW WHAT YOUR FEE RANGE WILL BE? Y N

IF YES, ASK: WHO WILL BE PAYING FOR THE SERVICES RECEIVED HERE?: _____

WHAT IS (CLIENT'S) OCCUPATION?: _____

WHAT IS (CLIENT'S) APPROXIMATE GROSS FAMILY INCOME? _____ FEE RANGE QUOTED: _____

Intake Interviewer Checklist

- I INFORMED THE POTENTIAL CLIENT OF LIMITS OF CONFIDENTIALITY FOR THE PHONE INTERVIEW
- I INFORMED THE POTENTIAL CLIENT OF THE NONREFUNDABLE \$25.00 INTAKE SESSION FEE.
- I INFORMED THE POTENTIAL CLIENT THAT CLINIC THERAPISTS ARE UNLICENSED GRADUATE STUDENTS WHO ARE SUPERVISED BY LICENSED PROFESSIONALS (CLINICAL PSYCHOLOGISTS AND/OR MARRIAGE FAMILY THERAPISTS)

8/7/08 2

ID# _____

- I INFORMED THE POTENTIAL CLIENT THAT AS PART OF THEIR TRAINING, THERAPISTS ARE ASKED TO PRESENT ~~VIDEOS AND~~
~~SOMETIMES AUDIO TAPED SAMPLES OF THEIR SESSIONS DURING SUPERVISION.~~
- (PER CLINIC POLICY)** I ASKED THE POTENTIAL CLIENT FOR PERMISSION TO HAVE THE INTAKE THERAPIST GIVE THEM A CALL
PRIOR TO THE INTAKE SESSION
- I INFORMED THE POTENTIAL CLIENT THAT THE INTAKE SESSION IS 2.5 HOURS IN LENGTH AND THAT THIS SESSION HELPS THE
THERAPIST AND HIS/HER SUPERVISOR GAIN A BETTER UNDERSTANDING OF THE POTENTIAL CLIENT'S PRESENTING PROBLEMS.
GATHERING THE INFORMATION DURING THIS FIRST SESSION IS CRUCIAL FOR TREATMENT PLANNING. I ALSO INFORMED THE
POTENTIAL CLIENT OF THE IMPORTANCE OF ARRIVING PROMPTLY FOR THE SESSION.
- I INFORMED THE POTENTIAL CLIENT THAT FOLLOWING THE INTAKE SESSION, THE THERAPIST WILL PROVIDE HIM/HER WITH
FEEDBACK AND MAKE TREATMENT RECOMMENDATIONS WHICH MAY BE FOR CONTINUED TREATMENT IN OUR CLINIC OR MAY
BE A REFERRAL TO ANOTHER CLINIC.
- I INFORMED THE CLIENT THAT THEIR PLACEMENT WITH A THERAPIST IS SOMEWHAT DEPENDENT ON THE POTENTIAL CLIENT'S
TIME FLEXIBILITY.
- (PER CLINIC POLICY)** I CREATED A CLIENT FILE AND PLACED THE TELEPHONE INTAKE INTERVIEW IN IT.
- (PER CLINIC POLICY)** I PROVIDED THE CLINIC DIRECTOR WITH THE TELEPHONE INTAKE INTERVIEW.
- (PER CLINIC POLICY)** I ASSIGNED THE POTENTIAL CLIENT TO A THERAPIST.
THERAPIST: _____
- ~~I INFORMED THE POTENTIAL CLIENT ABOUT THE CLINIC LOCATION AND PARKING ARRANGEMENTS.~~
- I CONTACTED THE REFERRAL SOURCE AND THANKED THEM.
- (PER CLINIC POLICY)** I SCHEDULED THE INTAKE SESSION.
DATE: _____
TIME: _____
THERAPIST: _____

sample

APPENDIX D

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 _____

OTHER SERIOUS ILLNESSES

DATE

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHOLOGIST, PSYCHIATRIST, MARRIAGE COUNSELING, GROUP THERAPY, ETC.)

DATE

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

ELEMENTARY/MIDDLE SCHOOL: LIST
GRADE_____

VOCATIONAL TRAINING: LIST
TRADE_____

HIGH SCHOOL: LIST
GRADE_____

COLLEGE: LIST
YEARS_____

GED

GRADUATE EDUCATION: LIST YEARS OR DEGREE
EARNED_____

HS DIPLOMA

CURRENTLY IN SCHOOL? SCHOOL/LOCATION:

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATES/DURATION
<hr/>		
<hr/>		

HOUSEHOLD INCOME:

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

Family Data

IS FATHER LIVING?

YES IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

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

CAUSE OF DEATH: _____

IS MOTHER LIVING?

YES IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____ OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

No

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

CAUSE OF DEATH: _____

BROTHERS AND SISTERS

NAME	AGE	OCCUPATION	RESIDENCE	CONTACT HOW OFTEN?

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

NAME	RELATIONSHIP TO YOU	STILL IN CONTACT?

THE FOLLOWING SECTION WILL HELP US UNDERSTAND YOUR NEEDS AND FACTORS THAT MAY IMPACT YOUR LIFE OR TREATMENT. BELOW IS A LIST OF EXPERIENCES WHICH MAY OCCUR IN FAMILIES. PLEASE READ EACH EXPERIENCE CAREFULLY. PLEASE INDICATE WHETHER ANY OF THESE EXPERIENCES HAVE HAPPENED TO YOU OR YOUR FAMILY. SOME OF THESE MAY HAVE BEEN TRUE AT ONE POINT FOR YOU OR IN YOUR FAMILY BUT NOT TRUE AT ANOTHER POINT. IF THE EXPERIENCE NEVER HAPPENED TO YOU OR SOMEONE IN YOUR FAMILY, PLEASE CHECK THE “NO” BOX. IF YOU ARE UNSURE WHETHER OR NOT THE EXPERIENCE OCCURRED FOR YOU OR IN YOUR FAMILY AT SOME TIME, PLEASE CHECK THE “UNSURE” BOX. IF THE EXPERIENCE HAPPENED TO YOU OR IN YOUR FAMILY AT ANY POINT, PLEASE CHECK THE “YES” BOX.

	SELF			FAMILY			
WHICH OF THE FOLLOWING HAVE FAMILY MEMBERS, INCLUDING YOURSELF, STRUGGLED WITH:	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	PLEASE INDICATE WHICH FAMILY MEMBER(S)
SEPARATION/DIVORCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FREQUENT RE-LOCATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EXTENDED UNEMPLOYMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

ADOPTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FOSTER CARE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
FINANCIAL STRAIN OR INSTABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEATH AND LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DRUG USE OR ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADDICTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PHYSICAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMOTIONAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RAPE/SEXUAL ASSAULT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIAGNOSED OR SUSPECTED MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SUICIDAL THOUGHTS OR ATTEMPTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
SELF HARM (CUTTING, BURNING)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEBILITATING ILLNESS, INJURY, OR DISABILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PROBLEMS WITH LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

FREQUENT FIGHTS AND ARGUMENTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INVOLVEMENT IN LEGAL SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
CRIMINAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INCARCERATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Current Difficulties

PLEASE CHECK THE BOXES TO INDICATE WHICH OF THE FOLLOWING AREAS ARE CURRENT PROBLEMS FOR YOU AND REASONS FOR COUNSELING.
 PLACE TWO CHECK MARKS TO INDICATE THE MOST IMPORTANT REASON(S).

- | | |
|--|---|
| <input type="checkbox"/> FEELING NERVOUS OR ANXIOUS | <input type="checkbox"/> DIFFICULTY WITH SCHOOL OR WORK |
| <input type="checkbox"/> UNDER PRESSURE & FEELING STRESSED | <input type="checkbox"/> CONCERNS ABOUT FINANCES |
| <input type="checkbox"/> NEEDING TO LEARN TO RELAX | <input type="checkbox"/> TROUBLE COMMUNICATING SOMETIMES |
| <input type="checkbox"/> AFRAID OF BEING ON YOUR OWN | <input type="checkbox"/> CONCERNS WITH WEIGHT OR BODY IMAGE |
| <input type="checkbox"/> FEELING ANGRY MUCH OF THE TIME | <input type="checkbox"/> FEELING PRESSURED BY OTHERS |
| <input type="checkbox"/> DIFFICULTY EXPRESSING EMOTIONS | <input type="checkbox"/> FEELING CONTROLLED/MANIPULATED |
| <input type="checkbox"/> FEELING INFERIOR TO OTHERS | <input type="checkbox"/> PRE-MARITAL COUNSELING |
| <input type="checkbox"/> LACKING SELF CONFIDENCE | <input type="checkbox"/> MARITAL PROBLEMS |
| <input type="checkbox"/> FEELING DOWN OR UNHAPPY | <input type="checkbox"/> FAMILY DIFFICULTIES |
| <input type="checkbox"/> FEELING LONELY | <input type="checkbox"/> DIFFICULTIES WITH CHILDREN |
| <input type="checkbox"/> EXPERIENCING GUILTY FEELINGS | <input type="checkbox"/> DIFFICULTY MAKING OR KEEPING FRIENDS |
| <input type="checkbox"/> FEELING DOWN ON YOURSELF | <input type="checkbox"/> BREAK-UP OF RELATIONSHIP |
| <input type="checkbox"/> THOUGHTS OF TAKING OWN LIFE | <input type="checkbox"/> DIFFICULTIES IN SEXUAL RELATIONSHIPS |
| <input type="checkbox"/> CONCERNS ABOUT EMOTIONAL STABILITY | <input type="checkbox"/> FEELING GUILTY ABOUT SEXUAL ACTIVITY |
| <input type="checkbox"/> FEELING CUT-OFF FROM YOUR EMOTIONS | <input type="checkbox"/> FEELING CONFLICTED ABOUT ATTRACTION TO MEMBERS OF SAME SEX |
| <input type="checkbox"/> WONDERING "WHO AM I?" | <input type="checkbox"/> FEELINGS RELATED TO HAVING BEEN ABUSED OR ASSAULTED |
| <input type="checkbox"/> HAVING DIFFICULTY BEING HONEST/OPEN | <input type="checkbox"/> CONCERNS ABOUT PHYSICAL HEALTH |
| <input type="checkbox"/> DIFFICULTY MAKING DECISIONS | <input type="checkbox"/> DIFFICULTIES WITH WEIGHT CONTROL |

- | | |
|---|---|
| <input type="checkbox"/> FEELING CONFUSED MUCH OF THE TIME | <input type="checkbox"/> USE/ABUSE OF ALCOHOL OR DRUGS |
| <input type="checkbox"/> DIFFICULTY CONTROLLING YOUR THOUGHTS | <input type="checkbox"/> PROBLEMS ASSOCIATED WITH SEXUAL ORIENTATION |
| <input type="checkbox"/> BEING SUSPICIOUS OF OTHERS | <input type="checkbox"/> CONCERNS ABOUT HEARING VOICES OR SEEING THINGS |
| <input type="checkbox"/> GETTING INTO TROUBLE | |

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

—

Social/Cultural (Optional)

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

APPENDIX E

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 Family History

(Family constellation, family of origin and current family, family dynamics, domestic violence/abuse; Include family psychiatric, medical and substance abuse history)

B Developmental History

(Note progression of development milestones, as well as particular strengths or areas of difficulty)

C Educational/Vocational History

(Highest grade completed, strengths/weaknesses, learning issues/interventions; Work history, including any work related difficulties)

D Social Support/Relationships

(Current social support network; Intimate relationships and their history, especially as related to presenting problem)

E Medical History

(When was client last seen by a doctor? Describe current/past medical conditions, injuries, medications, procedures/surgeries)

F Cultural Factors and Role of Religion in the Client's Life

(Cultural group identification/identity, acculturation issues relevant to presenting problems/therapy) (Religious affiliations, strength of commitment to and/or involvement in religion, view of spirituality and its role in emotional problems/suffering and intervention)

G Legal History

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

V Mental Status Evaluation

Hygiene & grooming:

Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

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

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

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

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

Thought Content (appropriate; delusions; odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

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

VI Client Strengths

(Intelligence, personality, internal resources, coping skills, support system, talents and abilities, motivation, education/vocational skills, health)

VII Summary and Conceptualization

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

VIII DSM-IV TR Multiaxial Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V: Global Assessment of Functioning (GAF) Scale:

Current GAF:

Highest GAF during the past year:

IX Client Goals

X Treatment Recommendations

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

Intake Therapist

Supervisor

Date

APPENDIX F

Treatment Summary

APPENDIX G

Research Project Transcription and Coding Manual

This training manual is intended to describe the methods of transcription and coding that will be utilized for the team's dissertation research projects. The specific therapy tapes used in the projects will be of clients and therapists at Pepperdine University clinics selected based on inclusion/exclusion criteria. Lauren Ford, Brian Louie, and Karyn Riel will be using this for their respective dissertations to gain a more in-depth understanding of psychotherapy with emerging adults.

I. TRANSCRIPTION INSTRUCTIONS

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

Research assistants will transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of therapist and/or client statements to then be coded. Attached at the end of this section is a template that you will use for your transcriptions. After reading this manual and discussing questions during training, you will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the practice, we will review with you a completed transcript to check your work and address any questions.

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

When identifying who is speaking, use a "T" to indicate the therapist is speaking and a "C" to indicate the client is speaking. In addition, please use numbers to indicate how many times each person is speaking. For example, the first time the therapist speaks represent it as T1: and the second time as T2, T3, etc., and vice versa for the client (C1, C2, C3, etc.)

In addition to capturing the actual words, speech patterns and thought patterns of the speakers, we would like to try and capture some of the more important non-verbal behaviors/communication taking place between the therapist and client.

- In order to do so, please use parentheses with numbers inside of them to indicate pauses in a speaker's response. For example, use (3) to represent a three second pause or (10) for a ten second pause. Use this whenever there are significant pauses or moments of silence between the speakers. When attempting to capture non-verbal behaviors/movements that are significant to the therapeutic interaction taking place, use brackets [] to indicate these movements and clearly state which person—the therapist or client—is performing the movement and what specifically he/she does. For example, [Client turned away from the therapist and looked down at the ground] or [Client laughs] or [Therapist sighed deeply and looked away briefly].
- Only note hand gestures that have meaning. For example, the therapist gestures toward her heart when asking about how the client feels, or gestures hands toward self when

asking client to say more. Do not note hand gestures that do not carry meaning, such as simply moving hands in the air while talking. Also use brackets to indicate the inability to hear/understand a word or sentence: [Unintelligible] or [Inaudible].

Please make every effort to hear and understand what is said. Sometimes you can figure out a word by the context of what the speaker is saying. If you can make an educated guess, type the closest possible approximation of what you hear, underline the questionable portion, and add two question marks in parentheses.

Example: I went to school in Maryville (??) or Maryfield (??).

If you and those you consult (i.e., other RA's) cannot make a guess as to what is said, leave a blank line and two question marks in parentheses.

Example: We'd take our cotton to Mr. _____ (??)'s gin in Cameron.

If a speaker lowers his/her voice, turns away from the microphone, or speaks over another person, it may be necessary to declare that portion of tape unintelligible.

Example: When he'd say that, we'd— [unintelligible].

While there is some merit in having an absolutely verbatim tape, which includes all the feedbacks (such as Um-hm and Yeah), too many interruptions in the flow of the therapist's remarks make for tedious transcribing now and exhaustive reading later. Knowing when to include feedback sounds and when to omit them calls for very careful judgment. Usually the therapist's noises are intended to encourage the client to keep talking. Look at your transcript. If every other line or so is a therapist's feedback, go back and carefully evaluate the merit of each feedback. Don't include every feedback, especially if it interrupts the client's comments in midstream. Only if the feedback is a definite response to a point being made by the client should you include it. When in doubt, please ask the research team.

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

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

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

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

- Uh
- Um
- Uh-huh

- Mm-hmm
- Unh-uh

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

Incomplete sentences are familiar occurrences in oral history because of its conversational nature. They are best ended with an em dash (—). Use one dash (-) for an incomplete word that is then continued (e.g., mo- mother). Interruptions should be indicated using an ellipsis (...). Similarly, an ellipsis should be used when the person who was interrupted continues their sentence after the interruption.

Example: Interruption

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

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

Interruption and continuation

T1: He was coming toward me and I felt, I felt... C2: Scared? T2: ...scared and confused.

Quotation Marks:

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

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

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

Example: They said, What are you doing here?

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

Example: I thought, Where am I?

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

TRANSCRIPTION TEMPLATE

CONFIDENTIAL VERBATIM TRANSCRIPT

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by

individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Session Number:
Client #:

Coder:
Date of Session:

C = Client
T = Therapist

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

VERBATIM TRANSCRIPT FOR CODING TRAINING

William Miller Therapy Session from APA Series III-Behavioral Health and Counseling

Therapist: Dr. William Richard Miller
Client: Ms. S

Session Number: 1
Date of Session: xx/xx/xxxx

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

T = Therapist; C = Client

Verbatim Transcript of Session	
T1: Ok, Well now that we're settled in just a little bit, um, I understand that what you wanted to talk about was alcohol and perhaps some other drugs and how that fits into some of the other things that you are dealing with in your life, so fill me in a little, what's happening?	
C1: Well, as far as the alcohol and drugs I've been in and out of recovery since 1995. I used to be basically a social drinker. I lived in Chicago 32 years and moved to California and that's when the heavy use started.	
T2: Uh-huh. [Head nodding]	
<p>C2: A lot of that had to do with, I think, the change in lifestyle. Out there, especially where I lived, it was the Palm Springs area. A lot of people, a lot of partying, a lot of drugs. And I just kind of got into it because the people were in the environment where I was living, it—um, that's what everybody did.</p> <p>C2.1: I actually started cuz I was going to college, and I wanted, a girl who I was a neighbor suggested I try speed to keep me awake. She used it as a waitress and it helped her and I thought, well, and that's how I got started into that part of it.</p> <p>C2.2: I had been smoking marijuana for the longest time, since the eighties, but I had done nothing else. And then when I moved to California, I started drinking because I hung out with younger people, and we would drink, I don't mean just beers, we'd drink hard liquor.</p>	
T3: Yeah, you get thrown along with the lifestyle	
<p>C3: Exactly, and that was also a problem because I have an addictive personality and it's, I believe it's hereditary and it's part of other problems that I have.</p> <p>C3.1: It just manifested itself very quickly. I did in perhaps one year, what some people would do 3, 4, 5 years. I just crammed it all</p>	

<p>together. I got started with the speed, and then I switched to cocaine. Now, people call it crack or rock, whatever you want to call it. Free, the freebasing. You buy the, buy it in the rock form or in the powdered form, and I spent, I spend \$7000 in 3 months on that.</p>	
<p>T4: So you're very efficient about the drug use, packing it into a short period of time.</p>	
<p>C4: Well I packed it in, unfortunately, I don't know if it's good or it's bad, I went from buying it from people I didn't really, trying to get what I could from wherever, to climbing up the ladder to finding the main source, so to speak. C4.1: And I was one of those people, who I'm always proud to say, I never did any sex or anything for drugs or anything like that. Now, I didn't do any, anything... prostitution, or there was a lot of girls that would, a lot of women that would do that.</p>	
<p>T5: [Head nodding] So it was very common.</p>	
<p>C5: And, I was the kind of person, I got my nose broken because I wouldn't sleep with somebody's; this one fella wanted me to sleep with him when his girlfriend was at work and I wouldn't do it so he busted my nose. That's the kind of person I am. I don't believe in, that the two have to meet. My love was drugs. I didn't need a man, I didn't need relationships. If I had the money, if I didn't have the money, I had a way to get, you know, get it through people. I had, I didn't just party you know. I partied with uh—</p>	
<p>T6: Contacts.</p>	
<p>C6: Yeah, people who used to be in the show business industry, so to speak. You know, or who were related, A girl that was related to a guitarist in a famous rock star's band, and I'm not gonna name names, and she unfortunately—she died of AIDS but she had the money and she had, always, there was always partying going on with her. We'd go to the hotel and party, party,</p>	

party.	
T7: And you got caught up in that very quickly.	
C7: Oh, very quickly, and it's easy to I guess, if you have the personality for it, you know. And I didn't have any, and I was at a point in my life where I didn't really care about anything. And I wasn't young either. I was 32.	
T8: So it sort of felt natural to you.	
C8: It felt fun, it felt, actually, it felt good, you know. I was trying to, as they say, chase that next high. It got fun, but when I started running out of the money and I don't know how I had the stamina for it because I actually still worked, paid rent, kept a job, I did everything, well, which a lot of people can do, but for the amount of drugs and drinking I did—	
T9: Pretty remarkable—	
C9: Some people would probably not even be able to get out of bed. I'm not bragging about it. C9.1: Now, ten years later, I feel like I'm physically, I'm just kind of burnt out, you know, C9.2: I stopped doing cocaine in '95, and then I admitted myself into rehab in California that same year, and I've done it still on occasion, but I'm on medication which, thank goodness, doesn't make it where the drug has addictive properties.	
T10: Really?	
C10: Ya, I found it very interesting. I could do cocaine and put it down and not go back to it.	
T11: Which was new?	
C11: Which is something new to me, I mean, this is as recent as moving back to Chicago. [Therapist's head nodding] You know, I haven't been able, I've struggled in and out of sobriety, you know, I feel like Robert Downey, Jr. sometimes. [Therapist laughs] C11.1: It's like okay, but I've not, I've never gotten arrested for drugs, or for	

<p>selling, you know, one of those people who was too smart to keep it in the house and you know, I even though I never had money I had the common sense of well, you don't keep it in the house, don't drive around with it, you don't drink and drive, you don't drink and use. You know, why ask yourself for trouble?</p> <p>C11.2: One time I had drank and drove, and that was because I was at my boyfriend's, we were out, I had an argument, and we both went our separate ways. So, I ended up having to go home inebriated. And, um, fortunately nothing happened so I was pretty lucky.</p> <p>C11.3: And um, I've been in and out of recovery with AA and NA and, although I love the program and I espouse to do it, they say anonymity in AA, but I think that the condition in a situation like this, it's... well, it's part of talking about recovery and addiction. And, I've worked in and out of the program, I was clean, and sober for 3 years until I moved back to Chicago. Because I had gotten myself surrounded by people in recovery. Yet, when I moved back here, I was not surrounded by people in recovery and I discovered that I was staying clean and sober for the wrong reasons. I was doing it for other people, not for myself. I was doing it to help my mother, because my mother was dying of cancer, so I tried to, I wanted to...</p>	
<p>T12: So the change again of, of moving—</p>	
<p>C12: Right, they say geographics, you are running away from yourself. But I left California for many reasons. And uh.</p>	
<p>T13: And coming back here in a way set off—</p>	
<p>C13: It set off, right. It set off everything because I felt like I had the freedom. There was nobody there, I had no sponsor, no clean and sober neighbor, nobody checking up on me so to speak to make sure I was still, I was still smoking pot. I hadn't quit marijuana and, but the alcohol was the one</p>	

<p>that really got to me. I had been, I had quit marijuana for about a 7-8 months after I got out of recovery, but ended up getting back into that situation when I moved in, uh, out of sober living and I ended up eventually moving in keeping a roommate who was a friend of mine from my drinking and using days who was dying of AIDS. But he needed someone to take care of him. And I was going back to school at night plus working, so basically, my drug use was limited to marijuana and alcohol, sometimes doing coke or whatever. I never liked speed really because I saw people, the more they did that their teeth would rot out and, you know, it's Drain-o or rat poison, it comes in so many different colors. I've noticed it's not that big here in Illinois, in Chicago.</p>	
<p>T14: So when you say your in and out of recovery now, its alcohol and marijuana your talking about—and every now and then cocaine.</p>	
<p>C14: Right, ya, well the cocaine, basically I've stopped, ah, pretty much avoided that because the individual who introduced me to that again, I avoid seeing him at all costs... which I do for my own well being. I don't want to ride the dragon again. I don't want to go there, even though I know that if I do, I'm not going to be going there again every day. I won't be getting loaded every day because of the medication I take. But, and, he was paying for it, but I realized it was just something that I wasn't even enjoying.</p>	
<p>T15: So why do it?</p>	
<p>C15: Right, you know, to me, everybody, I believe has an addiction. We all have addictions be it food, sex, drugs, alcohol, gambling, family life, work. You know, whatever it may be, I think everybody has one, one thing at least that they crave and that in the back of their mind that they focus on and they really desire.</p>	
<p>T16: And you said you think you have an addictive personality—someone who easily</p>	

gets drawn into things	
C16: Yeah, well right, I have been. I'm an artist, freelance artist as well, and my addiction used to just be drawing. As a child, I would just come home and draw, you know.	
T17: So whatever you do like that you do it intensely	
C17: Yeah, I wish I could do it to make money and do it, you know. [Therapist laughs] Get a money making idea and do like that, I'd probably be rich, it's just um, but not able to find a proper substitute, you know. At this time, I'm trying to get back into drawing and being more creative, and my personal life, though I feel so mentally, emotionally, and physically exhausted after all I've been through in my life, that all I want to do is almost not do anything. I'm trying not to focus on any addictions. I'm at the point where I'm getting tired. You almost get tired of it physically. Like, if I drink I feel, I don't get the hangovers cuz I won't even allow myself to drink enough, but physically the next day, I feel, I ache, you know I feel the hangover with the headache would manifest itself with my body aches, and I don't want to, want to get up on the...you feel as vital and I've just done so much that I'm burning out.	
T18: And you've used up your chances, huh?	
C18: Yeah, pretty much. And being single all my, which, since 1990 and not having...being blessed without having children, which I never wanted, thank God, I'm not a kid lover. I chose not to have kids also because of my husband and that was one of the reasons we also parted ways. I was happy. I'm lucky enough to where I've had my own life and I've not had to drag anybody, drag anybody down with me, you know. It did affect family members. Anytime you're, you have an addiction, people who care about you, it will, but eventually they turn you away too.	

T19: Now what is recovery for you besides not using alcohol or marijuana?	
C19: To me recovery would be going to meetings, having a sponsor, working a twelve step program, um, I still try to incorporate 12 step beliefs and behaviors in my life as far as, “Let go, Let God,” the use the steps, resentment, a lot of people say if you’re drinking and using you cannot work the steps, but I think you can use them in a behavior, method of behavior modification if you’re, instead of turning to getting loaded or anger or what have you, when you have a problem in life, try to do something positive, call somebody, read if you have an AA Big Book or an NA Big Book, pick something up in there and try to read it. Try to keep yourself as close to the, that behavior as you can because it helps you to get...the closer I try to stay to meetings, even if I’m drinking, if I go to meetings it helps me from not wandering too far off track to where I’ll say drink more, or just stop totally leaving in that whole lifestyle or that whole belief process.	
T20: There’s a piece here which were missing before we go, which is what are you wanting to move toward? What do you—	
C20: What I want to move toward is to just be able to totally not have to drink or use. And at this point—	
T21: Which is doing nothing.	
C21: Right. Well, at this point I still enjoy my pot. I’ll be the old person sitting out there smoking a joint on the steps with all my cats around me, you know, and that’s okay with me, but I don’t want to drink. That’s what I’m trying to avoid, and I’ll be, I’ll go a couple weeks without drinking and then maybe I’ll drink again. But it’s getting to where I want it less and less again.	

II. CODING OVERVIEW

The second step of the process involves the researcher-participants engaging in three distinct coding processes to be completed in the following order: open coding for themes related to emerging adults, acceptance and ethnic identity.

Open Coding:

Open coding is a three-part inductive process that involves examining data and organizing it categorically and hierarchically so that it can be organized in a manner that clusters specific groupings of ideas into categories that become increasingly broad. The specific steps of the process involve: a) identifying themes, b) creating categories, and c) abstraction. The researcher begins this process by examining the data and noting themes that emerge naturally. During the first step, the researcher-participant should simultaneously watch the videotapes while reading through the corresponding section in the session transcript. The researcher-participant should make notes and write down all thoughts/ideas about specific themes that emerge in both the content and the process of the therapy session, which answer the research question, in the margins of the transcript. The researcher participant should complete the first stage of this process as many times as necessary (i.e., multiple passes over the data) until he/she feels he/she has captured all of the relevant themes.

Then, the researcher-participant should scrutinize data that does not already appear to have been assigned to a theme to determine whether themes appear to be missing. As multiple participants/transcriptions/sessions are being examined in this study, the researcher-participant should complete this first stage with each examined participant/transcript/session before proceeding to the second stage.

During the second stage, the researcher-participant works to organize individual themes from all transcripts and videotaped sessions categorically into clusters. Themes that are specific in nature should be grouped together based on similarities. The researcher-participant should pay attention both to similarities and dissimilarities among themes added to a cluster.

During the third stage, abstraction, the researcher-participant begins the process of abstraction, or arranging themes from the transcripts and videotaped sessions hierarchically. Specific sub-themes should be compared and grouped together into more abstract and broader categories that represent an overarching parent theme for the combined themes. The researcher-participants independently each should continue this process, moving back-and-forth between the specific subcategory level and more general levels until each one can no longer break down categories into smaller units that fall within the broader concepts, and can no longer more broadly define themes.

At the end of the abstraction process, researcher-participants should compare their hierarchies with one another to evaluate them for similarity as well as disparity. Non-shared themes that are found in this checking process should be analyzed to determine if they can be re-conceptualized under a different theme, or re-categorized under a different category or branch in the hierarchy.

Coding Steps for Researcher-Participants

1. Watch the videotape and read the transcript all of the way through to make sure that the transcript is accurate. Familiarize yourself with the content and process of the session.
2. When coding, you want to **try to balance attention to details with an ability to think abstractly** and see the bigger picture. It is also important to maintain focus by pacing yourself carefully. It is difficult to code accurately when you are rushed or code in binges. In the discussion meetings, it helps to present your questions and confusions and to agree with others only when the consensus makes sense. Coding requires an **openness and flexibility but not acquiescence**.
3. Familiarize yourself with the open coding steps of a) identifying themes, b) creating categories, and c) abstraction. Then, begin the coding process, simultaneously using reading the written session transcriptions and watching the corresponding session videotape
4. Individually, read the transcript again in detail by looking at each statement (T1, T2, etc.) and write your coding impressions on the right hand column of the transcript sheet.
5. Meet with team of coders to discuss codes and determine inter-rater reliability. Codes that meet (66%) agreement will be chosen as final codes and recorded on data tracking sheet.
6. Provide auditor with final codes to determine whether the data reflective of the codes has been abstracted by the coders. The auditor will facilitate discussion with the coders regarding discrepancies that arise with the team's judgment, and provide suggestions for changes.
7. Final codes will be entered into the Excel data-tracking sheet for further analysis.

APPENDIX H

Institutional Review Board (IRB) Certificate



APPENDIX I

Client-Therapist Participant Pair Information & EA Frequencies

Client-Therapist Participant Pair Information & EA Frequencies

Participant Pair	Client Age	Client Gender	Client Ethnicity	Therapist theoretical approach	Freq. of EA initial session	Freq. of EA later session
1	23	Female	Latina	CBT	1.6%	3.3%
2	29	Female	Caucasian	<i>Unknown</i>	0.7%	0.4%
3	23	Male	Latino	Humanistic	1.2%	0.3%
4	20	Male	Caucasian	Psychodynamic	1.1%	5.4%
5	28	Female	African-American	Psychodynamic; CBT skills training	0.0%	0.0%

APPENDIX J

Institutional Review Board Approval Letter

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

May 7, 2014

Protocol #: P0314D01

Project Title: The Use of Experiential Acceptance in Psychotherapy with Emerging Adults

Dear Ms. Ford:

Thank you for submitting your application, *The Use of Experiential Acceptance in Psychotherapy with Emerging Adults*, 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, Dr. 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 7) 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 **Full Approval**. The IRB approval begins today, May 7, 2014, and terminates on May 7, 2015.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

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 **May 7, 2015**, 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.

6100 Center Drive, Los Angeles, California 90045 • 310-568-5600